



SIRPA SAARIO

## Audit Techniques in Mental Health

Practitioners' responses to electronic health records  
and service purchasing agreements



ACADEMIC DISSERTATION

To be presented, with the permission of  
the Board of the School of Social Sciences and Humanities  
of the University of Tampere,  
for public discussion in the Vainö Linna-Auditorium K104,  
Kalevantie 5, Tampere,  
on March 1st, 2014, at 12 o'clock.

UNIVERSITY OF TAMPERE

## ACADEMIC DISSERTATION

University of Tampere, School of Social Sciences and Humanities  
Finland

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Cover design by  
Mikko Reinikka

Layout by  
Sirpa Randell

Distributor:  
[kirjamyynti@juvenes.fi](mailto:kirjamyynti@juvenes.fi)  
<http://granum.uta.fi>

Acta Universitatis Tamperensis 1907  
ISBN 978-951-44-9378-2 (print)  
ISSN-L 1455-1616  
ISSN 1455-1616

Acta Electronica Universitatis Tamperensis 1391  
ISBN 978-951-44-9379-9 (pdf)  
ISSN 1456-954X  
<http://tampub.uta.fi>

Suomen Yliopistopaino Oy – Juvenes Print  
Tampere 2014



# PREFACE

I have prepared this dissertation for quite a while. It seems strange that my life as a doctoral student who writes and writes and writes her thesis has come to an end. The dissertation is finished. But thank god I am not finished with people who have been around me! My sincere thanks go to the following:

It is because of my PhD supervisor *Kirsi Juhila* that this study exists. She encouraged me to apply for a doctoral student place in social work, and, in doing so, opened the door for me to “all this” that has become such an important part of my life. During the years, whenever I thought there loomed an insurmountable obstacle in my research, talking with her turned that problem into a welcome challenge which, in the end, would only improve things. She instructed and encouraged me consistently, while still allowing freedom to make my own choices – even those funny and peculiar ones! Besides an impeccable hunch for exciting academic ideas, there is down-to-earth feel in her that makes working always a pleasure rather than a business. Maybe trust is lost in human service professionals as they say, but my trust in Kirsi thrives, and if possible, keeps growing.

I was lucky to have *Ilpo Helén* as the second supervisor for my thesis. His perceptive comments improved my papers greatly, and I gained valuable insights from our discussions. The pre-examinors of my dissertation were *Åsa Mäkitalo* from the University of Gothenburg and *Mirja Satka* from the University of Helsinki. I am delighted with the thorough and perceptive pre-examination statements of these esteemed professors. What is more, I am honoured to have Åsa as my opponent! Getting into the “ring” with this distinguished lady will be one of the highlights of my life.

While preparing the dissertation, I have had the opportunity to work on two research projects (Responsibilization of Service Users and Professionals in Mental Health Practices, funded by Academy of Finland, and Client-centeredness in Community-based Mental Health Rehabilitation of Young Adults, funded by TEKES). With *Kirsi Juhila* as the leader of the projects and *Kirsi Günther*, *Chris Hall* and *Suvi Raitakari* as my colleagues, I have been able to broaden my horizons towards mental health issues and qualitative methodology. Our project days are fun. Talking about ideas and finding ways to systematically analyse these ideas is gratifying, especially when done in comfy sofas and with home-made food. Besides many fieldwork periods in Finland, I look

back with special delight our joint ethnographic adventures in Saltburn-by-the-Sea and Middlesbrough in spring 2013. Even as an old lady I will surely reminisce those English days! Big hugs are also due to *Anna Kulmala* and *Riina Kaartamo* who worked on these projects for shorter periods. The best thing is that after the defense is over, I can get back to work with this exhilarating gang!

All in all, the social work community in the University of Tampere has offered an inspiring environment to engage in doctoral studies. Post-graduate seminars have been an important arena for presenting papers in progress and getting constructive feedback and encouragement. *Hannele Forsberg*, *Arja Jokinen*, *Kirsi Juhila*, *Tarja Pösö* and *Irene Roivainen* have all skillfully chaired these seminars. I am truly happy to have my fellow doctoral students – *Emma Vanhanen*, *Jenni-Mari Räsänen*, *Kaisa-Elina Kiuru*, *Kirsi Günther*, *Masaya Shimmei*, *Minna-Kaisa Järvinen*, *Outi Kauko*, *Outi Välimaa*, *Riikka Hahtela*, *Riikka Korkiamäki*, *Rosi Enroos*, *Regina Opoku*, *Sinikka Forsman*, *Sonia Nhantumbo-Divage*, *Suvi Holmberg*, *Tarja Vierula* and others – not just for the sake of all your support in professional sense, but for your friendship and all the FUN!

*Anna Metteri* has been my mentor all along. She grows organic plants in her garden, and in me she planted the joy of writing: from a very early stage, Anna encouraged me to write in professional magazines. She also involved me in various social work conferences and the union called *Terveys- ja sosiaalityöntekijät ry*, which have guided the approach of my dissertation, i.e. the pursuit for such analytic inquiry that is relevant for professional practices. Anna is always there to offer perceptive comments on my texts and to talk about “the big S” (social work), mental health, and life. She is a true mentor.

*Kyösti Raunio* made several useful suggestions on the draft manuscript of the dissertation. Being 10 years late, I also want to thank Kyösti for hosting a “speeding seminar” for those master level students near graduation. This seminar, along with his remarks on my master’s thesis’ manuscript, was crucial for my graduation as a qualified social worker.

*Rosi Enroos* has sat as a test-audience countless times when I have rehearsed my upcoming presentations, and gave very useful comments on my dissertation in the final stage.

*Suvi Raitakari* lightens up my days in two ways: She is a born editor of any text, and extremely resourceful when it comes to sports, relaxation and good times.

*Jenni-Mari Räsänen* has introduced so many relevant references to me that I start to think for what do I ever need systematic literature searches when I have her! Since our research interests intertwine, our discussions have been particularly useful to me.

Ever since I was a horrified student who had somehow deleted her whole Bachelor thesis from a floppy disc, *Seija Veneskoski* has patiently assisted me with computer matters (and I know I am one of many!)

*Ari Laitinen* has offered a lot of practical help during these years. It is good to know that his sense of humour will be present once again, as our unit moves back to the Linna building.



A special thank you is in order for the staff and management of child psychiatry clinic, outpatient clinics and the NGO maintaining supported housing unit, for giving me research permissions and your valuable time. Unfortunately I cannot mention you by name.

I have co-authored some of the articles of this dissertation. *Chris Hall*, *Sue Peckover*, *Suvi Raitakari* and *Paul Stepney* – I have learnt a great deal about effective writing from each of you.

I was extremely fortunate to be accepted as a doctoral student in a four-year doctoral programme in the Finnish National University Network for Social Work (SOSNET). The funding, along with high quality seminars, has been vital for me. I remember how *Tarja Pösö*, then director of SOSNET, somehow managed to give me tips worth of gold, just in a matter of seconds in seminar breaks, and how *Mikko Mäntysaari* chaired vigorously our group sessions.

I was also supported by a bursary from Finnish Work Environment Fund (Työsuojelurahasto). Because of this affiliation, I became more interested in studying audit systems from the point of view of practitioners' wellbeing. In the final stage, the Science Fund of the City of Tampere assisted in the publishing costs of the dissertation.

For one year I prepared the thesis in Sardinia, Italy. This would not have been possible without *Markku Salo's* significant help and contacts. Grazie per *Maria-Grazia Giannichedda* per accertarmi in Dipartimento di Economia, Istituzioni e Società all'Università di Sassari, per lasciarmi lavorare nel tuo studio e la possibilità di dare lezioni con te. Sono stata mantenuta allertissima da *Luigi "Giggi" Bua* e *Rosanna Mette* che mi portavano ogni mattina all'espresso in quel café il nome di cui non mi ricordo mai. Un grande abbraccio a *Roberto & Fabiana*, e tutti gli altri magnifici ballerini e ballerine che si trovano a Sassari! Ed a cara *Titti* naturalmente. Istituto Italiano di Cultura (Italian Kulttuuri-instituutti) granted me the travel expenses. My brother *Ari Saario* was also a great motivator for the Sardinia year and helped with loads of practical things.

I also worked on the thesis in Durham University, England. *Chris Hall* assisted me a great deal in the arrangements. In the School of Applied Social Sciences, *Sarah Banks*, *Helen Charnley* and *Karen Elliott* took interest in my research, and set up some interesting contacts for me, both in the mental health field and the university. They

also took me in numerous university and town happenings which I treasure as unique experiences. Thanks are due to my flat mates in Ustinov College for staying up late with me and admiring the nightly moors, and hence putting doctoral studies in the right perspective. As for *Chris Hall*, I thank him and his lovely family for many good times during my doctoral student years. I am happy to have Chris as a colleague and a friend who I can count on to have perceptive thoughts on academic research and discourse analysis in particular, let alone jazz, factories or football.

There are two long-term seminar groups that have enriched my doctoral studies: the international DANASWAC group (Discourse and Narrative Approaches to Social Work and Counselling) with stimulating debates and magnificent papers. The other important arena has been a series of informal seminars on “history of the present” in mental health, held in Tampere-Helsinki axis. This group of *Lotta Hautamäki, Ilpo Helén, Susanna Hyväri, Pertti Hämäläinen, Anna Metteri* and *Markku Salo* exercised critical thinking which strengthened my view on audit as not always being what it seems to be.



For FRIENDS outside the university: *Marika Mattila, Heidi Pitkänen* and *Kaisa Rinkinen*. Even though we meet rarely nowadays, you are in my heart constantly.

Thank you FAMILY:

*The Saarios!* My mother *Sirkka*; brother *Ari* with *Hanna, Minttu & Arno*; father *Kari & Mervi*; grandparents, isovanhempani *Eero & Hilja*: Whenever I am in a tough situation I think: Heck, I am a saario, I can do this!

*The Lievejärvet!* *Simo & Raija, Maarit & family, Marika & family, Riitingit*: When 15 years ago hooking up with Kalle, I never dreamed to have such a wonderful bonus as you guys.

... And one *Enroos!* As a researcher on unconventional family relations, Rosi understands why I have put her into this category. As my dear, dear friend, she has shown me how not just to live life, but to celebrate it.

My husband *Kalle!* You are the love of my life, as well as our daughter *Sara* who gives me such joy I never thought can exist.

Finally, I thank myself for allowing me to deviate from academic efforts to engage in all kinds of (let's say cultural) activities.

I dedicate this book to my dear mother *Sirkka Saario* who is always interested in the developments of my studies and who is always there for me.

Satakunnankadun 'Rättilinnassa', Tampereella nääs 14.1.2014

Sirpa Saario

PS: ... ja sama suomeksi: Monet ihanat ihmiset ovat auttaneet niin maan perusteellisesti eikä ilman heitä tätä väitöskirjaa olisi. Sydämelliset kiitokset!





# TIIVISTELMÄ

Arviointitekniikat mielenterveystyössä: ammattilaisten suhtautuminen terveydenhuollon tietojärjestelmiin ja ostopalvelusopimuksiin.

Väitöskirja on laadullinen tutkimus mielenterveysalan työntekijöiden suhtautumisesta uuteen julkisjohtamiseen (*new public management*). Uusi julkisjohtaminen on tuottanut monimuotoisia arviointivälineitä, joista on tullut olennainen osa sosiaali- ja terveyspalveluiden ammattikäytäntöjä. Näillä välineillä ammattilaisten työstä pyritään tekemään arviointikelpoista eli mahdollisimman seurattavaa ja mitattavaa toimintaa. Tutkin väitöskirjassa seuraavanlaisia suomalaisiin mielenterveyspalveluihin sijoitettavia arviointivälineitä: yhtä potilastietojärjestelmää, kahta hallinnollista tietojärjestelmää sekä kunnan ja palveluntuottajan välille solmittavaa ostopalvelusopimusta. Näiden välineiden avulla määritellään työn tavoitteita, kuten asiakkuuksien ja työmuotojen kestoja, määriä ja sisältöjä, sekä seurataan niiden toteutumista. Selvitän tutkimuksessa sitä, miten arviointivälineet vaikuttavat päivittäisiin mielenterveystyön käytäntöihin ja miten työntekijät sopeuttavat työtään näiden välineiden mukanaan tuomiin muutoksiin.

Tutkimus koostuu viidestä empiirisestä tapaustutkimuksesta, jotka kaikki vastaavat yhteiseen tutkimuskysymykseen siitä, miten arviointi muovaa mielenterveystyön käytäntöjä, ja miten työntekijät siihen vastaavat ja reagoivat. Tapaustutkimukset on tehty kolmessa eri mielenterveystyön organisaatiossa, jotka sijoittuvat erikoissairaanhoidon avopalveluihin, tuettuun asumiseen ja lastenpsykiatriaan. Aineisto koostuu työntekijöiden puoli-strukturoiduista haastatteluista (N=23), tiimipalavereista (N=21) ja organisaatioiden hallinnollisista asiakirjoista (N=24). Tutkitut työntekijät edustavat eri ammattiryhmiä: sosiaalityöntekijöitä, psykologeja, psykiatreja, erikoistuvia lääkäreitä, psykiatrisia sairaanhoitajia, lähihoitajia, päihdetyöntekijöitä ja hallinnollista henkilökuntaa. Asiakirja-aineisto koostuu arviointivälineiden tuottamista tai niitä käsittelevistä dokumenteista. Alustava aineiston analyysi tehtiin kuvailevalla koodauksella (*descriptive coding*), jossa poimittiin kaikki aineistossa esiintyvät arviointia käsittelevät kohdat. Tätä vaihetta seurasi tulkinnallinen koodaus (*interpretive coding*), jossa ryhmiteltiin ja tulkittiin koodeja hallinnan analytiikan

kehyksessä. Tämä kehys tarjosi analyysiin näkökulman arviointivälineistä tekniikoina (*audit techniques*), jotka ohjaavat ammattilaisten toimintaa ja samalla välittävät uuden julkisjohtamisen periaatteita arkisiin käytäntöihin.

Tutkimuksen tulokset ovat kaksitahoisia. Ensinnäkin kaikki viisi alkuperäistä artikkelia osoittavat sen, että arviointi vahvistaa tiettyjä mielenterveystyön käytäntöjä ja samalla estää toisenlaisia työtapoja. Artikkelit toimivat tapaustutkimuksina (*case studies*), joista kukin tuo esiin joko yhden tai useamman arviointitekniikan eri konteksteissa, ja raportoi kullekin tapaukselle ominaisia arvioinnin vaikutuksia. Toiseksi väitöskirjan yhteenveto-osio sisältää tapaustutkimusten synteesin, joka syventää ymmärrystä arvioinnin mikrotason vaikutuksista nostamalla esiin työntekijöiden toimijuuden – sen, kuinka he itse sopeuttavat työtään arvioinnin vaatimuksiin. Synteesin tuloksina esitetään kolme erilaista tapaa, joilla ammattilaiset suhtautuvat arviointiin. Ensimmäinen tapa on arvioinnin noudattaminen, joka ilmenee koodien ohjaamana käytäntöjen tehostamisena ja tehokkuusretoriikan hyödyntämisenä ammatillisessa puheessa. Toinen tapa suhtautua arviointiin on arvioinnin vastustus, joka ilmenee hienovaraisena vastarintana sekä perinteisten dokumentointi- ja kommunikointikeinojen hyödyntämisenä arviointitekniikoiden rinnalla tai niiden sijaan. Kolmas tapa on strateginen suhtautuminen arviointiin, jossa ammattilaiset tasapainottelevat asiakastyön ja arvioinnin vaatimusten välillä, ja arviointia noudatetaan tai vastustetaan tilannekohtaisesti. Jokainen näistä kolmesta suhtautumistavasta heijastaa työntekijöiden erilaisia kokemuksia arvioinnista: noudattamalla arviointia työntekijät kokevat sen rautahäkinä (*iron cage*), vastustaessaan arviointia he kokevat sen ammatillisen harkinnan mahdollistajana (*discretionary space*) ja suhtautumalla arviointiin strategisesti he kokevat sen epävarmuuden tilana (*state of flux*), joka kaipaa jatkuvaa tasapainottelua.

Erittelemällä sekä arvioinnin vaikutuksia käytännöille että ammattilaisten suhtautumistapoja arviointiin tutkimus tuottaa uutta laadullista tietoa uuden julkisjohtamisen toimeenpanosta sosiaali- ja terveyspalveluissa. Arviointitekniikoilla on perinpohjaisia ja kauaskantoisia seurauksia ammattikäytännöille. Näin ollen arviointitekniikat ovat paljon muutakin kuin teknisiä välineitä, joiden avulla seurataan ennalta määrättyjen tavoitteiden toteutumista ja tallennetaan työn sisältöjä. Työntekijöiden vaihteleva suhtautuminen arviointiin osoittaa sen, että arvioinnin toteutuminen käytännössä ei niinkään riipu arvioinnin virallisista tavoitteista, vaan arvioinnin kohteena olevien yksittäisten ammattilaisten valinnoista.

*Avainsanat:* arviointi, hallinnan analytiikka, lastenpsykiatria, mielenterveyspalvelut, mielenterveystyö, ostopalvelusopimus, psykiatrian poliklinikat, sosiaali- ja terveysalan ammattilaiset, terveydenhuollon tietojärjestelmät, tuettu asuminen.

# ABSTRACT

This doctoral thesis presents qualitative research on practitioners' responses to new public management (NPM) forms of governance in mental health. NPM has led to the creation of complex audit systems that form an essential part of professional practice in social and health care. In the context of Finnish mental health services, the research investigates four local audit instruments that practitioners deal with in their routine work: three electronic health records (one patient record and two administrative records), and an outsourcing contract between a municipality and a service provider (Service Purchasing Agreement). This research aims to explore the ways in which practitioners adapt their practice according to these instruments, and the relation between the changes brought by audit and mental health professionals.

The research is the result of five separate and empirical case studies, all corresponding to a common research problem of how audit reshapes mental health practice and, consequently, how practitioners respond to it. The studies were conducted in three mental health sites situated in specialised outpatient care, supported housing and child psychiatry. The data were collected through practitioners' semi-structured interviews (N=23) and team meetings (N=21). The practitioners studied represent various occupational groups: social workers, psychologists, doctors, psychiatrists, psychiatric nurses, practical nurses, substance abuse workers and administrative personnel. Furthermore, administrative documents (N=24) related to auditing procedures were collected from the sites. Initial data analysis was performed through descriptive coding, in which references to auditing were identified. This was followed by interpretive coding in which the codes were further narrowed and interpreted in the conceptual framework provided by the tradition of analytics of government. Within the frame of this tradition, audit instruments were identified as audit techniques due to their ability to employ various governing techniques which mediate the tents of new public management into everyday practice.

The findings of the research are twofold. Each original article shows how audit reinforces particular styles of mental health practice, and inhibits others. The articles function as case studies, illustrating in particular the micro-level impact of audit techniques on practice. Building on these effects, the summary section of this dissertation presents a synthesis of case studies by further studying practitioners' responses to

audit. The first response is adherence to audit, manifesting as code-led rationalisation of practice and deployment of effectiveness rhetoric in professional talk. The second response is resistance towards audit, which takes the form of subtle opposition and the substitution of audit by other means of recording. Finally, the third response to audit consists of a changing mixture of adherence and resistance. This response is displayed as a strategic use of audit techniques that attempts to consolidate audit problems and professional logic. Each response has a distinct function for practice and characterises the different reported experiences of audit: it is conceived by practitioners as either an iron cage, a discretionary space or a state of flux, respectively.

By making visible the impact of and professional responses to audit techniques, the research contributes to qualitative knowledge on the consequences of the implementation of NPM in human services. Far from being only technical procedures with exclusively anticipated goals, local audit instruments affect the core of professional mental health practice in complex ways. By doing so, audit incites a wide range of distinct responses from practitioners. This means that the final realisation of audit in practice depends upon practitioners' choices as they redefine NPM policies on their own terms, rather than the official aims of auditing.

*Keywords:* analytics of government, audit, child psychiatry, electronic health records, Finland, human services, mental health, mental health practitioners, outpatient clinics, Service Purchasing Agreement, supported housing.

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# ABBREVIATIONS

CAF	Common Assessment Framework
EHR	electronic health record
EPR	electronic patient record
NGO	non-governmental organisation
NPM	new public management
SPA	Service Purchasing Agreement

# LIST OF ORIGINAL ARTICLES

- Case study 1: Managerial Audit and Community Mental Health: A Study of Rationalizing Practices in Finnish Psychiatric Outpatient Clinics. Saario, Sirpa and Stepney, Paul (2009) **European Journal of Social Work**, 12 (1), 41–56. <http://www.tandfonline.com/doi/abs/10.1080/13691450802221030>
- Case study 2: Contractual Audit and Mental Health Rehabilitation: A Study of Formulating Effectiveness in a Finnish Supported Housing Unit. Saario, Sirpa and Raitakari, Suvi (2010) **International Journal of Social Welfare**, 19 (3), 321–329. <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-2397.2010.00726.x/abstract>
- Case study 3: Managerial Reforms and Specialised Psychiatric Care: A Study of Resistive Practices Performed by Mental Health Practitioners. Saario, Sirpa (2012) **Sociology of Health and Illness**, 34 (6), 896–910. <http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2011.01439.x/abstract>
- Case study 4: Inter-professional Electronic Documents and Child Health: A Study of Persisting Non-electronic Communication in the Use of Electronic Documents. Saario, Sirpa, Hall, Chris and Peckover, Sue (2012) **Social Science & Medicine**, 75 (12), 2207–2214. <http://dx.doi.org/10.1016/j.socscimed.2012.08.019>
- Case study 5: Audit Techniques and Mental Health: A study of tacking practices performed by practitioners.<sup>1</sup> Saario, Sirpa (2011) In Ilpo Helén (ed.) **Reformin pirstaleet. Mielenterveyspolitiikka hyvinvointivaltion jälkeen**. Tampere: Vastapaino, 182–230. [*Splinters of the reform. Mental health policy after welfare state*].

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1 The original Finnish title is "Arviointitekniikat ja mielenterveystyö: Tutkimus ammattilaisten luovinnasta työn arvioinnissa ja seurannassa."



# 1 INTRODUCTION

In this chapter, the starting points and key concepts of this research are outlined by going through literature which addresses the implementation of audit in human services, specifically in terms of professionals' role in this process. Building on these notions, this research embarks on studying various effects and variations that audit instruments bring to practitioners' everyday work. The underlying hypothesis is that audit instruments change the way everyday mental health work is performed and conceptualised by practitioners.

## 1.1 Why audit and why mental health?

Throughout Western Europe, ideologies of new public management are introduced in all human services<sup>2</sup>, resulting in substantial audit routines. This research investigates one domain of human service work, i.e. mental health in Finland. My key focus is on the relation between different forms of audit and practitioners working in the field. Mental health is a valuable context to study the introduction of various forms of audit because it easily stands out as a domain not easily audited. Everyday practice of mental health is highly complex and situational, which makes it difficult to consolidate with the imperatives of audit. Besides some definite and clear-cut interventions, mental health professionals deal with inherently imprecise psychological phenomena which need to be treated by a wide range of encounters and psychosocial interventions – all hard to demonstrate according to the logics of audit relying on meticulous classifications.

The Finnish context of mental health is particularly appropriate for studying the relation between audit and practitioners: the country is now imbued with various managerial reforms and administrative strategies that, with the help of audit instruments, set an emergent frame within which practitioners can perform. This is manifested in Finland's new governmental plan for modernizing mental health care (Ministry of Social Affairs and Health 2010). The plan confirms that mental health

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2 By "human services" I refer to a variety of service delivery systems involving professionals as a work force, such as social welfare services, education, mental health services, and other forms of healthcare. The term "human service organisations" in this sense has been used e.g. by Hasenfeld (1992).

services are increasingly driven by the principles of market economy, resulting in audit routines realised via new technology, such as electronic health records (EHRs) and renewed administration towards outsourcing of services by Service Purchasing Agreements (SPAs).

New public management (NPM) is a key factor which has led to the creation of complex audit systems in social and health services (Power 1999; Bowker & Star 2002; Ramon 2008). Audit has thus become a definite process of NPM (Strathern 2000, 2). NPM signifies the need for human services to meet the demands for transparency regarding the effectiveness and efficiency of services. Based on neo-liberalism, NPM aims to solve the problem of excessive public expenditure of services by adapting steering mechanisms from the market economy and commercial organisations (Clarke & Newman 1997; Greve & Jespersen 1999). In line with this, NPM aims to deconstruct bureaucratic hierarchies and encourage the creativity and participation of human service workers (Newman 2005).

Generally, audit is associated with regulative inspection and checking, often connected with financial aspects (e.g. Lymbery 1998). In addition to controlling and supervising fiscal matters, audit calls for effectiveness of services, like output, costs, and quality (Ministry of Social Affairs and Health 2002; Häkkinen & Lehto 2005, 86.) In his seminal book on audit, Power (1999, 4) sees no precise agreement on what auditing really is, but speaks of a cluster of definitions which overlap each other. In a broad view, auditing refers to a variety of highly dissimilar actions aiming to improve and streamline services. Common to these actions is that they evaluate people, organizations or processes.

The term audit<sup>3</sup> was originally used in financial accounting. In the 1980s and 1990s, it broke loose from finance and proliferated into a number of new domains (Power 1999, 3). The pervasiveness of audit has made Power (1999) talk about “audit culture” and “audit explosion” in which auditing is applied to all types of assessments, evaluations and measurements. Audit attempts to answer a wide range of current societal difficulties like the erosion of social trust, fiscal crisis, and the need for controlling risks (ibid., 14). However, Power notes that official definitions of auditing, which are found in political documents, are often idealised projections of the hopes invested in it, rather than the actual practice itself.

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3 The word ‘audit’ has no standard Finnish equivalent. The word generally used is a Finnicised form ‘auditointi’. In English-language research debate ‘audit’ refers fairly broadly to evaluation and inspection, whereas in Finnish it is understood in a narrower sense and refers to systematic auditing processes which are commissioned from an external body and include precisely defined methods, often with the results stated in an official end report. In this dissertation, I translate audit as ‘arviointi’ to bring forth the broader meaning of audit as various evaluation practices.

Despite the honourable goals of audit, professionals taking part in audit procedures in different fields are reported to communicate difficulties related to the use of audit instruments (e.g. Pajusola 2013; Shore & Wright 2000). In line with professionals, Finnish authorities have expressed criticism towards social and health care being directed by information steering which implements audit systems. For example, the Audit Committee of the Parliament, which is one of the main authorities on auditing in Finland, has stated that information steering is too abundant, focuses on the wrong things and thus suffers from a credibility crisis (Audit Committee 2008a). As a result, more empirical research on information steering is called for (Audit Committee 2008b).

In this research, I study audit through certain instruments which mediate auditing into mental health practices: electronic health records (EHRs) and a Service Purchasing Agreement (SPA). All these instruments aim to make practice transparent to monitor officially stated goals on access to services, the volume and content of services, or clients' case histories. In their own way, each of them defines or records various contents of mental health work and thus enables follow-up on professional practice. I study SPA with the EHRs in order to show that auditing of mental health work is implemented in many appearances. So, in this research I see audit as somewhat an umbrella concept, embracing rather different instruments which have rationalities of their own. In course of this dissertation, I refer to EHRs and SPA as "audit instruments" when writing about them in general. However, when analysing them in the frame of my methodological choices, I identify them by a more theoretical concept of "audit techniques" (beginning from the section 2.2).

## 1.2 Why practitioners?

In the service structure based on principles of NPM, practitioners are increasingly expected to provide evidence of the effectiveness of their practice (Germov 2005; Joyce 2001). As NPM utilises audit procedures to improve efficiency and quality of services, it requires documentation in databases by using the available audit instruments. Generating such data is largely managed by practitioners and assigned to them as an obligatory task. Via audit instruments, practitioners are obliged to report on their activities, and at the same time to follow the procedures outlined in contracts.

The obligation for practitioners to use audit instruments presupposes a relation of accountability in which they are required to give an account of their actions to other parties, in this case local authorities and people using their services (Flint 1988; Power 1999, 7, 10). They must also be prepared to account for their actions to the public, i.e. their wider political community, especially for the effectiveness of the services they

deliver (Banks 2004; Juhila 2009; Matarese & Caswell 2013). In health care, Taylor and White (2000, 4) have perceived a growing need for practitioners to demonstrate to inspecting bodies that they are using resources efficiently and effectively. Drawing on Banks (2004), I call this position of practitioners as *new accountability*. The concept refers to an increased tendency of social and health care professionals to work according to given procedures and to pre-defined standards and outcomes. For example, in this study practitioners are supposed to document the number and type of their activities. Their performances are individually monitored and then matched with established standards and targets.

Accountability in itself is not new in professional mental health work. For example, according to Rose (1999, 261–262), psychiatry has long been as much an administrative as a clinical science. Similarly in social work, financial aspects have always been important in addition to practitioners accounting for interventions to clients (Juhila 2009). The prefix *new* in front of *accountability* is particularly apposite because it emphasises the changed focus from accountability towards clients to accountability towards organisational and financial aspects. Being accountable in this particular way signifies that all required procedures are followed and documented, and the work is done according to officially accepted standards. (Banks 2004; Juhila 2009, 300.)

Making practitioners accountable for their actions by means of audit is argued to imply distrust in human service professions (Parton 1996; Scriven 1991; Smith 2001). According to Aas (2005, 96), one of the key attributes of audit culture is a perpetual state of mistrust which leads to a constant requirement for surveillance and evaluation of organisations and their activities, even to the extent that audit has been named by several commentators as a “technology of mistrust” (e.g. Power 1999; Rose 1999). Audits of various sorts have been claimed to replace the trust that social government invested in professional wisdom (Miller & Rose 2008, 110). When trust in professionals is lost, audit is presented as a tool to reinstate this trust. This is achieved by enhancing the efficiency of professionals and making their actions transparent (Munro 2004, 1091).

### 1.3 Aim and starting points of dissertation

The aim of the dissertation is to demonstrate how mental health practitioners adapt their practices to audit procedures carried out by specific instruments, i.e. electronic health records (EHRs), and a Service Purchasing Agreement (SPA) used in outsourcing of services. By examining practitioners’ talk on their everyday practice, my purpose is to demonstrate various concrete changes and variations these audit instruments bring to everyday work. This aim is founded on the following starting points:

First, audit procedures carry deeper consequences than just those explicitly stated to be its goals. The explicit goal of audit is to render practices visible, calculable, transparent and, all in all, amenable to evaluation. My hypothesis is the following: By including audit instruments as a tangible part of professional practice, they do not simply describe practice but change profoundly the way everyday mental health work is performed, and even conceptualised. For practitioners, this means that they must not only continuously organise their everyday work in relation to audit, but also create counter-acts and solutions to it. This way, audit will have more profound effects on professional practice than those stated originally about making practice amenable to evaluation. Far from being neutral and technical procedures, audit instruments are highly significant for the ways practitioners begin to think about their professional practice. As Bowker and Star (2002, 254) say, audit instruments are not just a question of “mapping a pre-existing territory”, but, on the contrary, they are about making “the map and the territory converge”. This hypothesis on the profound impact of audit builds on the body of work studying the connections between various types of information and communication technologies and different areas of working life (Aas 2005; Berg 1996; Chambon et al. 1999; Halford et al. 2009; Poster 1990; Parton 1999; Zuboff 1988).

Second, besides the above-mentioned studies, I set up this dissertation on the bulk of research on the dilemma between practitioners’ professional autonomy and their compliance with administrative and market principles. This theme has been acknowledged in the classic studies of Hirschman (1970), Lipsky (1980) and Prottas (1979). Within the developments of new accountability, the same theme has been widely investigated (e.g. Banks 2004; Banks & Gallagher 2009; Joyce 2001; Sawyer 2005). Studies on social and health professions also carry out empirical analyses on this dilemma in professional practice, paying particular attention to the variety of local and delicate responses and varying strategies that practitioners exert to NPM (e.g. Connell et al. 2009; Hjørne et al. 2010; Sawyer et al. 2009). Finally, this dissertation is motivated by social work researchers stating that too little is known about how daily work patterns of social workers are influenced by the impact of audit systems (e.g. Harris 2003; Munro 2004, 1089; Webb 2006, 142, 168), and studies on the relation between social work practice and various phenomena of NPM (e.g. Healy 2009; Juhila 2006; Metteri 2012; Pohjola et al. 2010; Stepney 2006; Taylor & White 2000; White et al. 2010).

Third, the dissertation utilises a street-level perspective (e.g. Lipsky 1980; Brodtkin 2008; Hjørne et al. 2010) to draw out the “frontline experience” of practitioners and those organisational practices that remain unnoticed in policy discussions on NPM. Thomas and Davies (2005) point out that while there is a view that NPM promotes new professional subjectivities, insufficient attention has been paid to professionals’

own experiences of changes in work content in relation to technological and managerial reforms (see also Håland 2012, 762; Leicht & Fennell 1997). Practitioners' views on mundane manifestations of audit can provide empirically informed understanding of NPM's nuanced presentations in specific organisational settings (Thomas and Davies 2005). Such an understanding enables analysis "to reach beyond formal administrative categories to unpack the policy experience" (Brodkin 2008, 325).

Fourth, I have developed these starting points through the lens of analytics of government (Dean 1999; Rose 1999; Helén 2004). Especially two notions from this tradition are utilised. The first notion is the functioning of various data formats and tools as techniques of government. In this sense, audit instruments are seen to employ various techniques that govern professionals and thus shape their conduct. In this process, the techniques emerging in everyday practices are connected to prevailing political reason of time, in this case NPM. The second notion utilised in this research is governmentalisation of government which comes close to "new accountability" of practitioners, stressing the growing importance of showing that a job has been done according to accepted standards. When government of things and people is in the process of governmentalisation, surveillance is shifted from the intricacies of the actual practice interactions to the paperwork attached to the work. Taken to the extreme, the concept implies a critical notion of how the main purpose of current institutions is becoming one of ensuring economic rationality of its own operations. This shifts the interest from the contents of mental health work per se to the mechanisms controlling it, like the studied audit instruments.

## 1.4 Structure of dissertation

The research consists of five separate case studies and a summary section. Case studies are reported in journal articles (see list on page 16). Each article concentrates on a specific combination of audit instruments and research sites (see table 1 on page 23). This summary presents a synthesis of these articles, and describes the methodology and the premises of the overall research process.

Table 1. Case studies 1–5 reported in journal articles.

MAIN TITLE STATING TYPE OF AUDIT AND CONTEXT	1. Managerial Audit and Community Mental Health	2. Contractual Audit and Mental Health Rehabilitation	3. Managerial reforms and Specialised Psychiatric Care	4. Inter-professional Electronic Documents and Child Health	5. Audit Techniques and Mental Health
SUBTITLE STATING KEY RESULTS	A study of rationalizing practices in psychiatric outpatient clinics	A study of formulating effectiveness in a supported housing unit	A study of resistive practices performed by mental health practitioners	A study of persisting non-electronic communication in the use of electronic documents	A study of tacking practices performed by practitioners
AUDIT INSTRUMENTS EXAMINED	<b>Aho</b>	<b>Service Purchasing Agreement</b>	<b>Aho and Oberon</b>	<b>Miranda and CAF<sup>4</sup></b>	<b>Aho, Service Purchasing Agreement, Oberon and Miranda</b>
SITES	Outpatient clinics	Supported housing unit	Outpatient clinics and child psychiatry clinic	Child psychiatry clinic and various sites in England	Outpatient clinics, supported housing unit and child psychiatry clinic

<sup>4</sup> Case study 4 examines Common Assessment Framework (CAF) as an audit instrument from England, and compares it to the Finnish audit instrument Miranda. However, I do not include CAF into the synthesis of this summary (see footnote 14 on page 47).

The summary of dissertation is structured as follows: Chapter 1 introduces the starting points for the research and presents the basic concepts: audit, NPM and new accountability of professionals. Chapter 2 reports the research process and the methodology used. Chapter 3 presents the results of the research in the form of a synthesis of five case studies. The sub-chapters (3.1, 3.2 and 3.3) share a similar structure: first, the findings of case studies on the micro-level impact of audit on practice are briefly summarised (sections 3.1.1, 3.2.1 and 3.3.1). These findings are analysed further in sections 3.1.2, 3.2.2 and 3.3.2 where it is described how practitioners respond to each impact of audit and what experiences of audit these responses are based on. Chapter 4 concludes the research by drawing further implications on the role of audit and NPM in mental health and, more generally, in human services. Original journal articles can be found in the end of this book (starting on page 69).



## 2 METHODOLOGY

This research uses qualitative case study methodology which provides a means of searching for and explaining patterns of practice from situational-specific data (Brodkin 2008, 328–329). In this case, patterns correspond to the impact of audit, and situational-specific data refer to various distinct audit instruments that are studied in different mental health sites, employing practitioners from various occupations. The bottom-line of the research is to make explicit the links between organisational arrangements of audit in three mental health organisations, and the professional practice taking place within these arrangements.

### 2.1 Data setting

The empirical context of the research situates in three different mental health sites – outpatient clinics, a supported housing unit and a child psychiatry clinic –, with each site having its specific instruments for audit purposes. These services are arranged by the municipality and supervised by the Finnish government. The main data collected from the sites include practitioners' interviews and meetings, which are supplemented by auxiliary data of administrative documents.

#### 2.1.1 Research sites and their audit instruments in Finnish mental health field

In Finland, the general planning, direction and supervision of mental health work is the responsibility of the government, more particularly the Ministry of Social Affairs and Health. The municipalities are given the statutory responsibility for arranging mental health and substance abuse services according to need, so they organise services autonomously, as a part of public social and health care (Mental Health Act 116/1990). The municipalities may produce services by themselves or purchase them from private businesses, hospital districts and semi- or non-governmental associations. As the Ministry of Social Affairs and Health directs municipalities, the municipalities, in turn,

supervise the mental health service providers which include the sites of this research. Outpatient clinics and the supported housing unit operate under the city council of a municipality, while the child psychiatry clinic, which is part of a university hospital, operates under the authority of joint municipalities which share the responsibility for organising university hospital services. On the whole, several different models, where purchasing and provision are separated, have been increasingly applied to municipal health services in Finland during the 2000s (Tynkkynen 2009).

In Finland, the introduction of audit followed the arrival of NPM in the late 1980s (Eräsaari 2002; Koskiahho 2008; Rajavaara 2007). Purchaser-provider models have led to large administrative reforms in Finnish mental health work, especially in the increase of contracts for outsourcing of services, which require audit procedures to enable follow-up. Likewise, Finland has adapted information steering as a management system for social and health care, which has also accelerated the import of audit systems. Information steering aims to ensure that local services follow the national policy guidelines (Audit Committee 2008a, b). It embraces the idea that when information is appropriately managed between government and local actors, it will help service providers develop their everyday operations and productivity (Audit Committee 2008b, 4; Jalonon 2008).

All three sites of the research are located in the same municipality in Finland: *outpatient clinics* offering community mental health care for adults, *child psychiatry clinic* offering specialist inpatient and outpatient care for children and *supported housing unit* offering rehabilitation and supported housing for adults with dual diagnosis. Why this particular combination of diverse sites? In their selection, I employed theoretical sampling by seeking out those organisations where the processes of auditing were known to be happening at the time of the data gathering. This way, sites were selected because of their relevance to the research inquiry on how practitioners are impacted by, and respond to, changes brought by audit instruments (Mason 2002, 124; Silverman 2000, 104–105). I also chose these particular sites to cover the diversity of the Finnish mental health service system. Each setting represents a distinct way of providing services: Outpatient clinics belong to community care services produced by the municipality itself; child psychiatry clinic belongs to specialised institutional services, produced by the hospital district and purchased by the municipality; and supported housing unit is maintained by an NGO and purchased by the municipality.

*Outpatient clinics* represent a prevalent form of community care in Finland. The seven outpatient clinics under study provide services to different regions of the city. They provide non-institutional psychiatric specialist care conducted by multidisciplinary teams including social workers, nurses, psychiatrists and psychologists. The main tasks of the clinics are individual intervention treatment, support to couples, as well as family

and group therapy. They also prescribe medication, carry out psychiatric tests and address social security issues.

*The child psychiatry clinic* represents services for children and their families which are now given high priority in Finland's political agenda (Ministry of Social Affairs and Health 2010, 40). The clinic under study is part of the university hospital maintained by a hospital district. It offers both institutional and non-institutional psychiatric specialist care for children, conducted by multidisciplinary teams including social workers, nurses, psychiatrists and psychologists. Treatment of children involves diagnosis and evaluation of treatment needs, as well as crisis therapy and psychotherapy. Also included is support for families and co-operation with day care, school and childcare authorities.

*The supported housing unit* under study is maintained by a mental health association (NGO) and offers long-term housing and rehabilitation for clients with dual diagnosis, i.e. people with severe and co-occurring mental health and substance abuse problems. Practitioners include psychiatric nurses, substance abuse workers and practical nurses. The unit is founded on the principles of community-based rehabilitation. The residents live in rented flats where they receive support, from which they may visit the unit's meeting point.

One common challenge for the sites is the management of large case loads. This is because mental health services have moved towards community-centred care, as is the case in most European countries (Foster 2005; Knapp et al. 2011; Ramon 1992). Rapid dehospitalisation started in the early 1980s, after which mental health services have been increasingly carried out by various forms of community care (Korkeila et al. 1998; Wahlbeck 2005, 68). This means that the sites, as providers of non-institutional care<sup>5</sup>, have to offer more services to an increased number of clients (European Observatory on Health Care Systems 2002). Consequently, these services are often characterised by unmet demand (Hiilamo 2008, 42; Ministry of Social Affairs and Health 2010). The on-going struggle to provide enough services is likely to challenge practitioners to pursue for high number of clients, while still trying to maintain their professional standards.

Even though each site is affiliated with different organisations under separate managements, they share some important similarities. First, they all include multidisciplinary teams consisting of practitioners with different occupational backgrounds. Second, all sites face parallel demands to account for their services via audit. They have experienced similar implementation processes of audit and related administrative reforms, with practitioners having to adapt their professional practice to novel structures. For once, these reforms include new management models: outpatient

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5 In addition to non-institutional care, the child psychiatry clinic offers institutional care with hospital beds.

clinics have been transferred from the administration of specialist health care to the services of municipality under municipal management. Consequently, there has been the advent of municipal administrative guidelines which contain instructions on specific ways of rudimentary information sharing between clinics and their partners in cooperation, like psychiatric hospitals and health-care centres. In the child psychiatry clinic, transfer to the new management model called Process model, in which children and their families follow the path of predetermined treatment processes, was introduced to substitute the previous model called Management-by-results. This transfer necessitated some changes in the EHRs. The NGO that provides supported housing is increasingly taking part in the tendering procedures of the municipality which purchases its services. Instead of previous regular allocations, this places the supported housing unit in a competitive market-oriented situation.

At these three sites, I approach audit through four instruments (see table 2 on page 29). In the outpatient clinics, the analytic focus is on the audit instrument *Aho*, an *electronic health record (EHR) for administrative purposes* in which practitioners use codes to record the daily content of their work. This information is used mainly for billing, planning appointments and finance, and caseload management. In the child psychiatry clinic, the analytic focus is on two audit instruments: an *electronic health record (EHR) for administrative purposes* called *Oberon*, and an *electronic patient record (EPR<sup>6</sup>)* called *Miranda*. *Oberon* contains figures of client numbers and other statistical information. Practitioners are supposed to mark their appointments and other activities in the system to produce statistical information needed to finance the clinic. *Miranda* is a medical database mainly used for recording case notes. In the supported housing unit, the analytic focus is on the audit instrument *Service Purchasing Agreement (SPA)*, which is a contract used in outsourcing and in the provision of local mental health services. The agreement is one of the key instruments in the purchaser-provider model of the municipality, as it defines the duration of the contract, the content and quality of services and the amount and price of products.

Each of these four audit instruments makes a unique contribution to the implementation of audit at the sites: EHRs oblige practitioners to record how their work is performed and to what extent. As a textual document, SPA defines and sets out the parameters for services prior to their execution. There are some distinct differences between the EHRs. Whereas *Aho* and *Oberon* are intended for managers, *Miranda* is primarily read by practitioners' colleagues and other collaborators who participate in the client's treatment. Unlike *Oberon* and *Aho*, *Miranda* allows free writing of case

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6 *Miranda* is an electronic patient record (EPR). I situate EPR as a subcategory of a more generic term of EHR (electronic health record). For the sake of clarity, from now on I will use the acronym EHR to apply to *Miranda* as well, in addition to *Aho* and *Oberon*.

records and clinical information. Thus, what can be controlled through Miranda is the content of clinical and therapeutic interventions. Oberon and Aho, on the other hand, produce statistical information from which one can check the performance of an individual practitioner or team, and match such performance with established standards and targeted budgets or timelines.

Unlike EHRs, SPA is “just a piece of paper” which is not used by practitioners on a daily basis. However, SPA still relates to several instruments of measurement and evaluation that are used in the follow-up of the unit. These instruments include annual reports, written definitions of each service product, clauses on confidentiality, regular invoicing and book-keeping. SPA is based on legal obligations to provide various reports to the purchaser. The contract is mediated by the Act on public contracts (348/2007<sup>7</sup>), which states that contracting authorities may set requirements relating to the tenderers’ financial and economic standing, technical capacity and professional quality. SPA entails the use of criteria like service standards and specifies performance targets and outputs, such as the number of clients to be treated or the length of time a client can stay in the service. Besides the agreement itself, its attachments are essential as they describe the quality and content of services in more detail.

Table 2. The studied audit instruments.

	Form	Function	Context of use
<b>Aho</b>	Data input systems	Description of completed services	Outpatient clinics
<b>Oberon</b>			Child psychiatry clinic
<b>Miranda</b>			Child psychiatry clinic
<b>Service Purchasing Agreement</b>	Textual document	Description of services in demand	Supported housing unit

### 2.1.2 Interviews, meetings and documents as data

The data were derived from three main sources: *interviews* that were used as primary data in four case studies (1, 3, 4 and 5); *meetings* that were used as primary data in two case studies (2 and 5); and *documents* which were used as additional data in every case study. Approvals for data gathering were received from the executive committees of each site. In outpatient clinics and the child psychiatry clinic, I presented the research design for the consecutive boards before they granted permission, and after data collection

<sup>7</sup> No. 348, Section 56: Requirements and references relating to the suitability of candidates and tenderers.

I presented them some initial findings of the study. In the supported housing unit, I was granted permission to use the pre-collected meeting recordings<sup>8</sup> and conduct one interview to get the necessary background information on the meetings.

## Interviews

There were altogether 23 *semi-structured interviews* conducted in the sites (see table 3 on page 32). In outpatient clinics and the child psychiatry clinic, I conducted 18 interviews with practitioners involved in client work, and four interviews with administrative workers. In the supported housing unit, I conducted one interview with an executive person.

In outpatient and child psychiatry clinics, the 18 interviewed practitioners were from the following professional groups: social workers, psychologists, psychiatric nurses and psychiatrists, all immersed in client work. Practitioners were asked to participate by a literal invitation, which was circulated at the weekly meetings of the staff. From the sample frame of 55 practitioners in outpatient clinics and 85 in the child psychiatry clinic, two practitioners from each occupation were invited to participate, to get an equal amount of interviewees from each professional group.

Interviews mostly consist of descriptions of daily working practices. The underlying idea for me as an interviewer was to generate talk on the relations between auditing arrangements, everyday practice and individual professionals' views on these. Practitioners explained their typical working day, two types of client cases (one which they regarded as successful and another which they perceived as unsuccessful) and the way they organised their interventions and schedules. In addition to these descriptions, I posed questions about their views regarding problems they had experienced in their current practice. At the end of the interviews I asked specific questions on audit techniques that practitioners had mentioned while describing their work and client cases.

After I interviewed practitioners, I wanted to know more about audit instruments. Thus I interviewed some *members of administrative staff* ( $N=4$ ) who were either main users of EHRs, administrative secretaries or executives. These interviews focussed on two themes: the background of the implementation processes of audit instruments and the issues and management models "behind" them. By logging into EHRs during the interviews, they also demonstrated to me how the systems are used in practice.

In addition to interviews from outpatient and child psychiatry clinics, I conducted one interview with an executive person of the NGO that maintains the supported housing unit. The interviewee was first asked to explain the connections of SPA to

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<sup>8</sup> These data were collected by Suvi Raitakari for another study (Juhila et al. 2005–2007) which examined the controlling and supporting dimensions of social work.

tendering procedures the unit takes part in. Second, the interviewee went through the contents of the SPA documents under study, and explained their background to me. Third, I asked about the nature of the meetings, which constitute the principal data from the supported housing unit.

Interviews lasted one hour and a half on an average, and were digitally recorded. They were transcribed verbatim, resulting in 529 A4 sheets with 1,5 line spacing. The initial reading of all collected interviews convinced me that with these samples, data saturation was achieved for practitioners' views on audit (Gibbs 2007, 151). This was due to the same themes regarding practitioners' descriptions and opinions of audit arising in the interviews from all three sites, even though they were conducted in different points of time<sup>9</sup>.

### Meetings

In the supported housing unit, *inter-professional team meetings* ( $N=21$ ) among psychiatric nurses, substance abuse workers and practical nurses were recorded (see table 3 on page 32). From the sample frame of 38 meetings already collected from the supported housing unit, I selected 21 because they were carried out when the unit's participation in tendering was strongly on the agenda. Hence these meetings contained considerable discussion on the issues relating to SPA, in addition to more common talk about clients' current situations and general issues related to the unit's routines. The objective of the meetings was to facilitate the everyday work by planning interventions and ways of supporting clients. As verbatim transcriptions, the meeting data amounted to 693 A4 sheets with 1,5 line spacing.

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9 The data from outpatient clinics were collected in 2002 for a master's thesis which was a pilot study for this research (Saario 2005). For the purpose of this dissertation, the data in child psychiatry clinic were collected in 2007, utilising similar interview structure and a similar collection of informants as in outpatient clinics. The interview in the supported housing unit was conducted in 2007, and meeting data from the same site was collected in 2006.



Table 3. Practitioners participating in interviews and meetings.

	The number of practitioners interviewed (N= 23)  (Total number of interviews: 23)		The number of practitioners participating in meetings (N=6) (Total number of meetings: 21)	
Occupation	Outpatient clinics (site 1)	Child psychiatry clinic (site 2)	Supported housing unit (site 3)	
Social worker	3	3		
Psychiatric nurse	2	2		2
Psychiatrist	2	2		
Psychologist	2	2		
Substance abuse worker				2
Practical nurse				2
Executive staff member		1	1	
Main user of EHRs or administrative secretary	1	2		

Both interviews and meetings illustrate practitioners' views on audit instruments as a part of their work. However, regarding interaction between the researcher and participants, these two sets of data were collected in rather different circumstances. The meeting talk was carried out among practitioners themselves as a weekly routine. The free-flowing and informal conversation was an ordinary part of practitioners' work. The researcher was a silent observer who was primarily there for the audio-recording. Interviews, on the other hand, were special occasions for practitioners. Their responses were guided by the structure of the interview schedule and the researcher posing the questions. This dyadic talk enabled me as the interviewer to ask specific questions if I felt it necessary. In contrast, in the meetings this was not possible since they were clearly an arena for mutual discussions of practitioners who were there to do their ordinary work.

### Documents

Documentary data (N=24) includes relevant administrative documents from the sites, like annual reports and statistics produced by the studied EHRs. Used as supplementary data, documents enabled me to locate the interview and meeting talk in the organisational context. They made audit instruments more conceivable and offered information on the broader structures they are a part of. In table 4 (on page 33), the



documents are organised into two groups depending on their type: documents that are *produced* by audit instruments and can be seen as their outputs (e.g. statistics that can be printed out from the system), and documents that *describe* audit instruments and are texts about them, but are produced by means other than audit instruments.

Table 4. Documentary data.<sup>10</sup>

DOCUMENTARY DATA N=24	OUTPATIENT CLINICS N=9	CHILD PSYCHIATRY CLINIC N=9	SUPPORTED HOUSING UNIT N=6
PRODUCTS OF AUDIT INSTRUMENTS	Various statistics from Aho	Various statistics from Oberon	Service Purchasing Agreement
	Prints of Aho views	Prints of Miranda and Oberon views	Attachment of Service Purchasing Agreement: Service description
	Classification of treatment entities: hospital wards and community care	Specialist medical care: products and prices	Attachment of Service Purchasing Agreement: Quality description
DESCRIPTIONS OF AUDIT INSTRUMENTS AND THEIR CONTEXT	Agenda for Mental Health Services [in the municipality]	Agenda for Mental Health Services [in the municipality]	Final report of the Supported housing unit
	Targets of outpatient clinics	Final report of development project: core processes of child psychiatry	Www-site on Purchaser-provider mode [in the municipality]
	Randomly picked pages of calendars of practitioners	Operating model for child psychiatry	Strategy of [NGO]
	Planning templates for psychiatric outpatient care [of the municipality]	Management duties in nursing: memo for staff	
	Project plan: psychiatric services in the community, outpatient clinics and day hospitals	Annual report of hospital district	
	Public service survey	Criteria for access to treatment	

<sup>10</sup> More detailed references to documentary data can be found in the journal articles, under the subtitle “Documentary data” in References.

## 2.2 Analysis

In the case studies, different data combinations were analysed by descriptive coding, followed by interpretive coding which utilised the conceptual framework provided by analytics of government. The joint analysis of these separate case studies forms a synthesis on practitioners' responses towards audit, showing how each response characterises a certain experience on audit, and has distinct functions for practice.

### 2.2.1 Research questions

The specific research questions of each case study are presented in table 5 (on page 35). While posing their specific research questions, combinations of settings and audit techniques, each case study addresses a more common research problem: *how does audit reshape professional practice and how do practitioners respond?* The first part of this common research problem (how audit reshapes professional practice) is mainly answered in the case studies. The second part (how practitioners respond to audit) is largely developed in this summary section of dissertation. This way, I have used the same analytical focus over the whole data, regardless of the combination of data in question (Mason 2002, 165).

Table 5. Research questions of case studies.

CASE STUDIES	RESEARCH QUESTIONS
Case study 1. Managerial Audit and Community Mental Health: A study of rationalizing practices in psychiatric outpatient clinics	In what way does inputting information in the Aho data system influence the activities of mental health practitioners?
Case study 2. Contractual Audit and Mental Health Rehabilitation: A study of formulating effectiveness in a supported housing unit	How does practitioners' effectiveness argumentation reflect and utilise practices related to the Service Purchasing Agreement?
Case study 3. Managerial reforms and Specialised Psychiatric Care: A study of resistive practices performed by mental health practitioners	What kinds of counter-discourses and resistive practices do managerial reforms yield for practitioners?
Case study 4. Inter-professional Electronic Documents and Child Health: A study of persisting non-electronic communication in the use of electronic documents	How do practitioners engage in non-electronic means of communication while using electronic documents?
Case study 5. Audit Techniques and Mental Health: A study of tacking practices performed by practitioners	What conflicts in professional practices do practitioners report as resulting from the audit techniques? How do practitioners adapt their daily care work with the demands of auditing?

With the above research questions, my aim was to set up each case study as a coherent part of the overall research. In the initial phase of designing each case study, I considered a farsighted plan to fit them into the entity of the research, and to make them conducive to the common research problem. So, in terms of their content and structure, I planned journal articles virtually as chapters of a book. This approach resulted in consistency of the titles of articles: First, the main titles indicate the combination of audit techniques studied (managerial audit, contractual audit, managerial reforms and inter-professional electronic documents) and the mental health service in question (community mental health, mental health rehabilitation, specialised psychiatric care and child health). Second, the subtitles of journal articles inform the key result of the impact of audit techniques: rationalising practices, formulating effectiveness, resistive practices, persisting non-electronic communication and tacking practices. (See also table 1 on page 23.)

## 2.2.2 Analytics of government as theoretical framework and provider of conceptual tools

A theoretical framework provided by analytics of government has been utilised in the construction of the overall research design, and, consequently, it has provided conceptual tools for each case study. When constructing the overall research design, the approach guided me to examine practitioners' relations with audit as an issue of government. Originating from ideas on governmentality (Foucault 1991), the perspective of analytics of government develops ways to conduct empirical analyses on how people govern and are governed within different regimes (Helén 2004; Dean 1999; Rose 1999). The term governmentality combines two words: govern and mentality. The latter indicates how it is not purely things and subjects as such that are governed, but governing entails specific forms of thinking and rationalising about government. NPM can be seen as one kind of rationality which, by implementing audit procedures, conveys a specific logic by imposing practice as characteristic forms of visibility, definite vocabularies and procedures (Dean 1999, 23).

In analytics of government, it is emphasised that government works by intervening and directing the activity and thought of those involved (Dean 1995, 561). Rose (1999, 52) writes about technologies that are "imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired events". He continues that "it is human capacities that are to be understood and acted upon by technical means." Therein lies an important notion on audit shaping the conduct of practitioners: audit not only converts practical events into targets of evaluation, but extends to micro-level practices and to practitioners' construction of their professional expertise (Rose & Miller 1992; Miller & Rose 2008, 33). In this case, analytics of government enables the study of diverse connections between everyday practice, practitioners' conceptions and the transformations in surrounding political reason (see Helén 2005, 107).

In this summary, I have so far called EHRs and Service Purchasing Agreement as "audit instruments" to refer to them generally as working tools used in professional practice. I will now, however, conceptualise this term into "audit techniques" to underline their capacity to shape practitioners' conduct. So, in the following, I will identify these instruments as audit techniques in the sense suggested by Dean (1994, 187): techniques are methods of organising work, forms of surveillance, and methods of timing and spacing of activities in particular locales. By incorporating these methods, SPA and EHRs function as *audit techniques* in the following ways: SPA defines and sets out the parameters for practitioners to provide services prior to their execution. By defining the kind of work required, SPA forms the first part of the auditing process.

EHRs, on the other hand, oblige practitioners to record afterwards how their work was performed, and to what extent. EHRs enable managers to control whether these requirements are completed as was defined in the first stage of audit process. EHRs thus constitute the second phase of the audit process in which it is monitored whether the required work was done as planned.

Besides the general framework, analytics of government also provided precise concepts that I used as analytical tools in each case study. In the case studies, the concepts functioned as clearly specified ideas derived from a particular model, in this case analytics of government. By offering particular approaches to mental health work, the concepts were an essential part in the interpretation of data. (Silverman 2000, 78–79). In case study 1, the results were further analysed by applying the concept of *governmentalisation of government* which focuses analytical attention on how information revealed by audit is itself becoming most important to scrutinise, instead of the actual contents of interventions. The results of case study 2 were further analysed by viewing SPA as a *technology of agency* to demonstrate how SPA encourages practitioners to formulate arguments that are compatible with the principles of outsourcing. In case study 3, Foucault's (2007) notion on *resistance* was utilised to study practitioners' confrontations to audit as delicate acts which take various, distinct forms. In case study 4, the findings were further analysed by applying the concept of *boundary object* to electronic documents as potential boundary objects. Unlike the other concepts, boundary object does not originate from analytics of government but from Star and Griesemer (1989), and it is mostly applied in the studies on computer-supported cooperative work. Similar to case study 2, case study 5 utilised the concept of *technology of agency* to demonstrate that auditing is primarily a moving force for professional activity because it provides practitioners with opportunities for improvisation.

## 2.2.3 Analyses of each case study and the joint analysis of all case studies

### Analyses conducted for the case studies<sup>11</sup>

During the analyses of case studies, I constantly contrasted interviews, meetings and documentary data with each other. In other words, I employed comparative analysis between different types of data (Mason 2002, 33). In each case study, the practical process of analysing interviews and meetings was conducted by coding the data by using the computer-aided qualitative data analysis system Atlas-Ti. There were two stages in this process. In the first stage, those instances were identified from interview

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11 More detailed descriptions of these analyses can be found in each original article, under the sections on Research design or Research methods.

and meeting talk in which practitioners either referred explicitly to audit techniques, or mentioned them indirectly while discussing something else. After this descriptive coding (Gibbs 2007, 149), I moved on to the second stage of analysis to form analytic codes (ibid., 44). Here, I divided the instances into more specific codes, according to practitioners' descriptions of the features of audit, and their own reactions and opinions towards audit techniques. In this stage, I further interpreted the codes within a conceptual framework adapted from the analytics of government (see section 2.2.2). This second stage of data analysis can be identified as interpretive coding (ibid., 150).

My viewpoint of studying audit as a technology of government slightly shifted as the research progressed. In the early days of the research process, my "analytic gaze" was focussed on audit techniques primarily as forms of regulative governance (Foucault 2005; Foucault 1984, 179–213). This phase resulted in case studies 1 and 2 which emphasise how practitioners try to follow the norms of audit techniques. After considering audit largely as a means of control, I then became interested in looking at the possibility of practitioners acting otherwise. At this point, I started to analyse whether audit can be challenged by practitioners. This effort was founded on Foucault's (2007) statement on the importance of raising questions about resistance, especially in such contexts where the conduct and government of individuals take place. As Gordon (1980, 255) puts it: "Human material operated on by programs and technologies is inherently a resistant material. Resistance is thus an essential aspect whenever people's behaviour is regulated by diverse programs and technologies." All in all, in the process of conducting five case studies my analytic focus evolved: I moved from the first two case studies on what I later call as "iron cage" view to audit, to respective case studies (3, 4) on what I will call as "discretionary space" view to audit. By the time I conducted the last case study (5), I included both views and analysed the aspects of control and discretion side by side.

Despite the shifting viewpoints in case studies, the analytic focus in each of them was on the affordances of audit techniques, i.e. the features that restrict or enable different actions of those involved. In this sense, the local affordances of EHRs and SPA offer various possibilities and obligations for practitioners. The term affordance is largely used in human-computer interaction studies to refer to the quality of an object which allows an individual to perform an action. Originating from the theory of perception by Gibson (1977), the term denotes "perceived possibilities of acting". Even though I aimed to understand the implications of audit techniques on practitioners' actions, no one-dimensional causal relation was constructed between a certain audit technique and a certain response. As Rose and Miller (1992) state, technical instruments in governmental practices intertwine in complex ways with a wide range of governmental programs and management models.

## Synthesis of case studies

Even though I call the original five articles “case studies”, I do not utilise a traditional case study design or use the term in a strict methodological sense. In a classic case-study design, one looks at each case as a discrete part and then documents something about those parts *specifically* (Mason 2002, 165). Instead, in the synthesis I use the same lens to explore similar themes and problems *across each case*. According to Mason (2002, 166), “you do not have to see yourself as doing “case study research” to be able to nevertheless to identify case studies, contexts or ‘wholes’ within your data set for analytical purposes”. For me, sometimes one case equals one site (case study 1 on outpatient clinics; case study 2 on the supported housing unit). However, one case can also represent a certain *combination* of sites (case study 3 on outpatient and child psychiatry clinics; case study 4 on the child psychiatry clinic and English settings on child health and welfare<sup>12</sup>; case study 5 on outpatient clinics, child psychiatry clinic and supported housing). By exploring the relations between apparently diverse sites and different combinations of data, I have tried not to raise strong boundaries between different audit techniques, but to demonstrate the common impacts of audit under different circumstances (Silverman 2000, 85).

In the synthesis of completed case studies, the already published findings are brought up in a new constellation. I have combined the case studies according to the features of the responses practitioners seemed to employ to audit. This concerns generalisation in which the individual elements discovered in the case studies (i.e. impact of audit) are embedded in the forms of larger social organisation (i.e. professionals’ responses). This can be called, according to Silverman (2000, 84, 85), as a comparative method which enables the comparison of cases, and views them from a wider social perspective. Finally, responses were analysed in terms of their functions for practice, based on a certain experience of audit: Audit as an iron cage, as a provider of discretionary space, and, finally, as a mixture of the two. This division on audit techniques will structure Chapter 3.

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12 See footnote 14 on page 47.

### 3 SYNTHESIS OF CASE STUDIES – PRACTITIONERS' RESPONSES TOWARDS AUDIT

This chapter presents a synthesis of the previously conducted case studies that are reported in five separate journal articles. In the following, I will call these case studies as “exemplars” to emphasise how each of them stresses a particular point in the relations between audit and professionals. Each exemplar presents one response to audit: code-led rationalisation of practice; deployment of effectiveness rhetoric; subtle resistance; substitution of audit techniques by traditional means; and consolidation of audit problems and professional logic. While the exemplars are indicative of their own specific points of responding to audit, they all underpin the same underlying argument on audit impacting professional practice to various extents.

The division into five different practitioner responses does not mean that the specific sites, or audit techniques for that matter, can be exclusively divided into these five responses. On the contrary, all responses can occur with any audit techniques. Exemplars 1–4 purposely highlight one response to a specific technique at a time, depending on the focus of analytic inquiry. Exemplar 5 demonstrates a mixture of responses appearing at the same time. In the following, I will group the five exemplars into three types of responses: adherent, resistive and strategic. I will also examine how audit is experienced differently within each such response – as either an iron cage, a discretionary space or a state of flux. Thus it is demonstrated that the responses are based on specific views and understandings of the role of audit.

#### 3.1 Adherent responses: Code-led rationalisation of practice and deployment of effectiveness rhetoric

Exemplars 1 and 2 highlight the contradiction between practitioners’ orientation based on psychotherapeutic and psychosocial work, and audit striving for efficiency of services. Managerial audit is carried out by Aho, an EHR which produces auditable information for the management level about the work performed. Contractual audit is carried out by Service Purchasing Agreement (SPA), the contract which establishes the interventions to



be included in tendering. The impact of both managerial and contractual audit is rather strong: practitioners comply with their standards by moulding their practice (exemplar 1) and their way of talking (exemplar 2) towards maximum financial accountability. Adherent responses connect resource allocation and managerial priorities to the way daily practice is talked about, planned and documented.

### 3.1.1 Summary of case studies 1 and 2

#### Exemplar 1. Managerial Audit and Community Mental Health: A study of rationalizing practices in psychiatric outpatient clinics

The first case study in psychiatric outpatient clinics assesses the impact of managerial audit on everyday practice. Managerial audit is manifested in a computer-based data system Aho, which is developed for financial management and monitoring staff performance. The analysis is driven by the question: *In what way does inputting information in the data system, which classifies content, influence the activities of mental health practitioners?*

Main findings include three perspectives on how inputting information in the data system influences practitioners' activities. *First*, practice is structured within a frame created by codes. When Aho classifies mental health work within a set of predetermined codes, professional work becomes designated into certain categories, e.g. "repeated visit" or "emergency duty counselling" with a financial value attached to these activities. The allocation of funds is based on a continuing assessment of the number of receptions completed by practitioners. By compiling statistics from the codes, Aho ensures that funding is linked to measurable outcomes and performance. Practitioners are aware of this and tend to perform activities that are most profitable. *Second*, data system's codes change the content of client receptions so that they are performed in a restricted manner, leading to shorter and infrequent sessions. This changes the relations between practitioners and clients, and the nature of interventions. *Third*, the data system enforces financial accountability of practitioners. Codes which classify interventions make practitioners more target-oriented. This position leaves practitioners to reconcile between two clashing demands: keeping up with the budget allocated to the organisation and accepting as many clients as possible. The study concludes that the impact of audit techniques on mental health practices has become highly debatable, since audit occasionally overrides the interests of clients or professionals themselves.

## Exemplar 2. Contractual Audit and Mental Health Rehabilitation: A study of formulating effectiveness in a supported housing unit

The second case study explores how outsourcing procedures in the NGO offering supported housing in mental health are reflected in professional meeting talk. Outsourcing procedures presuppose contractual audit which is realised through the Service Purchasing Agreement (SPA). Situating in the local purchaser-provider model, SPA mediates the provision of various rehabilitation services, provided by the supported housing unit and purchased by the municipality. The analysis is driven by the question: *How does practitioners' effectiveness argumentation reflect and utilise practices related to the Service Purchasing Agreement?*

Main findings show that practitioners' argumentation, carried out in the weekly unit meetings, clearly reflects the contractual audit procedures in that the practitioners actively use similar expressions of effectiveness as stated in SPA. This is done in two ways. *First*, practitioners formulate their work as economic interventions by talking about how competitive their prices are. *Second*, they formulate clients' long-term rehabilitation as progressive processes by aiming to make clients' progress more transparent to the purchaser. Both these ways of argumentation utilise similar utterances used in SPA. Interestingly, the conversations among practitioners are informal. No manager or municipal purchasing party is present to incite performances of effectiveness. By drawing on the rhetoric of economical interventions and progressive processes, practitioners mirror the contents of SPA in their conversations. It is concluded that SPA, as a technique that produces performances of effectiveness, extends its rationalities successfully to practitioners' informal and everyday dialogue.

### 3.1.2 Audit experienced as an iron cage

In this section, I will expand the analyses of the two previous exemplars by examining how adherent responses to EHR and SPA portray these audit techniques as *an iron cage*. Generally, the term iron cage<sup>13</sup> denotes increased rationalisation of social life. The concept is originally outlined by Weber (1991) in his description of workers "trapped" in the rules of bureaucracy. There, the iron cage confines individuals in systems based purely on efficiency, rational calculation and control. According to Aas (2005, 72), Weber's notions on bureaucracy as an iron cage present modern institutions

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13 The original German term is "stahlhartes Gehäuse", which was transformed into "iron cage" by Parsons in his English translation of Weber's seminal book *The Protestant Ethic and the Spirit of Capitalism* (1958).

as depersonalised, calculable, predictable and adhering to rules. The identity of the persons performing does not matter, but the answers lie in the technology or the rule.

Audit as an iron cage lies at the heart of developments described by Taylor and White (2000, 4) who note that increasing new public management (NPM) is exposing professional practice to scrutiny, characterized by a greater degree of anxiety about its goals and outcomes. My use of the concept is influenced by the way Wastell et al. (2010) describe performance management as an iron cage which strongly frames professional practice by reducing professional discretion. So, by increasing regulation, I see iron cage audit as something that makes practitioners adhere to its remits and subsumes their expertise to “formal calculative regimes”, as Dean (1999, 169) puts it.

Building on exemplar 1, I identify the first adherent response to iron cage audit as **code-led rationalisation of practice**, in which practitioners reduce non-coded interventions from their daily agenda. There are no codes in the EHR for home visits and extensive case conferences, which means that they are not included in resource allocation of the clinics. Consequently, these forms of work are often dismissed by practitioners. Also, practitioners reduce certain types of client receptions on the basis that they are not assigned to be as financially valuable in the code system as other types of receptions. These reduced receptions include sessions with on-going clients or recurring sessions with the same client. On the other hand, the code for receptions with first-time clients is allocated more resources, so practitioners try to meet as many new clients as possible, implying that under high demand for services, frequent receptions with old clients must be reduced. This way, supportive orientation is preferred at the expense of more therapeutic orientation which would mean longer and more frequent sessions with the same clients, but also fewer coded interventions. The preference for coded interventions ensures that the interventions assigned with codes have the primary position, namely receptions are as short as possible, and are repeated as rarely as possible. This response to EHR, called “code-led rationalisation of practice”, is presented in Figure 1 (on page 44). Its two main dimensions are marked in bold font in the side circles, and finally, their key impacts on practice are indicated in the small circles below.

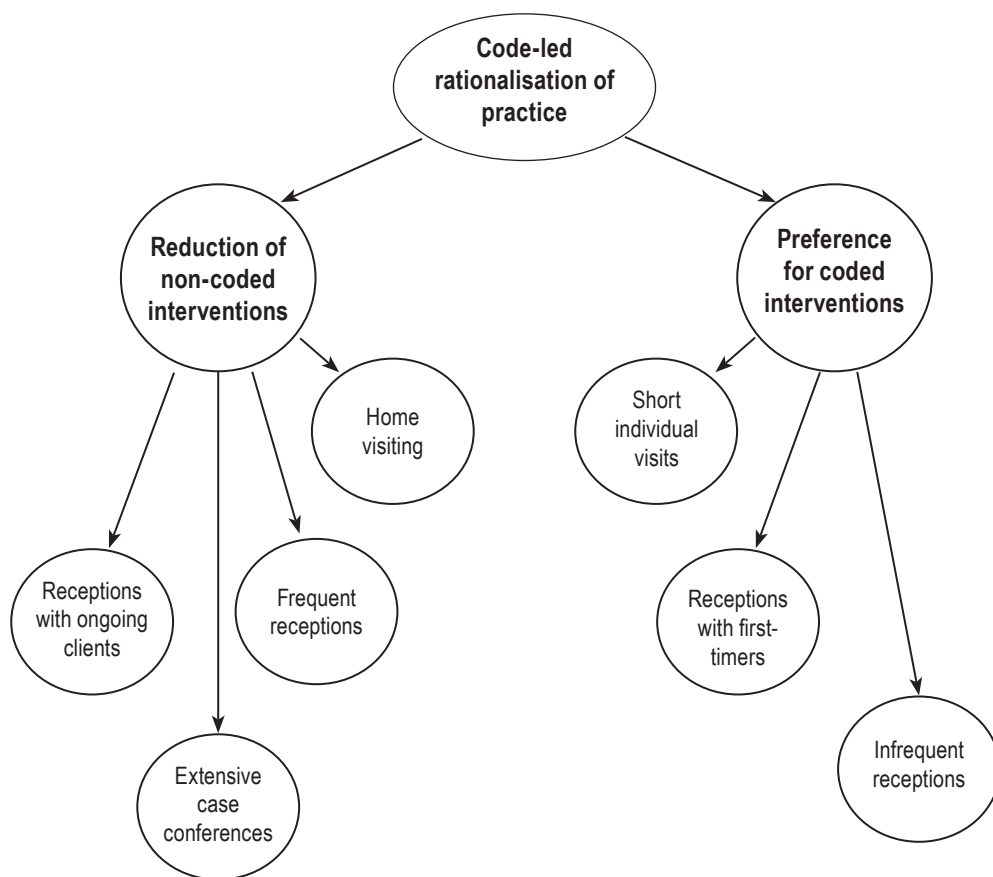


Figure 1. Adherent responses: exemplar 1.

The other adherent response to iron cage audit, carried out by SPA, is called **deployment of effectiveness rhetoric**, which signifies adapting expressions of SPA to the ways of talking about daily work (Figure 2). Effectiveness rhetoric is accomplished in two ways: first, by adapting expressions of progress that are frequently mentioned in SPA. When rendering was going on, there were a growing number of utterances implying clients' advancements and how these successful rehabilitation processes should be documented. Second, expressions of economic efficiency are reflected in practitioners' talk. These utterances emphasise the unit's potential for competitiveness in providing quality service at an economical price, which is specifically stated in SPA. Figure 2 presents the response to SPA called "deployment of effectiveness rhetoric". This response consists of two ways of adapting the expressions of SPA in professional talk, which are presented in bold font in the side circles. The actual utterances of the meeting talk mirroring the SPA contents are demonstrated in small circles.

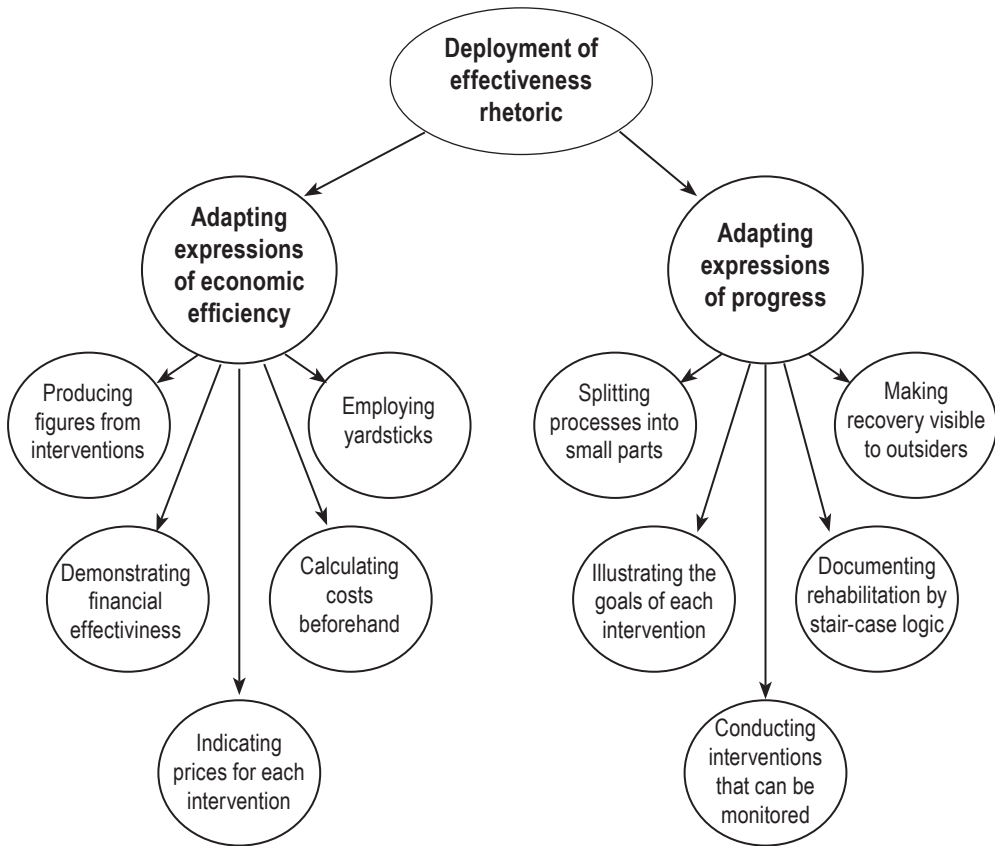


Figure 2. Adherent responses: exemplar 2.

When audit techniques are experienced as an iron cage, the main function of adherent responses is **to give priority to practices that are operationalised by codes and products**. Whereas the EHR studied includes existent codes on interventions, SPA states the ordered interventions as products. As “the bars” of an iron cage, both codes and products require practitioners to conceive their work through the classification in which tasks are assigned a certain financial value. Some parts of practice become effectively operationalised, while other parts remain ignored. It is the hierarchy of priced interventions that defines those forms of work which are supported by the audit techniques. This classification signals practitioners about the most salient aspects of their performance. Consequently, practitioners tend to choose those activities and modes of talk that are most likely to improve their performance. This happens simply by preferring some tasks and expressions to others.

With codes and products, caseloads become a primary measure for practice. Caseloads relate to clients' progress through services: when clients are successfully treated or rehabilitated, service can be offered to new people in the queue (Treatment Guarantee 2005). This idea of moving clients to another service is inherent for example in SPA's service products which are of fixed-duration, and in the high financial value of a first-time visit code in EHR. Efficient management of caseloads is partly introduced to ensure universal rights and improved access to services, and thus practitioners can quite easily adhere to such intentions. Making practitioners to assume increasing budgetary responsibilities is a mode of regulating them by allowing managerial control to function – through the construction of “appropriate” professional conduct and work identities (Fournier 1999, 282). In this case, practitioners are required to translate their actions into codes and products which will offer an intelligible description on their “expertise actions” from the point of view of management (Miller & Rose 2008, 108–110). Being a financially productive worker presupposes an alignment between an individual practitioner's conduct and institutional logic based on managerial and contractual principles. As Lipsky (1980, 50, 51) has noted, “Behaviour in organisations tends to drift toward compatibility with the ways the organisation is evaluated”.

### 3.2 Resistive responses: Subtle opposition and substitution of audit techniques

The findings of the two preceding case studies described adherence to managerial and contractual audit, which manifested in a preference for coded functions and effectiveness rhetoric. The studies presented various controlling and even submissive effects of audit techniques on practitioners' agenda. Case studies 3 and 4 on resistive responses, presented in this chapter, aim to address some breaches in the ‘iron cage’ image outlined earlier. Along with Healy's (2009, 402) inquiry on the changing role of professionals in NPM, my motivation for the following case studies is to see whether, and to what extent, professionals can develop effective responses to the challenges brought by audit. In other words, I will show how audit techniques are moderately resisted and occasionally substituted by other means.

### 3.2.1 Summary of case studies 3 and 4

#### Exemplar 3. Managerial Reforms and Specialised Psychiatric Care: A study of resistive practices performed by mental health practitioners

Situating in child psychiatry and outpatient clinics, the third case study explores managerial reforms relating to audit and the manifestations of practitioners' resistance to these reforms. The study demonstrates how practitioners employ opposition and modifications to new forms of audit that are implemented within managerial reforms of the clinics. The analysis is driven by the question: *What kind of counter-discourses and resistive practices do managerial reforms yield for practitioners?* Theoretical framework of the study is provided by Foucault (2007) who sees resistance as subtle strategies which take place as sporadic acts, likely to be found in varying forms.

The study presents three kinds of resistive practices. First, there is a dismissive attitude towards administrative guidelines, which instruct practitioners on filling various performance indicators and participating in EHR trainings. Second, there is a critical stance towards new management models which are altered frequently. The third resistive practice is an improvised use of EHRs whenever it is felt that they are unsuitable for appropriate documentation. It is concluded that each of these resistive practices, performed by individual practitioners, plays an important role in the implementation of audit procedures as a part of wider managerial reforms.

#### Exemplar 4. Inter-professional Electronic Documents and Child Health: A study of persisting non-electronic communication in the use of electronic documents

The fourth case study draws on data from the child psychiatry clinic in Finland, but, unlike other exemplars, it also draws on comparative international data from various child health and welfare agencies in England<sup>14</sup>. The aim of the case study is to illustrate the use of traditional non-electronic communication modes with official audit

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14 This case study includes interview data from Finland and England. Data from England consists of interviews conducted for another study (White et al. 2005–2007), which examined the use of CAF and other electronic systems for information sharing in everyday practice of child welfare. The interviews from England which were analysed for this case study include those with a hospital-based social worker, a CAMHS (Children and Adolescent Mental Health Services) psychologist, health visitors, school nurses and community midwives. These particular interviews were selected because they included relevant issues for mental health, and most interviewees had similar occupations to the Finnish ones. From the sample of 80, these nine interviews were selected to have a roughly similar size and corresponding data to Finnish interviews. Even though CAF and Miranda were examined together in this case study, I do not include CAF in the synthesis of dissertation. Including only Miranda seems apt because the case study investigated the similarities between Miranda and CAF. Thus, what is found in the relations between CAF and non-electronic means of communication can be applied to Miranda as well.



techniques. The examined audit techniques are Finnish Miranda, an EHR used for documenting case notes, and Common Assessment Framework (CAF) from England, which is a standardized assessment and referral form for children with additional needs, including those with significant mental health problems. In this case study, these audit techniques are called as “inter-professional electronic documents”. This mutual name was considered apt because, despite being diverse systems with different structures, both techniques share the objective of improving communication across professionals. The analysis is driven by the question: *How do professionals engage in non-electronic means of communication while using electronic documents?*

The major findings demonstrate that while Miranda and CAF are two distinct electronic systems, practitioners use them similarly in one aspect: they persist to rely on and make use of non-electronic means of communication while using the electronic documents. Four types of non-electronic means are illustrated that are resorted to by practitioners: personal notebooks, alternative documents, letters and phone calls. With them, particular issues are communicated which are excluded from the electronic forms. These issues entail practitioners’ personal contemplations, potentially offending information, criticism towards other agencies and preliminary observations. Formal entries of electronic documents are not seen as sufficient to adequately describe these issues. The findings are further analysed by considering the electronic documents as boundary objects, which, if successful, can communicate the same information across different professional groups that have different local modes of operation. Since electronic documents require practitioners to use additional modes of communication, they can be considered as only potential boundary objects. It is concluded that electronic documents created by audit techniques and non-electronic means of communication seem to offer two overlapping assessments on clients, with differing agendas.

### 3.2.2 Audit experienced as a discretionary space

In this section, I will deepen the analyses of the exemplars 3 and 4 by looking at how resistive responses to audit techniques provide a *discretionary space* for practitioners. “Discretionary space” is not an established concept, but I use it here to describe situations in which various adaptations and resistances regarding audit become possible. The idea is derived from Lipsky (1980, 14, 23) who uses the term “discretionary judgement” to express the idea that instead of having their “hands tied”, human service workers are capable of exercising discretionary judgement in their field (see also Satka 2011, 88–89). According to him, workers always possess at least minimal resources with which they can resist managerial imperatives. Building on Lipsky, Brodtkin (2008, 321) reports



about “discretionary decision-making” in which workers effectively formulate policies when formal orders are ambiguous.

Based on the exemplar 3, I identify the resistive response to audit experienced as **subtle opposition**. Here, practitioners justify their resistance by inadequacies in audit techniques and managerial reforms. There is opposition to EHRs when their features are deemed to be inoperable in client situations, or when their classifications are found to differ from practitioners’ own conceptions of professional practice. New managerial models which implement EHRs are criticised because they have been introduced without consulting practitioners. Also, their future impacts on everyday practice remain uncertain for practitioners. Finally, new managerial models are seen to bring more unwanted organisational responsibilities for practitioners, who already have demanding and busy work schedule. Subtle opposition to audit techniques also signifies dismissing administrative guidelines for audit procedures. Practitioners justify this dismissal with the viewpoint that the guidelines are too numerous and overlapping, which make them impossible to adhere to, at least literally. On the other hand, usually these guidelines do not affect the contents of client work, so in this sense they are considered “easy” to dismiss. Figure 3 (on page 50) presents the “subtle opposition” -response to audit techniques conceived as a discretionary space. The main dimensions of this opposition are represented in three side circles with bold font. Practitioners’ justifications for their opposition are in the small circles below.

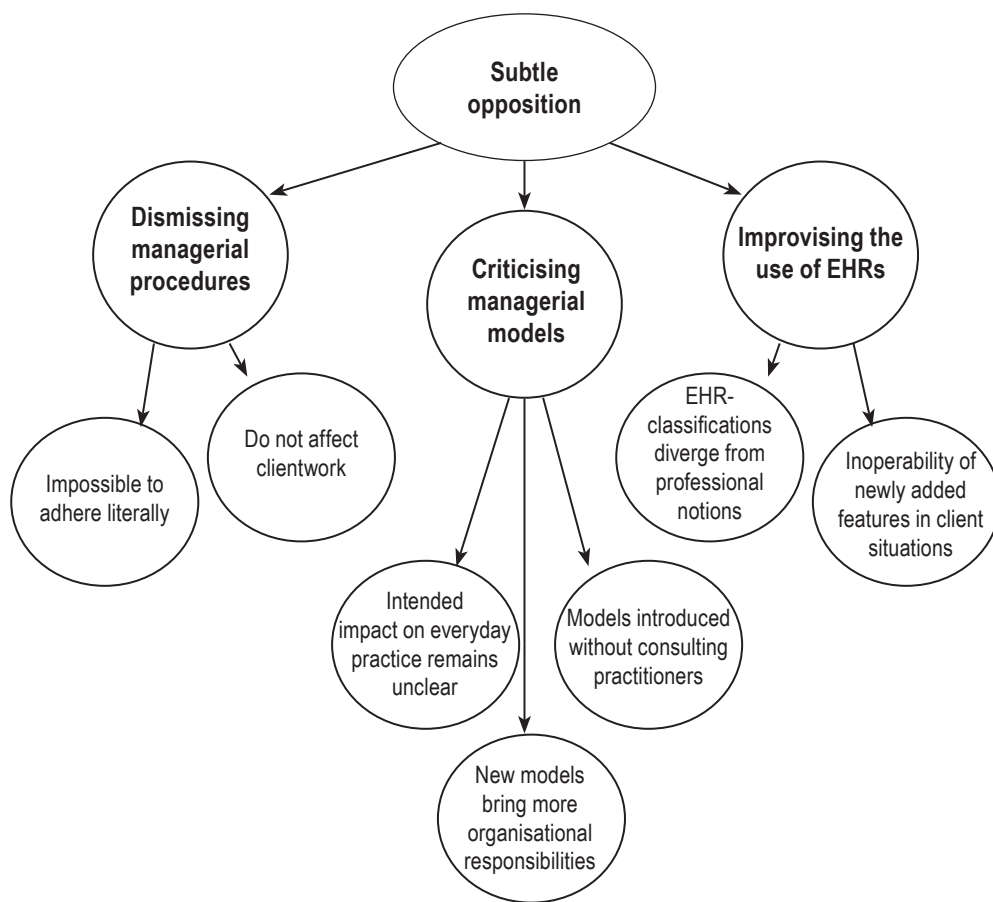


Figure 3. Resistive responses: exemplar 3.

Besides subtle opposition to audit, **substitution of audit by traditional means of communication** is another form of resistive response (Figure 4). However, it works in a slightly different way: this response does not develop new resistive strategies but resorts to traditional operations. Alone, official audit systems are seen to communicate information that is too vague for practitioners. Consequently, practitioners generate more specific documentation on the work by traditional means: letters, personal notebooks, alternative records and phone calls. These are used to convey additional and possibly crucial information that could also have been mediated by EHR. Practitioners' preference for traditional means to EHRs questions the usefulness of EHRs as the only tools for professional communication. Non-electronic means offer the following successful ways to communicate: letters can be addressed to a specific receiver, notebooks can be kept to oneself only and alternative paper-based records

usually have a very limited circulation. Similarly, oral communication through phone calls conveys issues that are not shared with a wide audience. Figure 4 presents this response to audit which is called “substitution of audit techniques by traditional means of communication”. Its four main dimensions are represented the bold font under the main circle. The small circles below represent issues that are omitted from the electronic forms and communicated by non-electronic means instead.

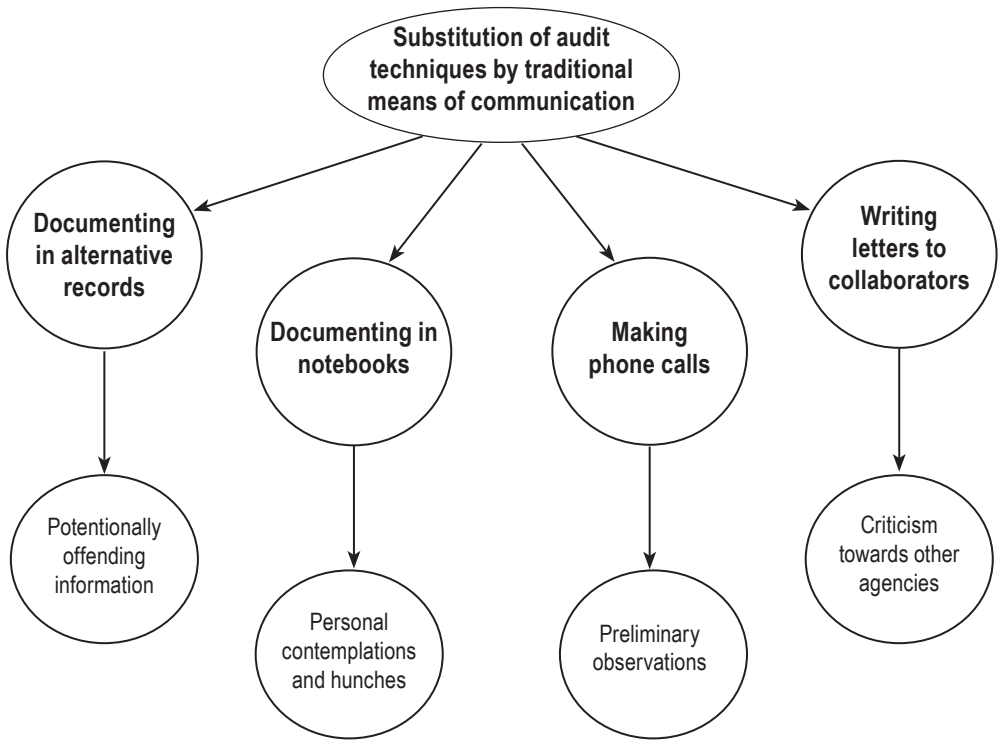


Figure 4. Resistive responses: exemplar 4.

With audit experienced as a discretionary space, the main function of resistive responses is **to keep audit ongoing**. One way how practitioners achieve this function is by ensuring that audit documentation will be understood in the best possible way by recipients and thus can be utilised properly. Audit provides a “must” for practitioners to display their version of the work for various recipients: Miranda for colleagues and partly for collaborative agencies; Aho and Oberon for the management; and Service Purchasing Agreement (SPA) for the municipal purchaser. For practitioners, there is no guarantees how these reports and numbers will be understood by the receivers from

different professional environments. As audit information delivered to other instances is always re-contextualised (Winthereik et al. 2007, 15–16), it is uncertain whether the issues will be successfully communicated. Thus discretionary space allows practitioners to communicate locally important aspects more efficiently by developing informal processing activities and by introducing their own “shadow systems”<sup>15</sup> to the audit process. By including alternative versions and modes of operation to formal audit, one can create a more reliable arena for reporting, and even for tailoring documentation according to preferences of the receivers. By holding this particular advantage, alternative versions challenge audit as the only means of documenting the work. Unlike audit information, alternative versions do not have to be “publication ready” (Greenhalgh et al. 2009, 755), as they allow criticism or speculative information. Audit, however, requires jointly ratified and finalized information (Star & Strauss 1999).

By ensuring that recipients understand audit correctly, resistive responses appear to be necessary to keep audit “alive” and guarantee its final implementation. So, audit does not succeed only because practitioners adhere to it, but because they find ways to work around it and improve it. As Thomas and Davies (2005) point out, resistance reproduces what is being resisted and is a means of privileging the object of resistance as a meaningful arena. For example, in the substitution of audit techniques, the final audit document emerges from a wide variety of non-electronic activities. The importance of resistive responses in this sense becomes illuminated by the original conception of resistance: electricity<sup>16</sup>. When thinking of any electrical object, the resistance of an object determines the amount of electrical current running through it. Without the current produced by resistance, the object does not function (Ohm 1969). The electricity metaphor has obvious limitations in complex mental health, where resistive responses are manifested as ad hoc strategies of practitioners, unlike the constant process of electronic current. While not reducing the conduct of practitioners to electricity, the idea still addresses the often ignored feature of human resistance, namely its service as a *primus motor* for the functioning of rules and control.

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15 “Shadow system” is a term used in computer science for any application that is not under the jurisdiction of a centralized information systems.

16 Electrical resistance was discovered by Ohm in the late 1820s.

### 3.3 Strategic responses: Consolidation of audit problems and professional logic

In this section, I present case study 5, which rounds up all previous exemplars by further examining the basic notion presented in each of them: the tension between audit and professional logic. This case study presents a variety of strategic responses to audit techniques, ranging from adherence to resistance, which all aim to balance this disparity. Strategic responses are close to the notion of workarounds, which refer to professionals' own alternative strategies for defeating obstacles within information systems (Huuskonen & Vakkari 2013; Wastell et al. 2010). Strategic responses demonstrate the highly negotiated and compromised reaction to audit. Hence this case study is the closest to everyday practice in which different responses are co-occurring and overlapping. On the other hand, previous case studies were purposefully more focussed views of specific effects of audit and one specific response at a time.

#### 3.3.1 Summary of case study 5

##### Exemplar 5. Audit Techniques and Mental Health: A study of tacking practices performed by professionals

This case study makes visible the ways in which practitioners attempt to solve, or at least alleviate, the problems they perceive in audit reporting. In this case study, all audit techniques are studied together. The analysis is driven by the following questions: *What conflicts in professional practices do practitioners report as resulting from the audit techniques? How do practitioners adapt their daily care work with the demands of auditing?* In the main findings, two characteristics of audit techniques are presented that are experienced as problematic: first, they consume considerable time from practitioners' daily agenda and second, they require a style of reporting which practitioners perceive as being ill-suited for mental health practice. The consolidation of audit and professional practice involves three strategies: adjustments and tweaks of audit to make it better fitting to existing practice; alterations of professional practice to make practice more amenable to audit procedures; and finally, adapting practitioners' own attitudes to better match audit's premises. With these strategies, practitioners try to perform their client work despite occasional collisions with audit responsibilities. I call these strategies

as “tacking”<sup>17</sup> which denotes moving forward between various obstacles. It is concluded that practitioners need to be resourceful and tactical to harmonise the non-desirable effects of audit with therapeutic mental health work.

### 3.3.2 Audit experienced as a state of flux

I will now extend the analysis of exemplar 5 by examining how strategic responses lead to experience of audit as a *state of flux*. Whereas adherent and resistive responses portrayed audit as a stable state of affairs, strategic responses relate to audit as shifting practices that require constant balancing acts conducted by practitioners. “A state of flux” signifies the position of uncertainty about what should be done after a major change in the common course of events. Audit presents this kind of significant change in work practices, after which practitioners start reconsidering existing ways to conduct their practice. The kind of response depends on the time and place – it can be either adherent, resistive or something in between. Thus, audit as a state of flux presupposes constant adjustments to new circumstances and is primarily a moving force for professional activity.

I call this strategic response to audit as **consolidation of audit problems and professional logic**. Practitioners attempt to alleviate the problems caused by audit by making it more conducive to their own professional logic and practice. There is a variety of ways to achieve this: fudging the codes, using other reporting channels, or adding mundane and voluntary observations in audit reporting. Practitioners engage themselves to a great extent in this balancing work, even though their expertise and main task lie in professional mental health work. They must become sensitised to managerial priorities, financial constraints and political realities, whilst trying to respond to the needs of clients and being loyal to their own professional ethics. This is a task of striking “a balance between demand, needs and resources, so the latter are not exceeded” (Wells 1997, 336). Figure 5 (on page 55) presents this final response to audit, called “consolidation of audit problems and professional logic”. Its three main dimensions are represented in the bold font in the side circles, and their key impacts on practice in the small circles below. The small circles are assigned numbers corresponding to the previous case studies’ (1–4) results<sup>18</sup>. Those without numbers are novel results of this case study.

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17 “Tacking” is a sailing term, used for sailing against the wind. In Finnish, “tacking” is metaphorically used to mean avoiding obstacles and difficulties. In everyday parlance, tacking often refers to attempts to find a balance between different viewpoints.

18 The analysis of this last case study produces some results similar to the preceding case studies which denote that saturation has taken place (see section 2.1.2).

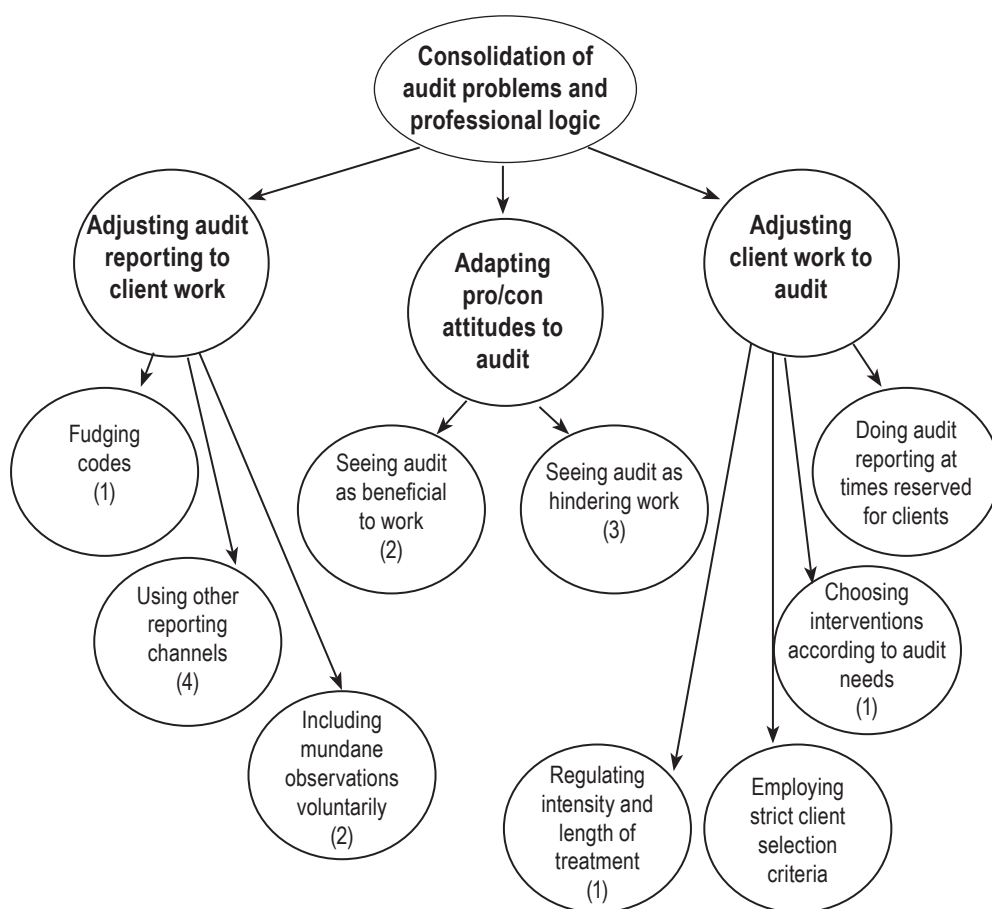


Figure 5. Strategic response: exemplar 5.

With audit experienced as a state of flux, the key function of strategic responses is to **keep client work as undisturbed as possible**. Alleviating the negative impact of audit is not a straightforward process, but one that involves miscellaneous variations, new solutions and additional processing activities that practitioners come up with on their own. Audit as a state of flux is explained as “rather heuristic and vague statements to be interpreted, instantiated and implemented by means of intelligent improvisation”, as Schmidt and Bannon (1992, 19) put it. When audit sets things in the uncertain state of flux, practitioners have to pay increasing attention to it, and thus audit gives rise to a new professional topic that focuses on EHRs and SPA, their technical features and procedures. As such, audit techniques become objects of negotiation in their own right. It has been noted that even slight changes in various audit procedures can signify quite a substantial reorganisation of work which can increase workers’ pressures (Huxley et al.

2005; Parry-Jones et al. 1998). In the long run, trying constantly to keep client work as undisturbed as possible can challenge the wellbeing of practitioners. All in all, the wide variety of strategic responses shows that audit has become a key issue in professional mental health work since practitioners allocate considerable time and energy to handle audit issues. On the other hand, it shows that individual practitioners have a central role in the final implementation of audit.



## 4 CONCLUSIONS

In the context of Finnish mental health services, this research has shown how practitioners adapt their practices to the local audit techniques by employing three different responses to audit (see table 6). *Adherent responses* make practices and professional talk more conducive to the logic of codes and products included in audit techniques. Adherence illustrates how audit, as a kind of an iron cage, firmly shapes professional practice towards efficiency. *Resistant responses* to audit are manifested as additional and informal activities that practitioners perform alongside audit. Resistance shows how audit offers practitioners discretionary space in which audit gets shaped by professionals themselves. The division of audit into an iron cage and a discretionary space illustrates how practitioners commit to the norms of audit but, on the other hand, modify these norms actively. Finally, *strategic responses* entail a changing mixture of adherence and resistance, which enables practitioners to balance practices with audit demands. In this case, audit is seen as a state of flux, requiring practitioners to employ overlapping responses which shift constantly.

Table 6. The dimensions of practitioners' responses to audit.

Response to audit	Adherent	Resistive	Strategic
Key function	to prioritize practices that are operationalized by codes and products	to keep audit ongoing and support its implementation	to keep client work as undisturbed as possible despite audit problems
Achieved by	assuming increasing budgetary responsibilities	opposing audit and ensuring recipients understand audit documentation correctly	allocating time and energy to handle audit problems
Experience of audit as	iron cage	discretionary space	state of flux

It is important to explicate the way practitioners respond to audit because the work will be ultimately realised through such responses. As a part of daily mental health work, the responses illustrate the concrete application of abstract audit policies. Hence

the research contributes to a better understanding of the conditions that audit sets for everyday practice, which allegedly has been described as “swampy lowlands” from the point of view of reflective practice (Schön 1988) and a “black box” (Brodkin 2008) from the point of view of policy implementation, such as NPM. According to Brodtkin (ibid., 319), policy ideas tend to disappear in practice “only to re-emerge in unrecognisable form, if at all”. By bringing out some tangible examples of how audit is received, this research provides an empirically-grounded understanding of the complexity of NPM implemented in mental health work. It illuminates how practitioners make policy on their own terms (ibid., 318) in the frame of NPM.

The findings on the responses to audit confirm the initial hypothesis of this research: Audit is neither purely a technical measure to describe a pre-existing domain of facts, nor a simple tool added to practice (Berg 1996; Halford et al. 2009). On the contrary, audit constitutes and changes the processes that are to be audited (Parton 1999, 124; Miller & Rose 2008, 110). By affecting mental health practice in various ways, audit sets up the following activities from which responses are generated: rationalising practice, formulating effectiveness into professional talk, opposing audit, complementing audit techniques with other methods, and balancing audit with professional logic. These actions show that audit has various impacts on practice which need to be responded to, despite the fact that audit techniques under study are not originally intended to conduct work, unlike decision-making technologies or flowcharts.

The impact of audit, which is reported in the case studies of the dissertation, is mostly met by adherent responses. Resistive and strategic responses remained rather inconspicuous and did not truly challenge audit. In the following, I raise three points which partly explain why the overall picture of responses lacks more radical features:

*First*, the unscrupulous reason is that most practitioners want to maintain their jobs and livelihood. If one resists dramatically, there is a chance of having to leave. In this case, resistance would amount to Hirschman’s (1970) famous “exit”. Also, one would have to be a bit of an outlaw to oppose strongly because there is no organised structure for professionals in Finland to openly criticise the effects of NPM on professional practice, unlike the structure in England for social workers (Saario 2010).

*Second*, audit is difficult to criticise because it is endorsed through “the twin passage points of economic efficiency and good practice”, as Strathern (2000, 1) puts it. Audit also advances those values that are generally treasured by those being audited, such as responsibility and openness about outcomes (ibid., 3). In mental health specifically, audit has been noted to provide information necessary for not only the efficient deployment of resources but for quality improvement (Glover 2000). Audit can improve clients’ rights to get treatment, for example,

by monitoring the access to services. Resistance or even denial to take part in audit processes would mean abandoning this positive rhetoric which fits the core values of mental health professions. As Fournier (1999) writes, practitioners appeal to the ideology of professionalism. Undermining these values would not be considered as worthy professional action.

*Third*, despite problems with audit procedures, practitioners perceive things to be “well enough” (Dickson et al. 1974). With EHRs, both facilities, hardware and software are usually of good quality and there is support available if needed. Also, practitioners can include their own viewpoints and local information into tendering procedures related to SPA, to a certain extent (Raitakari & Saario 2008). In other words, strong resistance is not necessary because the effects of audit are not profound enough to actually convert relations and roles of professionals (Hirschheim & Newman 1988). Reforms related to audit are articulated mostly at the level of administration and as a procedural facade, without overly profound implications for mental health care.

In future, iron cage experiences on audit will probably diminish while audit systems are further developed to allow more user discretion and, as Hardstone et al. (2004, 8) and Greenhalgh et al. (2009, 754) suggest, to acknowledge preliminary, revisable versions as important. Still, resistive and strategic responses to audit will probably remain and get stronger, since human input is always needed with electronic health records (Greenhalgh et al. 2009, 729). So, instead of iron cage created by EHRs, the new “cage” could be increasingly the contracts like SPA, as they seem to become more detailed and binding.

Drawing on interviews and meeting conversations of practitioners, this research has brought up three types of practitioner responses to specific audit techniques. There were also occasional positive comments about audit techniques, particularly in the interviews conducted in the child psychiatry clinic. Audit techniques were said to bring more clarity into one’s work and to motivate more careful planning of daily agenda. If these instances would not have been so marginal, they could have formed the fourth, “devoted response”, in addition to the existing three. This suggests that a further study could investigate whether slightly different methods or sites can produce more instances of devoted response to audit.

What is the significance of this research to practitioners working in mental health? Besides audit impacting on practice and requiring responses from practitioners, I suggest that audit techniques can minimise the differences between occupational groups that have distinct backgrounds, and thus make their orientation more unified. In this sense, audit procedures, which everybody must employ, place practitioners from distinct

professions “in the same boat”. Also, audit techniques can improve collaboration between different occupations and agencies by providing a common language by which work can be mutually addressed, evaluated and discussed. Finally, by imposing similar requirements to social workers, psychiatrists, nurses, psychologists et cetera, audit techniques might unite different professionals by giving them a common subject either to take inspiration from or to complain about.

Regarding practitioners, the findings confirm the importance of acknowledging different kinds of professional accountability. This research has shown that audit, when experienced as an iron cage, primarily calls for new accountability (Banks 2004) towards official procedures and financial aspects. Adding to the idea of new accountability of practitioners, Juhila (2009) introduces the notion of critical accountability which recognises difficulties of quantitative measurement in professional practice, and supports the importance of professional discretion along with official procedures and targets. Audit as a discretionary space and a state of flux allow practitioners to exert critical accountability, which can contest audit at those points when it would carry negative consequences for practice. Negative consequences can take place when audit captures most of practitioners’ attention by requiring them to produce more textual materials for audit purposes; when audit does not recognize a certain aspect of practice and it is in danger of being performed at all; when audit poses certain client groups as too costly for the organisation, or too time-consuming for practitioners.

I will now move on to relate my original topic – the impacts of audit techniques to professional mental health practice and practitioners’ responses to it – to the patterns of broader social organisation of “the audit society”, as put by Power (1999). The validity of the findings is strengthened by the fact that the synthesis on practitioners’ responses is based on five case studies, each of which employs various settings and analytic concepts. The findings can be claimed to be generalizable, especially in two directions:

First, as NPM and audit techniques exist nowadays in almost all human services, the findings are useful for the study of other professions going through similar changes. The specific point this research indicates for human service workers is that they need to exert a great deal of human judgement and sensitive observation in their work – both features that are particularly complicated to reduce to audit formats (see also Lipsky 1980, 161). In this sense, I suggest that human services present a distinct challenge for the implementation of NPM because there is the inevitable fuzzy side of work, resulting from multidimensional social encounters. As a result, programmed targets and quantities provided by audit remain more a description of the organisations, while “esoteric languages” (Miller & Rose 2008, 109) of human service workers continue to be inefficiently communicated by audit. This leads to two vital questions: How can

auditable criteria be generated for human services without oversimplifying complex practices? Is it necessary to be able to audit everything in the first place?

Second, this research has studied mental health practitioners from a certain point of view: as users of EHRs. Most human services, and “office work” in general, can nowadays be characterized as knowledge work, which entails the use of diverse information and communication technologies (Moran & Dourish 2001; Pyöriä et al. 2005; Ramirez & Nembhard 2004). From this viewpoint, mental health practitioners’ responses detected in this research can be fruitfully compared to workers using corresponding instruments in various environments. As this research indicates, it is the individual worker on “grass-roots level” who is in a central role when new audit systems are implemented.

This research has been conducted in the context of different mental health sites in Finland. Thus the results are tied with a national frame of Finnish traditions of occupational education, division of work between professionals, and ways of organising services and implementing audit systems. These specific features have, at least to some extent, affected how practitioners react to the implications of NPM. However, the wider international significance of the studied responses is brought up in two case studies of this dissertation: case study 4, which compared the English audit technique CAF with the corresponding Finnish audit technique, and case study 1, which was set up by referring to modernising mental health policy in England with similar practice outcomes found with the Finnish audit technique.

The critical dimension of this research points to the discovered incompatibilities between audit systems and practice. The descriptions on mental health work presented by audit will not necessarily have a counterpart in practice realities. Statistics and records can have considerable information about the “agency behaviour” (Lipsky 1980, 50, 51), but much less about the phenomena that audit aims to describe. In this case, ideal documentation created for auditing purposes might end up describing the organisational style and rhetoric of reporting, rather than practice itself. As Barry (2001, 2, 172) puts it, in “technological societies”, like Finland, political issues are easily framed as technical problems that call for technological solutions. Consequently, specific technologies, like audit, will dominate the general view of assumed problems that politics must address, as well as the responses and solutions to these problems.

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## ORIGINAL PUBLICATIONS ON FIVE CASE STUDIES



## **Managerial audit and community mental health: a study of rationalising practices in Finnish psychiatric outpatient clinics**

### **Auditointi psykiatrisessa avohoidossa: Tutkimus mielenterveystoimistojen käytäntöjen rationalisoinnista**

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In many European welfare states the reform of mental health services has been accompanied by the implementation of new forms of governance, including the introduction of managerial audit systems. While such systems have been developed for 'good causes', such as quality assurance, financial management and monitoring staff performance, they may simultaneously produce diverse and contradictory effects on practice. The aim of this article is to examine the role of one managerial audit system, introduced in psychiatric outpatient clinics in central Finland, and assess its impact on practice. Reference is made to modernising mental health policy in the UK as that has produced similar practice outcomes. The research was an empirical study of practice using a mixed-method case study design involving documentary research and semi-structured interviews. Insights from Mitchell Dean's notion of governmentalisation of government were utilised in the analysis. It was found that, although the audit system primarily served administrative needs, it began to reshape practice by reinforcing certain modes of working and excluding others. The analysis of community mental health work in Finland, with similar trends in the UK, highlights the connection between documentation, resource allocation and managerial priorities that reinforce particular styles of practice. In community mental health services it would appear that the problems of professional practice have become the problems of administration.

**Keywords:** managerial audit; mental health practice; non-institutional psychiatric care; governmentalisation of government; Finland; UK

Olenainen osa Euroopan hyvinvointivaltioiden mielenterveyspalvelujen uudistamista on ollut hallinnolliseen tiedontuotantoon kehitetyt teknologiat, joihin myös työntekijöiden toimintaa auditoivat tietojärjestelmät sisältyvät. Vaikka tietojärjestelmien käyttöön otolla tähdätään hyödyllisinä pidettyihin tavoitteisiin kuten laadunvarmistamiseen, taloudelliseen tehokkuuteen ja toiminnan seurattavuuteen, se saattaa samaan aikaan tuottaa hyvinkin moninaisia ja keskenään ristiriitaisia vaikutuksia käytäntöön. Artikkelissa tarkastellaan eräissä suomalaisissa mielenterveystoimistoissa käytettyä, hallinnollisiin tarpeisiin kehitettyä tietojärjestelmää ja arvioidaan sen vaikutuksia psykiatrisen avohoidon päivittäisille käytännöille. Näitä vaikutuksia suhteutetaan Iso-Britannian mielenterveyspolitiikassa toteutettuun palvelujen viimeaikaiseen modernisointiin. Tutkimus toteutettiin empiirisenä tapaustutkimuksena, jonka aineistona käytettiin suoma-

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laisten mielenterveystoimistojen dokumentteja sekä eri ammatteja edustavien työntekijöiden puolistrukturoituja teemahaastatteluja. Analyysissa hyödynnettiin Mitchell Deanin ideaa hallinnan hallinnallistumisesta. Tutkimus osoitti, että vaikka tietojärjestelmä palvelee ensisijaisesti hallinnollisia tarpeita, sen vaikutukset ulottuvat myös sisällölliseen työhön, kuten asiakasvastaanottoihin sekä työntekijöiden terapeuttiseen orientaatioon ja ammatilliseen itseyymmärrykseen. Toiminnan dokumentointi ja taloudellisten resurssien kohdistaminen osoittautuvat olevan kiinteästi toisiinsa kietoutuneita ja vahvistavan tietynlaisia avohoidon käytäntöjä, jotka painottuvat myös. Iso-Britannian uudistetuissa mielenterveyspalveluissa. Tässä kehyksessä psykiatrisen avohoidon ammatilliset käytännöt ja niiden määrittämisen ongelmat näyttävät tulleen yhä enemmän palvelujen hallinnoinnin ongelmiksi.

**Avainsanat:** auditointi; tietojärjestelmä; mielenterveystyö; psykiatrisen avohoito; hallinnan hallinnallistuminen; Suomi; Iso-Britania

## Introduction

In many European welfare states the reform of mental health services has been accompanied by the implementation of new and more extensive forms of governance. A major element in this has been the introduction of effective audit systems (Campbell *et al.* 2002). Such systems have typically been developed to provide a means for quality assurance, financial management and the monitoring of staff performance (Balogh *et al.* 1998). At the heart of the debate about audit in community mental health services is a central paradox: on the one hand a systematic audit can provide illuminating data necessary for the efficient deployment of resources and quality improvement (Glover 2000), whilst on the other, it might be said that at a time of limited resources and high profile incidents, managers and policy makers may have a vested interest in light touch monitoring of practitioner performance so that they can distance themselves from its consequences, especially when something goes wrong (Wells 1997).

In recent years managerial audit systems have been extensively introduced in health and social care agencies throughout Finland (Häkkinen and Lehto 2005, p. 86, Juhila 2006, pp. 74–76, 92). Audit in the Finnish context is designed to improve existing statistical information systems, closely tied to the principles of benchmarking, that will allow more transparency regarding the effectiveness of service providers concerning access, output and costs across different municipalities (Ministry of Social Affairs and Health 2002, Häkkinen and Lehto 2005, p. 86). Rather than determining the stance of managers and policy makers in case of client incidents, the implementation of audit in Finland has been viewed primarily as a way of providing better legal protection for grassroots practitioners (Ministry of Social Affairs and Health 2003). Within social work, audit has been greeted as a way to enhance the credibility of the profession by rendering professional performance more systematic and transparent (Kallinen-Kräkin 2001, Stakes 2007).

While audit systems are developed for ‘good causes’ associated with quality improvement, they may simultaneously produce diverse and unintentional consequences at the micro level of practice. The aim of this article is to examine the role of one particular audit system in non-institutional psychiatric care and assess its impact on practitioners working in psychiatric outpatient clinics in Finland.<sup>1</sup> Reference will be made to parallel developments in mental health policy in the UK to show that the practice issues raised are not confined to Finland. The audit system studied is the codifying, computer-based data system (hereafter referred to as AHO) in which



practitioners document their everyday tasks using a set of predetermined codes. One of the central questions to be explored is how AHO functions as an element that shapes the work of practitioners, more specifically, whether entering data on the system reinforces certain modes of working and simultaneously excludes others. Although the data gathered primarily serve the administrative needs of the clinic, its reach extends to influencing the content of the work actually done with clients. It is these content functions that are analysed in this article, in particular, to what extent the data system has begun to reshape practice.

The procedures for entering codes in the data system may be seen to reflect the notion of governmentalisation of government (Dean 1999), which indicates how the main purpose of the institution has become one of ensuring the economic rationality of its own operations. The concept describes the increase in the internal evaluation of administration in which the evaluation of an institution is focussed increasingly on its own administrative arrangements. What is essential is the testing and vindication of the 'economy' of operations occurring through evaluation. The analysis on mental health practices highlights the connection between documentation procedures of individual practitioners, on the one hand, and efforts to acquire resources and thereby maintain the position of outpatient clinics as local service providers on the other.

Initially the literature will be examined concerning the capacity of audit systems to divide the content of client work through a multiform process into calculable units. The literature provides a framework from which an empirical study was carried out to examine the impact of introducing a codifying data system (AHO) on practice in the outpatient clinics. After discussion of the research design and presentation of data, the analysis focuses on the operation of the clinic, paying special attention to the forms of activity as a whole, to client reception and to the workers' professional presentation of self. The analysis is driven by the question: in what way does inputting information in the data system, which classifies content, influence mental health practitioners' activities? More generally, to what extent does rational decision-making, facilitated through the introduction of a routinised audit system, reflect managerial priorities and reinforce particular styles of practice?

### **The problem of transforming client work through managerial audit**

The challenge posed by introducing audit and classification procedures as part of clinical governance has been discussed quite extensively in the social work literature. Often this topic has been approached through the concept of new managerialism (Harris 1998, Clarke *et al.* 2000). In the field of British social work research the new managerialism and marketisation of social care has brought significant alteration to working practices involving cultural as well as organisational change (Campbell *et al.* 2002). The bureaucratisation of practice removes practitioners from tasks and roles for which they were trained (Parry-Jones *et al.* 1998). The implementation of managerial procedures has been sharply criticised for changing the relationship between social worker and service users (Harris 1998). Managerial procedures are found to increase control and regulation, thus rendering practices more routinised, output driven and politically accountable (e.g. Clarke and Newman 1997, pp. 84–86, 101–102, Harris 2003, Stepney 2006, p. 7, Webb 2006, p. 150). In recent years managerial doctrines have been vigorously implemented in the social and health care

systems of the Nordic welfare states, the UK and Australia, producing similar outcomes on practice (Juhila 2000, 2006, Raunio 2002, Lien 2003, Vabø 2006).

In the UK the modernising policy discourse in mental health was designed to promote independence, improve protection and raise standards under a banner of *Safe, sound and supportive services* (Department of Health 1999). The framework for the delivery of modernised services was the Care Programme Approach (CPA) with an emphasis on risk assessment, collaborative working between health and social care professionals, pooled budgets and integrated audit systems. However, research evidence suggests that mental health practitioners are subject to competing pressures and claims (Huxley *et al.* 2005). They have become sensitised to managerial priorities, financial constraints and political realities, whilst responding to increasing demand from service users in a way that 'strikes a balance between demand, needs and resources, so the latter are not exceeded' (Wells 1997, p. 336). The introduction of a complex audit system as part of clinical governance arrangements may be viewed as an organisational response to this tension.

The need for public sector services to meet demands for transparency and accountability is now well established (Munro 2004, p. 1075) and has led to the creation of complex audit systems that have become an essential part of professional practice (Power 1999, Bowker and Leigh Star 2002). However, despite these developments, their precise influence and effect on practice are yet to be fully understood (Munro 2004, p. 1089). Also according to Webb (2006, pp. 142, 168) too little is known about how daily work patterns of social workers are influenced by the impact of audit systems, including the routine use of computerised case files. Munro (2004, p. 1092) sums up the importance of conducting empirical research on the effects of introducing audit systems by stating how 'the existing systems of audit and inspection should be seen as first drafts rather than completed pieces of work, requiring continual critique and improvement'. Similarly, Finnish social work researchers have called for a more active debate over exactly how and by whose criteria diverse classificatory audit systems are applied to social work practice (Juhila 2000, Kuusisto-Niemi and Kääriäinen 2005).

### Research design

The research was an empirical study of practice in four Finnish outpatient clinics. A mixed method case study design was used involving documentary analysis and semi-structured interviews. A primarily qualitative technique was employed in the collection and analysis of data from the two inter-linking parts of the research. The results reported here are part of a larger study in which the formation of mental health professionals' daily work was studied on the basis of various structural elements – the codifying data system (AHO) being one of these elements (Saario 2005).

The setting for this study comprised of four outpatient clinics operating in different districts of a town in central Finland. The clinics provide non-institutional specialised psychiatric care from a multi-professional team including social workers, nurses, doctors and psychologists. The main tasks are individual intervention treatment, support to couples, as well as family and group therapy. Also medication is prescribed, psychiatric tests carried out and social security issues addressed.

As providers of non-institutional care, outpatient clinics in Finland are facing similar challenges as community mental health teams in the UK, USA and Australia

(Foster 2005, p. 26). The process of dehospitalisation and desegregation makes the field of community mental health strongly contested, as local agencies are striving to cope with the growing numbers of vulnerable people decanted into the community. In Finland the reduction of incarceration started only in the early 1980s but was correspondingly carried out very rapidly, thus dramatically decreasing the number of psychiatric beds in a relatively short period of time, while placing increasing emphasis on outpatient care (Salo 1996, pp. 197–198, Helén 2007, pp. 152, 159).

The emergence of managerial reforms set the parameters for outpatient care. According to the policy of Finnish public mental health care, only more ‘severe’ cases are to be treated within specialised outpatient clinics or hospitals (Helén 2007, p. 152). Despite this, clinics still receive a ‘flood’ of referrals, partly due to the expansion of mental health care to meet rising demand. Simultaneously, clinics are obliged to meet certain time limits or targets for providing access to treatment (Ministry of Social Affairs and Health 2003, 2007).

The focus of the study is the computer-based data system referred to as ‘AHO’, in particular, the way practitioners use codes to record the daily content of their work. This information is used mainly for administrative purposes, such as planning appointments and finance, the organisation of queuing and general caseload management. It is restrictive in that professionals can’t write freely nor does it contain the case records of clients or other clinical and social information. AHO is an instrument that classifies and describes the content of mental health work within a set of predetermined codes. Thus it may be considered an important topic of research, both in the field of social work and mental health practice, where the drive for cost efficiency has increased the significance of the quantitative measurement of performance.

The data from this study were derived from two main sources – documents and interviews.

- i. First, documentary data included relevant administrative and policy documents, statistics produced by AHO, the calendars of professional staff, statistics, agendas and minutes dealing with the organisation of community mental health services in the four studied clinics (a full list of the documentary data is included in the References).
- ii. Second, thematic semi-structured interviews with practitioners ( $N=9$ ). Interviewees consisted of three social workers, two psychologists, two psychiatric nurses and two doctors. Interviews include descriptions of their concrete working practices. Practitioners explained their typical working day, client cases which they themselves thought to be either successful or unsuccessful and the ways of organising their interventions and schedules. No direct questions were asked about AHO, but the system was brought up by professionals’ own initiative when describing in detail their working practices.

### **Findings from the study and initial analysis**

The empirical data presented below are divided into three sections that respond respectively to the following three questions:

- a. How do the AHO data system’s documentation procedures construct and make conceivable the practices within outpatient clinics?

- b. What ramifications does the data system have for the content of client receptions?
- c. In what way does the data system shape the personal and professional orientation of practitioners concerning their work?

These questions were asked in order to clarify to what extent the work of mental health practitioners is interconnected with the rationalities of the computer-based data system, AHO.

The process of data collection and analysis was conducted in two stages: in the first stage the analysis points were taken from the corpus of interviews with practitioners in which there was either direct reference to AHO or those in which the workers mentioned AHO indirectly when discussing recording. In the second stage of the analysis the role of AHO is examined from three different perspectives: the entity of operations, the content of client interactions and professional issues raised by individual practitioners. These perspectives arise when addressing ways of governing diverse forms of individual action in contemporary welfare states. The analysis drew specifically on perceptions of how numerical documentation of individual performance converts practical events into targets of evaluation, and further, how this kind of statistical reasoning extends itself to the micro level of interaction and construction of subjectivity (Rose and Miller 1992, Dean 1999, Helén 2004). For this study the data from both stages of analysis are combined using extracts from interviews with practitioners to illustrate the three perspectives.<sup>2</sup>

### *1. The entity of operations: the structuring of practice within a frame created by the codes*

As a part of their daily routines, practitioners code the client contacts they have made (translated from Finnish as 'receptions') as clients' first time, repeated, first time emergency duty, repeated emergency duty or as 'other' visits in AHO. For each of these contacts there is a set price that is dependent on the time spent with a client, the occupational status or number of participant practitioners. The price is also dependent upon the content of 'receptions' marked as either individual, family, group, refugee or foreign visits (Documentary data: Statistics of AHO 2002, Project Plan 2002).

As each code equates to a certain amount of money, it becomes possible to compare the economic value of different kinds of contacts and, moreover, to measure the performance and attribute a cost to each individual practitioner and compare that cost to the publicly stated goals. At the same time as practitioners document the client's reception into the system, they are making their work quantifiably visible to themselves, to the administrators of the clinics and importantly to those who make decisions about clinic funding. This is currently a statistical procedure: from the receptions documented into the system, statistics are produced showing client numbers between different clinics, occupational groups and the workload of individual practitioners (Documentary data: Statistics of AHO 2002). These summaries serve as a basis for funding from the city health care budget (Documentary data: Public Service Survey 2002). The allocation of funds is based upon a continuing assessment of the number of receptions completed by practitioners. By compiling statistics from the codes, the use of AHO ensures that funding is linked to measurable outcomes and performance.

The use of AHO has a number of implications for practice. First, the activities of professionals have been constructed within a certain frame where activities are classified according to the data system's logic. Thus, professional work becomes designated as 'individual therapy', 'emergency duty counselling', or 'home visit' with a financial value attached. While the work has to be made visible using explicit classifications from the code system, the ways and manners of how practices are performed become more and more regulated. AHO has therefore helped to make practitioners work visible in a highly selective manner. To be precise, it is not possible for practitioners to make all their tasks and functions visible because codes do not exist for every activity. For example, there is no code for arranging housing rehabilitation, as the following social worker explains:

With us social workers, when we are counting the allowance for housing rehabilitation, when we are counting all those sums so that a client could move there, even if it takes one single day, it is not considered as performance because it is not a reception ...

When the work tasks are differentiated into fixed codes, they become rated and valued on the basis of whether it is possible to fit them into the code system or not. By making only certain tasks visible, AHO categorises them as either 'approved' or 'not approved' and thus 'not valued'. This raises the question whether practitioners should record those functions which are not approved, even though such functions (such as housing rehabilitation) might be valuable for both the practitioner and client. A number of practitioners reported that it was 'unwise' to do this too often and that 'working outside the box' became a deviant activity and was frowned upon. The procedure of coding the work solely as client receptions in this way promotes conformity and creates a normative system that standardises the content of work (see Rose and Miller 1992, p. 187, Karjalainen 1998).

The practitioners fill in their appointment books or diaries in almost the same way as they record their activities in AHO: daily tasks appear in them strictly detailed and precisely planned in advance. From these clinic managers can see how the practitioners working hours are filled and, for example, with individual client visits, no time is set aside for preparatory planning prior to the visit. All in all, AHO changes *the routines* of outpatient clinics and thus affects the prevailing way community mental health work becomes performed.

## ***II. Content of client receptions – performed in a supportive but restricted manner***

In this section it will be shown that even though the documentation in AHO is meant to serve administrative needs, it can have negative consequences for therapeutic client encounters.

In each outpatient clinic first time visits are classified as more expensive than repeated visits (Documentary data: Federation of Municipalities at Pirkanmaa 1999) and therefore they are accorded a high financial value. However, when practitioners are trying to see the 'first-timers' as soon as possible, it naturally becomes more difficult to see ongoing clients. With the overall number of encounters increasing, both for 'new' and ongoing clients, it becomes more and more difficult to practise intensive therapy. The inevitable result is an increasing emphasis on short-term intervention and limited contact, with all the attendant practice dilemmas this creates, as the following two practitioners explain:

We have young male clients here who obviously have a potential working career ahead of them. But right now their personality is in such a fragile state that intensive psychotherapy provided by Kela [Institute of National Pension] would probably be too demanding for them. More flexible but regular therapy would be needed and that is something we should offer here. But then we are able to meet this client only once in three weeks which clearly is not enough . . . This makes me feel most guilty about myself for not being able to treat them properly. Basically I'm neglecting them. (Psychologist)

It is wrong that I can see this client so rarely because it is not possible for me to meet her more often in this situation. Is it correct to go through her childhood experiences when she has no support in between our receptions? Is it right thing for me to . . . sort of open the casket of her mind when all I have time for is just opening it? I am not able to keep my promise to help her and explore the contents of her mind. (Psychiatric nurse)

At a time when demand for non-institutional psychiatrist care is increasing in all European welfare states (EU Observatory on Health Care 2002), the Finnish outpatient clinics in the study attempt to control demand by formulating quantifiable goals that effectively regulate client access to services. Efficiency has become the official and overriding goal of the clinics (Documentary data: Functional Changes 2002). If the practitioner is sensitive to demand and tries to see as many clients as possible, then the only way she/he can do this is by keeping the reception time short. Consequently practitioners' interventions can easily become hurried and rushed although they themselves would not want this. The difficulty of balancing numbers with client need is highlighted in the following quote:

In those kinds of situations when I feel that I have many . . . yes, too many clients, I feel very anxious and stressed. I don't know exactly how many clients I'm having right now, but I guess maybe 40 to 60 at any particular time. I can't respond to everybody with the same amount of enthusiasm and concentration. Somebody is always suffering because not everyone gets equal treatment. (Social worker)

It is therefore not possible for practitioners to give the kind of attention and intensity to clients they feel appropriate according to their professional values,<sup>3</sup> and this is seen to have negative consequences for clients. Clients are confronted with demands and expectations concerning their eligibility as recipients of treatment. They have to cope with intensive receptions whose timing is usually planned strictly in advance. Support offered by such interventions may be inadequate because the mental health clinic is usually the only institution in the district officially responsible for providing medical and psychological care.

The duration of a treatment programme for an individual client is accurately defined and specifies the number of encounters over a certain time period. As part of the aim to rationalise and standardise the function of the clinics, the treatment period of any one particular client is generally relatively short (Documentary data: Project Plan 2002). In this situation the use of AHO encourages a narrow approach to clients' problems that concentrates on surface issues rather than depth (Howe 1996). In order to log in to the data system, practitioners have to enter the identity number of the client. The log-in is possible only with those clients that are currently on a practitioner's official caseload. Those client meetings that are held at other points of time, outside the client's official treatment period, cannot be recorded in the data system. This situation is described as follows:

Some meetings, for example the multi-organisational rehabilitative meeting [attendees from the employment exchange office, public health care, public social welfare and Institute of National Pension, plus the client] concerning the situation of one particular

client ... so if this client is not currently in the case load of our organisation, it is not possible to record this meeting in the system. (Social worker)

The use of AHO codes effectively ensures that interventions will be done within the strict time limit of official treatment periods. This can produce fractured interventions, rather than a holistic approach, that views client problems individually, detached from wider social factors. This is despite official pronouncements that the preferred way to carry out the work is to adopt a comprehensive and wide-ranging orientation (Documentary data: Agenda for Mental Health Services in Tampere 2002, p. 56). At a grassroots level it is not possible to work with clients' wider networks, if professionals want to make their performances visible via the data system. Naturally, it is still possible for practitioners to document those interventions performed outside the official treatment periods in traditional case records. However, without a code they are not included in the administrative follow-ups and income statements, and as a result such work becomes marginalised.

### ***III. Professional issues: accountability towards the agency versus the client***

There was evidence that the drive towards greater efficiency through meeting administrative targets, became adopted by individual practitioners and began to shape their thinking and professional goals. The data system is a tool, and when the practitioners log in to it they are inevitably compelled to evaluate their work against quantifiable achievements. AHO thus assumes the role of a silent supervisor persuading practitioners to assess the efficiency of their own actions on a daily basis. Accepting responsibility for one's own productivity was also reflected in the documentary data revealed in practitioners' appointment books and daily schedules:

Tomorrow I have three patients. So it's, it's a bit, a bit too full up, but that's what you have to do, and then there's the group. (Social worker)

So this Thursday is a bit pointless, but then I'm the one who fills up my book! It's too hectic, but you have to learn to do your calendar a bit better yourself. (Psychiatric nurse)

These two brief entries illustrate how professionals make sense of their work and interpret their experience through a discourse of being a productive worker, one who (albeit reluctantly) acknowledges the demands of meeting administrative targets (see Dean 1994, 1999, p. 32). However, it was found that practitioners moved beyond recognition and began to adapt their own actions to ensure they were using language consistent with AHO codes. In other words they attempted to make their activities fit quantitative objectives. When taken to its logical conclusion practitioners turned themselves into a business unit. This connects with the experience of managers in the UK,

the person I need to see most is the Finance Officer. As the culture of my work has changed, so 'my speak', my attitude, has changed. At the end of the day the last thing I want on my epitaph is 'he filed the last invoice', because that is what it feels like ... Now you feel that you are a business unit. (Cited in Harris 2005, p. 9)

The AHO data system can be seen to produce a certain kind of target driven worker. Conformity to the system becomes a precondition for being able to work in an outpatient clinic and this may be interpreted as autonomy, the reward for responsible behaviour:

In my opinion we don't have much directedness.

(Interviewer) And do you think that's a good thing or a bad thing?

Oh it's good, a good thing ... more good than bad. Because we are all professionally skilled in any case and accept responsibility and are responsible people. (Social worker)

Although this quote infers a consensus between professional and organisational goals, it was found that the process of negotiation involved reconciling contradictory pressures and led to increased worker stress (see Huxley *et al.* 2005). Professional judgement and discretion becomes encircled by the discourse of budgetary calculation (Miller and Rose 1991, pp. 132–133). Entering work completed on the AHO system puts the practitioners in a position where they have to balance the demands of quantitative productivity on the one hand with their own professional values on the other. Individual workers weigh up how to get sufficient visits done and still do therapeutic work with clients as well. Reconciling these competing demands has become increasingly difficult:

I could of course decline a patient, not see him/her, but those which are already, well, with them it has confused this schedule an awful lot. But once the referral has been made out, well then these people must be seen. (Psychologist)

Further, there is the problem of keeping within budget and accepting as many clients as possible, and this may override the interests of both worker and client. Here organisational compliance may swamp professional thinking at the expense of quality and client need:

The treatment negotiation, if it's my client, then they're very important. But they are what ... in a way, what gets sacrificed first, just those co-operative partners and the like, that are not absolutely compulsory. But they'd be important in a way from the perspective of our work, as we should know what's going on elsewhere. (Social worker)

Thus, the AHO system can be seen to produce a certain 'appropriate' way of being a mental health practitioner, in which the essential skill becomes the ability to control one's professional self to meet organisational goals.

### Further analysis and discussion

Further analysis was carried out by applying the notion of governmentalisation of government, the concept situated in the tradition of analytics of government derived from the work of Foucault (1991) and based on his concepts of power and subjectivity. This was further elaborated by Dean (1994, 1999) and Rose (Rose and Miller 1992, Rose 1999) who introduced the notion of 'reflexive government' to denote how government may conceive its task as operating upon existing forms of government as a way of managing highly differentiated populations (Dean 1999, p. 196). The study highlights how the aims and management of the clinics become closely inter-twined with the everyday activities of practitioners. The deployment of various audit instruments therefore becomes vital in order to monitor institutional performance and evaluate how they function as efficient, accountable and transparent organisations (Dean 1999, p. 193). The notion of governmentalisation of government is relevant to the study as it focuses attention on how the information revealed by audit is itself becoming important to scrutinise, instead of the 'actual objects' of care, the service user or client and their life situation. Consequently,



the impact that auditing instruments have on institutional practices has become problematised and contested.

The modern audit system may be viewed as a technology of government,<sup>4</sup> designed to subsume domains of expertise to formal calculative regimes (Dean 1999, p. 169). From the study it would appear that AHO makes possible certain ways of working and inhibits others. Drawing on Rose and Miller (1992, pp. 183–187) the influence of AHO is based on its inscriptive nature, i.e. its capacity to render practical aspects of clinic practice into written and calculable forms. Presented in this structured way, practitioner tasks become amenable to calculation, codification and evaluation. Webb (2006, p. 142) has described the programmatic effects and procedure for carrying out tasks in practice, brought about by diverse technologies as rational schemas for organising work. In other words, many different care-based interventions are organised, arranged and regulated on the basis of meeting organisational requirements and managerial goals. Findings from the study would appear to support Webb's analysis.

Questions can be legitimately raised about whether audit systems such as AHO are being used as a Trojan horse to justify the continuing use of institutional practices. Munro (2004, pp. 1079, 1093) has pointed out that when audit is done in order to enhance the credibility of the organisation, it is focusing on policing internal systems of the organisation rather than making a direct examination of practice itself. Although the work might be subject to closer monitoring and evaluation than ever before, the surveillance is directed at the paperwork attached to the work, not at the intricacies of the actual practice interactions. However, evidence from the UK suggests that one of the consequences of this is that the energy of practitioners is directed towards meeting official targets that are only tenuously related to the quality of outcomes for users (Wells 1997, Stepney 2006). Tsui and Cheung (2004, pp. 439–440) address the same concern by emphasising the ratio of 'output to input' as the primary benchmark for measuring the performance of social workers and their organisations. When professionals are increasingly required to manage diverse audits, the time for this is inevitably taken from direct service with clients – something which caused practitioners in the study much concern.

Research suggests that individual practitioners are subject to multiple pressures that become embodied in the classification systems (Parry-Jones *et al.* 1998). Attention should thus be paid to the tension between control and autonomy in order to evaluate the diverse implications of new classificatory infrastructures (Bowker and Leigh Star 2002, p. 227). Individual practitioners in the study devoted considerable time to meeting administrative targets, whilst at the same time being 'managers of risk' in the community, an essential role in the field of mental health care. As Foster (2005, p. 26) concludes, professionals in mental health teams are expected to use their professional knowledge for the purposes of risk management. This knowledge is crucial since the public mental health services are increasingly held accountable and exposed to public disparagement and political criticism, if any deficits are retrospectively discovered (see also Sawyer 2005).

## Conclusions

The aim of this article has been to illustrate the diverse ways in which the codifying data system, AHO, increasingly shapes the practices of mental health clinic

practitioners. Although drawing firm conclusions from a small qualitative study of Finnish practitioners is clearly inappropriate, three general points emerge:

- First, it was shown how AHO influences the content of outpatient clinic work making it quantitatively and selectively visible. It thereby creates a normative system defining what kind of practice is acceptable.
- Second, this creates a form of electronic quantitative surveillance, such that AHO acts like a modern day panopticon – something Jeremy Bentham might have been proud of. The way in which data are entered on the system determines what actions will be carried out in what way.
- Third, the code system sets the boundaries as to what kind of work can be approved and financially supported. It thus becomes difficult to justify other forms of work with clients.

Although it is not the stated or official intention that AHO codes determine the content of worker–client interaction, it is significant that financial resources are allocated solely on the basis of work rendered visible by the codes. It was found that whilst receptions were performed in a supportive manner, the processing of quantitative evidence inevitably creates encounters that are shallow and superficial. It may be difficult for practitioners to orientate in a focussed manner to the client's situation when at the same time they are required to demonstrate the efficacy of the work measured by quantifiable codes attached to individual visits. Moreover, this leads to short-term interventions whilst attempts to offer long-term care and support are made more difficult (see Sawyer 2005, 2006).

The findings from the study emphasise how professional ways of working can quickly assume a statistical form in order to serve as a basis for gaining scarce resources. However, efficient ways of working are not always conducive to supporting and maintaining psychotherapeutic relations with clients, which is one of the stated purposes of the work (Documentary data: Agenda for Mental Health Services in Tampere 2002). Even though the procedure of code documentation relates primarily to the statistical compiling of data for administrative needs, it was found to have a direct impact on client work. What is striking here is the contradiction that even though it is possible for professionals to document performances freely in case records, only documentation recorded in AHO was taken into account when the performance of the clinic and its staff was evaluated. In this way the data system makes the work visible, documented and thereby legitimate.

Finally it was shown how practitioners themselves have begun to define and make sense of their work within the modality of the codes: as a daily used device, the system offers a reflective arena for practitioners to evaluate and compare their own performances against administrative norms. Thus AHO acts as a catalyst that intensifies aspirations for efficiency rather than the 'quality' of receptions. In other words, the programmatic nature of the data system is based on its capability to boost the personal accountability of practitioners, but may do little to make them better practitioners at managing risk. The relationship between individual practitioners and agency can be perceived not only in terms of administrative accountability but raise issues of self and identity (Dean 1999). These findings bear similarity to the findings of Harris (2003, p. 68) on social workers in the UK where the modernisation of mental health services is further advanced. Practitioners in both the UK and Finland are required to act responsibly and to develop professional aspirations that are largely in keeping with managerial priorities. However, as other research has

confirmed, this is achieved at a cost in terms of reduced job satisfaction and worker stress and client contact (Parry-Jones *et al.* 1998, Huxley *et al.* 2005).

Overall, the analysis has demonstrated how various strategic objectives articulated at the administrative level are conveyed in a form that shapes the actions of the practitioners. By placing the audit system of caring institutions into the trajectory of governmentalisation of government, it becomes possible to locate the personal and professional responsibilities of practitioners within the administrative aims of organisations and wider policy structures. This article has cast light on how a particular set of administrative procedures may have far reaching consequences. In so doing they frame the possibilities of the practitioner to act in contradictory roles as budgetary calculators and care facilitators. Habermas (1978) once suggested that the problems of politics have become the problems of administration. In community mental health work it would appear that professional practice is now being reshaped by managerial audit and might go much the same way.

### Acknowledgements

Please note that part of the analysis presented in this article has been previously published in the *Finnish Journal of Social Policy and Social Work Research, Janus*. See Saario, S. and Hämäläinen, P., 2007. Mielenterveystoimiston käytäntöjen muotoutuminen tietojärjestelmän välittämänä [The formation of mental health clinic work via computer-based data systems]. *Janus*, 15 (2), 149–164. It has been translated and developed here with the kind permission of the publisher and Chief Editor of *Janus*.

### Notes

1. Outpatient clinics are the prevalent form of providing specialised psychiatric community care in Finland. Administratively, clinics belong either to special health care or primary health care. Operating in a defined district, clinics collaborate with other regional agencies like municipal health centres, psychiatric hospitals, day hospitals, domestic social work teams and various voluntary and semi-public NGOs. Access to treatment requires a doctor's referral.
2. Interviewees have given their consent for presenting the data, with original extracts in Finnish translated into English.
3. The values of Finnish mental health practice are primarily based on psychotherapeutic approaches. Amongst Finnish mental health professionals, psychotherapeutic encounters are seen as an essential part both in the treatment of depression and schizophrenia (Helén 2007, pp. 153, 163). Unlike the UK, in Finland psychotherapy is mainly provided within public mental health services.
4. For a more thorough account of the concept of technologies of government see Dean (1994, pp. 187–188, 1999, p. 173).

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# Contractual audit and mental health rehabilitation: a study of formulating effectiveness in a Finnish supported housing unit

Saario S, Raitakari S. Contractual audit and mental health rehabilitation: a study of formulating effectiveness in a Finnish supported housing unit  
*Int J Soc Welfare* 2010; 19: 321–329 © 2010 The Author(s), Journal compilation © 2010 Blackwell Publishing Ltd and International Journal of Social Welfare.

Mental health NGOs in Western Europe are increasingly managed by contractual audit procedures. This article concerns how contractual audit and its emphasis on effectiveness of care impact on the practices of long-term mental health rehabilitation. To demonstrate this, a case study of a Finnish NGO that provides supported housing is presented. The study looks at how service purchasing practices, as stated in the contract between the municipality and the NGO, are reflected in the meetings among practitioners. Documentary and meeting data were utilised together with Mitchell Dean's notion of technologies of agency. It was found that practitioners actively sought to show the effectiveness of their everyday work in terms of contractual audit by demonstrating both the economic and progressive aspects of care. Thus, professional competency in mental health rehabilitation appears to entail both the skills of care interventions and the ability to perform these interventions as efficient and financially accountable activities.

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Accepted for publication January 24, 2010

## Introduction

In Western welfare states, reforms of management models in the social and health services have often been implemented according to the principles of new public management.<sup>1</sup> In the service structure based on these principles, practitioners in social and health services are increasingly expected to provide evidence of the effectiveness of their practice and embrace an effective work orientation (Germov, 2005; Joyce, 2001; Juhila 2006). Within these demands, the dilemma between the practitioners' professional autonomy and their

compliance with administrative and market principles has been widely acknowledged (Banks, 2004; Joyce, 2001; Lipsky, 1980; Prottas, 1979; Sawyer, 2005, 2006). According to Rajavaara (2007), the practices related to evaluating effectiveness have been widespread also in Finnish social policy and the governance of the welfare state since the late 1980s.

This article looks at a Supported Housing Unit (from now on referred to as the Unit), which provides long-term mental health rehabilitation and holds a position as a service provider within a local purchaser–provider model that applies the principles of new public management. The actors of the model include the municipal purchaser of services and several competing providers, the latter being evaluated on the basis of the economic efficiency, on the one hand, and the perceptible results, on the other. To be worth funding, long-term rehabilitation and its results have to be made visible in a way that the purchasing party accepts. This kind of market-orientated situation is a new one for the Unit, which previously was managed by administrative steering and

<sup>1</sup> New public management (NPM) is not a homogeneous system, but rather a plurality of ideas and objectives based on neo-liberalism. The central aspect of NPM is that the problems of public management will be solved as soon as actors embrace the modes of operation of commercial organisations, and, instead of the excessive expenditure of bureaucratic mode of activity, strengthen the role of markets as a steering mechanism (see Clarke & Newman, 1997; Dean, 1999, 2007; Greve & Jespersen, 1999).

run by regular allocations from various sources. Within this transitional stage, being able to show the effectiveness of the Unit is becoming more and more vital as competitive bidding procedures related to the purchase-provider model favour service processes that are as cost-effective as possible (Joyce, 2001; Salo & Kallinen, 2007). Also, the front-line practitioners of the Unit are required to provide arguments for the effectiveness<sup>2</sup> of their daily work with residents. The practitioners are experienced with psychosocial client work, but representing a cost-effective service provider is a new role for them. This means that they need to learn to view their everyday work from a new angle: instead of concentrating mainly on client work under bureaucratic administration, they now have to increasingly argue for the effectiveness and productivity of their work for the market-oriented management.

The salient feature in the purchase-provider model is the use of contracts that mediate the provision of services between the purchaser and provider. In this article, the contract called Service Purchasing Agreement (from now on referred to as the Agreement) is examined as an empirical case. This Agreement between the municipal purchaser and the Unit is studied as a concrete artefact by which market-oriented principles are implemented in the Unit's practices. By focusing on one specific practice, i.e. the inter-professional meetings among the Unit practitioners, it is studied how the contents of the agreement are echoed in practitioners' meeting talk. The interest is cast on how practitioners' argumentation, carried out in the meetings, reflects the contractual audit procedures and how practitioners utilise the policy level expressions of cost-effectiveness stated in the Agreement.

After discussing the research design, the article continues by examining the contents of the Agreement. It shows how practices related to the Agreement generate a trading relationship between the municipal purchaser and the service provider in which, above all, the accountability of the latter is strongly emphasised. Following this, the analysis focuses on the professional meeting talk of the Unit practitioners. The analysis concentrates especially on the ways in which practitioners' argumentation utilises expressions stated in the Agreement. In the next section, these ways of argumentation are reflected with the notion of *performative agency*, in order to illustrate more carefully how the Agreement contributes to a certain kind of professional orientation of mental health practitioners. The overall analysis is driven by the interest on how practitioners account for

the effectiveness of long-term mental health rehabilitation within the framework of the market-oriented and contracted service provision.

## Research design

The setting of this study is the Supported Housing Unit which offers long-term housing and rehabilitation for mental health and substance abuse rehabilitees, who are often called 'double' or 'dual diagnosis patients'.<sup>3</sup> The Unit is maintained by a mental health association (NGO) and is located in the field of community care services in mental health. The housing is founded on the principles of community-based rehabilitation. The residents live in normal rented flats where they receive professional support and from which they may visit the Unit's activity centre in the same housing area.

The data consist of two main sources: inter-professional meetings of practitioners and the Agreement that regulates the Unit's service provision. Inter-professional meetings are held amongst psychiatric nurses, mental health nurses and substance abuse workers. In these weekly meetings, the practitioners discuss general issues related to the Unit's practices and review the current situation of each resident. The meetings often discuss very concrete matters related to the residents' everyday situation. The discussion is rather informal. The residents themselves are not present at these meetings, which can therefore be seen as an arena where professionals produce descriptions and narratives about an absent client (Mäkitalo, 2002; Nikander, 2003).

The meeting data are interesting when considering the argumentation for effectiveness precisely because the meetings are what are called 'naturally occurring situations'. Meetings are not special strategy sessions or 'quality circles' with the explicit purpose of producing evaluative information for the representatives of the purchaser. The management of the mental health association or the municipal purchaser party is not even present, as the meetings are exclusively arenas for front-line practitioners. Thus, the objective of the

<sup>2</sup> In this article, effectiveness is understood as a concept that includes both economic efficiency and the impacts of welfare state interventions. On effectiveness as a part of Finnish evaluation practices, see Juhila (2006) and Rajavaara (2007). On effectiveness as a part of business ideology in British social work, see Harris (2003).

<sup>3</sup> The concept of double diagnosis is often used ambiguously. It refers generally to the simultaneous appearance of substance abuse and mental health problems, but 'double' or 'dual' diagnosis is not an official medical diagnosis in that it is not listed in DSM (Diagnostic and Statistical Manual, 2000) or ICD (International Classification of Diseases and Related Health Problems, 2007). Nevertheless, in psychiatric diagnostics, it is usually understood as a condition where the individual has both a psychiatric illness with psychotic characteristics and a parallel diagnosis of severe substance addiction. At the Unit, a resident is considered to meet the criteria of double diagnosis if he/she has both a psychiatric illness and a substance abuse problem, both of which affect his/her daily life. For other definitions of double diagnosis, see Brunette, Mueser and Drake (2004); Drake, Osher and Wallach (1991) and Kavanagh et al. (2000).



meetings is to serve the everyday work and mundane problems of the Unit. It must be highlighted that the meetings contain a very rich variety of practitioners' ways of argumentation, effectiveness argumentation being only one element in the data.<sup>4</sup>

The principal documentary material consists of the agreement (Documentary Data: Service Purchasing Agreement 2006) established between the mental health association (NGO) and representatives of the municipality. The agreement was analysed as one of the manifestations of the purchaser-provider model. Therefore, special attention was paid to those parts of the agreement that require the Unit to explicate the contents of long-term mental health rehabilitation and to report on the effectiveness of these interventions for the municipal purchaser. In addition to the Agreement, documents concerning the Unit's administration were also used in order to clarify the logic of the purchaser-provider model and the principles utilised in its implementation (Documentary Data: Purchaser-Provider Model 2007; Report on the Supported Housing Unit 2008).

The meeting data contained 26 recorded inter-professional meetings. These transcribed meeting discussions were analysed by contrasting them with the contents of the Agreement. Particularly those kinds of episodes were searched for in which practitioners argued for the effectiveness of the Agreement or otherwise used expressions contained in the Agreement. In these episodes, either the terminology pertaining to economy, effectiveness or efficiency (Clarke & Newman, 1997; Newman & Clarke, 1994; Rajavaara, 2007) was included. The criteria for including the episodes were that in each, the practitioners discussed how to transform their own work into information that financiers could evaluate, utilise and, at best, even quantify. The exact utterances indicating the terminology of economy, effectiveness or efficiency were marked, both in presented data extracts of the meetings and in the Agreement. The analysis was driven by the following question: *How does the practitioners' effectiveness argumentation reflect and utilise practices related to the Service Purchasing Agreement?*

### **The implementation of contractual audit through Service Purchasing Agreement**

In Finland, the general planning, direction and supervision of mental health work is the responsibility of the government, more particularly the Ministry of Social

Affairs and Health. The municipalities are given the statutory responsibility for arranging mental health and substance abuse services according to need (Mental Health Act 1116/1990). So municipalities organise autonomously the services as a part of public social and healthcare. The municipalities may produce the services by themselves or purchase these services from private businesses or associations. In recent years, numerous services provided by other actors have been set up alongside those produced by the municipalities themselves. Several sectors of the administration, NGOs, volunteers, parishes and the rehabilitees themselves have been invited to take part in producing mental health and substance abuse rehabilitation programmes (Government Platform, 2007). In particular, long-term rehabilitation, such as supported housing services, has increasingly been transferred to various NGOs which negotiate regularly with municipal decision makers (Murto, 2007; Salo & Kallinen, 2007). This cooperation is usually regulated by various contracts and agreements.

The Agreement studied in this article is one example of the proliferation of contracts<sup>5</sup> evidenced in the 'contracting out' of formerly public services to private and community agencies (Dean, 1999). The NGO that maintains the Unit is invited as one of the actors participating in cooperation based on contracts. The Agreement actually assigns a very crucial role for contractual audit procedures:

Service Purchasing Agreement concluded between the purchaser and the provider is the most important steering tool in the Purchaser-provider model. The agreement defines the parties, the scope and the purpose of the contract, its duration and amendment procedure, the content and quality of services, the amount and price of products, quality assurance, contract follow-up and eventual special issues with regard to the service. (Documentary Data: Purchaser-Provider Model, 2007)

All in all, the implementation of the Agreement is considered to improve the visibility of the 'product' provided, which enables the pricing of products ready to be bought and sold.

When scrutinising the Agreement, it is firstly seen that the naming of the parties is essential. The parties are termed the Purchaser (the city's Basic Welfare Department) and the Service Provider (NGO). The contact persons are named as the city's Basic Welfare Director and the Executive Director of the NGO. The Agreement is made for a one year at a time, so the relationship between parties is one of a predetermined duration.

<sup>4</sup> The meetings have been analysed earlier concerning how professionals justify residents' right to long-term care (Raitakari & Saario, 2008), professionals' accounts of residents' troublesome behaviour (Juhila, Hall & Raitakari, 2010) and negotiation of ethics in inter-professional action (Juhila & Raitakari, in press).

<sup>5</sup> On the concept of contractual implication, see Burchell (1996). On contractual implications in relations between NGOs and government, see Sending and Neumann (2006). For new contractualism, see Dean (1999).

Second, agreeing on the prices of specified service entities is a central means of setting a framework for the quantity and way of providing services. The Agreement lists the prices per day of all services (products) provided by the organisation, so that the municipal purchaser is able to compare the price of the Unit as a product with other services on offer. The Agreement thus establishes a trading relationship based on differentiated products.

Third, the trading relationship is also accompanied by legal obligations to provide various reports to the purchaser. As an example, each individual client's invoice is accompanied by a report of the services provided. The service provider also submits an annual report of activities in which is described the service process and the financial statement concerning the services provided. 'Confidential business information' is required, which means that the Agreement must include clauses on the confidentiality of documents and the provision of information.

Thus, the trading relationship between the purchaser and the Unit as a service provider requires both financial and contentual accountability of the latter. Although the agreement does not directly describe the targeted results expected from the Unit's rehabilitation programme, it is still a good example of how the service provider is required to commit, by means of the service purchasing negotiations, to acting as a transparent informant which monitors its own effectiveness, reports on it and strives for maximal efficiency in its service production. To conclude, trust between the trading actors is established largely through the external auditing in which the purchaser conducts a formative evaluation of the service provider's practice (Scriven, 1991).

### **Findings from the study: effectiveness argumentation in inter-professional meetings**

The analysis shows that the data contain a great deal of episodes where practitioners present the effectiveness of long-term mental health rehabilitation. A total of 78 episodes were found in which practitioners talk about the long-term mental health rehabilitation in relation to the Agreement's contents. In these episodes, the vocabulary referred either to the economy of the Unit's services, the progress of individual residents, or the Unit as an organisation. The number of episodes varied between the meetings. Five meetings in particular contained a great deal of effectiveness argumentation, whereas in nine meetings it was totally absent. The large number of effectiveness arguments demonstrates how the practitioners, on their own initiative, try to find ways of formulating the effectiveness of their practice. The number of episodes is notable when one remembers that generating evidence for the Unit's effectiveness is not the official task of the meetings.

### **Arguing long-term rehabilitation as economic interventions**

As was previously demonstrated, the central issue of the Agreement is the economy of the 'service product'. A great amount of background work to produce actual figures and reliable price information on rehabilitation is carried out in the meetings. Practitioners generate this information in order to serve the external decision-making process. For example, the figures are first presented to the Executive Director and the management team of the Unit, through which the economy arguments are adopted as a resource in the purchase and sale negotiations of services. Practitioners negotiate about producing prices for their own activities and proving the efficiency of the Unit. The following extract demonstrates how this is done by presenting the Unit as an alternative place for care which, for its own part, decreases the costs of special healthcare:

#### **Extract 1: Practitioners (P1, P2)**

P1: *then this thing with the cost of special health care decreasing, it goes without saying that we can produce figures that is for all, which [the Executive Director] already said that you have to produce figures now, so that you have to, have to start calculating and producing them, producing that is firm, firm figures for how much it costs, things such as treating these people there [at a certain hospital] and [at another hospital] plus who [of the residents] visits which place, but how much [hospitalisation costs] have sort of decreased since last year up to this one, and so on. But it is*

P2: (–) *a short question here (.) well (.) you had asked some, since you had put (–)*

P1: *yes*

P2: *those days*

P1: *yes, yes, yes*

P2: *but well, it, then you should have a yardstick for what the situation was like before these people moved here [to the Unit]*

P1: *yes, I will certainly get it by, so that it would be, well, somewhere like by the seventeenth [day], but in a way that, they would also indicate the prices, how much a day of care at the hospital costs, costs so that we could sort of compare [our prices with] the prices for the days of treatment at the hospital.*

At the beginning, the external requirement for 'producing firm figures' is stated. The need to define prices for service is established at the managerial level. By comparing the costs of the Unit days to those of hospital days, the economy of supported housing as community care is argued for by showing how much less expensive it is than specialised medical care.

What is essential is that the information on prices does not exist anywhere as a ready-made list, but the

practitioners themselves generate the figures and compare them on the basis of the client data they have gathered. The following data extract shows how it is very much the meeting situation in which this ground-work for production of financial values is carried out: in order to be able to compare the cost of treatment days between hospital and community care, practitioners are searching for background information on clients' previous periods of care.

Extract 2: Practitioners (P1, P2, P3, P4)

P1: *then what would be a good period of monitoring it [time spent in hospital services], before they came to the Unit?*

P2: *yes, before that*

P3: *this was the problem, do you remember us talking about whether we could show the financial effectiveness*

P1: *well, it's things like this that can be used to demonstrate it roughly, we may not be able to give it [financial effectiveness] in euros but roughly anyway, that this is how much they used the services before [the Unit] and . . .*

P3: *yes but for what period?*

P4: *would it be, one year?*

P1: *yes*

P4: *a year's a pretty good period*

P1: *yes, for the previous year but er we'll have to look at their, the papers from before [to find out how residents have used hospital services before the Unit]*

[some words removed]

P2: *it may be difficult to get that info from the hospital.*

P1: *yes that was the problem. I mean if we are going to get the actual documents [of previous treatment periods] the idea was that you could ask them [residents] about this*

P2: *if it's based on that and we trust in what people themselves say if they can remember*

P1: *or we can ask their [residents'] permission, [that whether] can we ask the [hospital's] social worker which would be different from*

P5: . . . *yes*

P1: *for example, you could ask the social worker, like can we phone the social worker and ask [about the length of treatment periods]*

Here the practitioners discuss how to make the profitability of the activity perceivable. This is done by roughly estimating how much the cost of special medical care has gone down for the residents now that they are living in the Unit. Practitioners do this by finding out the number of hospital treatment periods before the resident came to the Unit and comparing this number with the volume of hospital services required during their residence in the Unit. They make

background inquiries by asking either the clients themselves or the hospital social worker about the residents' hospitalisation periods, in order to contrast previous costs of care to current costs at the Unit. These figures are not taken from existing forms or administrative databases, but the practitioners themselves consider ways to construct a financial comparison between the Unit and other services.

While complying with the demand for presenting economical arguments, practitioners do not repeat directly the exact amount of euros as stated in the Agreement. Instead, they interpret and adjust their argumentation by constructing thereabouts figures and rough estimations. The argumentation thus reflects the Agreement's requirement to produce prices in a slightly different way. Anyhow, the practitioners do look for new ways to quantify their work and thus emphasise the economy of the rehabilitation: the Unit's alternative treatment is demonstrated to be less expensive, and, as is often stated in the meetings, the Unit's alternative treatment is considered to diminish the overall need for more expensive hospital treatment.

#### Arguing long-term rehabilitation as a progressive process

It is often mentioned at the meetings that even the maintenance of the current state of a resident from worsening is a remarkable achievement in itself, from the point of view of both practitioners and residents. However, maintaining the status quo is not always seen as being sufficient if, from the perspective of external evaluators, the most desirable result is considered to be a rapid turnover of clients that enables terminations of client relationships so that new ones can be started (cf. Paasio, 2003). Thus, the practitioners must describe their work as a process consisting of the difficult initial situation of the client, the goal-oriented interventions and the many, if small, successes. In doing this, they have to be able to make visible exactly those interventions that have a positive effect on a resident's situation. The following extract shows the client's situation being structured in a way that brings out the progressive nature of a goal-oriented intervention:

Extract 4: Practitioners (P1, P2, P3, P4)

P1: *we have been talking about Ari [fictitious name of the resident] that much that I'll briefly demonstrate the process thought system, in other words, well, that idea of Hanna's [practitioner] was damn good, there's Ari's case, so that (→) the process, the processes are split into small parts, so that these meetings of ours would run more smoothly, that we consider what's essential for the client, something for the client, such as, I mean, these goals that you mentioned for Ari, so only those that are essential and affect his life at the moment*

P2: yes

P1: *so that we won't be pushing it terribly far but it, but what we are trying to do, that we, that nothing's going to waste*

P2: *and in real life precisely what, I don't know if you Minttu [fictitious name of the practitioner] were here then what the researcher emphasised what means of therapy then, the real-life approach is the best of all, that we just talk about those things in terms of actual events, illustrating our goals when setting them*

P3: right

P2: *about these addicts*

P1: *yes, yes, and at the same time as we sort of always consider when we visit them at home, what the purpose of this visit is, what, what we're getting at through our home visit. What is the idea of that*

P4: *now this is very down-to-earth plans when it comes to Ari*

P2: yes

P1: *precisely*

P4: *that is, they [plans and goals of rehabilitation] are easy to monitor; well, how they are materialised*

In assessing the progress of a given resident, the practitioners strive to bring out clear sub-goals for home visits. Daily interaction with the clients is conceptualised as a concrete goal that is possible to monitor. Utilising the idea of process, the practitioners build progress out of the client's situation and aim to show what concrete advances can be achieved with a specific intervention. The interventions are shown to be effective because they are goal-oriented and at the same time anchored in the residents' reality. Actually, the practitioners construct cause-and-effect relationships: when the client's situation is structured as a more or less linear narrative, the fact that rehabilitation as separate interventions has a beginning, a middle and an end is emphasised.

The requirement in the Agreement to make the progress of work transparent is amply addressed in the meeting argumentation. This is done by making visible real-life and mundane achievements that are crucial contents to be included in monthly accounts and explanations of services. These achievements will concretise the progress of rehabilitation periods for external evaluation.

Whereas the previous data extract dealt with setting concrete goals for an individual resident, the next one shows that in addition to the progress of residents, the practitioners construct the overall organisation of the Unit as being of a progressive nature:

Extract 5: Practitioners (P1)

P1: *and it surely, this starting point that it's sort of this view of what rehabilitation is for these clients, that I've personally, I kind of think that whatever*

*activity that we've got here, will have to be justified by [the fact that the activity] contributes to rehabilitation, in a way no matter what, [our activity] will be one that takes these people forward in one way or another; and this aspect of rehabilitation is included in some way, no matter what.*

It is stated that the entire Unit, as a part of the mental health association, is change oriented. The practitioner above suggests that the Unit evaluate its interventions in order to meet the requirement for advancing the mass of residents. This argumentation on progress can be considered as one kind of spur that encourages practitioners to develop more concrete measures in order to model rehabilitation processes. For example, practitioners formulated a specific way to illustrate the progress of the residents: they presented the Unit's model of rehabilitation that contains three phases through which residents are expected to pass within a certain time limit (Documentary Data: WWW-pages of Supported Housing Unit 2008; Report on Supported Housing Unit 2007).<sup>6</sup> In the ideal case, a resident would be expected to transfer from the Unit to independent housing within three years.

The significance of argumentation for progressive processes is that simply collecting 'service products' and being accountable for their costs is not enough; instead, effects must be actively constructed. This requires the ability to present even apparently static situations to include progressive elements and thus to also regard them as important achievements, where the practitioners have at least succeeded in preventing a worsening of the resident's situation and a nose dive. Demonstrating static situations in 'a progressive light' is not necessarily in conflict with mundane practice; on the contrary, it can encourage practitioners to consider more carefully, for example, the contents and quality of upcoming home visits.

### Reflections of the service purchasing agreement in the practitioners' argumentation

It has been suggested that both establishing competitive prices and making the course of processes transparent are important ways of arguing on behalf of effectiveness. The previous analysis illustrated how both these ways of argumentation reflect the utterances present in the Agreement. Certain expressions of the Agreement, such as the requirements for a 'price list of service entities' and a 'service provider's monthly account', are utilised in the practitioners' argumentation, such as 'we have to give it in euros' and 'we must have down-to-earth plans that are easy to monitor'. Although these

<sup>6</sup> The exact URL of the WWW-pages and the title of the report are not mentioned in the article in order to maintain the anonymity of the Unit.



expressions are not identical with the Agreement, they are based on similar expressions of economy and progress. Within these linkages, the Agreement can be seen as an artefact that, on its own part, encourages practitioners to use effectiveness argumentation. Naturally, the Agreement is not the only factor that contributes to the economical and progressive language used in the meetings, as similar utterances could also be read in other textual data related to the purchaser-provider model.

#### Further analysis: Service Purchasing Agreement as a technology of performative agency

This section analyses further the role of the Agreement by applying the concept of *technologies of agency*<sup>7</sup> (Dean, 1999: 167–170). The concept emphasises how the Agreement functions as a mechanism that inspires front-line practitioners to formulate certain kinds of arguments. As the previous analysis showed, the Agreement contents and related practices can be seen to incite individual practitioners to transform their professional practice to be more compatible with the principles of the purchaser-provider model. It is the position of practitioners as representatives of the service provider that can be seen to elicit from them those expressions and utterances that are of particular interest to the purchaser party.

This connection between the Agreement's expressions and the practitioners' effectiveness argumentation demonstrates how a key feature of mental health practitioners' professional expertise is the ability to perform daily action in a certain way: they themselves, spontaneously, produce different arguments for the required effectiveness. Thus, argumentation for economical interventions and progressive processes can be seen to illustrate the *performative agency*<sup>8</sup> of the practitioners. It is not sufficient for practitioners only to master the content of client work and therapeutic skills; they must also be able to portray their own work convincingly in the eyes of the external municipal purchaser. Even though there are no outside evaluators and municipal purchasing parties directly present in the meetings, the meetings still function as arenas in which practitioners

raise up and innovate effectiveness argumentation. Besides their original purpose of serving the mundane problems and everyday work of the Unit, the meetings become situations in which practitioners train themselves for a performance that is consistent with the rationalities of the purchaser.

Although performative agency is something that practitioners produce seemingly on their own initiative, the Agreement includes a number of controlling features. In this sense, the Agreement can be seen as a kind of indirect managerial audit system. The Agreement introduces several instruments of measurement and evaluation that are used in the follow-up of the Unit. These instruments include annual reports, written definitions of each service product, clauses on confidentiality, regular invoicing and book-keeping. In other words, the controlling features of the Agreement play a substantial role in guiding the orientation of individual practitioners towards the aims of the policy level to render the Unit's practices calculable and comparable (see also Rose & Miller, 1992). To some extent, practitioners have the possibility to figure out how to describe the effectiveness of their work. At the same time, practices related to the agreement produce quite strict frames as to what kind of mental health rehabilitation is desired by the Unit's evaluators. Therefore, performative agency of practitioners, raised in the purchaser-provider model, includes both these features. It is based on the front-line practitioners' ability to create new kinds of means to justify long-term rehabilitation, as in this case innovating detailed ways of showing effectiveness. They do this, however, without forgetting that this 'voluntary' task is assigned to them by the management level and controlled by audit systems stated in the Agreement.

#### Discussion

The aim of the article was to demonstrate how service purchasing practices stated in the agreement are used as a resource in the meeting talk of front-line practitioners working in long-term mental health rehabilitation. Two ways of argumentation for explaining effectiveness were demonstrated: the practitioners construct mental health rehabilitation both as economical interventions and as progressive processes. This argumentation is largely based on the ability to report and deal with everyday work in terms that are congruent with the rationality of competitive service provision. This kind of active redefining of rehabilitation work in order to answer for accountability demands was conceptualised as performative agency of the practitioners. The study showed how the Agreement, as a technique that produces performances of effectiveness, extends its rationalities successfully also to professionals' informal and everyday dialogue.

<sup>7</sup> Dean has presented the concept of technologies of agency as a part of his considerations of neoliberalism as one kind of transformation of governmentality in contemporary liberal democracies (Dean, 1999; see also Rose & Miller, 1992).

<sup>8</sup> In this article, the idea of performance is proportioned to the administrative frame of the purchaser-provider model; consequently, performative agency of practitioners refers to such agency that carries out certain acts or routines, as in this case the performance or act of effectiveness argumentation. On technologies of performance, see Dean (1999). For the concept of performance in relation to modern technology, see Grint & Woolgar (1997). For the concept of performance in gender studies, see Butler (1990).

The performance of individual practitioners is interconnected with the fact that the Unit, as an institution, is facing the need to present itself in as good a light as possible. The Unit must increasingly pay attention to its internal administrative processes in order to generate evidence of its effectiveness. Long-term rehabilitation must be presented as convincingly as possible in order to win over other competing service providers in the field. Still, once the service is included in the regional service provision, this inclusion is defined only in fixed-term periods and thus the position of the service provider will eventually be evaluated again. If the service does not appear effective in the eyes of the financing body, it might be dropped from the outsourcing competition and left without resources. Consequently, the effectiveness arguments of individual practitioners are interconnected with the legitimacy of the long-term rehabilitation programme and the almost constantly uncertain status of the Unit.

Despite the fact that this article has dealt with the effectiveness arguments that are in line with the purchaser-provider model, the meetings do not focus only on these. An important aspect of the meetings is the fact that the practitioners' effectiveness arguments are often followed by a critical assessment as to how aptly this kind of argumentation is capable of describing practice. In economic argumentation, continually different modes of services are compared, which is often problematic because long-term rehabilitation is easily evaluated narrowly and out of local context. The financing bodies are rarely familiar with the content of mental health rehabilitation, even though they are the ones who decide which services will be purchased by the municipality.

Besides the critique, effectiveness argumentation was often accompanied by the practitioners' more straightforward observations of the residents' mundane problems. In these utterances, the effectiveness of rehabilitation was grounded by describing how the residents cope in their daily lives. For example, because of the Unit, the rehabilitees are able to live in the Unit's rented flats relatively independently and still receive the support needed. This manner of arguing emphasises the recognition of the multiple dimensions of the residents' situation. In these instances, the daily aspects of rehabilitation were used as counter-arguments for financial accountability. This was often followed by pointing out the difficulty of transforming the commonplace routines of rehabilitation into efficient interventions. The dynamics of this dilemma call for further empirical research, as well as the extent to which the formulation of effectiveness argumentation might also facilitate everyday practice by encouraging more careful planning of interventions.

Although the practitioners point out the inadequacy of effectiveness arguments to describe fully the

contents of the rehabilitation, they nevertheless do not problematise their own professional role in providing evidence of the effectiveness. Thus, despite the critical talk, being accountable for the effectiveness of one's work may be regarded as a fairly self-evident thought among studied practitioners. Perhaps this kind of performance is seen as an inescapable fact and a necessity in order to secure the resources for the Unit and to be able to concentrate on the actual rehabilitation work with residents. Meeting argumentation shows that the practitioners see themselves as personally responsible for giving the figures and depicting their work in an expected manner. It is worth noting that they do not in any way see it as the residents' responsibility to strive for a more quick recovery and thus 'help' the Unit to get results (see Matarese, 2008). Rather, the professional identity of the practitioners appears to utilise two kinds of rhetoric: the one emphasising financial issues and the efficiency of interventions, and the other highlighting the regular everyday problems and routines of the residents.

Western welfare states are becoming increasingly faced with a situation in which standardised forms of accountability are not enough, but practitioners in social and health services are beginning themselves to innovate measuring instruments in order to show their effectiveness (see Dean, 1999). At least as far as the mental health practitioners studied in this article are concerned, this is true: it is no longer enough to master the skills of psychosocial rehabilitation, one also has to master the effectiveness argumentation. It can be argued that performative agency, which accounts for the effectiveness of mental health rehabilitation, is necessary when it comes to maintaining the Unit's position as a service provider. By arguing for effectiveness in line with contractual audit, practitioners can ensure their right to conduct long-term rehabilitation within the current management structures that prioritise economy and short-term effects.

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## Managerial reforms and specialised psychiatric care: a study of resistive practices performed by mental health practitioners

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**Abstract** Throughout Western Europe, psychiatric care has been subjected to 'modernisation' by the implementation of various managerial reforms in order to achieve improved mental health services. This paper examines how practitioners resist specific managerial reforms introduced in Finnish outpatient clinics and a child psychiatry clinic. The empirical study involves documentary research and semi-structured interviews with doctors, psychologists, nurses and social workers. The analysis draws on notions of Foucault's conception of resistance as subtle strategies. Three forms of professional resistance are outlined: dismissive responses to clinical guidelines; a critical stance towards new managerial models; and improvised use of newly introduced information and communications technologies (ICTs). Resistance manifests itself as moderate modifications of practice, since more explicit opposition would challenge the managerial rhetoric of psychiatric care which is promoted in terms of positive connotations of client-centredness, users' rights, and the quality of the care. Therefore, instead of strongly challenging managerial reforms, practitioners keep them 'alive' and ongoing by continuously improvising, criticising and dismissing reforms' non-functional features. In conclusion it is suggested that managerial reforms in psychiatric care can only be implemented successfully if frontline practitioners themselves modify and translate them into clinical practice. The reconciliation between this task and practitioners' therapeutic orientation is proposed for further study.

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**Keywords:** psychiatric care, child and adult mental health, mental health professionals, resistance, Finland

### Introduction

This article examines forms of resistance employed by Finnish practitioners as a part of their everyday practice in public mental health care. It will demonstrate how practitioners resist specific manifestations of managerial reforms taking place in practice. The aim is to illustrate how the continual introduction of new guidelines, management models and information and communications technologies (ICTs) evokes reactions from practitioners and is resisted by them. The article presents three manifestations of professional resistance: dismissive attitudes towards clinical guidelines; a critical stance towards new managerial models; and improvised



use of ICT applications. Resistance is approached by examining practitioners' talk as well as managerial documents, based on empirical research in a child psychiatry clinic and outpatient clinics.

Resistance among professionals in healthcare has been previously studied in terms of the implementation of various administrative policies, such as the standardisation of care and the introduction of various market imperatives that are noted to challenge practitioners' discretion (Corwin 1961, Goss 1961, Doolin 2004, Greenhalgh *et al.* 2008). Outside the realm of healthcare, studies of public or private human services have identified different forms of workers' reactions to managerial control and mapped their discretionary space (Hirschman 1970, Raelin 1985, Hirschheim and Newman 1988, Thomas and Davies 2005). As for practitioners' resistance taking place in psychiatric care specifically, there are studies on opposition to the dominance of biomedical practice (Turner 1995, Pilgrim and Rogers 2009) or ways of labelling patients (Griffiths 2001, Godin 2004). However, there are only few studies on reactions to particular managerial reforms (Danzinger and Welfel 2001, Sawyer *et al.* 2009).

Like many other fields in European welfare states, mental health care in Finland is increasingly driven by the principles of market economy, resulting in routines of calculation and audit (Miller and Rose 2008). Relating to this context, the article examines psychiatric care in terms of its increasing modernisation and technologisation. Managerial reforms are realised through increased technology and renewed administration which is well illustrated in Finland's new governmental plan for modernising mental health care (Ministry of Social Affairs and Health 2009). The plan, composed by representatives of several governmental stakeholders, includes the definition of a policy both for mental health care and substance abuse work. It accords a key role to various guiding tools and technological instruments, which are seen to guarantee the compilation of a range of casual and local 'good practices' into a standardised and uniform mental health practice at a national level (Ministry of Social Affairs and Health 2009). Guiding tools are also introduced to increase the efficiency of services. This is why specialised psychiatric care in Finland is appropriate for studying resistance: it is currently imbued with managerial reforms and administrative strategies that, with the help of technologies, set an emergent frame within which practitioners can perform.

Questions about resistance are especially vital in those contexts where people's behaviour is regulated by diverse programmes and technologies. This idea draws on Foucault (1990: 95), who states 'where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power'. Thus the government of practitioners' conduct through managerial reforms is always interwoven with their dissenting counter-conducts (Gordon 1991, Foucault 2007). This suggests that as managerial reforms are implemented to conduct professionals, reforms become tightly entwined with the choices of individual practitioners. This article focuses especially on certain productive aspects of managerial reforms: what kind of counter discourses, 'work-arounds' or 'wiggle room' do they yield for practitioners? More specifically, I will ask how individual practitioners employ opposition and modifications in specialised psychiatric care that is constantly being moulded by new technologies representing managerial reforms.

In this study the idea of resistance is approached by emphasising mundane manifestations of resistance which are embedded in microlevel practices of workers. In order to study the forms of resistance emerging in daily professional practice, the descriptions of front-line practitioners themselves are of great significance. That is why practitioners' professional views are studied, how they identify various flaws in their practice and make known their opinions on what is not working. Besides this, I will demonstrate how concrete routines of clinical work are affected by resistive measures taken by practitioners. As Hoy (2005) phrases

it, the forms of resistance appear usually both as an activity and an attitude. This focus on a wide variety of different resistances around managerial reforms is founded on Foucault's (2007) view on resistance taking place as sporadic and dispersed acts, likely to be found in varying forms and contexts.

The next section of the article discusses the research design, the nature of the empirical data and the methodology used. This is followed by analysis of various expressions of resistance employed by front-line practitioners in the context of a child psychiatry clinic and adult outpatient clinics. The analysis focuses particularly on how practitioners employ forms of resistance both in their professional views and in their daily routines. Special attention is paid to the ways in which practitioners rationalise and provide reasons for their resistive actions and opinions. To grasp a sense of what kind of issues the resistance is aimed at, the analysis of the interview data is carried out alongside documentary research. Finally, consideration is given to whether the studied local manifestations of resistance imply any political or collective dimensions.

## Research design

The setting of the study comprises two Finnish mental health institutions, both providing specialised psychiatric care. The first is a community mental health centre (CMHC) composed of four regional outpatient clinics (OPC), operating in different districts of a relatively large city. Outpatient clinics are the prevalent form of community mental health care for adults in Finland. Along with treating medical conditions, treatment entails mainly psychotherapy and counselling. The other institution is a child psychiatry clinic (CPC), operating in a hospital which is located in the same city as the OPCs. Treatment of children involves diagnosis and evaluation of needs, as well as crisis therapy and psychotherapy, support for families, and collaboration with day care, school and childcare authorities.

Even though the two settings are affiliated with different organisations under separate managements, they were chosen for investigation on the basis of their similarities. They both offer specialised psychiatric care conducted by multidisciplinary teams and both have been recently reshaped by administrative reforms, which have created challenges for practitioners when trying to adapt their professional practice to novel structures. Furthermore, as providers of public healthcare in Finland, both organisations are facing the need to provide more services and thus to increase the number of clients. Consequently these services are often characterised by unmet demand (Ministry of Social Affairs and Health 2009). In mental health services for children and their families, from the 1990s the focus has moved more towards specialised care, for example, to units such as child psychiatry clinics (Ministry of Social Affairs and Health 2009). Regarding psychiatric community care for adults, since the 1980s, there has been a constant and increasing need for services, especially in outpatient clinics (Korkeila 1998, Wahlbeck 2005). These issues are likely to produce similar problems concerning the professional agency of front-line practitioners: they need to actively adapt themselves to new situations and demands while still carrying out their normal work tasks.

The empirical study involved both documentary and interview data and was conducted according to the guidelines for research ethics in Finland (Academy of Finland 2010). The approval for the study was sought and obtained from the executive committees of both organisations. From the sample frame of 55 practitioners in OPCs and 85 in CPC, two practitioners from each occupation were recruited per site, in order to get data representative of each professional group. With two test interviews, the interview data resulted in 18 semi-structured interviews of practitioners (see Table 1). This sample was presumed sufficient

for detailed analysis on practitioners' reactions to new managerial reforms. Practitioners were asked to participate in the interviews by invitation, and were advised to choose the interviewees among themselves. The professionals who volunteered explained that their willingness to participate was due to being less busy with clients at that moment, or by expecting the interview to offer them a refreshing change from their normal position as the ones 'interviewing' the clients.

In the digitally recorded interviews, practitioners were asked to describe their daily practice in a detailed way. In addition to these descriptions, practitioners were asked about their views regarding problems they had experienced in their current practice. In addition, some specifically tailored open-ended questions were asked on the issues that had arisen from the descriptions of daily practice, which seemed relevant for understanding the relations between institutional structures and individual professionals' action. All the following data extracts from the practitioners' interviews represent cases that appeared equally in both research settings. The persistence of the issues brought up by practitioners is partly demonstrated by the fact that the interviews were conducted at different times, OPCs in 2002 for a pilot study (Saario 2005) and later with the same interview structure in CPCs in 2007 for this particular study.

The analysis proceeded through a number of stages: first, all instances that referred to resistive action or generally to critical utterances, were marked in the interviews. The instances were then divided into various themes, each describing one particular form of resistance. The themes crystallised gradually, each of them casting light on a different dimension of practitioners' resistance. The themes were identified as 'dismissal of administrative guidelines', 'criticism of management models' and 'improvising the use of audit systems'. Only those themes that contained the issues that had arisen in both settings were included in the analysis. This was done because the analysis was not intended to compare child and adult psychiatric care on the basis of their differing features, but rather to view both institutions as 'being in the same boat' when it came to practitioners' position, agency and possibilities for resistance (see e.g. Nancarrow and Borthwick 2005).

During the process of identifying themes, the interview data were constantly contrasted with the documentary data. These data included relevant administrative and policy documents, such as minutes and annual reports from both settings (a list of the documentary data can be found in the Appendix). They provided the frame of local objects and rules in relation to which issues raised by practitioners in the interviews could be contextualised. The significance of the documentary data was that it located the interview talk of practitioners in the organisational context. Thus the documents helped to concretise those objects of resistance that practitioners sometimes brought up rather vaguely.

Table 1 *The mental health practitioners interviewed for the study (N = 18)*

<i>Occupation</i>	<i>Number of practitioners in OPC</i>	<i>Number of practitioners in CPC</i>
Social worker	3	2
Psychiatric nurse	2	3
Psychiatrist	2	2
Psychologist	2	2

The category of psychiatrists includes two residents in psychiatry, one from each setting. The numbers include two test interviews, conducted with one OPC social worker and one CPC nurse.

The central question guiding the analysis was as follows: What kinds of variations are embedded in prevailing psychiatric practice, and how do psychiatric practitioners perform them? In order to comprehend the interconnection between the forms of resistance and managerial reforms, I also explored how practitioners themselves justify their resistant acts. The particular interview extracts presented in the following section were chosen because they most aptly illustrate the most common forms of resistance, shared by each profession studied.

### **Findings: forms of practitioners' resistance**

This section is structured as follows: the main headings name the form of resistance and also the object of this resistance, namely, the structures at which resistance is mostly directed. Three particular forms of professional resistance are presented: dismissal, criticism and improvisation. Each of these forms demonstrates different manifestations of managerial control in clinical practice. The subheadings demonstrate the reasons and motivations for resistance in more detail, as expressed by the interviewed practitioners. So, first the target of resistance is described and then the practitioners' reasoning towards the resistant behaviour.

#### *Dismissal of administrative guidelines*

This subsection presents the first form of practitioners' resistance, which is dismissal. The object of resistance is ubiquitous administrative guidelines. Practitioners argue for their dismissal by pointing out: first, the impossibility of complying with guidelines; and second, these guidelines are not seen to have any real significance for therapeutic work.

New administrative guidelines are frequently being introduced both in child psychiatry and outpatient clinics. The guidelines in question deal with various procedures in everyday practice, mostly in order to improve the productivity and quality of care in various ways<sup>1</sup> (Appendix: Report on CPC 2007). The content of guidelines includes, for example, how to fill one's own personal indicators of work performance, the desired frequency of participation in further training, specific forms and scales with which to evaluate one's own know-how, how to participate in 'development conversations' on a regular basis and how often to participate in ICT training. The guidelines also instruct the multidisciplinary team as a whole, for example, on the desirable ways for the staff to contribute to projects guided by external consultancy, and how people at the grass-roots level should get together regularly to go through the results of performance indicators (Appendix: Report on CPC 2007).

*Guidelines are impossible to adhere to literally:* In the child psychiatry clinic, the range of imported guidelines is especially wide. The following interview extract presents a nurse's dismissive attitude towards adapting newly imported guidelines in her work. She talks about guidelines in general, as an entity, without explicating any specific instruction:

Nurse: So that it is, it's really strange, this administrative organisation, it feeds itself, this complexity, and then they assume that once a list of instructions is issued, everybody follows them, but it isn't so. We wouldn't have time to do anything else than read the instructions and keep the folder updated, and that would be OK, but then they think that there should be paper and electronic files as well, but that is not on, not on at all.

Interviewer: What is your experience, is there some kind of control to make sure that the instructions are followed?

Nurse: No. No control at all. Not once have I been caught out being completely ignorant of an instruction (Psychiatric nurse, CPC).

Practitioners point out that it would take considerable time to familiarise themselves with the contents of various instructions. Being so numerous, detailed and continuously changing it is nearly impossible to know how to comply with every single one of them and keep them updated. Practitioners feel that guidelines have to be dismissed as it is impossible to keep up with all of them in everyday work. In addition, the nurse quoted above does not feel that reading the guidelines is even monitored at any level.

By resisting the guidelines on the basis of their excess quantity, practitioners challenge their significance by not familiarising themselves with their contents. In other words, guidelines are dismissed and even experienced as being futile. It might be seen in accordance with good mental health professionalism to dismiss futile things and maybe in this way invest one's professional capacity towards 'real work', such as therapeutic sessions. When the significance of ubiquitous administrative guidelines is dismissed, it frees time for more important things.

Even though it is predominantly presupposed by managers that guidelines are being followed by front-line staff, this is coincidentally challenged by some managerial texts. There are some documents which declare that regular front-line practitioners should be guarded against excess guidelines. For instance, the head nurses' guide actually states as one of the managerial duties 'the protection of staff from futile guideline information and excess administration' (Appendix: Management Duties in Nursing 2002, CPC). By describing guidelines as something avoidable, the administrative documents actually back up practitioners' right to dismiss new guidelines.

Certain routine procedures instructed by guidelines are purposefully ignored because they are experienced as constraining the practice or interrupting it unnecessarily. The fact that guidelines are not followed by front-line practitioners can be compared with the reception of national service frameworks (NSF) for mental health in the UK. There, it was found that it was a matter of personal choice as to whether any of the NSF guidelines were read (Checkland 2004). This response is partially based on the belief that many of the new managerial requirements are unnecessary or even harmful. Similar reaction can be found with managers who select beforehand those agency instructions to be followed by the workers, wanting to 'make life easier' for frontline staff (Raelin 1985).

*Guidelines do not affect the client work:* In outpatient clinics, the increased amount of administrative guidelines is the result of clinics' transfer from the administration of special healthcare to municipal services, under municipal management and ownership. At this point instructions on particular ways of information sharing between clinics and their partners in cooperation were introduced. This is demonstrated by the following nurse who describes the practices within the process of implementing instructions after the municipalisation of outpatient clinics:

Well, it [the municipalisation] took place then, and they said that nothing would change, well, everything, every single slip and note, and altogether phone numbers, all changed; all of us certainly felt it in our daily routines in some way, that we had all sorts of forms to fill in, and the City, well, it was all kind of changed, these forms. As a matter of fact, the basic work which I do and many do, did actually not change terribly much; we naturally



cooperate in the same way, and our cooperative partners are the same as well, but it certainly doesn't mean any terribly big changes ... We still do the nursing and caring and sending people for treatment, and I don't really know how. And if there were any particular projects going on, like there are still some now, the importance of care protocols and contacts, has always been pointed out (Psychiatric Nurse, OPC).

Despite the vast importation of new instructions for daily documentation, it is argued that these procedural changes do not in any way manifest themselves in actual work with clients. This could also be seen as another justification for dismissing the guidelines: they are not seen to affect the everyday work with clients and cooperative institutions. So, even though administrative guidelines signify new ways of rudimentary information sharing, they are not considered to have a concrete impact on performing the clinical work. However, when compared to the guidelines in the child psychiatry clinic, in outpatient clinics the new administrative forms themselves are not dismissed. Instead, they are noted as requiring some extra attention due to the modification of routine information change including a lot of new details to take on board.

The guidelines for outpatient clinics regulate only the routine modes of information change while clinical work remains intact. Perhaps this detachment of guidelines from clinical work is the reason why they are found to be easy to dismiss. They can be resisted while still maintaining 'good mental health practice'. When the administrative guidelines are experienced primarily as a procedural facade without profound implications for care, the resistance – in the form of dismissal – can be stronger and more visible. Practitioners can question the importance of guidelines and decide themselves to what extent to adhere to them. In this case the increase of instructions does not necessarily mean the increase in practitioners' compliance towards their organisation. As Evans and Harris (2004: 871) put it, 'the proliferation of rules and regulations should not automatically be equated with greater control over professional discretion; paradoxically, more rules may create more discretion'.

Again, the reception of guidelines in outpatient clinics is similar to that of NSF's in the UK: the general practitioners studied identified that nothing to do with mental health had changed as a result of the frameworks (Checkland 2004). A similar finding has been noted by Timmermans and Berg (2003) who state that as long as individual physicians select which guidelines to heed and to what degree, the impact on their clinical autonomy will be minimal.

### *Criticism of management models*

Criticism is a second manifestation of practitioners' resistance. It points towards the way managerial models are executed. Practitioners give the following reasons for their criticism: first, reforms are introduced without hearing the opinions of front-line practitioners; second, the possible future impacts of reforms on everyday practice remain unclear and blurred; third, new management models are seen to bring extra responsibilities that are detached from therapeutic work. In all of these descriptions, practitioners demonstrate abundantly the dissonance and stress caused by managerial imperatives that are changing too often.

The reforms of management models were carried out in both institutions during the data gathering. In outpatient clinics the services have just been municipalised from the hospital district. In child psychiatry the transfer to the new 'process model', in which the children and their families follow the paths of predetermined treatment processes, was introduced to substitute the previous model, called 'management-by-results'. Criticism towards diverse flaws in the implementation of these management models is utilised to resist the unreceptive way of implementing managerial reforms.

The critique does not necessarily lead to any concrete acts of resistance. Instead it is manifested in personal opinions of practitioners, which nevertheless mark strongly the negative consequences of the implementation of the reforms: affective expressions on frustration, lack of motivation, fatigue and discomfort. Criticism as a manifestation of practitioners' dissonance is focused on the fact that clinical work is experienced as a primary task which is increasingly hindered by additional organisational duties.

*Managerial level introduces reforms without consulting front-line practitioners:* The following interview extract from an outpatient clinic demonstrates how the manner of executing changes at the general level is not receptive to front-line practitioners:

Nurse: Well, there have been all sorts of changes, if you think about it in that way, and when you think about it, all the novelties that we have been through. In that respect, well, there might be more to comment on. It certainly, it feels every now and then that there, I don't know, all the management team, well, the management end on the whole, well, it isn't necessarily what shall we call it, there are all sorts of new things brought in, but, well, what's within our power, and how we can do it, and what we have the energy to do, it doesn't seem that they necessarily know.

Interviewer: That they are not kind of, you mean quite up-to-date with the field?

Nurse: Yes, sure. I mean what it's all about. I mean it seems that people get tired all of a sudden, take long-service leave, swap, go and work somewhere else, or, you know ... So that it isn't, they probably don't know, or I don't know if they're interested in how we're actually doing (Psychiatric Nurse, OPC).

An executive group established as a new steering team of the municipalised outpatient clinics is described as disinterested and unacquainted with the conditions of clinical practitioners. The introduction of new organisational changes is not experienced as receptive to the needs of front line practice, but nevertheless these changes become implemented without the steering team first becoming familiarised with the conditions at the grass-roots level. Reforms are carried out as top-down procedures with little consideration for the opinions of practitioners. It is precisely the way in which managerial reforms are carried out that attracts criticism, not the reforms themselves.

*The intended impacts of the reforms on everyday practice remain unclear:* The nurse from the child psychiatry clinic describes how the transformation of the management model makes the position of practitioners precarious regarding the future of professional practice:

All that talk and paper and communication about it [management-by-results] kind of, and, well, the hustle and bustle of the world like, it's so tiring, if I may say so in plain language, that now, on top of everything, there's this new thing [the process model], so I just feel that it's way too much, on top of these daily routines, that it's difficult enough as it is, this work, that if they start making this kind of, sort of a big change, only from a starting point which is just an excuse, just that people would be sort of getting this kind of good care. That the communication here, well, these changes should be informed professionally that the staff wouldn't need to feel that it's some kind of traumatic messing about all over the place, the same as it feels here now, which has been traumatic. Well, there's been kind of a lot on the move here, and, I don't know what I should be doing, how it affects my work, there's, there's a thousand questions about what it does to this team of mine (Psychiatric nurse, CPC).

Here, the various inconveniences for individual practitioners caused by the implementation of managerial reform are demonstrated. The transition is seen to include loads of paper, talk and fuss. Changes are seen as poorly informed and energy-consuming to handle alongside work with clients. Similarly, from the previous example from outpatient clinics, the management board is criticised for the disrespectful manner in which they announce reforms. Most importantly, managerial reforms signify changes also in other practices, thus having an impact also on professional practice. It is pointed out that while the future impacts of managerial reforms are not known, there is considerable insecurity regarding what the concrete effects and consequences in the end will be on daily practice. This comment contrasts to previous descriptions on the insignificance of guidelines, because here new managerial models are expected to have considerable effects.

*New management models bring more organisational responsibilities:* While talking about the municipalisation process in the outpatient clinics, the social worker explains its ramifications for the practitioners' general orientation:

Our basic task before was the care and rehabilitation of psychiatric patients. That was it. And of course it is still the same basic task, but now there are other things being added, like things have to happen exactly in this way and in this time, or this extensively, or something like that. Projects are being launched and there are constant negotiations on further developing things. We have to think here about these kinds of strategies and policies (Social worker, OPC).

The new management model is seen to require more explicit awareness of various administrative undertakings and policy strategies. The criticism is directed at the way practitioners, now working for an efficiency-driven municipal service, are made to assume more responsibility for their own organisation. Being attentive to cost-effectiveness, proceduralisation and follow-up has become an important professional quality (Banks 2004, Ramon 2008, Saario and Raitakari 2010).

A similar kind of situation exists in the implementation of the process-model in the child psychiatry clinic. A nurse illustrates how new tasks outside clinical work related to the organisation's functioning are being implemented:

There are many kinds of duties in a big organisation like ours, and all staff should be doing their duty, sharing the developmental process, with somebody in charge of safety and security, and tasks associated with medication, such as the pharmacy, dispensary, all sorts of duties, educational working groups, where I have been involved as well, all sorts of running around here and there and everywhere that you can think of. Well, these are such pressures, these duties, kind of, under the terms of our contracts, that they want us to do ... We should be maintaining things in rescue services, fire-fighting and life-saving in other words, and these things associated with resuscitation kind of, and training people, and keeping the records, educational records within the framework of these things ... these kinds of activities closely related to our organisation, and they then try to give everyone their fair share of these duties (Psychiatric nurse, OPC).

The tasks relating to organisational duties include administrative responsibilities that are detached from clinical work, and do not require therapeutic expertise. Besides providing psychiatric care, practitioners are required increasingly to orientate themselves to tasks which presuppose skills outside the realm of therapeutic expertise. These new organisational



features are found to be difficult to implement alongside already demanding everyday work with clients. Compared to the previous nurse's comment on how managerial models affect practice, the increase of new organisational responsibilities might be one of these unwanted consequences.

### *Improvised use of incomplete ICTs*

Resistance as improvised and selective use of ICTs is the third form of practitioners' resistance. The target of improvised use is the unsuitability of ICTs to transform client cases and interventions in a way that would be congruent with practitioners' professional notions and their daily practice. This is why practitioners employ either partial refusal or use ICTs in an applied way. They state the following reasons for this: first, some particular new features of ICTs are clearly inoperable in certain client situations; second, the accuracy used in ICT classifications is found to diverge from professional logic.

Several undertakings regarding the introduction of new ICTs have been carried out recently in both research sites. ICTs are utilised especially in the improvement of scheduling of upcoming appointments and the follow-up of the services produced (see Appendix: Report on CPC 2007; Project Plan 2002). Particularly in the child psychiatry clinic, the need to further develop and modify systems is often stated. The importance of the theme becomes apparent by the large number of ICT training sessions that the staff undergo each year (see Appendix: Report on CPC 2007).

*Newly added features can be inoperable in client situations:* The first type of improvised use of ICTs can be demonstrated by the Oberon system which is used in the child psychiatry clinic. The programme contains figures of client numbers and other statistical information. There is a newly added feature in the Oberon's electronic calendar which is meant for reserving appointments so that colleagues in the clinic can see each other's schedules. The idea is to move daily schedules of practitioners from the personal books of each practitioner into the Oberon system. However, often practitioners simply do not use the electronic calendar. In the following extract, a doctor explains her refusal to use the electronic calendar when asked about using it for making her appointments:

Yes, well, no, I'm not, I mean I still have my old usual, conventional calendar system, because those appointments are quite often made there and then, settled when family and cooperating partners are present, and I write things down straight away. So if it were in electronic form, then I'd have to have the appointment system there, in the meeting room, so that it would certainly be sensible to make a transition, but for the present this is easier, this ordinary paper calendar system, it's easy to take with me, and, and then it's so easy to update. I mean it's also easy to rub them out then, those hours reserved for paperwork, and make the time for something else. (Psychiatrist, CPC)

In this case the electronic calendar is rejected due to a very reasonable justification: in the place where the times for the appointments are agreed upon, there are no computers. Thus the old style of documenting using the manual calendar is more functional, also from the point of view of the family, child and collaborators who are meeting in a room where there are no opportunities for using ICT programmes. In addition, the electronic calendar does not allow changes in one's entries as easily as on paper.

Practitioners' resistance is not aimed directly at these systems themselves, but rather at shortcomings in their usability. The programmes are rejected by refusing to use certain parts of them, and not the whole programmes. In order to cope with the unfinished applications of

ICTs, some of their most inoperative features are resisted. Mostly they are those new features which do not serve client situations, and thus are experienced as being unsuitable for practice. The fact that practitioners refuse to use the new features is justified by noting that there are no possibilities for its use in the current circumstances and infrastructure of the clinic. Successful utilisation of the system would require improvements in the facilities and equipment, as well as internal modifications of the software.

*Classifications of ICTs do not correspond to professional conceptions on the contents of work:* The ICTs studied in this subsection refer to systems in which practitioners are supposed to enter their appointments and other activities in order to produce statistical information needed to finance the institutions. They are used mainly for audit purposes. In the following interview extract an outpatient clinic's psychologist explains how the computer-based code system (in which all the appointments of outpatient clinics are gathered) functions. She continues by illustrating the rather complex and detailed documentation system innovated by her, that she uses alongside the official system:

That is, we have this ICT recording system where we record every visit and then keep annual statistics of the events, but unfortunately we record things, relatively small things, such as the number of visits, and if it's a single person, or a family or a couple, a group or, well, and what's added furthermore, the examinations, tests and evaluations ... But then I certainly sometimes try to make up a kind of roster for myself, so that I can check how many acute cases I've got, I mean, and how many of the visits are less frequent, but it still definitely means that they're in treatment with me, you see. And then I also indicate how many is being so-to-say monitored through regular check-ups, and then I also look at the annual service production, I mean how many of my treatments have been completed. And then what the total number of patients is, I mean it's well kind of a way of illustration for me, I use this kind of relatively simple system, this might not be clear to you [showing a paper with concentric circles and figures] (Psychologist, OPC).

While using the official system for the documenting of client visits, as practitioners are expected to do, they often have simultaneously their own personal system for more specific documenting. Generating more thorough and detailed notes than the data system is justified by pointing out that the existing way of doing it is not felt to be accurate enough. The 'ready-made grid' formed by the official audit system is seen to gather information too vague and approximate from the point of view of practitioners. Too constricted descriptions of the existing data system incite the practitioners to generate a more specific and thorough data collection on the work. Developing personal ways to count and categorise the work by utilising the logic of the official system is regarded as a way of clarifying the purpose and course of one's work.

The need to maintain the official and personal reporting coexistently suggests that the way the ICTs record information does not match with the professionals' views on psychiatric work. More generally, those IT systems which gather substantial user resistance are those which tend to remain distanced from realities of everyday practice due to their failure to align with professional tasks (Hirschheim and Newman 1988, Doolin 2004, White *et al.* 2010). Practitioners' tendency to create personal modifications in addition to the existent ICT forms can be also due to systems being brought into use too early. As stated by Munro (2004) at the point of implementation in practice, the programmes are often uncompleted pieces of work, thus requiring constant improvement. This feature of ICTs produces resistance in the form of improvised use with which practitioners try to fit ICTs into practice. Improvised use of ICTs

thus demonstrates the continuous reappraisal of technologies, guided by the organisational demands of practice and the situational requirements of client cases (see Hall *et al.* 2010).

## Discussion

The article has demonstrated how constant reforms of management are identified and resisted by practitioners. Three forms of practitioners' resistance were discovered in the studied specialised psychiatric care: dismissive attitudes towards clinical guidelines; a critical stance towards new managerial models; and an improvised use of ICT applications. Following Foucault (1990), the findings demonstrate that these resistive practices are contextually bound to the managerial structures that are being resisted. The very process of governing practitioners within managerial reforms contains the 'counter acts', such as 'work-arounds' regarding guidelines and ICTs, and also 'counter discourses' in the form of criticism addressed to the management.

The key conclusion is that resistive practices do not imply dramatic departures from the managerial procedures but appear as minor and low profile alterations of routines. Even though practitioners identify some failings in practice produced by managerial reforms, it does not lead to any major dissent that would truly challenge the implementation of reforms. This echoes the notions of social and health professionals' resistance as a subtle process, comprising of moderately altered ways of working in which the agency policies are partially overlooked or adopted (Thomas and Davies 2005, Timmermans and Berg 2003, Wastell *et al.* 2010). Subtleness signifies also that practitioners themselves do not necessarily perceive their actions as resistance, but rather they act this way in order to 'get their job done', adhering to professional practice while not dissenting too much from the managerial rationalities. This tendency of practitioners to exert a variety of local and delicate responses to new public management has been brought up in recent studies on human service professions (Connell *et al.* 2009, Hjørne *et al.* 2010). Hirschheim and Newman (1988) have suggested that the absence of stronger forms of resistance is due to the fact that the object of resistance does not cause profound changes in the social relations of those involved. In this case there is no need for radical resistance, like exiting from the institution (Hirschman 1970) or sabotaging the reforms (Dickson *et al.* 1974).

As for reasons for the moderate nature of resistive practices, practitioners seem to explain their resistance often with the same vocabulary that is utilised in the managerial documents of the studied clinics. Dismissive attitudes to guidance are adapted to ensure the continuity and intensity of care, and managerial models are criticised for drawing professional attention away from care. Managerial reasoning is most obvious in the improvisation of ICTs, where the data system, experienced as inaccurate, is complemented with voluntary documentation on regularity, frequency, methods and completions of care episodes, plus the total number of a practitioner's patients. This suggests that as the process of technologisation has addressed itself in an increasingly immediate way to improve mental health management, practitioners also formulate their resistance by the terms and acts which are actually based on that same process. So, when forms of resistance operate mainly with the same formulations by which they are restricted or confronted (Foucault 1990), resistance becomes even more inconspicuous in daily practice.

The lack of more straightforward forms of resistance might also be explained by the specific nature of policy rhetoric utilised in Finnish mental health care, namely, a strong emphasis on client-centredness, clients' rights, and the quality of the care. Thus also administrative guidelines, new managerial models and computer-based technologies are often

aimed at similar kinds of 'good causes', like improved legal protection for clients and staff. It is not in line with practitioners' professional practice to resist such good intentions. Resisting managerial reforms would mean, at least to some extent, challenging the benefits of clients and the quality of care, as agency guidelines and regulation are increasingly associated with positive connotations of equity, accountability, and coherence to ethical standards (Banks 2004). Thus resistance is not so much an attempt to increase one's clinical autonomy but a way to display practitioners' adherence to the established values of the mental health profession. In this respect the views of interviewed professionals are strikingly similar: regardless of their occupational background, they see resistance as a way to strengthen their expertise and reliability. A similar process has been brought forward by Fournier (1999) who points out how the appeal to professionalism works as a mode of regulating employees by allowing managerial control to function — through the construction of 'appropriate' professional conduct and work identities.

One impetus for resistance derives from professionals' will to support their employer and promote the institution they work for. This way, resistance drawing on the quality of care and professionalism serves the ends of the management: composed modification of practice points out managerial shortcomings which are most clearly experienced in face-to-face work. So by dismissing, criticising, and applying the routines differently practitioners keep managerial reforms 'alive' and ongoing, and guarantee their final implementation. Managerial reforms can only be implemented if frontline practitioners modify and translate them into practice, and point out their limits. This way, resistance evoked by managerial reforms has other outcomes than merely opposition to them (Foucault 2007). Resistance is an institutional necessity, as it maintains the functioning of prevalent rules.

By exploring the connections of resistive practices and managerial reforms, this article has offered insights on how managerial reforms are responded to in local practices in public mental health services. The context of mental health poses a particular challenge for practitioners to perform resistance which aims to consolidate highly complex, situational and multifaceted everyday practice with managerial imperatives. Besides definite interventions like medication and diagnostics, mental health professionals deal with inherently 'fluffy', psychic phenomena which need to be treated by a plethora of multidimensional encounters and psychosocial interventions — all difficult to demonstrate according to the logics of managerial reforms relying on meticulous classifications, guidelines and statistics.

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## **Appendix: documentary data**

Management Duties in Nursing (2002) Memo of the staff of Child Psychiatry Clinic.

Project Plan (2002) Psychiatric services in the community, outpatient clinics and day hospitals. Form 2360/07. Department of Social and Healthcare.

Report on Child Psychiatry Clinic (2007) Annual report on Pirkanmaa Hospital District.

Statistics of AHO, the computer-based data system for patient caseload management (2002) Quantitative and qualitative follow-up of receptions in outpatient clinics. Department of Social and Healthcare.

Targets of Outpatient Clinics (2002) Administrative Department of Social and Healthcare.

## Acknowledgements

I wish to thank Sarah Banks from Durham University and the colleagues from DANASWAC group (Discourse and Narrative Approaches to Social Work and Counselling) for the helpful comments on this article. This research was funded by the Finnish Work Environment Fund and SOSNET (Finnish National University Network for Social Work).

## Note

- 1 There are also guidelines on methods of therapeutic interventions and different treatments and proper medication (best practices). These guidelines that define the content of the treatment are not included in the analysis.

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# Inter-professional electronic documents and child health: A study of persisting non-electronic communication in the use of electronic documents

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## ARTICLE INFO

### Article history:

Available online 1 September 2012

### Keywords:

Child health  
Information and communication technologies  
Inter-professional electronic documents  
Non-electronic communication  
Health professionals  
Finland  
England

## ABSTRACT

Information and communication technologies are widely used in health and social care settings to replace previous means of record keeping, assessment and communication. Commentary on the strengths and weaknesses of such systems abound, thus it is useful to examine how they are used in practice. This article draws on findings from two separate studies, conducted between 2005 and 2007, which examined how child health and welfare professionals use electronic documents in Finland and England. Known respectively as Miranda and CAF, these systems are different in terms of structure and function but in their everyday use common features are identified, notably the continued use of and reliance on non-electronic means of communication. Based on interviews with professionals, three forms of non-electronic communication are described: alternative records, phone calls and letters, which facilitate the sharing of the electronic record. Finally, the electronic documents are further analysed as potential boundary objects which aim to create common understanding between sites and professionals.

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## Introduction

In recent years, a wide range of Information and Communication Technologies (ICTs) have been introduced in health care to improve clinical practice. As assessment, planning and referrals are increasingly managed through inter-professional and inter-agency communication, the focus of ICT development has been moving from questions of information storage to those of information distribution (Avison & Young, 2007; Clarke, Hartwood, Procter, & Rouncefield, 2001, 168; Heath & Luff, 1996, 358). The advantages of communication using ICTs are emphasised (Commission of the European Communities, 2004) across a wide range of professional practices (Greenhalgh, Potts, Wong, Bark, & Swinglehurst, 2009, 767; Heath & Luff, 1996, 358), with electronic patient records often replacing paper records (Clarke et al., 2001, 168). Electronic means of communication are considered efficient when sharing information, as it is assumed that non-electronic communication by professionals will be reduced.

However, the enduring significance of non-electronic communication between professionals is recognised in a number of health care studies. Munkvold, Ellingsen, and Koksvik (2006) note that maintaining informal practices are necessary when participating in

formal electronic practices. In fact, electronic systems' initial objective of reducing the informal practices may actually reintroduce those very same practices. As Woolgar (2002, 16) points out, the introduction of virtual technologies often 'supplement rather than substitute for real activities', thus rather adding than reducing the workload. Winthereik and Vikkelsø (2005) state that while electronic documents become further standardised in order to facilitate electronic exchange, their role as a tool for organisational accountability gets stronger while their clinical value may suffer. More generally, Kindberg (1998), Doyle (2009) and Baines, Wilson, and Walsh (2010) note that ICTs may be at odds with local working practices of how information is assessed and managed.

The continuing use of non-electronic communication by professionals is the focus of this article drawing on findings from two separate research projects undertaken in Finland and England. We examine information sharing between professionals and agencies in child health and welfare, in particular the role of non-electronic communication strategies used by professionals. In Finland, we study documents in Miranda, a medical database used for recording case notes and assessments in children's psychiatric care. In England, we focus on the Common Assessment Framework (CAF), a standardized assessment and referral form for children with 'additional needs' in various child health and welfare agencies. Collectively, we refer to these documents as I-PEDs (inter-professional electronic documents), i.e. documents that are completed by

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practitioners to be delivered to inter-professional and interagency networks. The motivation for this article derives from the authors' observation that in using these two distinct electronic systems, professionals continue to make extensive use of non-electronic communication. Our analysis identified many descriptions of electronic communication being complemented by letters, phone calls and alternative documents. This echoes the findings of [Hardstone et al. \(2004, 2\)](#) who have noted that as clinical documentation is increasingly held and distributed electronically, the presumptions of the role of ICTs and the ways in which healthcare professionals actually use and communicate information do not always match. Indeed in the implementation of CAF and Miranda, the extensive documentation emphasized the advantages of electronic communication, while the role of more traditional, non-electronic forms of communication was ignored ([Appendix A: Report... 2007; Children's ... 2009](#)).

In the next section, we describe the research settings and the development of the ICTs. After this, we outline methods of data analysis. In the findings, we demonstrate how practitioners use three kinds of non-electronic means of communication—letters, phone and alternative documents—alongside electronic documents. They do this by excluding relevant issues from the I-PEDs and then resorting to non-electronic means to communicate these issues. Finally, we explore how the concept of boundary objects contributes to a better understanding of why electronic documents are supported by non-electronic means.

### The ICTs in practice: introducing Miranda and CAF

In Finland, the medical database Miranda is used in various specialised health care institutions for adults and children. In this article we examine its use in a large child psychiatry clinic, comprising over 140 workers, which provides inpatient and outpatient care for children and their families. Professionals use Miranda primarily for case recording, the main section being the Medical Report Sheet in the Speciality of Psychiatry (PSY sheet), in which the documentation is divided under separate titles like Daily Record and Medical Case Summary. The PSY sheet is accessible to the entire hospital staff. Selected parts of these records, most often Medical Case Summaries, are printed and sent by confidential fax or post to collaborating agencies like primary health care, school and municipal child care authorities. Usually these collaborating agencies do not have access to the system itself.

The introduction of Miranda developed from a national project which aimed to promote information technology in social and health care ([Ministry of Social Affairs and Health, 1996](#)). The project called for the standardisation of electronic records to replace a system of incoherent and unconnected ICTs. Miranda was implemented specifically in the field of special health care and primary health care. By replacing paper-based patient records, Miranda's implementation was expected to standardise internal documentation practice and improve communication with other agencies.

In England, the CAF (Common Assessment Framework) is used nationally as an early stage standardised assessment in child health and welfare, for children who are considered to have 'additional needs', i.e. they require more support than is provided by universal health and social services. The CAF is completed by a single practitioner as an assessment initially for their own agency. The CAF Assessment Summary is divided into four subsections of "Strengths and Needs": Development of the child; Parents and carers; Family and environmental; Conclusions, solutions and actions. Where appropriate, the CAF functions as an official referral to other agencies which are considered as able to provide a service to the child. Electronic versions of the CAF can be sent to collaborating

professionals using secure databases. On occasion paper versions of the CAF are sent via confidential fax or post.

The CAF replaced a variety of referral forms that were used either for specific agencies or across a local authority. These forms tended merely to indicate the appropriateness of the child for a specific service, in contrast to the generic assessment required of the CAF. Government guidance included an exemplar version of the form but local authorities were able to make minor adjustments. The forms were piloted in "trailblazer" authorities which informed the structure of the national form. The extent to which the forms were completed and stored electronically took longer to develop, with resistance from some professionals. Subsequently a database of all completed forms was established by some local authorities. An individual professional could access the database and identify who had completed the CAF even if they could not see the CAF itself. They could then seek permission of the writer to read the form.

In both countries the implementation of electronic systems marks a transfer from paper files to electronic templates, thus implicating new ways of documentation. Whilst the two systems are different in function, they share common features. First, both produce documents to be shared with other agencies. The CAF is used in various settings of education, social and health care and is meant to cover all aspects of social wellbeing of the child. It is mainly intended for children having less serious concerns, i.e. children with additional needs. It is occasionally used with children with more complex needs such as children diagnosed with significant mental health problems ([Appendix A: Children's ... 2009, 14](#)). Miranda, when used in the child psychiatry clinic, has a narrower focus: it deals exclusively with children with complex health needs and children diagnosed with significant mental health problems. Second, with both systems, professionals provide information on the child and family by entering free text into sections in a structured template. Although the sections are organised differently, both systems include similar information on the child's overall situation, family relations, emotional development and behaviour and possibly treatment and diagnostics.

There are, however, important differences in terms of the intended reader of the document. In Miranda, the 'ratified readers' ([Goffman, 1981](#)) are in the main other professionals in the hospital who also work with the child. They have routine access to the case records to examine the work of other professionals. They may be interested in, for example another professional's contact with the family or the child's medication. It is essentially a search for information. In contrast, the CAF is primarily used for sharing information with professionals in other agencies. It is less a record of current work and more an assessment of what needs to happen now. When received as a referral, the reader may have little knowledge of the child, and as [Doyle \(2009, 146\)](#) notes '[the document] may have to stand alone in representing a case'. It is likely to be more persuasive than reporting facts ([White, Hall, & Peckover, 2009](#)). Both documents address other professionals but with different rhetorical intentions.

### Research methods

This article draws upon data from two separate research projects which examine the role of ICTs in professional practices across health and welfare. The English study received NHS Research ethics and governance approvals. The Finnish study received approvals from the executive committees of the sites. This procedure complied with the guidelines for research ethics in Finland. In both studies semi-structured interviews were undertaken with professionals, in which they described their work in relation to the electronic documents, both in general terms and via case examples. The Finnish interviews were carried out in 2007 and the English between 2005 and 2007. For this analysis extracts were identified in which the use of non-electronic communication in the process of using ICTs was



discussed, although in neither interview this was an explicit question. The joint analysis of the two data took place in 2011.

The Finnish study examined professional responses to Miranda and other ICTs, as well as professionals' reactions to outsourcing services (see for example Saario, 2012; Saario & Stepney, 2009). For the purposes of this article, nine interviews conducted with child health professionals were selected, consisting of nurses, hospital-based social workers, doctors and psychologists, all users of Miranda. The English study took place in four local authorities and studied how the CAF and other electronic systems for information sharing in child welfare were used in everyday practice (see for example Hall, Parton, Peckover, & White, 2010; Peckover, Hall, & White, 2009; White et al., 2009). For this analysis, comparison with the Finnish sample was achieved by examining nine interviews with child health professionals from the corpus of 80 English interviews, mostly with education and social welfare professionals. The nine English interviews were selected because, like the Finnish interviews, they were conducted with professionals specialising in child health. These interviewees included health visitors, school nurses, a pathway coordinator, community midwives and a CAMHS psychologist. Detailed analysis was therefore carried out on 18 interviews with child health professionals in the two countries.

The analysis proceeded inductively. By examining practitioners' detailed descriptions of the two I-PEDs, we gradually constructed our basic argument: non-electronic means of communication frequently takes place in the use of I-PEDs. In order to further explore the role of non-electronic communication in practice, we then investigated how far the concept of boundary objects would help us understand the practices surrounding the I-PEDs. The comparative analysis proceeded in two phases: first, after careful reading of the data corpus of 18 interviews, practitioners' descriptions of CAF and Miranda as a part of their everyday practice were marked according to different aspects of information sharing. We coded these aspects as new digital documentation versus old paper files, procedures of using the systems, ICTs hindering practice, ICTs helping practice, practitioners' ICT skills, and professional versus ICT reasoning. From this coding, a common theme emerged in both data sets: the significance of non-electronic communication as a part of the everyday use of CAF and Miranda. At this point, the following research question was posed: how do child health and welfare professionals utilise various non-electronic means while in the process of using I-PEDs?

In the second phase of the analysis, we selected those descriptions in which CAF and Miranda were used together with different forms of non-electronic communication. There were altogether 105 instances, 67 in the UK interviews and 38 in Finnish interviews. The majority of these were *phone calls*, which often related to professionals' experiences of inadequacy of electronic documents in sharing detailed observations. *Alternative records* were mentioned when dealing with delicate issues and described as an arena to record professionals' own contemplations. *Letters* were used when describing the difficulties in coordination of care with other agencies. Usually professionals mentioned the use of non-electronic means in parenthesis while describing a specific client case, not as a main topic. They were raised regularly by professionals even though no direct questions were asked about them.

**Table 1**

The numbers of instances about non-electronic means of communication in the interviews.

	Finland	UK
Letters	4	16
Phone	19	29
Alternative records	15	22
Total amount of non-electronic means	38	67

Finally, we selected the most representative example of each non-electronic means for detailed analysis, presented in the [Findings section](#). Each example demonstrates the typical characteristics of the use of a specific non-electronic means. They also display the most common practices that interviewees addressed when talking about non-electronic communication: home visits and collaboration with the school and the social services.

## Findings

Our analysis on non-electronic communication proceeds on the basis that the affordances of the I-PEDs restrict or enable what can be written in them. This is displayed in a number of ways (Saario, 2012; Saario & Stepney, 2009; White et al., 2009). First, the forms include various headings which require the writer to conform to a specific structure. Second, in some cases there are restrictions on how much can be written, or strict instructions regarding how the forms should be completed. CAF in particular was associated with changes regarding how to write about children which were much debated and criticised during training sessions. Initially at least completing the new forms took much longer than even the designers envisaged. Busy professionals found it hard to find time to access the system, with restricted access to a shared computer, remembering passwords and were often timed out. The extent to which workers complied with these affordances therefore varied. Boxes were left empty, information was placed in the "wrong" places and essential instructions were bypassed. Greenhalgh et al. (2009) note that even successful initiatives of electronic patient records are typically plagued by delays and technical glitches.

Furthermore, new features of checking were made available through the I-PEDs. For example, later readers (including managers or auditors) could check on both the quality of the assessment (CAF) and the content and frequency of interventions (Miranda). Importantly, the I-PEDs make the record available to new audiences. Paper based records are located in filing cabinets, only accessible to other professionals and service users with much preparation and often with restrictions. I-PEDs, in contrast, are widely available: other professionals can have access through shared data bases, in different parts of the same institution as well as partner agencies which can mean unknown readers. Unsurprisingly, professionals were more circumspect about what they included in the I-PED.

In the following sections we demonstrate how these affordances impose restrictions on the writers to the extent that the formal entries are not seen as sufficient to describe adequately all that the writer wishes to communicate. Each of the following sections demonstrates a different non-electronic strategy which is used as a "supplement" for the I-PEDs.

### *The use of alternative paper-based records for sharing potentially offending information and initial contemplations*

In this section we first view the role of non-electronic documents as raw data in preparing the I-PED. The following example illustrates how non-electronic communication is used as material for creating electronic documents and is thus a preparatory step. Excluded from the electronic documents, alternative records are utilised to document valuable information on children and to decide whether to complete an I-PED. In this extract, the pathway coordinator from a Specialist Unit of a Children's Hospital which provides services and assessments for children with complex disabilities, explains how she is completing a CAF on a child with a visual impairment while collaborating with the child's teacher. The extract starts with the professional's response to the interviewer's question regarding

whether she has any problems with CAF being simultaneously aimed at various recipients, including parents.

I suppose with this child I'd obviously picked up a lot of information from the conversations that I had with the teacher for visually impaired but how much of that goes onto the CAF. And I chose not to put it on to the CAF. But you know I have recorded it elsewhere. But its where that goes really. Because we are also trying to engage with the parents, and the parents wouldn't. The parents would be very offended and upset as I would, and I am sure you would, if you knew that a conversation had happened in an office over the phone or face to face about your child, before that person had made contact. And yet that's going on all the time, and that's how we collect information, that's how we make a decision to complete the CAF or not to complete the CAF. But would you put all that information, given that it is going to be owned by the family.

The pathway coordinator describes conversations with the child's teacher. Whilst the topics of the conversations are not explained, they are seen essentially for gathering information on the child. The professional explains that she chose to leave these conversations out of the CAF, because a specific audience, the parents, could potentially find the content, or the way in which the information is gathered, offensive since the conversations were carried out at a very early stage. The pathway coordinator does not want to risk collaboration with the parents so she chooses to omit information acquired from these conversations from the CAF which will be accessible to the parents. She and her team want to engage with the child's parents in the future and not offend them by letting them know conversations took place about their child before the professional had contacted them. This illustrates one way of using non-electronic documents strategically. CAF as a joint record with the parents encourages professionals to exclude some issues.

Censoring of these conversations is also justified by the fact that they can be recorded "elsewhere", although the practitioner has difficulty in locating where it should be recorded, "but it's where that goes really". Official documentation ([Appendix A: Children's ... 2009](#)) advises professionals to record certain things in their "own records", referring to institutional records, since CAF's role is mainly to share information. Practitioners are advised to respect the child's and parents' wishes regarding any information that they do not wish to be recorded on the CAF or shared with other services. For example, it is written that if parents refuse particular information, the practitioners should record it only in confidential case records (*ibid.*, 61). The professional's statement about alternative documents "and yet that's going on all the time and that's how we collect information, that's how we make a decision to complete the CAF", signifies that this case is not an exception and often information is collected but not recorded. The alternative paper-based record probably has fewer readers and supplements CAF by documenting these preliminary discussions between professionals in a way that does not offend parents. All in all, the extract illustrates the difficulty practitioners face when trying to address multiple audiences with a single text.

[Hardstone et al. \(2004\)](#) describe electronic documents as based on informal talk. Such oral reporting among professionals enables discussions around observations where they are uncertain. But such uncertainty means oral reports are omitted from the written report. With the pathway co-ordinator and the child's teacher, informal conversations are carried out for sharing and formulating professional hypothesis and impressions. They served as raw material to consider whether to initiate a CAF, but the resulting CAF will not contain the history of these conversations. It could be that such information appears elsewhere in paper or electronic records

internal to agency, however as the pathway co-ordinator points out, it is not clear where this should be stored.

Similarly practitioners' initial contemplations and initial impressions are omitted from I-PEDs. This is the case with informal paper-based documents like practitioners' notebooks which are intended for a practitioner's own eyes only. In the next extract, the hospital-based social worker from the Child Psychiatry Clinic in Finland has explained how she documents various things in Miranda, like overall themes of discussions and summaries of family meetings. However, she then describes these documents as "vaguer" than what she used to write in her notebooks. The notebooks included more impressionistic descriptions of "tones, moods and hunches" which helped her to bring various important issues back to her mind:

Like of course you don't just write in Miranda anything like "oh, I feel the mother is a bit like this and that now, not very well at all, I don't know what's the deal about her.." so all these are now missed. In my previous notebooks I put all the tones, moods and hunches and then when I read them I was like oh goodness, there was this thing as well. Now these are forgotten and what you document [in Miranda] is vaguer.

She continues by explaining how the transition from notebooks to electronic documentation is due to Miranda's capacity to make information available to a number of readers. The recorded information, however, is different than the contents of the notebook. In contrast to the official I-PED, private personal notes allow the documenting of miscellaneous provisional ideas when the practitioner is only tentatively trying to understand what is important, and comparing various possibilities. [Doyle \(2009, 155\)](#) reports similarly that the contents of notebooks often do not make it into the case file, as tacit knowledge remains with the social worker. What is included in the electronic document is mostly factual information ([Räsänen, 2012; Taylor, 2008](#)).

#### *The use of letters for addressing criticism aimed at other agencies*

This example demonstrates how professionals use letters to communicate additional issues that they have not included on the I-PED. Here the social worker from the Child Psychiatry Clinic explains how she shares information with Social Services, describing the contents of the letter she writes as an attachment to Miranda's Medical case summary. Unlike the summary, the letter communicates important new details concerning the child's situation and inter-agency issues on work distribution and responsibilities. The extract follows the practitioner's description of family therapy sessions conducted in the clinic.

We made a very thorough and extensive summary in Miranda about this one child attending [clinic's] family therapy, so I sent the summary [to the Social Services] and I also I added a letter, as a kind of an attachment in which I told about the most recent situation and told about the worries I have concerning this situation, you know, because in a way the situation wasn't in that summary. There had been new details appearing you couldn't see in the summary, the child had threatened his mum various times with a kitchen knife, so I put that in the letter to get this documented in some way. I wrote also that it seems that the child psychiatry services have run out of means and resources in helping this family. I tried to open up the process what we have been doing here with the family and I asked whether it is enough what Social Services have done, that maybe they should think about this one more time, that maybe there are reasons for them to start acting more, or assess the situation once again.

First the social worker explains how she added, on her own initiative, a non-electronic means of communication, a letter, to the “thorough and extensive summary” in Miranda. What is lacking from Miranda’s summary is brought up in her letter, outlining the most recent developments and her own worries concerning the situation: the child has threatened the mother with a kitchen knife. In this case, the letter does not only verify the message of the summary but brings out new, significant information, thus crucially complementing it. The social worker continues to describe the other themes of the letter which the I-PED apparently fails to communicate: issues relating to the boundaries and coordination of tasks between her organisation and the collaborating one. In the letter, the practitioner describes her team’s work with the family, justifying her statement that her agency, the child psychiatry clinic, has now run out of means and resources to help the family further. The strong ending of the letter states the refusal to go on with the case, followed by a question “whether it is enough what Social Services have done” and a suggestion that Social Services should think about and assess the situation one more time. The letter clearly instructs the other agency to take action in response to the new concerns. The social worker does not describe the contents of summary from Miranda but indicates that the letter is more suitable for addressing clashes in coordination of care and the practitioner’s personal worries relating to the child and his family. The recipient organisation is questioned and even confronted in the letter.

The letter as an additional document is interesting not only because of its significant contents but because of the way the professional uses it to persuade the recipient to act. It is written to steer the interpretation of the collaborating agency in a certain direction. One reason for this can be found in the narrower audience of the letter. The fact that Miranda is used for inter professional and interagency collaboration while coordinating the cases, makes it open to interpretation by a variety of other professionals. However, the letter can be directed to more narrowly defined receivers, even at a particular person. It thus serves as a more reliable arena for delicate information and organisational criticism than the generic electronic document. Electronic and non-electronic communication seems to offer two overlapping assessments with differing agendas and concerns. The professional’s choice to write a letter as an extra document which contains additional and obviously crucial information can be seen to question the usefulness of the Medical case summary of Miranda alone in coordinating cases.

Doyle (2009, 145) describes the I-PED, in her case a standard assessment form (similar to the CAF), as a “proxy object for the case that can speak for the case in different circumstances”. The I-PED presents the professional’s view of the case when they are not present. Here the social worker is concerned to add extra information to strengthen the message of the I-PED.

#### *The use of phone calls for sharing detailed observations*

This example illustrates how detailed and initial observations are left out from electronic documents, but later communicated through a phone call. The following extract presents the pathway coordinator describing how she records a home visit to a small child with a visual impairment. There were concerns about the child’s developmental delay and possible lack of stimulation at home that have been brought to the attention of the pathway coordinator by Social Services. The extract is preceded by the practitioner describing the issues she recorded on CAF from this particular visit. After that she describes two incidents which she found difficult to record in the CAF: first, even though the child appeared to have woken up a while ago Mum had not attended to him, and second, Mum has not changed the child’s clothing even

though the change of clothing is helpful for the visually impaired child to distinguish day from night.

And actually found those things quite difficult to record in the CAF in that the... I was able to record some of them, but not all those issues. And because there didn’t seem to be the spaces really. I suppose that’s about parenting capacity. But what I did do was I obviously rang the social worker and informed them of that. And it’s not, they weren’t issues, I mean it may have been that by me ringing the doorbell I may have woken him up. However it may have been that he was in his cot and had been awake for some time, and mum hadn’t got him up and started the day.

The practitioner describes the observations made on a home visit that had caused her concern but which she found difficult to include in the CAF document. She is uncertain whether her observations are crucial: the mother seemed to be unaware that the child was already up, and that the child was already fully dressed suggesting that important opportunities for a visually impaired child to be able to know the difference between night and day were being missed. The professional justifies the exclusion of these details by telling how she “found those things quite difficult to record in the CAF”, and that the form did not seem to have the spaces for those kinds of observations. Although the CAF has boxes in which free text be entered, she did not find suitable headings. Furthermore, she is aware these are initial suspicions, but considers it important to be able to communicate such uncertain opinions of the case. Even though not documenting them on the CAF, she regards the observations as worth communicating, as she states “I obviously rang the social worker”. In making the phone call, the professional makes sure that she addresses these details directly to a “targeted” colleague, the Social Services, and that the information she gives is interpreted in a preferred way and not misunderstood.

As with the earlier example with Miranda and the use of notebooks, one reason for not recording some detailed observations is that the CAF creates a common arena for different audiences, including parents and other professionals. It is necessary to address specific readers so that they would interpret the information as the writer intends. Only the compromised version of her observations appears on the CAF, whereas on the phone the situation is expressed circumstantially. Winthereik, van der Ploeg, and Berg (2007, 15–16) remind us that electronic documents are always recontextualised when arriving in a recipient agency. The phone call helps recontextualise the home visit for a specific audience. The need to undertake a telephone call to convey information to the social worker may also reflect the inherent structure of the CAF document which does not allow the professional narrative to be recounted (White et al., 2009). In this example the practitioner draws on a story of her home visit to illustrate the complexity of moving from narrative to information (Lash, 2001).

In summary, the analysis has demonstrated the highly strategic, negotiated and compromised nature of producing I-PEDs for sharing information in child health and welfare. The electronic document emerges from a wide variety of non-electronic activities. Besides contributing to the final electronic document, non-electronic activities aim to persuade collaborators.

#### **Inter-professional electronic documents as boundary objects**

Both CAF and Miranda are documents written in order to be read by colleagues, service users, managers, or professionals from other agencies. While intended for multiple audiences, they operate across various boundaries of child health and welfare practice. The concept of *boundary object* has been developed by Star and Griesemer (1989) and discussed recently by Star (2010), to



understand how an object could be used by different groups for different local purposes. Boundary objects are defined as:

... those scientific objects which inhibit several intersecting social worlds and satisfy the informational requirements of each. Boundary objects are both plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use and become strongly structured in individual-site use. (Star & Griesemer, 1989, 508)

Star (2010, 602) gives the example of a map which can be used by tourists, geologists or developers for different purposes. Users can cooperate without agreeing on the nature of the object. Cooperation without consensus and the movement of objects across organisational boundaries is particularly salient here.

Star and Griesemer (1989, 411) identified standardised forms or procedures which facilitate communication across workgroups as an example of boundary objects. For example Kimble, Grenier, and Goglio-Primard (2010) and Heldal (2010) examine case files in health care, Wenger (1998) forms to manage medical insurance claims, Allen (2009) looks at care pathways. Much of the discussion concerns how far the boundary object facilitates agreement and whether it moves the users towards standardisation. The boundary object is both an object, but also the process of which it is a prerequisite. In Wenger's example, the boundary object is both the medical claim form and the systems for processing them.

Our interest is on how successful boundary objects establish, at least temporarily, sets of relations which enable actors to cooperate. In child health and welfare, an I-PED like a CAF or Miranda becomes a boundary object when it moves across boundaries to other agencies, is read, discussed in multi-agency meetings and comes to be the definitive description of the child. If successful, it directs the actions of all professionals in the network. This suggests that these I-PEDs are not (yet) boundary objects. We have not examined how far the I-PED succeeds in enrolling others in the definition of the child for it to become a successful boundary object. This would require a much more complex study of following what happens to the report when it leaves the writer. We might suggest that they are 'potential' boundary objects. As Wenger (1998, 107) notes:

Not all objects are boundary objects, whether by design or in their use. Nevertheless, to the degree that they belong to multiple practices, they are nexus of perspectives and thus carry the potential of becoming boundary objects if these perspectives need to be coordinated.

How do we explain the non-electronic work of the professionals to enable the I-PEDs to be read correctly by others? It has been noted that work is necessary for the object to cross the boundary, sometimes re-negotiating professional relations (Huvila, 2011). Lee (2007, 311) considers that boundary objects 'may need to be augmented with additional contextual information in order to be effective'. Wenger (1998, 111) notes the problem of an object crossing boundaries 'unaccompanied by people': "In order to take advantage of the complementarity of participation and reification, it is often a good idea to have the artefacts and people travel together."

Articulation work refers to the mundane and often unseen activities required to carry out a task, in particular a cooperative task. Staff produce orderly methods of managing the vagueness of formal procedures and plans, as noted by Schmidt and Bannon (1992, 19): "Organisational procedures are not executable code but rather heuristic and vague statements to be interpreted, instantiated and implemented, maybe even by means of intelligent improvisation." To pass I-PEDs to other professionals requires entering into the complex (and sometimes alien) world of other professionals, with their own

ways of managing artefacts. I-PEDs are interpreted and assigned meaning by receivers, not necessarily as anticipated by the sender:

The semantics of the information carried by the artefact, however, is, put crudely, 'in the mind' of the beholder, and the acquisition of information conveyed by the artefacts requires an interpretive activity on the part of the recipient (ibid., 21).

Our data suggest that much effort is put into creating the artefact and helping it cross the boundary by anticipating its reading and interpretation. Lee (2007) is concerned that boundary objects require standardisation, whereas a variety of 'boundary negotiating objects' 'live in space between collaborating communities of practice'. She describes a range of practices which appear in our data: keeping personal notes, activities to develop agreements and practices which "give the artefact meaning" (ibid., 314–325). The non-electronic communication in our data then can be seen as activities to facilitate the I-PED to become a boundary object. Letters can be addressed to a specific receiver and phone calls convey issues not shared with the wider audience in the I-PED. In this way, non-electronic communication enables practitioners to tailor the communication according to the presumed requirements and concerns of the receiving party. Kimble et al. (2010, 442) consider the selection of a boundary object as a 'political act', to further the interests of actors. Our data displays the small scale politics of inter-agency work, not in the selection of the object, but in the supporting activities to enlist allies in its passage across organisational boundaries.

Whilst we have been concerned with the similarities between our two sites, there are also differences. Given the different readership of the two systems – internal versus external professionals – we might have expected more informal contacts in the child psychiatry clinic since the other professionals are on site and are colleagues. Lee (2007, 321) reports that different professional groups in the same institution worked together to create 'inclusion artefacts' which create alliances. This can be seen in the use of Miranda as the professionals plan and discuss with each other what to include in the records. For example, a psychologist notes that after each meeting with the child and the family, "*me and Erik [a nurse who is her designated working partner], always continue together by writing those issues into texts [in Miranda] and so we talk about it. Of course, we have to revise it and make it more compact*". Creating I-PEDs together with colleagues demonstrates one way that inter-professional communication is carried out in order to construct potential boundary objects.

## Conclusion

The two diverse systems—CAF, a referral and assessment form, and Miranda, a medical record—share the objective of improving communication across child health and welfare professionals. Our analysis has demonstrated that despite this objective, a great deal of non-electronic communication is still performed alongside their use. With detailed data examples, we have shown how the compromising contents of I-PEDs are restricted from the wider, and possibly unknown, audience. This is done in two ways. First, non-electronic means are used to make some features of the electronic documents stronger, to boost their message. Second, practitioners communicate additional information to compensate for the restrictions which the structure of I-PEDs imposes. Non-electronic communication is used to include those issues that were excluded from electronic documents. The pertinence of non-electronic means shows that crossing inter-agency boundaries by electronic documents is not a straightforward process, but often involves miscellaneous 'workarounds' by practitioners while performing their everyday practice. Professionals as users engage in a range of strategies while sharing information and communication via the I-PEDs.

Two diverse systems illustrate how the same phenomenon takes place even though the implementation processes of the systems were quite different. Whereas the CAF as a new way of writing about children required major changes in professionals' documentation practices and procedures to fit it with the existing work routines (Peckover et al., 2009; White et al., 2009), Miranda signified only a slight change from previous paper-based case records which were now to be continued "as usual", only in the electronic version. Documenting patient records on Miranda is an everyday routine, completed for every child attending the clinic, but completing a CAF is more incidental, up to professionals' discretion. Also, CAF cannot be undertaken unless the children or parents agree (Appendix A: Children's., 2009, 39). One could assume that as completing CAF indicates more demanding changes, professionals would utilise more non-electronic activities than with the more modest changes brought by Miranda (see Table 1). Even so, it was found that traditional, non-electronic means of communication clearly persist with both systems, even situated in different national contexts.

A key explanation for the attractiveness of non-electronic communication can be found in the study of Clarke et al. (2001, 170) who write that people contact others to discover 'what the record really means'. When information is gathered about a particular case by professionals, rarely does the effort reflect a wish to obtain access to the patient record itself. Rather, it reflects a wish to get a 'reading' of the record from its author. Here, the ability of someone who knows the client to summarise, and make a relevant selection from the corpus is key (ibid., 169). Thus information sharing is not – and probably cannot be – supported solely or simply by electronic documents.

Our analysis also draws attention to the non-electronic communication which takes place in order for I-PEDs to convey a common understanding of the case when read and used in a different agency or professional environment. This is additional and anticipatory work and is part of the process through which I-PEDs operate as potential boundary objects. Hence this article draws attention to the significant role of those professional processing activities which are not documented in the boundary object itself. The success of boundary objects depends significantly on such additional articulation work, we suggest.

Understanding I-PEDs as artefacts which require additional professional articulation work has important implications for policy makers and managers who are often seduced by the standardisation of information sharing implicit within IT developments, and fail to consider the professional processing activities that continue to be required to enable I-PEDs to successfully operate across professional boundaries. As Parton (2006, 263) notes professional knowledge is reduced to information which "becomes a self-contained substance which can be shared, quantified, accumulated, compared and stored on a database". This points to the need for the design of ICTs to be developed based on everyday practice and collaboration, and in conjugation with non-electronic communication (Wastell et al., 2011).

## Acknowledgements

The Finnish study was funded by the Finnish Work Environment Fund. The English study is entitled 'E-Assessment in Child Welfare' and was funded by the Economic and Social Research Council e-Society Programme. RES-341-25-0023, 2005-7.

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## **Audit techniques and Mental Health:**

### **A study of the tacking practices performed by practitioners**

#### **Abstract**

The article discusses the technologisation of mental health work in Finland. With the increasing use of technical applications, mental health work can be audited, making it as easy to monitor and measure as possible. In practice, this is done by incorporating the technical instruments that are used to audit the work as an integral part of the daily practices. As practitioners interact with these instruments, auditing becomes part of the routine of mental health work. I examine three instruments, each of which makes a unique contribution to the incorporation of auditing in mental health work. They include two electronic health records developed for administrative statistics and a Service Purchasing Agreement that steers the provision of mental health services.

The data consists of interviews with practitioners involved in treatment. I analyse this data with the help of two research questions: 1) What conflicts in professional practices do practitioners report as resulting from the audit techniques? 2) How do practitioners adapt their daily care work with the demands of auditing? The article presents some ways in which practitioners attempt to solve or alleviate the problems caused by increased auditing of mental health work. I demonstrate how practitioners adopt a creative attitude towards the need for monitoring mental health services, and describe various ways of tacking posed by the audit techniques. The abundance and variety of tacking shows that the harmonising of the non-desirable effects of audit techniques with therapeutic care work has become a key issue in professional mental health work.

## Introduction

Mental health problems have been identified as a threat to Finnish public health, and the increasing number of sickness benefits and disability pensions paid out due to mental health and behavioural disturbances is considered to be an alarm signal.<sup>1</sup> Thus, the means of decreasing morbidity and organising more appropriate services are being discussed in nationwide debates on the development of mental health services. One such suggestion advocates a more intensive use of information technology<sup>2</sup> in mental health work. Technical applications are seen as instruments that can support the working ability and mental well-being of Finns. Even though IT (information technology) is not perceived as the only way to develop mental health work, it is the focus of great expectations from the perspective of the productivity of healthcare – especially as presented by software developers and representatives of production economy.<sup>3</sup> The Government IT Manager also notes that the main potential of the shared use of Finnish information reserves lies in the field of “health and illness information”.<sup>4</sup> The potential afforded by various technologies has also been noted in the field of healthcare.<sup>5</sup>

Thanks to IT, information can be generated to serve as the basis of auditing mental health work. An important goal and consequence of technologisation<sup>6</sup> is the transformation of mental health work into actions that can be audited, i.e., they can be monitored and measured. In practice, this is done by incorporating the technical instruments that are used to audit the work as a tangible part of the daily practices of professionals. As practitioners use these instruments, auditing becomes a part of the routine of mental health work. In my article, I analyse three instruments, each of which makes a unique contribution to the incorporation of the logic of auditing in mental health work. They include two electronic health records for client administration and a Service Purchasing Agreement required by the Public Procurement Act.



The electronic health records for administrative statistics (Oberon and AHO) are used by practitioners to record quantifiable treatment data. In contrast, Service Purchasing Agreement, which steers the provision of mental health services, obliges the practitioners to report on the content of their work, through the electronic health records, using the actions defined in the agreement as products. In this way, mental health work is recorded in the manner required by auditing. In this process, the electronic health records and the agreement, both in their specific ways, may be seen as instruments that enable auditing. In what follows, I will call them both ‘audit techniques’, for, used in a certain way, they generate statistics, descriptions and other material needed in auditing. In addition to auditing, these techniques provide instruction and steering for professional activity and make it quantifiable. This is because practitioners deal with them frequently, as a rule daily.<sup>7</sup>

The audit techniques that I have studied do not cover all documentations of mental health work. For instance, they do not include notes concerning the condition, treatment, therapy or social support of clients. The medical, therapeutic and social dimensions of mental health work are recorded in case records, rehabilitation plans and various specialists’ statements, which are outside the scope of this text. The information required by the electronic health records and agreements are needed, above all, for the external reporting on mental health work, for the bodies that manage and finance mental health services. As factors that enable the assessment of efficacy of activity, audit techniques are strongly intertwined with the marketisation of social and healthcare, which started in the late 1990s and has grown stronger in the 2000s.<sup>8</sup> From the perspective of professional practice, marketisation signifies an increase in steering based on outcomes and evidence in daily work.<sup>9</sup> The concepts used in research literature illustrate the multiplicity of ways in which healthcare is seen as a market activity based on outcomes and evidence. These concepts include economisation of care<sup>10</sup>, more accurate monitoring of treatment processes<sup>11</sup>, evidence-based methods<sup>12</sup> and agreements.<sup>13</sup> All these

are related to the auditing of practice, and each concept in itself includes a range of systems and instruments for auditing.

The technologisation of mental health work has partly been accelerated by the fact that, in recent years, there has been a drive to direct social and healthcare services by means of information steering.<sup>14</sup> It stresses the role of information in the provision of services. When information is appropriately managed, it will “help the actors to develop their own activity and its productivity”.<sup>15</sup> Related to this, research results have been presented on the benefits of technologies in increasing the impact of services.<sup>16</sup> However, the solution-oriented picture of IT, generated by mental health policy programmes and information steering, appears to be in conflict with those engaged in practical work. They sometimes find the new techniques problematic in their daily care work. This is shown by my research data, in which practitioners representing various professions talked about their work in research interviews and in meetings. What problems do they mention? The practitioners experience two kinds of problems related to audit techniques. First, the content of practice consists increasingly of recording, reporting and different types of self-evaluation, which steal time away from their work. Second, they consider the reporting format required by the audit techniques to be awkward because the style of reporting is defined externally and is subject to continuous change.

To grasp the ways in which practitioners relate to the difficulties created by audit techniques, I have borrowed the sailing term “tacking,” used for sailing against the wind. In the Finnish language, “tacking” [luovinta] is metaphorically used to mean “moving forward between various obstacles” and “avoiding obstacles and difficulties.”<sup>17</sup> In everyday parlance, tacking often refers to temporary arrangements or attempts to strike a balance between different viewpoints. As a conceptual tool, tacking helps me examine the ways in which practitioners attempt to solve, or at the least alleviate,

problems associated with audit techniques. My article examines the forms of professional activity that tacking takes in daily working practices, in which three different audit techniques (two electronic health records and one service-purchasing agreement) are present. The data shows that practitioners use various ways to adapt to the growth of audit information. By tacking practitioners either accept or resist measures related to technologisation of their daily work.

After Introduction, I move on to describe the mental health organisations that I have studied, as well as the data sets I have collected from them. Next, I discuss the concept of auditing and examine its position in mental health work. I first discuss how the selected techniques enable auditing of mental health work. I also describe the characteristics and requirements of audit techniques that were reported as problematic by my interviewees. To mental health practitioners, these problems appeared like” a headwind against which they had to try to sail in their care work”. The use of audit techniques is related to tensions that cause practitioners to look for solutions to allow them “to sail on”. This is the actual object of my analysis: how practitioners adapt care work to the demands of auditing. Using the practitioners’ forms of tacking as a basis, I outline the dimensions that tacking may have for mental health policy. Finally, I discuss auditing practices, lately so popular in societal policies, in mental health work in the light of the tacking of practitioners. Does their tacking only involve a superficial, cosmetic adjustment of routines, or does it possess a transforming power that might affect the structure of the service system?

## **How to study the auditing of mental health work and the practitioners' tacking?**

When Finnish mental health work is studied as a professional practice, it is defined as actions by practitioners of different professions, such as care and treatment and daily routine. The practitioners that I have studied work in three different organisations of professional mental health work: psychiatric outpatient clinics (formerly called mental health centres), a supported housing unit maintained by a mental health NGO and a child psychiatric clinic.

The empirical data consists of semi-structured interviews with employees at the research sites and administrative documents related to the sites. In addition, the data includes transcriptions of meetings at the rehabilitative housing unit. I conducted the interviews ( $N = 21$ ) with mental health practitioners representing different professions. They include physicians, psychologists, nurses and social practitioners. The interviews mainly describe work practices: sessions with clients, discussions and routines of daily work, such as recording of work and drawing up work schedules. The employees also present their own opinions of what good professional mental health activity consists of. In addition to care personnel, interviewees included persons working in the administration of the same workplaces. These interviews focus on describing the background of audit techniques and illustrating the ways of using them.

The audiotaped team meetings ( $N = 21$ ) are with rehabilitation practitioners at the supported housing unit. The practitioners include psychiatric nurses, practical nurses and substance abuse practitioners. In these weekly meetings, practitioners discuss the situation of each resident, as well as general matters related to the unit.

The third set of data consists of administrative documents (N = 16). They describe the organisations in question, such as the statistics of client visits generated by the electronic health records, annual reports, and the Service Purchasing Agreement related to the supported housing unit and its attachments. The documentary data provides information on the administrative system of the organisations. It describes the quality or impact targets of the services, which reflect the legislation and policies that regulate mental health work.

My baseline assumption is that auditing may have many, and even surprising, effects on the practice of mental health practitioners. My reading and thematic grouping of the data is based on Mitchell Dean's<sup>18</sup> concept of the technologies of agency.<sup>19</sup> Dean developed this as part of an analysis of power practices, which emphasises how various arrangements, data formats and instruments direct the activity of people working with them. I examine auditing as a way of exercising power, which obligates, directs and encourages activity and thought in certain ways.<sup>20</sup> I discuss these actions, produced by auditing, as the tacking of practitioners. This frame of reference forms the basis of the research inquiry of this article: What are the forms of practitioners' tacking in their everyday work, in which three different audit techniques are present? Electronic health records and the Service Purchasing Agreement function as techniques that have been developed for recording and transferring audit information.<sup>21</sup> As a tool, the Service Purchasing Agreement differs from electronic health records, yet they all function as mediators of auditing practices. I position the agreement alongside electronic health records to show that the monitoring of mental health work may be implemented in many guises.

The three types of data enter into a dialogue, such that the interviews and meetings reveal the practitioners' tacking, i.e., how they adapt to the audit techniques. The documents reveal the administrative targets and regulations for the audit techniques.<sup>22</sup> In the analysis of data sets, I

examined how the adaptation and auditing of work were visible in the descriptions of professional practices. The interview and meeting data were studied using the same methods: I identified all descriptions related to electronic health records in the interviews and those related to the Service Purchasing Agreement in the meeting data. I grouped all instances under thematic headings, describing the practitioners' reactions to the auditing. The groups formed were named as acting otherwise, voicing criticism, bypassing or renouncing auditing, obligations of auditing, accepting auditing, identifying unintended consequences and drawbacks of auditing, usefulness of auditing and self-blame. In the results section, I present data extracts to provide concise illustrations of the various reactions to auditing.<sup>23</sup>

The data sets are positioned in the current mental health work, in which information steering has a key role for intensifying and improving the cooperation between various actors. It has been considered important for cooperation that gaps between institutional and community care are eliminated and substance abuse work and mental health work are linked.<sup>24</sup> With the help of information steering that links various units, the national impact of and access to services may be monitored. According to the Mieli 2009 programme,<sup>25</sup> standardised electronic health records and agreements may be used to identify and nationally disseminate local best practices. This requires that the fragmented recommendations and instructions concerning mental health work are brought together in a national database. In addition to unifying the fragmented field of mental health work, nationwide information steering is associated with mantra-like references to client equality and the quality of services. These principles are also expressed in legislation and in mental health policies.<sup>26</sup> Audit data generated by IT appears to be a strong candidate for redeeming various promises.

The audit systems<sup>27</sup> widely adopted in Finnish public services hail from business accountancy.<sup>28</sup>

The increased adoption of auditing has been accelerated by its links to the concept of outcome,

popular in the context of welfare services.<sup>29</sup> Moreover, the on-going outsourcing and adoption of competitive bidding for social and healthcare services require that practice can be assessed from many different angles.<sup>30</sup> Recently in Finland, there have been audits not only of social and health care, but also of universities and information steering itself.<sup>31</sup> Within information steering, audit data has been named as one of the instruments of public steering.<sup>32</sup>

In practice, auditing refers to various highly dissimilar activities. For instance, auditing may refer to a systematic auditing process<sup>33</sup> commissioned by an external body and including precisely defined methods. In this case, the auditor is generally a professional with no links to the entity audited.<sup>34</sup> An example of external auditing in mental health work is the audit of mental health services of the City of Tampere in 2009, which was linked to the national objectives of developing, monitoring and improving mental health services.<sup>35</sup>

In this article, I use the word “auditing” to refer to strategies which are broader than an external audit and which aim to make the activity suitable for being monitored, but at the same time end up steering the activity in a certain direction. I focus particularly on administrative reporting of mental health work.<sup>36</sup> Tackling of practitioners related to this emphasises, first, the targets set on the activity. The aim of auditing is to make the activity transparent and to monitor the organisation’s success with the tasks assigned to it.<sup>37</sup> Using audit techniques, practitioners themselves generate data for the purpose by reporting their activity according to the conditions set by electronic health records and Service Purchasing Agreement.

The second essential characteristic of auditing is that it is obligatory. Auditing in the studied mental health organisations is based on classification systems documented in databases, instructions or other documents. Practitioners record the necessary data by using the technique appropriate in each

instance. Psychiatric outpatient clinics and the child psychiatric clinic use electronic health records that determine the structure of record-keeping. In the supported housing unit, Service Purchasing Agreement defines what things are to be audited and reported. Electronic health records and the agreement create different types of obligations. In electronic health records, the practitioners record information directly. They have a set structure that directs the practitioners to record and convert the data generated by their activity into a quantifiable form. As regards the agreement, practitioners do not record anything, but the agreement and its attachments obligate them to generate information on their work according to a set format. By defining the contents, goals and products of rehabilitation, the agreement imposes a certain form of reporting. What these audit techniques share is that the matters to be recorded have been defined in advance. The agreement includes verbal and numerical definitions visible as text, while certain fields in the electronic health record oblige the worker to enter data of a predefined kind. Consequently, using either of these audit techniques is not a matter of choice.



## **What features in auditing encourage tacking?**

What conflicts do practitioners report as resulting from the audit techniques? From practitioners' viewpoint, two features of auditing appear particularly problematic: the reporting format is ill-suited to the work and reporting takes too much time. The mental health practitioners consider that they have been recruited primarily for client work, and they strive to implement care and treatment based on a psychotherapeutic, interactive or social orientation. To make auditing possible, they must expend time to convert care into written information. What is more, this must be done in a way that is ill-suited to their work. Audit techniques require work to be reported in an unsuitable format. In addition to documenting the content of mental health work<sup>38</sup>, another form of reporting is required, which forces practitioners to learn a "new language". The audiences of administrative reporting do not consist of clients or other practitioners; rather, the reporting is targeted to the service purchaser, who is not necessarily familiar with the content of mental health work.

The reason why reporting is regarded as ill-suited to the work is that product names and codes have to be used in reporting the work. Both audit techniques require work to be defined as products. The agreement requires a list of products in accordance with the purchaser-provider model, while electronic health records used in child psychiatry requires the definition of products because of agreement-based steering and the treatment guarantee. The need to define products at the psychiatric outpatient clinics is related to municipal steering and the treatment guarantee. To enable external actors unfamiliar with professional practices to monitor the work and the attainment of targets, the work needs to be described as unambiguously and quantifiably as possible.

Service Purchasing Agreement for the supported housing unit requires that the services offered are audited, and this can be done when the services are defined as products. This process is illustrated by the unit's managing director while reviewing the content of Service Purchasing Agreement:

Under this heading we promise to deliver an annual report and financial statement concerning activity within the scope of this agreement and also other information needed by the purchaser, so within this service purchasing relationship they have the right to audit us. Since we apply the purchaser-provider model, the only way to succeed is to do your job as well as you can, to describe it, to show what you do and how well you do it. Plus, you have to be able to calculate the price at which you can offer your services.

Thus, the role of the housing unit as a contractual party requires reports to explain the contents of rehabilitation in such a way that the purchaser can review the services as products. Carrying out the actual work as well as possible is one condition for success in the competitive bidding for housing services, but another criterion in the selection process is price. In this case, the housing unit set the price of their main product, "intensified supported housing of mental health rehabilitants," at 60 euros per day. If the package also includes extras, such as "daytime activity," the price will go up. For the pricing, the activity has to be broken down into discrete rehabilitation products, such as "making a rehabilitation plan" and "recreational activity." For each client, the purchaser receives a separate invoice based on a detailed specification of the products offered.<sup>39</sup>

Thus, Service Purchasing Agreement requires the products of supported housing to be defined, described and priced. In addition, practitioners have to think about how to report the information on supported housing so that it convinces the purchaser that the work is done well, leading to a positive

audit result. This aspect is discussed in joint meetings, such as the following extract from a meeting with a supported housing unit practitioner:

In the city meetings the NGO representatives talk an awful lot about product definition. So really, we should also start thinking about how to put our work on paper. We must be able to show in writing what the work is about and what it includes. Of course, setting a price is one thing, but it's also important to show what the price includes and how it differs from the other service providers.

Practitioners find it difficult that their main product, “intensified supported housing,” involves encounter work with several dimensions and cannot be positioned unequivocally on the price scale in the purchaser-provider model. Practitioners are required to be able to convert rehabilitation into a commodity and to match day-to-day situations with the city’s financial policy.<sup>40</sup>

Presenting encounter work as products and pricing means that practitioners themselves must provide descriptions of the contents of mental health work for Service Purchasing Agreement. In this case, achieving a suitable reporting format requires more work than using electronic health records with their built-in product logic. Oberon, an electronic health record used at the child psychiatric clinic, includes a set of product codes defined in the contractual negotiations of the hospital district. The practitioners only need to select a category matching what they have done and to record their actions accordingly. To take an example, the services offered to the municipalities include the product “family treatment package,” with the code 77501 and the price of 15 108 euros.<sup>41</sup> The package consists of a three-week treatment period in the family ward for the whole family, including a set of intensive examinations and treatment by a multi-professional team. The package also includes networking activity, and each family has a designated team of two carers.

The electronic health record Aho<sup>42</sup> was formerly used by the psychiatric outpatient clinics and had a similar set of product codes, though less extensive than in Oberon, containing a shorter list of codes for various activities. Using the system was fairly straightforward, since the worker had to choose among six types of visits and record the professionals involved during the visit, the duration of the visit, the payment category, and an eventual further appointment. The difficulties of quantifying the work in Aho were due to the fact that, according to the practitioners, the six codes used to describe client work only covered a limited part of the psychosocial work done. At the turn of the millennium, software companies did not normally offer the possibility of updates after the software had been adopted, with the result that new codes required by the users could not be added ‘along the way.’ The system was rigid, and activity had to be reported by using a limited set of codes, which meant that all aspects of the care work were not visible in the reporting. Actions with no designated code had to be entered under inappropriate codes or omitted completely.<sup>43</sup> Oberon has a more flexible coding system than Aho, and its users do not report similar difficulties. In IT terminology, Oberon is ‘agile.’ Practitioners can propose changes to the actions included in the set patterns whenever they see a need for this in the course of their work. Because of requests to update the system, Oberon is in a constant state of change. The code system continues to be diversified as practitioners become aware of new categories of action and add them to the drop-down menus for codes. Because the application structure is continuously changing, the practitioners have to orient themselves to a reporting system that changes and expands continuously. This never-ending change is described by a worker as follows:

The IT systems are like the eye of a storm in the care field. It shouldn’t have such an important role, but unfortunately that’s how it is. I know that you can’t point the finger at anybody because of this, it’s just that we have had to adopt the applications before they were

complete. You can't expect anyone to be able to design them exactly the way we wanted, like great, bang on, and then we just start using them. It's us practitioners who serve as guinea pigs, and the supplier can only correct the application when we tell them what we need. There's just no other way, no one can know better than we what we really do. But it's a painful road and it's a great burden on the users.

However, detailed reporting results in fragmentation of the content of the work into ever smaller sub-entities. When codes are continuously added to the electronic health record, the end result is a detailed and complicated classification of mental health work. In addition to the types of interventions proposed by practitioners, the work is classified according to diagnoses, which means that new codes are added with each new version of the DSM classification.<sup>44</sup> This creates more problems: the codes can easily overlap and practitioners may interpret them in different ways. It is not easy to define the content of individual events in mental health work, since actions classified under separate codes are often intertwined. For instance, a therapeutic discussion may include many interventions, such as counselling on legal aid, consulting a physician to check a prescription, a call or letter to the job centre or, say, phoning to get a cleaner to the client's flat. Using the complex code system, some only record this as a therapeutic discussion, while others can enter several codes.

Oberon represents a modern electronic health record, which can be modified on the basis of user comments and new diagnoses.<sup>45</sup> Taking into account the feedback from 'end users,' i.e., practitioners, is aimed at increasing the user-orientation of electronic health records.<sup>46</sup> Similarly, building new diagnoses into the system structure is meant to make the application more flexible in daily use. However, these positive intentions make for a complex and detailed system structure, which is difficult to harmonise with holistic mental health work. In this way, the limited options and

stability of Aho and the complexity and fluidity of Oberon both cause different types of problems for users.

In addition to the ill-fitting format, the reporting required by audit techniques takes time away from actual care. Practitioners also see reporting on mental health work as conflicting with professional orientation because reporting simply detracts from the time used in care. Even though the actual entering of codes in the system does not take very long, learning the system logic and updating one's own skills is time-consuming. The training associated with the use of electronic health records is considered to be almost endless. This is described in the annual report of the hospital district<sup>47</sup> running the child psychiatric clinic, which notes that “during the year, the hospital arranged a staggering 240 training events for the staff, with the sole topic of adoption of the patient systems.”

What is particularly time-consuming is that the contents of rehabilitation, often self-evident to the practitioners themselves, must be opened up and ‘described for dummies.’ Moreover, reporting is subject to strict deadlines. Information entered in Aho and Oberon is transferred into monthly statistical reports. Similarly, the invoices based on the Service Purchasing Agreement are subject to specific deadlines since the funding for supported housing is granted for specific periods.

Negotiations on the content of the Service Purchasing Agreement are repeated each year. Article 8 in the agreement gives the following deadlines for invoicing and reporting: “For each resident, a monthly invoice is presented to the purchaser. It shall be accompanied by a detailed specification of the services provided.”

The awareness of the agreement running for a fixed period requires practitioners to think about time management when considering how to put in a better bid than other service providers and how to

best describe the support provided.<sup>48</sup> Time is also required for the preparation and planning of documents to satisfy the demands of auditing specified in the agreement. Drawing up these documents is intertwined with daily work and the rehabilitation processes of individual clients. The progress of residents' rehabilitation, required by the agreement, is an important indicator when the further "placement" of clients is assessed on the basis of their fixed-term residence. This is visible in the following extract from a team meeting with a housing support unit worker:

The evaluation period is documented in advance so that it will be included in the documents. The price is set at 31 euros, including meals. There must be a written document for the municipal purchaser and it mustn't be late, so when the client leaves it should be completed immediately. So you need to take notes for it all along the way.

In their meetings, practitioners also have lengthy discussions on how to calculate as competitive a price as possible for housing expenses. Time must be set aside for the reporting required by the agreement, since reporting something that is unfit for auditing will lead to the organisation losing the bid, and in the worst case this would lead to an end of the housing unit and loss of jobs.

In addition to administrative reporting, electronic health records are used to generate information required in project auditing. This may require generation of a massive amount of written documents from electronic health records. The final report of the child psychiatry clinic's development project<sup>49</sup> mentions about forty meetings that generated and assembled auditing material. In this time-consuming reporting on professional work, electronic health records had a key role:

The description utilised existing flow charts of the central operational processes of the various units. The units' existing operational descriptions were updated and converted into

the digital QPR Process Guide format. The targeted deadline was end of November, but the implementation phase dragged on because the project manager decided to include written descriptions of each unit in the project. The volume of work delayed the project from the planned schedule, for producing 16 charts and 10 written descriptions required about forty project meetings of different compositions or meetings of stakeholder groups during the year. Despite pressure of work at the end of the year, the clinic teams were able to find time for the purpose to a commendable degree.

Another time-consuming aspect is the ‘technical snags’ in the systems. When the systems do not function as expected, the practitioners, as users, must report any problems to the IT support person, who will contact the software supplier if necessary. Reporting on snags takes time, since it requires contacts with technical support and a careful description of the problem both on the phone and often also in front of the screen with the IT support person. In fact, the annual report of the hospital running the child psychiatry clinic states:

The use of electronic health records was extremely challenging. Personnel resources were tied down by their adoption, and there were significant problems as regards both the usability and the technical availability of the software

Preparing for auditing is difficult because it requires foresight and calculation of future events, which are needed particularly in preparing Service Purchasing Agreement. The managing director of the supported housing unit, in particular, must be able to anticipate economic trends and the NGO’s situation because of the negotiations involved in the competitive bidding:



Pricing must take into account future trends, inflation, and whatever costs may be changing. You can't just present a framework price in the bid, because the margin may not be sufficient later on. The price must be calculated for a period of three years and you have to take into account how expenses change during that time, because the number of practitioners or weekend work, for example, could increase. Since the housing unit applies a framework budget, we have no right to exceed the budget, so the sums are fixed. Still, allocations may be transferred from one year to the next, which increases the need for anticipatory planning.

The reporting required by the audit techniques is considered particularly problematic when it has to be done beyond official working hours. This is a familiar situation for senior practitioners in mental health organisations in particular, for they are responsible for ensuring that all clients seen, actions completed by the practitioners and all forms of activity are duly entered in electronic health records. In describing her daily routine, the psychiatrist in charge of a ward at the child psychiatric clinic says she takes care of the following:

Operation of the clinic, that no one is under- or overburdened, but that the treatment periods are implemented as planned and are evenly distributed across the teams. Proving that the clinic is functional eats up a fairly large part of the working day. In practice, however, the paperwork is done as overtime after the normal working hours, since there is no time for it during normal hours in addition to acute care work. If I set aside time for paperwork, then generally some emergency will crop up, such as calls or other contacts, which will then use up the time I've reserved. Because if you set up something with people, you have to keep your promises, but it's always possible to shove papers aside.

The reporting for auditing, being ‘less important,’ is allocated for periods when there are no clients or colleagues around, which generally means after normal working hours. The fact that reporting has to be done at the expense of care work or in one’s own time causes criticism in the supported housing unit meetings:

Reading information, in addition to recording, takes up a shocking number of working hours. The recording has grown to practically unreasonable proportions. It always takes up time that could be spent doing something else, so it has to be done somewhere during the care work.

How do the practitioners adapt their practice, so that they can juggle with the time-consuming and ill-fitting demands of recording matters as described above? In the following section, I describe the kinds of tacking practices that these drawbacks cause.

## **The tacking practitioner: adapting to auditing**

The data contained a many examples of how practitioners attempt to strike a balance between their professional activity and the problems created by electronic health records and Service Purchasing Agreement. By adapting their work and attitudes, the practitioners' creative attitude to the auditing and monitoring of their work focuses on three elements of mental health work: reporting on the work, practices in client work and practitioners' attitudes. First, in reporting, practitioners tack by adapting to the audit techniques. They subtly alter the reporting style required by auditing or develop new ways of reporting. Second, tacking can also be seen as modifying client work and care practices. In this case, tacking does not directly concern the use of audit techniques, but the ways of performing client work. Third, practitioners adapt themselves to the auditing logic by either complying with it or resisting it, and thus adopt a specific attitude towards it.

### **1 Adapting to reporting**

By adapting to reporting, practitioners decide not to comply with customary forms of audit reporting. In practice, this means a variation in the way and style of reporting within the framework of the audit techniques. Practitioners vary reporting in two ways: by adapting to the codes describing the activity and by including mundane observations based on professional notions in client reports.

Adapting to the codes describing practice is widespread among practitioners. I previously described the code structures of electronic health records, which have to be complied with in documenting the care work. Tacking with the intention of adapting to the codes is implemented so that practitioners together consider how well or ill the existing codes match the reality. They consider how to bring

the activity under codes so that they could best match the operational practices which they actually implement with the clients. Practitioners at the supported housing unit discuss the use of the codes as follows:

If we have to take hours to run errands with a client or sit at meetings at the mental health centre, the healthcare centre or at the doctor's, then that is not actually recorded anywhere.

Yet it ought to be visible somehow. We have to think of what we record as actual actions in order that important work does not remain invisible.

Practitioners note that the coding does not match all the work that they actually do. For this reason, they discuss ways of recording that would allow all activity to be covered by the code-based auditing. This requires flexibility and improvisation in the use of codes; for example, an intervention may be entered using codes that do not correspond to its content.

Home visits from the supported housing unit's support point to the residents' flats is one form of activity which, in the opinion of practitioners, requires an adaptation to the codes. An attachment of Service Purchasing Agreement states that practitioners make home visits to support the residents' coping with daily life. Their purpose is to guide the residents in "household tasks, hygiene and daily activities," for example. The time used in visiting is included in the monitoring of working hours, beginning from the time when the team leaves the support point of housing unit to visit the client and ending when they return. What is problematic about describing this intervention is that a psychiatric home visit usually takes longer than home help visits that the municipal purchaser is used to. An 'ordinary' municipal home help visit is defined to take half an hour, which corresponds to one 'k' code. The housing unit practitioners consider this to be too short a time for home visits related to mental health rehabilitation, and they ponder how to act in this problematic situation:

We should just play the game. What the city people traditionally did during home visits, they have actually pared down all extras from their visits. There's nothing else, they just pop in really briefly and do this thing or that, but it just won't work like that. If we did that, our work would simply have no significance. On the contrary, we would increase anxiety if we started having 15-minute visits and then just said ok, that was it, you'll be fine, and see you again. In every discussion where, when we discuss these things, the first criticism is always that our visits are too short.

The problem with the home visit code is that two activities with different content have been assigned the same code, both of them taking place at the client's home. Practitioners ponder how to act to avoid deterioration in the quality of work because of the current practice of associating home visits of mental health rehabilitation with home help visits. To make the longer visit visible appropriately, the codes should be fudged. One of the options proposed is to enter two visits for the client, even though just one visit has actually been made. As one of the practitioners of the supported housing unit says, "Of course we could split one visit, to say that one person has sort of received two visits, even if you've spent the time with one and the same person, so that would bring the time up to one whole hour." In this case, the reporting would not correspond to reality. Tacking is incited by ethical responsibility towards the client, so that the visit would not be hurried simply because the measuring practice does not fit the work.

The second way in which the practitioners adapted the reporting was to include mundane observations in the reporting. So far, I have described reporting consisting of codes. In addition, various annual reports and descriptions of the operation of organisations are written for reporting. They include information required by auditing and for comparisons between service providers

concerning the volume of services and specified service descriptions. Tacking within these documents enters the picture when practitioners wish to include matters which they consider important from their own professional viewpoint, but which are not officially required as basis for auditing. This means that they will spontaneously include them in the reports, and they generate local descriptions based on daily experiences on the basis of which the purchaser audits them later as potential service providers. In this way, practitioners generate information based on their professional standards. This is called 'local information'.<sup>51</sup>

For example, practitioners present matters related to their own work in the annual report of the housing unit, to which they contribute as writers. The housing unit report includes several passages where the impact of rehabilitation is expressed in the form of concrete and down-to-earth 'outcomes.' Practitioners present signs of progressive rehabilitation based on daily life that can be observed during the period of residence:

The residents have not received notes, evictions or warnings from the housing company; many residents have lost weight; some clients have been sober for over a year; some have been employed by the workshop or the residents' association; the resident has started spontaneously to come and do her laundry at the support point; some have adopted a regular daily schedule.

In the negotiations leading to the agreement, the service provider is expected to promote residents' potential for more independent living. This would increase resident turnover and the service would be available to new clients. Even if residents of the supported housing unit do not progress to more independent living within the period specified by the purchaser, practitioners strive to show the benefits of care and rehabilitation by pointing out small steps of progress. The housing unit report

mentions that the low turnout of residents is not necessarily a problem for the residents themselves; on the contrary, it can also be interpreted as commitment and motivation for rehabilitation. The managing director of the NGO maintaining the supported housing unit justifies the importance of describing day-to-day events as part of the negotiations with the purchaser in the following way:

The negotiations with the purchaser should not simply consist of a review of external criteria or a discussion of how to provide rehabilitation as cheaply as possible. We should also discuss various impacts that cannot be measured in terms of money. Instead of comparing cost savings in euros, prices per day or intensity of care, we should be able to describe our activity more comprehensively. The purchasing of services should be based on recording systems which are better suited to NGOs, and there should be more interest in what the rehabilitant-client receives, since the current systems of recording emphasise the benefits to the purchaser.

Practitioners also stress that despite the definition of work as products and marketing it, as required by Service Purchasing Agreement, they are able to focus on their professional caring task, that is, on supporting the clients in more independent daily living. The report stresses that practitioners have been able to adapt to the purchaser-provider model while simultaneously developing their own work:

As an organisation, the unit is capable of self-evaluation since there has been a conscious strive to adapt the activity to the purchaser-provider model, by breaking down the service process to its constituents and by generating descriptions of the services. It is a resource that the work community has found useful, despite the fact that the purchaser-provider model

creates pressures to use an increasing number of the working hours for marketing the work and defining the work as products

The tacking described above expands the content of information generated for auditing, in that it introduces new elements in addition to the criteria experienced as narrow. Other reporting channels for auditing include PowerPoint presentations compiled for the management team and for the purchaser, the quality manual, brochures and presentation videos, all of which describe the rehabilitation work. All these are instances of tacking, through which practitioners attempt to describe the content and impact of rehabilitation for the purchaser. The crucial message is that practitioners take the agreement-based auditing seriously and see it as part of their work, yet they continue to see rehabilitation of clients as its main content.

## **2 Adapting client work and care practices to audit**

The practitioners also tack across daily working practices by adapting client work and care practices to comply with the reporting required by auditing. This type of tacking shows how the reporting format required by the audit techniques also affects the actual practices and content of mental health work. In other words, client work is done in a way that matches the structures of the audit techniques.

The operational targets of psychiatric outpatient clinics<sup>52</sup> state that the need for non-institutional psychiatric care has increased, and the target is to increase access to services. This requires that work is made more effective and efficient. A certain number of sessions per year should be conducted in psychiatric outpatient care, and the number of such sessions should not decrease from one year to the next. The waiting period for treatment should not exceed three weeks. These



indicators can be monitored through the statistics generated by Aho. Instead of adapting the codes used to record the sessions, tacking related to the above targets concerns the regulation of treatment periods. Practices related to treatment and scheduling of sessions are adapted so as to make the targets accessible. This requires that the sessions are restricted. The restrictions apply to both the duration and the number of sessions. Practitioners make the sessions shorter to increase access to care. When there are many clients waiting for appointments, a logical solution is to give shorter sessions. A physician at the psychiatric outpatient clinic notes:

These appointments are basically for one hour, especially with new patients, but if you've already seen the patient a few times, we shorten them to 30 minutes, unless there are reasons for not doing so. And particularly if there are many urgent new patients, then we are practically forced to shorten the sessions to 30 minutes.

The targets related to number of patients and access to care lead to tacking in which client work begins to be done in a different way, i.e., the sessions are shortened as far as possible, so that it is possible to see new patients within the time periods specified. The attainment of targets such as treatment guarantee and access to care is audited on the basis of statistical data generated by Oberon. Implementation of the treatment guarantee has been listed as a central target of the child psychiatric clinic. An assessment of the need for treatment must be initiated not later than three weeks after the referral has arrived, and the first treatment session must take place within three months.<sup>53</sup> Tacking is needed at the child psychiatric clinic to enable clients to access treatment within the target period and to manage the increasing number of clients. Tacking to improve the turnout at the clinic can be seen in the practitioners recognising their limits vis à vis the burden of work. Practitioners in child psychiatry are aware of the targets regarding access and client numbers, but at the same time, they define the limits of how much work an individual worker is capable of:

We have so many children in need of care, but we haven't got the resources. The queues in therapy, treatment and rehabilitation are so huge, and one single child can actually consume huge amounts of our services. It just isn't possible for me to do everything.

Because of the treatment guarantee there is a pressure to work as much as possible, and the queue creates a pressure. The queues are long, there are lots of children in various queues. They should be shortened simply because the law says so. There are so many wanting to come and they should have an appointment as soon as possible. On the other hand, it's not my task to organise that, it's not part of my job.

Choosing interventions according to audit needs is also a part of the tacking by practitioners. In addition to curtailing sessions, the requirement for greater effectiveness dictates a preference for the modes of operation emphasised, or at least mentioned, in the auditing. The limited set of codes in Aho used by the psychiatric outpatient clinics causes practitioners to consider the selection of treatment practices employed. The following example describes how practitioners begin to do less of what is not covered by the codes. Instead, they begin to prefer activities covered by the codes. A physician at the psychiatric outpatient clinic is about to wrap up a long course of therapy:

I had a patient who had a series of 10 therapy sessions, he came every week, and then another who has been with me longer and has fortnightly sessions. I've come to the conclusion that I'll wrap this up, that I haven't really got the time or possibility for that sort of thing. Yet, in the first instance I should be doing what physicians have to do, that is examine patients, think about diagnoses and write certificates and prescribe medication.

Tacking concerns the time limits posed on treatment periods, monitored with Aho. The physician no longer conducts intensive therapies, but acts as consultant for others, diagnoses and writes statements.<sup>54</sup> Diagnoses are necessary for the progress and completion of treatment processes. Like the physician quoted above, psychologists also cut down on the number of psychological examinations to be able to see more new patients and to meet the targets of access to care within the prescribed time:

Assessing work ability is something that is actually done by a physician. If it can't be done with sufficient reliability, then we conduct a psychological examination. I tend to do it fairly thoroughly, so it requires several sessions, which means that when a physician requests a psychological examination I tend to be reluctant, since there are too many patients requiring treatment anyway.

In Aho's set of codes, psychological examinations are included as repeat visits by the same client. However, they require several sessions, which implies that psychologists have to allocate substantial resources to one client. Omitting psychological examinations shortens the duration of treatments. Thus, tacking is manifested in the restriction of the professional repertoire, since auditing prioritises such aspects as access to treatment, and that too within a certain period of time.

The selection of rehabilitation practices at the supported housing unit is directed by Strategy of the municipal purchaser, which emphasises that more and more services should be delivered at the clients' homes. The forms of interventions expected from the supported housing unit are home visits and reception of day visitors at the unit's support point. A team leader had the following to say at a team meeting:

The city strategy says that the focus of services should be at the home. In practice this means that our statistics are lagging behind. We've increased the share of home visits, but it's still not enough. So this must be taken into account, we need to keep developing it and we must make more home visits. What we'll do is everyone will think of how to make more home visits with the people they are counselling, so that we could have a slightly larger output of home visits. We also need more daytime visitors, two more of them, for the truth is that we have never had six day visitors here at the same time.

In this way, the agreement targets for the number of home visit products encourage practitioners to include more visits to the clients' homes, and to simultaneously increase the number of day visitors to the unit. Treatment practices are also adapted so that space for the reporting is created between or instead of treatment sessions. Practitioners continuously reorganise their timetables to fit the tasks required by auditing in their working hours. To find time for recording activities, practitioners are required to take the initiative to reorganise daily routines and meetings with clients, since there is no jointly agreed time set aside for generating auditing information. Frequently, the time and space for reporting is taken away from the time reserved for clients. A social worker in the child psychiatry clinic describes the need to designate a certain hour for the written work related to auditing and to block all meetings and visits during that time:

There's little time left for recording activity, since those who come to work here tend to be conscientious, and they expressly strive to manage client work as well as possible. And since there is such a lot of it, you end up using part of your working hours for it and that is time away from your other work. Personally, I no longer set up any appointments for Friday afternoons. Sometimes there may be meetings or work supervision, but in the main I set that time aside so I can at least try to get an overview of what I've done during the week.

Practitioners also consider how to select their clients. In this type of tacking, practitioners select clients who are ‘best treatable.’ This helps them attain the target of keeping treatment queues short and giving clients access to treatment as soon as possible. The referral teams of the psychiatric outpatient clinics, which discuss new clients in need of treatment, are a permanent forum for this type of tacking. Practitioners restrict the reception of clients by reviewing the referrals to select clients who are ‘capable of being rehabilitated’ and most likely to recover.<sup>55</sup> A nurse at the psychiatric outpatient clinic describes how the referral team applies strict criteria for those accepted for treatment:

These days we get more and more referrals that are simply impossible. For example, people who are severely alcoholised or long-term unemployed are put up for pensioning, and when the pension statement is not approved by the Social Insurance Institute, then what do you know, these guys are sent on for treatment to the mental health centre. Quite often they are not even capable of carrying on a conversation; they have such a major problem with alcohol in their lives. We’ve simply turned such people away. Or we’ve tried to write a better pension statement, but we haven’t accepted them for treatment and discussions.

One of the targets monitored in the statistics generated by Aho is that emergency patients should receive an appointment at the psychiatric outpatient clinic on the same day or the following weekday. Even if the person has evidence of being ill, one means of selection is to point to the lack of acute crisis. The nurse continues:

If the patient has a personality disorder and their treatment history includes many treatment periods at different units that have often been interrupted, are we going to automatically

accept someone like that with no particular emergency, to visit at intervals of three or four weeks? I'm very much afraid that that is likely to make the problem worse.

The fact that clients are selected to treatment is justified by judging the referring organisation.

Practitioners consider that the wrong kind and 'impossible' referrals are the responsibility of the referring organisation. A physician at the psychiatric outpatient clinic notes:

I sometimes feel that the patients are the wrong kind. There are too many of those, say, who have no work ability or are already pensioned off, chronic alcoholics who come to the visit from some shelter.

How far is this opinion based on the fact that effective treatment is more difficult to achieve with certain patients? Practitioners find it difficult to describe the treatment of clients who cannot be helped to the extent of successfully completing the treatment. This means that the practitioner's productivity could appear questionable in the auditing. On the other hand, how far does the above opinion describe the problems in cooperation between various organisations in the service system? Most people mentioned in the examples, who have no work ability or are chronic alcoholics, are in contact with the service system through primary services, such as social services or primary healthcare. If psychiatric outpatient consultations are not sufficiently available to primary services, it is likely that these clients will end up in specialised medical care.

Tacking in client work shows that auditing not only affects how things are reported, but also the methods of work in services. In their work, practitioners focus on tasks that are known to be covered in the auditing. If this cannot be done, work practices are adapted so that they correspond to quantitative targets of auditing. This raises the question whether current audit techniques encourage

tacking, which has less to do with alliances with service users and more with efficient services from the viewpoint of those paying the bill.

### **3 Defining personal attitude to auditing**

Besides the use of audit techniques or the content of client work, tacking practices by practitioners also covers the practitioners' personal opinions on the nature of mental health work and their professional activity. This means that auditing is harmonised with practical work by adapting one's personal attitudes. Tacking as an attitude may be based on two opposing ways of thinking about auditing: it may be considered useful or questionable.

Practitioners may consider auditing to be useful since it enables them to prove their effectiveness. In such a case, practitioners emphasise the importance of statistics based on the codes. They can make their personal input visible. A psychologist at a psychiatric outpatient clinic demands that Aho should be better utilised in quantifying actions. She proposes that the monitoring based on the restricted set of codes should be developed further:

It is important for us to have some quantitative indicators. Never mind how close they are to reality. I think it's good to have some at least, and we can now make use of IT as a qualitative description system. Personally I'd also be prepared to assume some sort of budget responsibility. I'd even be prepared to develop this much further, since our pay bears no correspondence to the amount of work we do. If this was really based on quantitative statistics, psychologists would benefit from it more than many others.

Practitioners regard the use of electronic health records and the statistics generated through them as instruments that enable comparisons between the output of different practitioners and professional groups. Emphasising the quantitative and official criteria of personal work achievement helps practitioners bring their own thinking in line with auditing.

In addition to calculation of the quantitative work output, employees consider it important—since auditing requires work to be defined as products—for forms of activity to be categorised according to their duration and ‘desirability.’ A physician at the child psychiatric clinic expressed the need for better guidance on the volumes of each mode of work that should be accomplished and within what time period. Although practitioners record all their actions in Oberon, physician calls for instructions on the targeted quantities of each action. This would clearly show the actions that the administration considers important:

We have such long queues and they cause pressures, so I’d like to have a framework on how many examination periods we are expected to carry out, how many treatments, what should the patient turnover be, how rapidly should we get them to move to primary-level units. These are some of my questions and I do get answers, too, but I’d like to have more of general instructions, and I mean from my superiors.

One of the aims of auditing is to assure the quality of work. In addition, it is used to even out the workload between practitioners and to provide clients equal access to treatment. In the supported housing unit, too, practitioners hope for a clearer assessment and feedback. The unit practitioners would like to have the following:



A blessing on what we do, on our work from somewhere higher up, I don't know if it should be the managing director or someone else. I've been hoping for specific feedback all the time, instead of just hearing, 'well, you seem to be doing pretty well here' and so on. I think we should have continuous feedback and auditing.

In addition to the quality and effectiveness of work, practitioners consider auditing to be useful in developing professional practices. The concepts related to auditing are important for practitioners; they are used to reflect on the work and to determine the effectiveness of rehabilitation. The following extract from a team meeting at the supported housing unit describes how tacking uses expressions from the auditing rhetoric to describe elements of rehabilitation:

We'll have to think about showing the effectiveness of our work ourselves, as a tool of evaluating our own work as well, and look for the kind of essential data that affects our work, where we have succeeded and where we haven't. What have we been able to achieve for the client, what changes can we see in the client's condition. And that's the route to go when developing our work and thinking of projects for change. What's more, people outside will be able to understand our work through our know-how and activity.

The attitude that auditing can be made useful implies an expansion of the ways of operation: in addition to obligatory auditing, practitioners carry out voluntary auditing and monitoring. This ensures the continued existence of the background organisation. The service purchaser must be convinced that the organisation is capable of providing precisely the service that it has been ordered for. The crucial thing is to create trust, and this is why information such as that required for auditing is generated.

In the following example, practitioners of the supported housing unit discuss the reports and other information given to the purchaser:

We'll have to start drawing up charts and block diagrams and include factual information about where the client has come from and why, and what their diagnosis is. Then we'll calculate percentages, which will show the outcome, or to put it in a fancier way, even scientific evidence, for the future. So we'll have statistical information for later use. Our workshop, for example, has written a detailed process description, and this is specifically related to the definition of products.

The use of administrative auditing rhetoric can also be seen in public documents, which the practitioners have been involved in writing. The strategy of the housing service<sup>56</sup>, for example, states as follows:

Our vision can be quantified. The goal is to describe and document our activity and define it as products, so that we will have a strong position in the competitive bidding based on the purchaser-provider model. We have to take concrete measures to determine the impact of our work.

The use of auditing rhetoric in tacking corresponds to Michael Power's<sup>57</sup> characterisation, according to which making activity valuable implies, to a great extent, attaching appropriate labels. The attitude that auditing is useful shows that tacking can be a resource that not only challenges auditing practices, but also upholds them. In this case, tacking is less of a response to the potential conflict between auditing and treatment work, and more of a way of using auditing to develop the

work. When practitioners document the matters requested in the way required, they safeguard both the resources of their organisation and their own position as a professional worthy of appreciation.

Practitioners demand more instructions concerning the targeted volume of actions, since a better grasp of the criteria applied to the work helps streamline personal thinking and actions with auditing logic. Ultimately, the ability to adapt to auditing is important if each individual practitioner is to execute the job and experience it as meaningful. The rationalisation auditing helps make personal work meaningful or, at the least, helps carry out the work in the organisation.

Renouncing the auditing logic is the other extreme of tacking as an attitude. Renouncing may be manifested as resistance to auditing practices or as distancing oneself from it. This type of tacking is particularly present in situations where auditing is not considered to provide a realistic picture of mental health work. The quantity of work calculated on the basis of codes entered in electronic health records, for example, does not always correspond to reality, as described by a social worker at the child psychiatric clinic:

The information on client numbers which is entered in the treatment statistics for municipal invoicing can be viewed by anyone, so you can see how much each of us has done. Say you take the family ward team and make a printout and see, “Let’s see, this one has seen 200 clients during this year, but that one’s only seen 54”. But that doesn’t show, for instance, if a worker is part-time, because it only shows the actions related to client work. Maybe when I was younger, I was worried about that, but personally I feel it has no significance because you understand that this is related to the municipal invoicing and not to what you’re like as a worker.

The social worker mentions that output is affected by many things that cannot be seen in the calculations, such as the person's working hours. The possibility to check the internal workload of the clinic in the electronic health record does not appear to be crucial, since it is not seen as an indicator of the appropriateness of work. The output calculations are regarded as part of the economics of the hospital district, which is why they should not be regarded as an evaluation of individual practitioners. The following extract from a statement by a psychologist at the child psychiatric clinic is a description of the errors in work reports:

We also have statistics of visits which are calculated by the administration, and then they are monitored and sometimes shown to us with the comment that we now have this number of visits per worker. The comment may be delivered in a tone that says, how come they are this few, and yet there have often been errors in the calculation so that the volumes are not true. But the people who bring them to us aren't always even aware of these errors, and they actually get worried and think, what on earth, aren't these people doing anything.

The output generated by the codes is renounced by showing that it is unreliable as an indicator of work done. This selectivity can be seen in team meetings at the supported housing unit, with practitioners discussing the appropriateness of both content-related and statistical records:

In the end, no one is able to read or process all the information recorded, and no one will do it, and it's nobody's main task to read, summarise or analyse the records. So why should we take the trouble to record things that no one needs?

In addition to pointing out mistakes related to the definition of services as products, humour is a means of making auditing appear ill-suited to work. The following extract from a team meeting is

an example of the use of humour in tacking, relating to the requirement of defining products for Service Purchasing Agreement:

These days you've always got to have a package deal to sell. In fact, Simo and I were designing some at the physicians' meeting. We came up with several entertaining ones, we had the Crazy Days package and the Depression package. If you have repeated depressive episodes, then your tenth visit will be free of charge. So now's the time to get depressed!

Practitioners distance themselves from auditing by constructing a confrontation between the administration and the practitioners. Auditing is renounced because the organisational reforms related to it are experienced as so tragicomic that the worker does not want to be associated with them. This is described by a nurse when telling about the new model of process management at the child psychiatric clinic, one of the goals of which is to improve the monitoring of treatment periods:

To begin with, the idea about a process-based organisation started with the Retiring Alive project, that is, the Physicians Retiring Alive project. So this is not something I'd have come up with in my sarcastic mind; this is how it got started. Later, in fact, it was changed to mean Everyone Retiring Alive, when we noticed the blunder we'd made, and at the moment no one is sure any longer whether they'll be able to retire alive, this is the feeling I've got.

Practitioners have varying attitudes towards the usefulness of auditing and its disadvantages. Some practitioners may consider auditing useful for their work in one situation, and then clearly distance themselves from it in another. Compulsory auditing makes practitioners adapt their client work for purposes of reporting, but as the work becomes more technological, they must ultimately also adapt their own attitudes and their professional self-image.<sup>58</sup>

## **Tacking and the complications of auditing in mental health work**

Tacking caused by auditing is closely intertwined with empirical analyses of how practitioners apply new public management in the professional practices of social and health care.<sup>59</sup> What I call tacking has also been studied by using such concepts as a workaround, in which practitioners resort to provisional, self-made solutions to be able to use IT appropriately.<sup>60</sup> It can also be described as a kind of “wobble room,”<sup>61</sup> in which the new methods introduced at work are used for purposes other than those for they were originally designed. Tacking also comes close to moderate resistance by practitioners.<sup>62</sup>

I have reviewed the ways in which practitioners adapt their practices and attitudes to auditing of mental health work. These types of tacking share the feature that they are subtle and do not challenge auditing as such. Tacking is intertwined with normal work so that individual practitioners are not necessarily even aware of doing it. Tacking is manifested as a mundane strategy used by practitioners to adapt their professionalism to match the increasingly technological mental health work and its ubiquitous auditing. Despite the fact that audit techniques are experienced as problematic, practitioners use them as a basis to structure and organise their work. The substantial framework created for daily work by audit techniques denotes how the language of steering systems has become an established part of the day-to-day talk of practitioners.<sup>63</sup> By now, in fact, there is talk about the conceptual inflation of auditing.<sup>64</sup>

As a technology of agency, auditing is primarily a moving force for professional activity.<sup>65</sup> It provides practitioners with opportunities for doing their work with improvisation, but at the same time it forces them to adopt a new way of thinking and implementing such things as client selection. It is difficult to create uniformity between local applications of professional work through

nationwide and organisational instructions. According to Jyrki Korkeila, the acceptance of recommendations concerning psychiatric services varies considerably from one organisation to the next. Similarly, the practices found good by individual practitioners are difficult to disseminate.<sup>66</sup> This is largely due to the fact that practitioners always have their own local interests and priorities.<sup>67</sup>

Even though tacking does not appear to strongly challenge the current situation, it holds an important role in mental health policy. Practitioners' tacking is what ultimately shapes the implementation of political programmes. For instance, auditing and streamlining of work planned in nationwide programmes<sup>68</sup> and steering systems<sup>69</sup> is ultimately realised in the daily reporting routines of practitioners, at meetings with clients or in treatment interventions. Audit techniques are not enough to embed the objectives of national mental health policy in client work. The forms of tacking show that transforming mental health work into something that can be audited is much more than a purely technical measure; the personal choices of individual practitioners also have an important role.<sup>70</sup> Practitioners engaged in auditing are always political subjects, whether they want it or not. The essential message of tacking, which makes use of auditing practices, is that a technique aiming to standardise the professional tasks of practitioners does not guarantee the uniformity of services; rather, uniformity is implemented through day-to-day decisions and applications of the practitioners. However, the voice of individual practitioners is not articulated in national programmes. As an example, the Mieli 2009 programme<sup>71</sup> mentions that the key personnel in developing the work are "managers of mental health and substance abuse work and the professors and lecturers of the various professions involved in mental health and substance abuse work." Nevertheless, tacking, which practitioners in the field resort to, shows that it is only the local application of political programmes that produces the content of mental health work.

Difficulties related to audit techniques are described not only by practitioners in the field. The Audit Committee of the Parliament of Finland, which may be considered as one of the highest authorities on auditing in Finland, has also expressed criticism towards IT in the social and health care services.<sup>72</sup> The Audit Committee has noted that information steering is inefficient, that there is insufficient empirical research on it and that it may actually be suffering from a credibility crisis.<sup>73</sup> The Audit Committee also criticises auditing, “which is too abundant and which focuses on the wrong things.”<sup>74</sup>

Auditing generates complications and unintended consequences in mental health work. In medicine, one definition of the concept of complication is a side effect related to the treatment. If we consider auditing as a ‘treatment’ to improve the appropriateness of mental health services, we can see what “side effects” it has on mental health work. One of the complications of auditing revealed by tacking is that the emphasis on steering systems and technical instruments, which is typical of auditing, appears to have become a ‘natural’ part of professional mental health work. The ubiquitousness of auditing suggests that mental health work as such is not the primary target of national steering; on the contrary, the targets are constructed quantities of work and modes of description that can be used to prove the functionality of the system. Michael Power has aptly noted that auditing culminates as questions of whether a monitoring system exists, what it consists of and how it functions.<sup>75</sup> In contrast, the social or individual outcomes of interventions are topics of lesser interest. In line with Markku Salo, it may be asked whether the instruments of the welfare state, such as helping organisations and administration, are becoming the object and the self-evident goal of mental health work.<sup>76</sup> In particular, tacking to modify client work raises the question whether the auditing logic has become so ubiquitous that, parallel to treatment, therapy and rehabilitation, the correct use of audit techniques becomes a goal in itself, so as to produce the ‘desired’ reporting and outcomes. This creates the risk of professional vision turning upside down, so that care work (so far



considered by practitioners to be their main task) becomes a factor that hinders the maximal utilisation of audit techniques.

If mental health work is primarily described as classifications and statistics based on accountancy, the reforms of the work are clearly visible in the documents produced by the steering system, but they will not have a counterpart in reality. In practice, care work is very often multidimensional. Ideal documentation created for auditing purposes does not necessarily describe ideal practice; rather, it describes the style and rhetoric of reporting. This conclusion is supported by the fact that most tacking was related precisely to the use of audit techniques and the reporting on the work. Auditing with clear indicators and steering instruments will generate tacking related to these. Thus, practitioners will focus on varying the audit techniques instead of beginning to adapt the content of actual care work.

Since the targets set for the steering system are subject to audit, it is understandable that the description of mental health work increasingly focuses on the means of steering it. The increasing focus on the steering system is a response to how 'the problematic of madness' and working with it can be transformed into an activity that can be quantified and audited. Practitioners have to audit the things they can audit. These include programmed targets, administrative arrangements and output of mental health work, but these are more a description of the organisations than of the well- or ill-being of clients.<sup>77</sup> If mental health work is expressed in a taxonomy based on biomedical diagnostics, it can still be positioned in the auditing framework, but how can we generate auditable criteria for encounter work, which embodies multidimensional social interaction? Likewise, it is difficult to audit treatment, which regards mental health problems primarily as a holistic crisis.<sup>78</sup>

*For comments that took this article forward, I would like to thank Mikko Mäntysaari at the University of Jyväskylä, and my research colleagues in the project 'The responsabilisation of service users and professionals in mental health practices', funded by the Academy of Finland and carried out at the University of Tampere.*

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2. By 'information technology' (IT) I refer to applications and tools enabling the management and generation of information. I define the word 'technology' in the same way as Pohjola et al. (2010, 15), who use it to refer to information steering and the procedures and techniques related to it. They also observe that in the Finnish language, the meanings of the concepts 'technique' and 'technology' are fairly fuzzy and they are often used as synonyms for each other.

3. E.g., Medici-dataa 2005; Lillrank et al. 2004; Jääskeläinen 2009.

4. CIO 2010. The Government IT Manager holds a position at the Ministry of Finance and leads the Management Unit of the state's IT activity.

5. E.g., Salmi 2005.

6. I speak of the technologisation of mental health work to refer particularly to the development in which an increasing number of technical instruments developed for information steering are introduced in mental health work. The instruments developed for auditing are included in this.

7. Miller & Rose 2008.

8. Helen in this publication; Hänninen 2009; Koivusalo et al. 2009; Henriksson & Wrede 2008.

9. Juhila 2009, 57-58; Metteri 2004, 137.

10. E.g., Conrad 2005.

11. E.g., Danzinger & Welfel 2001.

12. E.g., Timmermans & Berg 2003.

13. E.g., Burchell 1996; Sulkunen 2006.

14. Audit Committee 2008a+b.

15. Audit Committee 2008b, 4.

16. E.g., Ryyänen et al. 2004; Aaltonen et al. 2009.

17. Kielitoimiston sanakirja 2006. [Dictionary of Finnish language department].

18. Dean 1999, 169.

19. For a more detailed breakdown on technologies and techniques, see Dean 1994; 187-188.

20. See Helén 2004, 208-209.

21. See Dean 1994,187; 1999, 202.
22. See Gordon 1980, 255.
23. I have condensed the extracts by removing passages related to spoken language, such as repetitions and filler words. At the same time, I have inserted a few words to assist understanding. Consequently, the extracts are not a verbatim representation of interview or meeting talk. In modifying the extracts I have, however, striven to preserve their essential content, the tone of talk and the original word choices. In translating the extracts into English, the intention has been to preserve the essential content and the tone as far as possible.
24. Wahlbeck 2005; STM 2009.
25. Sosiaali- ja terveystieteiden ministeriö 2009, 44.
26. E.g., Mielenterveyslaki 1990; Sosiaali- ja terveystieteiden ministeriö 2003; Kehittämishankkeen ohjelma 2002.
27. Rajavaara 2006, 2007, Virtanen 2007.
28. Miller & Hopwood 1994; Power 1999.
29. Rajavaara 2007,164,166.
30. Op. cit, 167.
31. Korkeakoulujen 2007; Rekilä et al. 2008; Audit Committee 2008b.
32. Other tools mentioned include education, statistical and research data, register data, information generated within development projects and its dissemination, and guides and recommendations (Audit Committee 2008b, 4).
33. The English-language word ‘audit’ has no standard Finnish-language equivalent, and the word generally used is a Finnicised form of ‘audit’. The closest equivalents of the word in Finnish correspond to the English words ‘inspection’ and ‘evaluation’. In English-language research debate the word ‘audit’ refers fairly broadly to evaluation, whereas in Finnish it is understood in a narrower sense. It is used to refer to a systematic exercise commissioned expressly from an external agent, applying certain methods. Audit results are generally presented as a separate report. Thus, the English word ‘audit’ can be translated into Finnish either as the broader term ‘evaluation’ or more narrowly as ‘auditing’. The broader word ‘evaluation’ is a better equivalent for the audit techniques used in this article.
34. Mäntysaari 1995,73-75; Scriven 1991.
35. Wahlbeck et al. 2009.
36. Here, I speak of administrative reporting to distinguish it from the documentation of treatment or the evaluation of treatment quality.
37. Mäntysaari 1999; Scriven 1991.

38. The problematic characteristics of the reporting required by auditing are expressly related to the reporting generated for administrative purposes. In contrast, the documentation of the content of mental health work, describing the service users and various treatment and social services interventions, appears to the practitioners mainly as supportive of a holistic work approach. This being so, the documentation of work promotes the continuity and systematic nature of treatment and the taking into account of the clients' financial management and social security (Saario, forthcoming).
39. Ostopalvelusopimus 2007.
40. See Salo & Kallinen 2007, 25, 334.
41. Erikoissairaanhoidon tuotteet ja hinnat 2007, 67. [Documentary data: Specialist medical care: products and prices].
42. Aho at the psychiatric outpatient clinics was mainly used for intra-municipal statistics, since these clinics are administratively a part of the basic services of each individual municipality. This means that there were no negotiations such as those conducted by the child psychiatric clinic in the run-up to concluding the agreement.
43. Saario & Hämäläinen 2007.
44. Diagnostic... 2000.
45. Aaltonen et al. 2009.
46. Avison & Young 2007.
47. 2007, 18.
48. See Raitakari & Saario 2008.
49. 2008, 5.
50. 2007, 18, 82.
51. Raitakari 2008; Raitakari & Saario 2008.
52. Suunnittelulomakkeet 2000-2003. [Documentary data: Planning templates].
53. Toimintakertomus 2007, 6, 40, 81 [Documentary data: Annual Report].; Erikoissairaanhoitolaki 1990 31 § [Act on Specialist Mental Health Care]; Sosiaali- ja terveystieteiden ministeriö 2007 [Ministry of Social Affairs and Health]; Hoitoonpääsyn kriteerit 2005 [Documentary data: Criteria for access to treatment].
54. A compromise of this type does not have the same consequences in 2011, since the psychotherapy paid for by the Social Insurance Institute is no longer needs-based; a sufficient condition for receiving it is that the person has had a treatment relationship of three months at least and the physician has recommended therapy. Thus, the role of the psychiatric outpatient clinics as

providers of therapy has changed, since the Social Insurance Institute will also pay for therapy by private providers. (H E/ 2010)[Proposal by the Finnish Government].

55. Lipsky (1980, 49) has called this selection process “skimming off the cream”.

56. 2008, 4, 5.

57. 1999, 17.

58. Shore & Wright 2000, 62,76-77; Rose 1999,178-179.

59. E.g., Banks 2004; Connell et al. 2009; Hjärne et al. Metteri & Hotari 2011; Taylor & White 2000.

60. Wastell et al. 2010.

61. Erickson 2001.

62. Saario (forthcoming b).

63. Rose 1999, 221; Taylor & White 2000,181.

64. Shore & Wright 2000, 59.

65. Dean 1999,169.

66. Korkeila 1998; Hjärne et al. 2010; Lipsky 1980.

67. Parton 1999,105; Raitakari & Juhila 2011,190-191.

68. Sosiaali- ja terveysministeriö 2003 [Ministry of Social Affairs and Health]; Kehittämishjelma 2002 [Documentary data: Agenda for mental health services].

69. Audit Committee 2008a+b.

70. Cf. Julkunen 2001; Koivusalo et al. 2009.

71. Sosiaali- ja terveysministeriö 2009,45 [Ministry of Social Affairs and Health].

72. Audit Committee 2008a, 3.

73. Audit Committee 2008b, 5.

74. Audit Committee 2008a, 7.

75. Power 1999, 8.

76. Salo 1996,321.

77. Rajavaara 2007,161,164-165; Rose 1999.

78. Basaglia 2000,155.

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