Controlled by Knowledge

A Study of two Clinical pathways in Mental Healthcare

Mona Jerndahl Fineide
Controlled by Knowledge

A Study of two Clinical pathways in Mental Healthcare

Mona Jerndahl Fineide
# TABLE OF CONTENTS

## 1 INTRODUCTION

1.1 **IN CONTEXT: NORWEGIAN HEALTH CARE**  
1.1.1 **MENTAL HEALTH CARE SERVICES**  
1.1.2 **CHALLENGES**  
1.1.3 **“STREAMLINED” APPROACHES AND STRATEGIES IN HEALTH POLICY**  
1.2 **CLINICAL PATHWAYS**  
1.2.1 **TERMINGOLOGY AND DEFINITIONS OF CLINICAL PATHWAYS**  
1.2.2 **“EVIDENCE-PRODUCING” ORGANISATIONS**  
1.3 **THE APPROACH OF THE STUDY (AIM & OUTLINE)**  
1.4 **CONSTRUCTION OF THE THESIS**

## 2 THEORETICAL PERSPECTIVES

2.1 **STANDARDISATION AND RULES IN ORGANISATIONS**  
2.1.1 **THE IMPORTANCE OF STANDARDISATION**  
2.1.2 **DIRECTIVES, NORMS OR STANDARDS**  
2.2 **KEY ASPECTS OF NEO-INSTITUTIONAL THEORY**  
2.2.1 **LEGITIMACY**  
2.2.2 **DECOUPLING**  
2.2.3 **INSTITUTIONS CONstrain AND REGULATE BEHAVIOUR**  
2.2.4 **THE LOGIC OF APPROPRIATENESS**  
2.3 **SCIENTIFIC BUREAUCRATIC MEDICINE**  
2.3.1 **EPISTEMOLOGICAL PERSPECTIVES OF MEDICAL CARE**  
2.3.2 **AUTONOMY IN THE PERSPECTIVE OF SOCIOLOGY OF THE PROFESSIONS**  
2.3.3 **THE “PROFESSION STATE”**  
2.3.4 **PROFESSIONS ARE SUBJECT TO CONTROL**  
2.3.5 **REGULATION TOOLS**  
2.4 **RESEARCH QUESTIONS**

## 3 METHODOLOGY

3.1 **ACCESS TO THE FIELD**  
3.2 **DATA COLLECTION**  
3.2.1 **INTERVIEWS**  
3.2.2 **PARTICIPANT OBSERVATION**  
3.2.3 **RECORDED DATA FROM INTERVIEWS AND PARTICIPANT OBSERVATIONS**  
3.2.4 **DOCUMENTS**  
3.3 **ANALYSING THE DATA**  
3.3.1 **EXAMPLES OF “OPEN CODING”**  
3.3.2 **MICRO-SOCIOLOGICAL ANALYSES**  
3.4 **REFLECTIONS ON THE VALIDITY OF THE STUDY**  
3.5 **SUMMARY OF METHODOLOGICAL CONSIDERATIONS**  
3.6 **THE STRUCTURE OF THE FOUR EMPIRICAL CHAPTERS**
4 RULEMAKING FOR THE CLINICAL PATHWAY FOR CHILDREN WITH ADHD 55
4.1 THE DESIGN PROCESS 55
4.1.1 THE INITIAL DESIGN PROCESS OF 2003 AND 2004 55
4.1.2 THE IMPLEMENTATION PROJECT DURING 2005 AND 2006 64
4.2 KNOWLEDGE IN USE 75
4.2.1 "THESE ADHD DISCUSSIONS" 79
4.3 SUMMARY: THE DESIGN OF THE CP FOR CHILDREN WITH ADHD 83

5 RULEMAKING FOR THE CLINICAL PATHWAY FOR ADULTS WITH ADHD 85
5.1 INTERNAL COORDINATION PROBLEMS ARE IDENTIFIED 85
5.1.1 THE IDEA OF A CLINICAL PATHWAY FOR ADULTS WITH ADHD 87
5.2 THE DESIGN PROCESS OF 2007-2009 87
5.2.1 A CLINICAL PATHWAY EXECUTIVE DOCTOR AND A CP TEAM IN PLACE 88
5.2.2 IN-HOUSE CLEAN-UP FIRST OF ALL 89
5.3 KNOWLEDGE IN USE 101
5.3.1 FIRM KNOWLEDGE? 112
5.4 SUMMARY: THE DESIGN OF THE CP FOR ADULTS WITH ADHD 117

6 AN ANALYSIS OF RULEMAKING 120
6.1 THE INFLUENCE OF THE NPM IDEOLOGY 121
6.2 DECOUPLING, PROFESSIONAL INVOLVEMENT AND LEGITIMACY 122
6.2.1 PROFESSIONAL INVOLVEMENT AND CONTINUOUS IMPROVEMENTS 123
6.3 INNOVATIVE BUT LIMITLESS WORK 123
6.3.1 LACK OF "RESPONSIBLE LEADERSHIP" 124
6.3.2 THE "STANDARDSERS": PROFESSIONALS SUPPORTED BY TECHNO STAFF 125
6.4 INITIATED IGNORANCE -- "IN A STRAITJACKET" 132
6.4.1 PRIMA FACIE KNOWLEDGE 133
6.4.2 COMPETING MODES OF KNOWLEDGE 136
6.5 SUMMARY OF RULEMAKING 141

7 RULE FOLLOWING - RESPONSES TO THE CP FOR CHILDREN WITH ADHD 143
7.1 KNOWLEDGE AMBIGUITY OF ADHD DIAGNOSIS AND MEDICATION 144
7.1.1 COPING WITH UNCERTAINTY IN DIAGNOSING 145
7.1.2 ETHICAL RESERVIATIONS ABOUT A "FAST LANE" MEDICATION 149
7.1.3 "YOU HAVE TO TAKE WHAT YOU’VE GOT" 152
7.2 REDISTRIBUTION OF WORKLOAD 152
7.2.1 "WHAT CAN BE COMPLETED LOCALLY SHOULD BE COMPLETED LOCALLY" 153
7.2.2 PROFESSIONAL BOUNDARIES AND JURISDICTION OF A FIELD 156
7.2.3 REFLECTIONS ON SUBOPTIMISATION 159
7.3 DIFFERENT INTERPRETATIONS OF THE CP: A DIRECTIVE OR A STANDARD? 161
7.3.1 AFTERTHOUGHTS OF THE PROJECT MANAGEMENT 163
7.4 ANALYSIS OF RULE FOLLOWING 165
7.4.1 REGULATION OF PROFESSIONAL PRACTICE 165
7.4.2 THE "FOLLOWERS": COMMITMENT AND ENGAGEMENT? 166
7.4.3 THOSE "LEFT IN THE LURCH": WITHDRAWAL, DENIAL AND HOSTILITY 167
7.5 SUMMARY OF RULE FOLLOWING 168

8 TOWARDS SCIENTIFIC BUREAUCRATIC MEDICINE IN MENTAL HEALTH? 170
8.1 DIFFERENT FORMS OF CLINICAL PATHWAY AND POTENTIAL CHALLENGES 170
8.2 TRAINING FOR CERTAINTY BY EVIDENCE BASING MENTAL HEALTH CARE? 172
8.3 THE CIRCULATION OF EVIDENCE-BASED KNOWLEDGE 173
8.3.1 INSTITUTIONALISING PRIMA FACIE KNOWLEDGE 175
8.4 A PRAGMATIC MIX OF “OLD” AND “NEW” GOVERNANCE 176
8.5 TOWARDS “SOFT” BUREAUCRACY? 177
8.5.1 THE PROFESSIONS’ GOODWILL AND CREATIVE INVOLVEMENT? 178
8.5.2 PROFESSIONALS CONTROL EACH OTHER 179

9 SUMMARY AND CONCLUDING REMARKS 181
9.1 SUMMARY 181
9.2 CONCLUDING REMARKS 183
9.2.1 HYBRIDISATION IN A JOINT PROJECT WITH THE STATE? 183
9.2.2 “SOFT” CONTROL AND CONTEXTUAL KNOWLEDGE 184

REFERENCES 185
LIST OF ILLUSTRATIONS AND APPENDICES 198
APPENDICES 199
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>ASRS</td>
<td>Adult ADHD Self-Report Scale</td>
</tr>
<tr>
<td>BAL</td>
<td>Clinical Pathway Executive Doctor</td>
</tr>
<tr>
<td>BUP</td>
<td>Child and Adolescent Psychiatric Services</td>
</tr>
<tr>
<td>BUPP</td>
<td>Child and Adolescent Psychiatric Polyclinic</td>
</tr>
<tr>
<td>CP</td>
<td>Clinical Pathway</td>
</tr>
<tr>
<td>DPS</td>
<td>District Psychiatric Centre</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
</tr>
<tr>
<td>EBK</td>
<td>Evidence-Based Knowledge</td>
</tr>
<tr>
<td>EBM</td>
<td>Evidence-Based Medicine</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner (family doctor)</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>ICF</td>
<td>International Classification of Functioning, Disability and Health</td>
</tr>
<tr>
<td>ICP</td>
<td>Integrated Care Pathway</td>
</tr>
<tr>
<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
</tr>
<tr>
<td>IPLOS</td>
<td>Individually Based Care Statistics</td>
</tr>
<tr>
<td>KITH</td>
<td>The Norwegian Centre for Informatics in Health and Social Care</td>
</tr>
<tr>
<td>KM</td>
<td>Knowledge Management</td>
</tr>
<tr>
<td>KRT</td>
<td>Knowledge-Based Regulatory Tool</td>
</tr>
<tr>
<td>NAPHA</td>
<td>The Norwegian Knowledge Centre for Mental Health Care</td>
</tr>
<tr>
<td>NAV</td>
<td>The Norwegian Labour and Welfare Organisation</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NOKC</td>
<td>The Norwegian Knowledge Centre for the Health Services</td>
</tr>
<tr>
<td>NPM</td>
<td>New Public Management</td>
</tr>
<tr>
<td>NPR</td>
<td>The Norwegian Patient Register</td>
</tr>
<tr>
<td>PPT</td>
<td>Educational and Psychological Counselling Service</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
</tr>
<tr>
<td>SMP</td>
<td>Socio-Medical Polyclinic</td>
</tr>
<tr>
<td>SPC</td>
<td>Statistical Process Control</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Acknowledgements

Let me make it quite clear at the outset: this is not a study of whether clinical pathways "work" or "don't work" in mental health care. It examines what the introduction of clinical pathways may mean for professional practice and as the title "Controlled by Knowledge" suggests, I argue that the introduction of this concept may involve steering through knowledge. The thesis bears my name, I assume full responsibility for the content, and any input or critical reflections on my interpretations should therefore be addressed to me.

The first people to be thanked here are all you informants who have offered your time and shared your experiences. You have been involved in exciting new projects and ways of working in mental health and your ardent professional commitment to achieving good solutions for your patients and clients is most impressive.

Many are those who have "cheered me on" during my work on this thesis and who deserve a big thank you! As a doctoral student at Karlstad University and research fellow at Østfold University College, I would first like to thank to my supervisors Professor Lena Gonäs at Karlstad University and Professor Helge Ramsdal at Østfold University College. You have each in your own way kindly shared with me your significant academic experience and given me fruitful and constructive feedback and input throughout my work on this thesis. A very special thanks to Helge who opened the door for me into the KNOW & POL project, and who enthusiastically leads us to exciting new projects and publications. A special thanks also to Professor Eva Bejerot of the University of Stockholm for a very thorough review and valuable comments on my manuscript at the final seminar.

I discovered a brilliant academic environment at Karlstad University in the Department of Working Life Science, represented by Professor Jan Ch. Karlsson and Professor Birgitta Eriksson. Being a doctoral student here means very relevant and informative courses and seminars, the annual PhD day with dinner at home with Jan Ch. and his wife Lisa, not to mention friendly meetings, where I would especially like to thank my fellow students Line Holt, Susanne Strømberg, Louise Weibull, Erik Fjell, Jan Moren and Jennifer Hobbins. Jan Ch. knocked on a door for me in Scotland and I was welcomed as a visiting scholar at the University of Strathclyde (HRM) for a couple of months. Many thanks to Professor Dora Scholarios for her friendly and helpful manner, and the rest of the researchers at this excellent university, represented by research fellow Douglas Martin.
I cordially thank the management team of Østfold University College, represented by Dean of Studies Synnøve Narten, also Coordinator of EVU Studies Finn Samuelsen and all my colleagues at Faculty of Health and Social Studies. A very special thanks to my friend and colleague Nita Ørmen, my roommate and fellow student Siv Øveraas, colleagues Gunnar Vold Hansen, Jørg Kirchhoff, Professor Egil Skorstad and all members of the women’s research network KvinnForsk, led by Professor Eva Skærbæk. Thanks also to students and colleagues from Østfold University College Master's Degree in Interdisciplinary Collaboration and all colleagues at EVU.

There is a great deal of practical work involved in a thesis, not least translation and proofreading. First of all thanks to Simen Gudevold who helped me in the early stages, but otherwise through much of the final spurt Paul Farmer has been a tremendous resource for me. Many thanks!

Thanks to my dear friends and family who constantly remind me of all the good things in life: my son Terje with Tonje and the boys, and my daughter Camilla with Henrik and their little girl, who deserve a special thank you for their help with the texts and models. Thank you dear Per and Bjørg, Synnøve and all my family for cheering me on throughout. But the biggest thank you is reserved for my beloved Bent who supported me in my decision to apply for a job as a research fellow, cheered me on and gave me plenty of welcome breathing space during the writing process.

Mona Jerndahl Fineide
Herføl 17.04.12
1 Introduction

This study sheds light upon relations between knowledge and rulemaking in mental health care as it conveys the empirical findings and analysis of certain actors' experiences and interpretations of the design processes of two different Clinical Pathways (CPs) for ADHD for children and adults respectively.

A CP describes and visualises all the activities of medical interventions and treatments for a specified diagnosis in order to govern the interactions and behaviour of actors and organisations within the health care system, prescribing step-by-step instructions of care and treatment. A CP is consequently a regulatory instrument, intending to bring actors to think or act in ways which they might not have considered (Salamon 2002, Lascoumes & Le Gales, 2007). Clinical pathways standardise treatment knowledge; they are a knowledge-based regulatory tool grounded in evidence-based knowledge, providing rules for professional practice.

In the present study, the CPs are designed in contexts of mental health care involving a number of professions, such as psychologists, psychiatrists, health visitors and educational therapists; they are all experts representing diverse bases of knowledge and competence in dealing with the diagnostics and treatment of patients. Professions have undoubtedly the power to open doors to the goods and services that others need (Terum 2003, Molander & Terum 2008), they have professional discretion which is the cornerstone of professional work (Goodin 1986, Freidson, 2001, Grimen 2009), and they also define what is normal and what is abnormal (Grimen 2009). They can thus be said to wield considerable power in their professional practice.

According to Brunsson & Jacobsson, many actors make regulations and rules in various settings without us being aware of their existence (Brunsson & Jacobsson et al. 2000). Thus, by shedding light upon the relations between knowledge and rulemaking, the intention of this study is to understand what clinical pathways mean for professional work in mental health care.

This study is based on two empirical cases from Norwegian mental health care, both of which represent professional involvement in developing and implementing a CP for ADHD. By exploring the design processes for standardising, the processes of
“transforming knowledge into rules” for professional work, the following main research question arises:

- How do professionals standardise their own work?

This introduction consists mainly of a presentation of CPs in an international and national context. CPs are not developed in a social vacuum; rather, these instruments can be seen as a response to quality and coordination problems in the health care system. Thus, this section starts with a brief overview of the “landscape” of mental health care, presenting recent health care reforms and schemes from a health policy perspective, followed by a description of the CP concept and a presentation of the approach of the study. The final part of the introduction is a presentation of the construction of this thesis.

1.1 In Context: Norwegian Health Care

In Norway, as in other countries, there is a demand for instruments to improve coordination and quality in the health care system. Currently, one of the main strategies is to develop the idea of a standardised “patient pathway” across organisational boundaries.

1.1.1 Mental Health Care Services

A brief retrospective glance at Norwegian mental health care brings us back to the de-institutionalisation of psychiatric services which intensified from the mid-1970s, with the downsizing of psychiatric hospitals. The “Escalation Plan for Mental Health” for 1998-2008 called for a restructuring of the specialist services based on hospital wards; these now provide highly specialised services such as acute wards, psychiatric emergency wards, psychiatric intermediary wards and psychiatric day hospitals (Parliamentary Report No. 63/1997). The District Psychiatric Centres (DPCs) and ambulatory mental health teams were expanded and provided less specialised services at a decentralised level along with local authority services. People suffering from mental disorders will now receive health services where they live, reflecting ideologies of normalisation, integration and mastery. These ideologies consequently lead to a shift of the focal point from specialist health services to local services. As an illustration of this shift, the term “psychiatric health services” was changed to “mental health care”. This indicates that the medical speciality
“psychiatry” no longer should be the main focus in services for people with mental health disorders, because they are now provided with local support (Kolstad, 2004). What is striking is that the Escalation Plan for Mental Health occurred at the same time as a series of public service reforms inspired by the ideology of New Public Management (NPM), which meant that the framework for this national action plan changed considerably (Hammerstad, 2006). The NPM approach led to several reforms resulting in comprehensive structural changes in Norwegian health care focusing on efficiency and modernisation in the public sector (Christensen & Lægreid 2001, Christensen et al. 2004). The 2002 Hospital Reform underpinned this shift by reorganising the specialist health services and implementing new management principles for hospitals (Parliamentary Report No. 5/2003). Part of the Hospital Reform reflects post-NPM approaches, introducing a rather complex combination of centralisation, decentralisation and commercialisation into its formal structure (Lægreid, Opdal & Stigen 2005). Economic factors were important aspects; the hospital trusts did not simply become subjected to “autonomy, transparency and management” (Byrkjeflot 2006), but also to optimisation and reorganisation in order to make patient treatment more cost-efficient.

The local authorities are responsible for providing locally based health services. It is here important to point out that Norwegian local government over the last couple of decades has also introduced NPM-inspired governance principles characterised by “two-level” models and a “flat structure” (Hovik & Stigen, 2004, 2008).

The 2001 Regular General Practitioner (RGP) Reform (Directorate of Health Circular I-52/2000) provided all citizens with a family doctor to assist patients in navigating the system. Another typical feature of this scheme is that the GPs (who previously were largely employed in local authorities) have now become self-employed.

Mental health care in Norway is regulated by the Mental Health Care Act and its requirements¹. In addition, mental health work is regulated by other laws regarding health issues, such as the Patients’ Rights Act and the Specialist Health Services Act. For adult patients there are a number of public services available in addition to family doctors (GPs) such as psychiatric day care, social welfare provided by NAV (the Norwegian Labour and Welfare Organisation), community care and nursing homes. Additional resources for children are Educational and Psychological Counselling Services (PPT), schools, kindergartens and health centres.

¹ The Mental Health Care Act of 2 July 1999 with later amendments relates to the provision and implementation of mental health care.
1.1.2 Challenges

All these agencies/actors presented here are responsible for various subtasks, creating a variety of coordination challenges. It is well known that organisations typically split the number of complex tasks in order to become more manageable. Formalised job splitting allows specialisation to take place but the disadvantages of differentiation become problems of coordination. However, the organisations in the system become interdependent in providing health services to accommodate patient needs.

Collaboration among the professions within and between organisations is necessary, yet put to the test, as they not only represent different organisations but also different professional approaches (Johannessen 2004, Hansen 2007, Willumsen 2009). Moreover, it is crucial to recognise that the system of mental health care is characterised by disagreements, uncertainties and ambiguities; paradigmatic controversies of knowledge in diagnosis and treatment are major challenges for service provision. Furthermore, patients show great individual variation in disorders and other issues relating to mental health care. Patients often have co-morbidity (more than one diagnosis) and the patient’s health conditions change over time Hansen & Ramsdal 2006, Ramsdal & Fineide 2011). To summarise, the coordination challenges are greater in mental health care, and measures to solve such problems are therefore an important part of the health policy agenda.

1.1.3 “Streamlined” Approaches and Strategies in Health Policy

The paradigmatic controversies that we have seen in mental health care meet an eclectic government policy based on ideas of standardised patient pathways across organisational boundaries.

Recent schemes address the challenge that patients’ needs for quality and coordinated services are not sufficiently met in the welfare state. In recent years, a number of measures have been carried out to support integration among the organisations in the health care system, and one of the main strategies developed is standardised “patient pathways”.

2 The dominant understanding of health care organisations is that they are characterised by professional bureaucracy, but there are various other explanations of why the organisations are notoriously difficult to manage, see for example an analysis of the four different “worlds” within hospitals (Glouberman & Mintzberg 2001)
From Piecemeal to Comprehensive – A Continuous Chain in the Health Service (The Wisløff Committee, NOU 2005:3) points out that well coordinated patient pathways will contribute to improved quality of services, effective use of resources and stimulating work environments. “And it is Going to Get Better!” (National Strategy for Quality Improvement in Health and Social Services 2005-2015) establishes that one of the main strategies for quality\(^3\) is coordinated and integrated services. Patients’ contact with the services will consist of a continuous and complete chain of measures with the aim of good quality. The National Health Plan for 2007-2010\(^4\) emphasises the priority of further development of standardised patient pathways across organisational boundaries, pointing out the importance of such pathways in solving the problems of many patients in a similar way. Patient pathways are regarded as a useful tool in structuring elements in the design of service provision in the system\(^5\). One of the measures in the pathways is national professional guidelines. Here, standardisation is considered necessary to maintain equitable, high quality provision, which is a relevant criterion for e.g. major diseases. The plan declares these professional guidelines to be knowledge-based, and they are therefore prioritised over the internal guidelines, procedures and routines already developed in health care organisations. The Coordination Reform entitled “Proper Treatment – at the Right Place and the Right Time” points out that coordination remains a major problem and the reform aims to provide patients with the correct treatment at the correct place and time. Here, “well-designed patient progressions” will to a greater extent become a common reference point for all actors in the health care services.

Public policy documents thus use terms such as “patient pathways” or “cohesive treatment chains” to underpin approaches and strategies to solve quality and coordination problems and to make for a more effective use of the resources within the system.

---

\(^3\) “High quality means that the services are: effective, secure, involve users and give them influence, coordinated and continuous, available, utilise resources efficiently and are evenly distributed” (p.12)

\(^4\) Parliamentary Proposition No. 1 (2006-2007)

\(^5\) The plan points out that there is a lack of data to achieve comprehensive analyses of patient pathways, but base data will be strengthened by IPLOS (individually based care statistics). However, further databases need to be developed.
1.2 Clinical Pathways

Most European countries today reveal a lean approach in hospitals and primary health care. In this context, the focus is on work processes and how one can organise these in a more beneficial, result-oriented and cost-efficient manner. Several authors claim that a number of lessons from lean thinking are relevant to health care in order to remove bottlenecks and unnecessary steps in the patient’s journey through the system. The key factor here is the implementation of effective clinical pathways, as exemplified by the Norwegian Health Enterprises and the NHS in the United Kingdom (Rechel et al. 2009, Docey & Reddy 2010).

A number of Norwegian hospitals are now focusing on the use of standardised care processes through CPs, and are thus responding to the political strategies of a continuous “patient chain” and the effective use of resources. There is no uniform definition of a clinical pathway in Norway or internationally. The following definition is from one of the Regional Health Enterprises in 2006: “A Clinical Pathway is an expected patient progress based on medical evidence, in connection with an efficient exploitation of resources and measurable results”. In the particular hospital studied here, approximately forty clinical pathways are under construction or implementation, four of which cover diagnoses within mental health care. Thus, standardisation of work through CPs has become an important strategy in order to provide high quality and cost-efficient service provision in association with lean approaches in health care based on an optimisation paradigm (Timmermans & Berg 2003, Ramsdal & Skorstad 2004, Vikkelso & Vinge 2004, Ramsdal & Ramsdal 2007).

The use of the CP concept started out as an instrument for balancing costs and quality in Boston, USA in the mid-1980s as a response to the introduction of DRG (diagnosis related groups) implementation in hospitals. By the late 1990s, more than 80% of US hospitals were using at least some clinical pathways. In the early 21st century, the instrument has been increasingly developed and utilised worldwide in different settings (Vanhaecht 2007, Panella & Vanhaecht 2010, Kinsman 2010). Evidence-Based Medicine (EBM) and related evidence-based terminology are fundamental to the clinical pathway knowledge base (Timmermans & Angell 2001, Timmermans & Berg 2003, Muir Gray 2009).
1.2.1 Terminology and Definitions of Clinical Pathways

Since this instrument has been increasingly developed and utilised worldwide in different settings, there is no single recognised definition of a clinical pathway. This section presents descriptions of CPs to date as they appear from recent literature in what may be called a “package of ideas” explaining both what CPs are and the methodology of techniques of the design of CPs.

Interestingly, De Luc et al. (2001) found 17 different terms encompassing clinical pathways and five years later, De Bleser et al. found 84 different terms that may refer to a clinical pathway. The most common terms are “critical pathway”, “care pathway”, “integrated care pathway” and “care map”. The terms “clinical pathway” and “critical pathway” are in use worldwide and Integrated Care Pathway (ICP) is mainly in use in the United Kingdom. The latter term reflects pathways as an instrument of integration within the organisations in the health care system (De Bleser et al. 2006, Vanhaecht 2007, Panella & Vanhaecht 2010). It should be mentioned that in the Scandinavian countries clinical pathways are referred to as “vårdkedja” in Sweden (literally: care chain) and “patientforløb” in Denmark (literally: patient course). Even within Norway there are various terms in use; apart from “patient flow” and “treatment line”, this tool is also referred to in Norwegian hospitals as “patient-focused redesign”. For the purposes of this thesis, the term Clinical Pathway (CP) will be used throughout.

Let us start by citing a commonly used definition of clinical pathway: “A clinical pathway is a document outlining a standardised, evidence-based multidisciplinary management plan, which identifies the appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group” (Queensland Health Clinical Pathways Board definition 2002). Muir Gray (2009) draws on Kitchener’s definition, which is similar to the definition above regarding the requirements of a well-defined patient group and set timeframes, yet his definition is less detailed: “Care pathways define the expected cause of events in the care of a patient with a particular condition, within a set time-scale”. The CP knowledge base is grounded in scientific evidence and the author points out that a care pathway is precisely a tool that can facilitate the introduction of an evidence-based approach into clinical routines. He claims that even if it is possible to make generic CPs, the pathway is often unique as it is developed by members of a team involved in a particular area of care and reflects details which vary among the different organisations involved (Kitchener et al. 1996, Muir Gray, 2009:26).
Based on the lack of uniformly accepted definitions of CPs, an international consensus meeting in Slovenia held by The European Pathway Association in 2005 resulted in the following definition of care pathways: “Care pathways are a methodology for the mutual decision making and organisation of care for a well-defined group of patients during a well-defined period”. Later on, international discussions and a study of the impact of CPs (Vanhaecht et al. 2006, Vanhaecht et al. 2007) resulted in the following adjustment of the definition above: “A care pathway is a complex intervention for the mutual decision making and organisation of care processes for a well-defined group of patients during a well-defined period”. Further, the aim of CPs is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimising the use of resources. The characteristics of CPs were adjusted to a lesser extent, with a clarification that a CP includes an explicit statement of the goals and key elements of care, based on evidence, best practice, the characteristics and expectations of patients and the facilitation of communication between team members, patients and families. The CP encourages cooperation in the care process by coordinating the roles and sequencing the activities of the multidisciplinary care team, patients and their relatives. It is also a documentation, monitoring, and evaluation of variances and outcomes and an identification of appropriate resources (Vanhaecht, De Witte & Sermeus 2007). Thus, by clarifying these characteristics of CPs the Association added three new elements to the previous definition mentioned. Firstly, the European Pathway Association makes clear the complexities of the intervention, secondly they tone down the scientific approach in the knowledge base and thirdly, because of the expanded evidence term, they clarify the patient’s important role in the CP.

The definition above provides a basis for debate among members of the European Pathway Association and members of the Cochrane Collaboration. In order to study the effect of CPs, the authors of the Cochrane Reviews made efforts to develop criteria to assist in the objective identification of CP studies in the literature as they confirmed the characteristics of the CPs made by the European Pathway Association. However, the Cochrane authors informed the debate of “What is a clinical pathway?” by stating that they, after pilot testing, had decided that if an

---

6 The European Pathway Association was established in Italy in 2004 and is an international non-profit association under Belgian law. As of January 2010, the association has national sections in Belgium, Ireland, England, Scotland, the Netherlands and Wales (and Mongolia). In addition, France, Italy, Norway and Spain are in the process of becoming members. The association focuses on conducting international research into clinical pathways in order to promote an international network for pooling know-how and fostering collaboration among health care researchers, managers and providers from European countries.
intervention met the first criterion (a structured multi-disciplinary plan of care),\(^7\) plus three of the other four criteria (documentation, monitoring, evaluation of variances and outcomes and an identification of appropriate resources) it was to be regarded as a clinical pathway. They thus claimed that these criteria could constitute a foundation for an internationally accepted definition (Kinsman et al. 2010). However, there is still an ongoing discussion of the definition as members of the European Pathway Association addressed this by claiming that the Cochrane Collaboration definition could lead to more confusion as to what CPs are and are not (see Kinsman et al. 2010, Panella & Vanhaecht 2010).

The final Cochrane Review included 27 studies as Kinsman, along with Rotter et al., reviewed the effect of CPs on professional practice, patient outcomes, length of stay and cost to the hospital. The review describes the aim of CPs “to link evidence to practice for specific health conditions and therefore optimise patient outcome and maximise clinical efficiency”. They concluded the study by stating that CPs are associated with reduced in-hospital complications and improved documentation without influencing length of stay and hospital costs (see Rotter et al. 2010). Here clinical pathways are used as a tool to determine normative quality goals in the treatment process. The Norwegian Knowledge Centre for the Health Services\(^8\) and a number of Norwegian hospitals have paid much attention to this study.

Several additional reviews on the effect of clinical pathways describe a variety of outcomes. Most of the studies reported stem from comparative RCT\(^9\) trials of pathways for defined diagnoses in various clinical areas, typically reporting reduced length of stay and reduced in-hospital complications (see for example Zevola et al. 2002, Panella et al. 2009, Rotter et al. 2010).

\(^7\) The structured “multi-disciplinary plan of care” corresponds to “Cooperation in the care process by coordinating the roles and sequencing the activities of the multidisciplinary care team, patients and their relatives” (Vanhaecht, De Witte & Sermeus 2007)

\(^8\) The Centre was established in 2004 and is organised under the Norwegian Directorate of Health.

\(^9\) The ultimate criterion to establish scientific validity is a meta-analysis of Randomised Controlled Clinical Trials in which patients are randomly assigned to a treatment and a control group. Austin Bradford conducted the first RCT in 1946 to determine the effect of streptomycin on tuberculosis (Timmermans & Berg 2003:89).
Studies of CPs in mental health care are seldom reported, but there have been some trials of CPs in this area with varying results (see for example Emmerson et al. 2006, Evans-Lacko 2008, Desplenter et al. 2009, Scheuer 2003).10

As I have shown, public policy documents and reforms underpin “patient pathways” across organisational boundaries in order to solve quality and coordination problems, but also to provide effective resource use. The overall impression of the debate and reviews of CPs is the non-communication of important aspects of design and implementation. The battles over the definitions seem to have a prescriptive and instrumental perspective: “How to do it”. This observation is in line with a previous literature review of CPs which revealed little criticism of failures in implementation and limited attention to the challenges of CPs in clinical practice (Ramsdal & Ramsdal 2007). The discussion of criteria and characteristics of CPs seems to be connected to the potential of doing meta-analyses of systematic reviews based on comparable RCT studies, as such meta-analyses will make it possible to determine the actual effectiveness of the CP. In addition, as Evans-Lacko et al. point out, CPs are connected to a “payment by results” system in mental health care. Here, CPs can be used in calculation costs for commissioning or reimbursement of service use (Evans-Lacko et al. 2008).

1.3 “Evidence-Producing” Organisations

As mentioned earlier, the Norwegian Knowledge Centre paid considerable attention to a study by Rotter et al. (2010). In recent years, the Norwegian Directorate of Health has established new bodies as knowledge centres and agencies for the supervision and control of health services. The Norwegian Knowledge Centre for the Health Services, The Norwegian Patient Register, InnoMed and KITH are all examples of “evidence-producing” organisations promoting and shaping evidence-based thinking in Norwegian healthcare.11

Evidence basing becomes institutionalised in large independent organisations whose objective is to summarise knowledge and give advice about what should be done (Grime 2009: 203), as in the case of the national clinical guidelines which are

10 This is a qualitative study of how the CP idea was implemented in a Danish hospital. Scheuer (2003) studied the meeting between the idea of clinical pathways and how the idea was translated when it met two different contexts of local practice; orthopaedic surgery and psychiatry.

11 See Appendix 1.1 Agencies/bodies and tools in the “packages” of CP ideas.
increasingly being produced. The core of evidence-based thinking is quality control of the knowledge to be applied in professional practice. Quality control of knowledge is not new, but what is new is that its extent, methodology and control are institutionalised in particular organisations based on a political mandate (Grimen 2009:216). Presently the Norwegian Knowledge Centre for Health Services (NOKC) is regarded as the most important advocate of EBM in Norwegian health administration, making a significant mark on political decisions on the organisation and performance of health care work in the country (Byrkjeflot & Aakre 2008). The establishment of such a knowledge centre as a novel political strategy in health and social services has however given greater prominence to the issue of “evidence-based knowledge/medicine” (ibid.). The Centre is the foremost institution of evidence-based knowledge in Norway and explicitly embraces the idea of the hierarchy of knowledge, which is adopted from the Cochrane Protocols. Here, RCT-based scientific knowledge is at the highest level of evidence, and expert and users’ knowledge is rated as second best. Case studies are regarded as less informative than the RCT meta-studies (Grimen & Terum 2009). This hierarchy has several implications, primarily that research that does not satisfy the assessment criteria of global, de-contextualised knowledge is considered irrelevant, whether this knowledge is based upon research, expert knowledge on “best practices” or on patients’/clients’ experiences (Rønnestad 2009). The knowledge base for decision-making is thus no longer supplied by the academic institutions, which have been traditionally associated with the professions, but from the evidence-producing organisations (Grimen, 2009:204). Evidence basing can be institutionalised at various levels, e.g. as a requirement for the individual practitioner, at the organisational level or at the professional level. The next paragraph describes the approach of the study, followed by a brief summary.

1.4 The Approach of the Study (Aim & Outline)

As pointed out in the introduction, standardisation of professional work is an important policy concern to ensure quality and efficiency of services. Clinical pathways standardise treatment knowledge; they are regulatory tools grounded in evidence-based knowledge. The study thus uses the introduction of clinical pathways in mental health care as a point of access to shed light on the processes set in motion when ideas about standardisation meet local practice. This section gives a more detailed account of the purpose of this study.
One aspect that I realised early on would be relevant in the study was the fact that the CP concept seems to stress the importance of professional involvement in the actual work of designing CPs. The work of standardisation is conducted “from within” through decision making in multidisciplinary teams, and this is a strategy that basically may seem to give CPs greater legitimacy among professionals than control measures generated “from without”. This was also something I discovered when I studied the “processes of adoption” (Røvik 1998) of a lean-inspired tool for standardisation: the entry of the “best practice” concept into two Norwegian local authorities (Fineide 2006). So-called “lean organisational forms” such as lean production, just in time and “Toyotism” are an expression of a post-Fordian form of organisation that is making powerful strides in both the private and public sectors12 where it is claimed that the control of the workflow is moved down to the operational level, where the employee's goodwill and creative involvement will ensure the gain in efficiency. In this case it is most likely that such involvement will not take place, due to the system's negative impact on working conditions (Skorstad 2002, 2006). Some of the ideas associated with so-called lean production are thus advancing strongly into the public sector and not least into hospitals. When I discovered that CPs as regulatory tools were also moving into mental health care (which is an area I know relatively well on the basis of many years as a social worker and manager of a local health and social service centre), this immediately captured my interest to study the phenomenon further.

Standardisation of work processes by means of clinical pathways represents regulation of professional practice, or at least an attempt to regulate professional practice. Clinical pathways can thus basically be perceived as a restriction of the prerequisites for the exercising of professional discretion, the cornerstone in professional work. More specifically, I wished here to develop a better understanding of how this span between control and autonomy is dealt with by the professionals. And here the point is that I wish to capture the context into which CPs may be inserted: new political guidelines for streamlining health services, new evidence-producing organisations and the methods used in the standardisation process; overall, these comprise a set of techniques for the management of professionals. Bejerot and Hasselbladh (2008) have studied this regulatory landscape in the Swedish health service where by the use of the term “a trans-organisational hybrid regime” they refer to a strategy in which hierarchical control and self-regulation are woven together in such a way that the form of control is given, while

12 As a curiosity in this connection I might mention a quote from the then Health Minister Bjarne Håkon Hanssen on his study tour to Japan to gain inspiration for the organisation of the Norwegian health care system, “There's a difference between people and cars of course, but still there's something to be said for this kind of thinking,” he said on a tour of the Toyota factory (from the film Health Factory, 2010).
The content is created by those who are controlled (Bejerot & Hasselbladh (2008:109).

The attention of this study is thus directed to the mechanisms by which knowledge production takes place; how the professionals design clinical pathways as “standardisers” directly involved in the design process, transforming knowledge and interests into rules presented for utilisation by professionals in their work (Brunsson & Jacobsson et al. 2000). CPs consist of rules based on one or more specific knowledge bases, thus legitimacy of the different “modes” of knowledge is an important aspect of the study. Therefore, by shedding light upon the relations between knowledge and rulemaking, this study aims to understand what clinical pathways mean for professional work in mental health care.

In the course of my work on the dissertation I have benefited from an international project which in my opinion has contributed to the study's alignment with a profession-state perspective. The international research network KNOW&POL (Knowledge and Policy in Education and Health Sectors) discusses the questions of why knowledge is becoming increasingly embedded in regulatory tools, how knowledge circulates among the different actors involved in the policy process, and how Knowledge Based Regulation Tools are promoted, altered and shaped (Pons & van Zanten 2007:120). In my view, this approach provides an opportunity to bring the CP concept into the discussion of whether we are now seeing the outlines of new forms of governance of the professions. I shall later return to the formulation of the specific research questions of the study.

1.5 Construction of the Thesis

The thesis is divided into nine chapters. The following chapter provides a theoretical frame of reference focusing on key aspects of a neo-institutional organisational framework and outlines perspectives on health care in a section labelled “Scientific Bureaucratic Medicine” which emphasises different epistemological approaches, professional autonomy and the governance of professions. In the concluding part of the chapter, the specific research questions are presented. In Chapter 3, I describe the research setting in order to provide a context for design and methodology of the qualitative study. In order to furnish an

13 The research network has developed a definition of the term Knowledge Based Regulation Tool (KRT) as “instruments that are essentially political, and the making of regulations is embedded in policymaking as well as knowledge production”
understanding of what clinical pathways mean for professional work in mental health care, the analysis is divided into four empirical chapters. Chapters 4 and 5 explore how the two CPs for ADHD are produced, being empirical chronological presentations of each of the two CPs. These two chapters are followed by an analysis of the design processes of the two CPs in Chapter 6: “Rulemaking”, where the main approach is to ascertain which mechanisms were important in securing the legitimacy of the standardisation work. Chapter 7 explores how the professionals working in the diverse organisations in the system respond to the CP for children with ADHD\textsuperscript{14}, followed by a relatively brief analysis of “rule following” in a logic of appropriateness perspective. Chapter 8 discusses the findings of the study in light of the debate around the emergence of new forms of governance of the professions, so-called “scientific bureaucratic medicine”, followed by a summary and concluding remarks in Chapter 9. The following chapter provides the theoretical framework of the study.

\textsuperscript{14} The full title of this CP is “Clinical Pathway for Children and Adolescents in (name of country)” but for simplification, and as most of those concerned are children, it will be referred to as the “CP for children with ADHD”.

20
2 Theoretical Perspectives

Here I will briefly explain the structure of the three sections of the theoretical chapter and show how the various theoretical elements are related to each other. The first section of the chapter presents an organisational theory perspective, primarily based on neo-institutional theory around standardisation and distinctions between various types of rules. The second section deals with some key neo-institutional concepts like legitimacy, decoupling, institutions and the logic of appropriateness, which I consider central to the understanding of rulemaking and rule following in organisations. These first two sections can be seen as key theoretical pillars for the third and final section of the chapter, namely perspectives on health care: Scientific Bureaucratic Medicine. And here we move into the world of health care with different epistemological perspectives, professionals as experts in their field of knowledge, professional autonomy and not least the governance of professions.

2.1 Standardisation and Rules in Organisations

The literature on CPs and “packages” of CP ideas can be seen in a rational instrumental perspective. This instrumental perspective has been challenged by an alternative understanding of health care organisations as research has become more directed towards organisational-sociological neo-institutionalism, where the traditional differences between organisations and their environments have partly been erased (Perrow 1986, Røvik 1998, Byrkjeflot & Jespersen 2005). Here, new paths were followed compared to the traditional focus on management-driven creation and implementation of rules as a classical theme in organisational studies (Brunsson & Jacobsson 2000 et al.).

Neo-institutionalism is a broad term, with different meanings for different scholars; however, they all modify or contrast with the rational instrumental approach in their understanding of organisations. The basic reasoning is that many formal organisational structures arise as a reflection of rationalised institutional rules. Organisations and professionals are embedded in a society, which makes them

15 In its origin, institutionalism draws on early social theorists such as Durkheim 1961, Weber 1968 and Berger & Luckman 1967. Similarly, Meyer & Rowan (1977) recognised that many formal organisational structures arise as reflections of rationalised institutional rules and that these rules have the function of myths. The formal structures of many organisations in society reflect their myth of their institutional environments instead of the demands of their work activities (Meyer & Rowan 1977: 340-341).
susceptible to rules that come from the surroundings rather than from their own management (Brunsson & Jacobsson et al. 2000:7). First, let us take a closer look at the importance of standardisation, followed by a distinction between different kinds of rules.

2.1.1 The Importance of Standardisation

As we saw in the previous chapter, policy formulation reveals a clear tendency towards the streamlining of health care through standardisation, and this includes mental health care. Clinical pathways have been launched as a “recipe” (Røvik 1998) for the stated quality and coordination problems in the health care system which aims to standardise treatment knowledge and is thus a regulatory tool based on rules for professional practice. Brunsson and Jacobsson (1998) claim that standardisation is a form of control and coordination, and has the same level of importance as market and hierarchy (Brunsson & Jacobson et al. 1998).

Standardisation is an important instrument in coordination, allowing job-sharing and specialisation to take place in organisations. By applying this mechanism, competence, work processes and output can become more effective in coordination and will thus eliminate much uncertainty (Mintzberg 1983, Glouberman & Mintzberg 2001). This makes the process of combining different components less problematic, which consequently allows it to be implemented on a larger scale and at a faster pace. Standardisation of work processes is considered the most important factor in standardisation, although Mintzberg emphasises that organisations cannot exist without leadership and informal communication. His thesis claims that there is a limit to the extent to which standardisation is possible. In a situation of high complexity and in rapidly changing surroundings, standardisation will not prove to be as effective. In such a situation, mutual adjustment will be the preferred coordination instrument in order to secure an efficient response and the ability to change (Mintzberg 1983). Highly differentiated systems generally require correspondingly high degrees of integration: “Either differentiation has to be reduced or integration increased” (Glouberman & Mintzberg 2001).

In medicine, standardisation is not a new phenomenon; however, for the various reasons mentioned above, we find increasing attention to and arguments for standardisation in diagnostics and also the standardisation of knowledge and working practice. As early as 1912, the programme of Scientific Management was introduced in some hospitals, but was discredited by employees (Ekeland 2004:57). From the late 1980s, standardisation re-emerged as a focal point of interest in the
health care field, and at the same time, EBM gained ground as a conceptual space for forms of standardisation.

Evidence-based medicine has seen a significant expansion as a global approach. CPs are based on EBM and this term is commonly used in health care and in society, see for example the definition by Sackett et al. (2007). EBM relies largely on clinical practice guidelines and research protocols in prescribing rules of medical care; thousands of guidelines and procedures have represented the farthest-reaching and most direct attempt to prescribe and preset the actions of health care professionals (Timmermans & Angell 2001, Timmermans & Berg 2003).

Johannessen (2004) has further examined leadership and evidence in the mental health care sector, and she states that the connection between EBM and related models of evidence-based treatment is becoming an important factor to consider in managerial control. This involves a stronger emphasis on procedures based on standardisation of treatment (Johannessen 2004).

Standardising can be an effective mechanism of control as argued by Perrow (1986), with reference to the so-called “Neo-Weberian Model”; “Because the range of stimuli is greatly reduced by standardisation and specialising in one activity, the subordinate has fewer opportunities to make decisions that maximise personal interest rather than the organisation’s interests” (Perrow 1986:129). This claim has similarities to that of Brunsson & Jacobsson (2000) that standards and standardisations can be seen as parts of a wider discussion of regulation, since regulation is not a narrow, largely technical matter, but should rather be viewed as rulemaking in a broad sense, as a form of organised governance, but which can also constitute an institutional arrangement for coordination and control (Brunsson & Jacobsson et al. 2000:10, Scott 2004b). In general, rules are important mechanisms to increase action capabilities and efficiency. Rules make it possible to coordinate activities between and within the organisations of the health care system as well as reducing uncertainties. Rules provide codes of meaning for the actors, but a well working system also needs discretion and flexibility (Brunsson & Jacobsson et al. 2000). Now let us consider the distinctions between various types of rules.

2.1.2 Directives, Norms or Standards

Directives are rules that have elements of forcing someone to execute certain actions, and very often there are sanctions connected to the directives. Hence, the directives can be in others’ interest and not in one’s own interest; in general, directives are in an explicit written form. Norms are internalised rules we can follow without
reflection, but when someone is breaking a norm, it is noticeable (Brunsson & Jacobsson et al. 2004). Good norms or rules are often those that are rarely noticed, they may be written down or just a matter of custom, but they rarely pose challenges. They simply make sense (Perrow 1986:25). Standards are quite similar to directives, but are separated from norms by their distinction of being explicit and having an obvious originator/author. Standards constitute rules that tell us what to do in certain situations. They are distinct from directives because of their character of being voluntary; it is in the receiver’s interest to follow the standard or not (Brunsson 1998). More specifically, there are three types of standards; standards about being something, about doing something, or about having something (Brunsson & Jacobsson et al. 2000:4). A number of rules are formally voluntary, however in practice they can be experienced as compulsory (Fernler 2006). Standardisation is based on expectations that some organisations and actors will adhere to the standard concerned, or at least that they will consider following the standard (op cit: 1998/2000).

In my view, based on both the literature on clinical pathways and Brunsson & Jacobsson’s (2000) distinctions between the three types of rules, a CP can be considered as a standard. But it is quite likely that the actors who relate to the CPs will have varying perceptions of the status of the rules in the pathway, i.e. whether they are to be construed as directives, norms or standards. Charles Perrow (1986) makes no distinction between different types of rules, but points out that rules are needed in organisations when complexity increases, and when organisational matters are complex, the personnel are not allowed to do their own things no matter how much they might prefer to do so. Rules are required to limit the discretion of those with power to handle people under them (Perrow 1986:20). Administrative norms, private norms, collective norms and professional norms are mechanisms for the execution of work along with the social structure of the organisation. These factors constitute the employees’ scope of work (Kirchhoff 2010).

However (in an optimistic view) the strongly established professions within the health care system can reduce the need for standardisation because coordination and control may be exercised largely through shared professional norms (op.cit. 34-35).

How can neo-institutional theories contribute to the understanding of the research question presented above? The next section deals with some key neo-institutional concepts.
2.2 Key Aspects of Neo-Institutional Theory

This section deals with some key neo-institutional concepts such as legitimacy, decoupling, institutions and the logic of appropriateness which are necessary for an understanding of rulemaking and rule following in organisations.

2.2.1 Legitimacy

Legitimacy is a central concept in institutional theory. Scott describes the concept of legitimacy as “a condition reflecting cultural alignment, normative support, or consonance with relevant rules or laws” (ibid 1995:45). Suchman (1995) has in my opinion a definition which is both broader and more illuminating: “a generalized perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed systems of norms, values, beliefs, and definitions” (ibid 1995:574). He argues that in the context of organisation theory it makes sense to distinguish between three main forms of legitimacy; moral, cognitive and pragmatic legitimacy. Moral legitimacy reflects a positive normative evaluation; in this study, the hospital can be perceived to attain moral legitimacy precisely through its initiation of a solution to problems of coordination and quality. This normative legitimacy is then linked to the perception of the clinical pathway as an appropriate solution to these problems, and the hospital’s actions are based on dominant norms (ibid: 577-580). The neo-institutional perspective in organisational theory is especially concerned with this approach. Legitimacy is thus understood as “a set of constitutive beliefs.” Within this tradition, one can connect legitimacy to institutionalisation, because both of these phenomena make explanations for the organisation’s existence (Meyer & Rowan 1977, DiMaggio & Powell 1991). “Taken for granted” indicates the cognitive form of legitimacy that is based on the fact that organisations, or individual parts or features of organisations, are accepted without question. The organisation will not be evaluated by whether it is useful; it simply has legitimacy because it fits in with our mental images of reality. Pragmatic legitimacy is linked to “self-interested calculation of an organisation’s most immediate audience” (op.cit: 1995:578); in other words, it concerns what is perceived as useful in a social perspective.

Scott et al. (2000) confirm here that the importance of legitimacy is rarely questioned, but there has been much debate as to what is meant by legitimacy (Scott et al. 2000:237). In agreement with Suchman, they distinguish between three different forms of legitimacy: regulative, normative and cognitive legitimacy; legitimacy is “a condition reflecting the alignment of an organization to normative, regulative and cultural-cognitive rules and beliefs prevailing in its wider field and
social environment” (Scott et al. 2000:236, Scott 2001). Thus, the arguments that are used to legitimise the CP concept depend on the discourses available and on current trends and interpretations of what it means to legitimate. As I understand Scott et al., the regulative institutional pillar is defined as legalisation of sanctioned behaviour, thus legal sanctions here constitute the main basis for legitimacy. The normative institutional pillar indicates a moral basis for legitimacy, and in my understanding the moral obligation of professionals in relation to their social mandate is an example of this form of legitimacy. In the cultural-cognitive pillar, primarily it is a common situational awareness that is the common cognitive platform that we “take for granted” without question.

As I see it, the forms of legitimacy of both Suchman and Scott are relevant for an understanding of what creates and promotes the legitimacy for the introduction and use of clinical pathways in mental health care, and also for an understanding of why a certain type of knowledge is introduced into rule production while other forms of knowledge are excluded. We now move on to another phenomenon, or rather a mechanism, which maintains legitimacy, namely decoupling.

2.2.2 Decoupling

“Organisational decoupling” refers to the creation of gaps between formal policies and actual practices; it is a pervasive organisational phenomenon. Organisations are driven to incorporate new practices and procedures defined by prevailing rationalised concepts of organisational work, in order to increase their legitimacy. Therefore, these new practices and procedures function as powerful myths (Meyer & Rowan 1977:340). The processes by which rules, norms and routines become established as an authority’s guidelines for social behaviour can be seen as symbols such as the “metaphor of isomorphism” which provides legitimacy rather than improving performance (DiMaggio & Powell 1991, Scott & Meyer 1994, Brunsson 1998, see also Scott 2004b, Fernler & Helgesson 2006). Meyer & Rowan (1977) claim that decoupling enables organisations to gain legitimacy with their external members. This approach can partly explain the fact that organisations adopt recipes in considerations of legitimating and keep these new recipes decoupled from the field of practice in order to avoid conflicts and loss of legitimacy (Meyer & Rowan 1977:340, Brunsson & Jacobsson et al. 2000). There are several explanations for

---

16 Regulative legitimacy is legalisation of sanctioned behaviour (Scott 2000:238); normative legitimacy implies a deeper moral base, thus an obligation; cultural cognitive legitimacy is recognisable, taken for granted – “comes from adoption of a common frame of reference or definition of the situation” (ibid:61).
why the decoupling takes place, and a standard interpretation is that the recipe (the CP idea) does not fit in with complex internal logic and task performance, and is therefore repelled (cultural interpretation). Organisations that adopt the idea of clinical pathways, do so as “window-dressing” for their surroundings, but do not follow the changes in practice. Another more instrumental understanding of decoupling is that the “recipes” are kept separate on purpose, which Brunsson (2002) calls “organised hypocrisy”.

2.2.3 Institutions Constrain and Regulate Behaviour

There are many ideas, patterns of actions and rules in modern society that actors do not take for granted; they are not institutionalised. Standards may not explain as much of individual and organisational behaviour as institutions do (Brunsson & Jacobsson et al. 2000).

A sociological understanding of the term *institution* implies that institutions are understood as organised, established procedures or patterns of action (Jepperson 1991:143). Institutions are thus something man has created and continually reconstructs (Eriksson-Zetterquist et al. 2005). Berger and Luckmann’s (1967) social constructionist approach focuses on cognitively based patterns of interpretation and action. Here the basic view is that society and its institutions are a product of recurrent patterns of action and the meanings that members of society attach to them. The concept of institutionalisation is used to refer to the process that takes place when we create the social conditions under which we live. Institutionalisation has its origin in habit formation, i.e. in the form of actions repeated so often that they fit into a pattern that can eventually be reproduced without special effort. As I understand Berger and Luckmann, all institutionalisation is based on the continuation of such habit-forming processes, and in this social constructionist perspective, *institutions* are based on a social group through interaction creating a separate entity (institutions) where they have also created a common perception of the habitual actions. These institutions are justified by means of various legitimising formulas, which must (if they are to succeed) be consistent and appropriate for the social order.

The prevailing view in neo-institutional theory is that institutions can be studied as phenomena in inter-organisational fields and sectors, as the organisational and structural forms and components are institutionalised, not the particular organisations (DiMaggio & Powell 1991, Dent 2003).
Scott's (2001) three institutional pillars are linked to cognitive, normative and regulative mechanisms, and consequently we can study various aspects of institutions from these perspectives. The three institutional pillars have acquired different meanings for different research traditions, but in a broad sense, all researchers involved in institutional theory are conscious of the fact that institutions both constrain and regulate behaviour (ibid: 51). Let us now examine the three institutional pillars more closely. The regulative pillar emphasises conformity to rules and if necessary the application of reward and punishment. The normative pillar stresses the importance of collective values and norms, and is particularly related to the idea that social life is guided by the notions of what goals should be pursued and how things should be (ibid: 51-55). This study on rule production and rule following gives priority to the normative pillar, which is here linked to what is perceived as legitimate for the production of clinical pathways in mental health care, not least because normative conceptions of the status of knowledge in mental health are closely related to the type of knowledge perceived as legitimate. The “logic of appropriateness” is connected to the normative pillar, but it also captures the cognitive elements in the third institutional pillar, namely the cultural-cognitive pillar that emphasises consistency between cultural-cognitive schemas and models, where thought patterns and opinion-forming processes lead to institutionalised behaviour. The professional's actions are based on established patterns of thought that provide guidance for what is perceived as possible. An individual's deliberations about the possibility of changing institutionalised habits and routines take place in continuous interpretations of the situations faced.

2.2.4 The Logic of Appropriateness

Individual decision-making can be a result of rational calculations, since pure rationality and limited rationality\(^{17}\) share a common perspective: they are both based on an evaluation of alternatives in terms of their consequences for preferences. This is a logic of consequence, in contrast to the logic of appropriateness, which is a perspective where decision making is seen as resulting from rule following and the fulfilment of an identity (March & Olsen 1989, March 1994:57). It is also named the logic of appropriate behaviour (Christensen 2007:40) or the logic of following rules

\(^{17}\) The core notion of limited rationality is that actors intend to be rational, but are constrained by limited cognitive capabilities and incomplete information, involving problems of attention, memory, comprehension and communication. Limited (and bounded) rationality have dominated most theories of individual decision making (March 1994).
Professionals will act according to what is considered appropriate in a given situation by asking three main questions:

1. What kind of situation is this? (the question of recognition)
2. What kind of person am I or what kind of organisation is this? (the question of identity)
3. What does a person such as I, or an organisation such as this, do in a situation such as this? (the question of rules)

Actors following the logic of appropriateness act upon institutional rules and do their best to fulfil the obligations inherent in their institutionally given identity. Professionals in health care are often working in multiprofessional teams and can experience a stronger identity with other actors outside the organisations than with their own organisation or profession. Thus, in a pluralistic view, these actors can possess multiple identities because of their multiple institutional memberships; however, professionals are often guided by normative standards laid down by their particular profession. These professional standards are perceived as so binding that the professionals act contrary to rule-based expectations (Scott 2001: 61). The next part of this chapter considers elements of scientific bureaucratic medicine.

2.3 Scientific Bureaucratic Medicine

This final section of the chapter considers different epistemological perspectives, professionals as experts in their field of knowledge, professional autonomy and not least the governance of professions.

2.3.1 Epistemological Perspectives of Medical Care

March and Simon’s (1958) statement that “knowledge must always be knowledge from a certain position” demonstrates their recognition that knowledge is socially constructed (see March and Simon 1958: 22). The representation of knowledge as a social construction characterised a new approach in organisational studies as “knowledge is sealed to processes of legitimating at different levels” (Berger & Luckman 1967). Knowledge can be regarded as socially embedded/constructed, in opposition to the view of knowledge as a set of “disembodied, neutral, reified facts about the world” (Hellström & Raman 2001:139), just as an opposite epistemological perspective to a “social construction of reality” was seen a hundred
years ago in the programme of scientific management: “there is only one method and one implement which is quicker and better than the rest. And this one best method and best implement can only be discovered or developed through a scientific study” (Taylor 1911/1998: 9).

Let us now examine various models of understanding related to the nature of science, and here I find it useful to consider the four models of medical care presented by Harrison et al. (2002). As I understand Harrison’s distinctions between these different models, they can be linked to two main perspectives: scientific evidence-based knowledge and contextual knowledge.

According to Harrison, the model of *reflective practice* is centred on the notion that the professional as an individual should always be self-critical of his/her own practice, facilitated by a regular audit of outcomes (for the patients) and by an open and non-defensive collegiate approach involving other professionals as equals. He acknowledges that, even though “reflective practice” can be said to represent an idealised image of professional practice, there has been a seemingly successful implementation of this model in the UK (Gruer et al. 1986; Harrison 2002: 5). And here Argyris and Schön’s “theory in practice” probably represents the best theoretical approach for reflection and learning (Argyris and Schön 1977: 90-91). This model points out the importance of personal experience as the main source of valid knowledge. The second model of medical care is built on the generation of professional *consensus conferences* where participants, mainly through personal experience of a particular clinical topic, produce guidelines that lack an underpinning of solid scientific data (Woolf 1992; Harrison 2002:5). Harrison’s third model is called “*critical appraisal*” after its preferred approach to the examination of published research findings within a clinical topic. And here professionals must be prepared to set aside time for a critical review of published research results in their particular field. This is basically a very difficult and time-consuming task, but this approach focuses on ensuring that professionals can be trained in these skills. This model undermines personal professional knowledge in the field. The fourth and final model, *scientific bureaucratic medicine*, centres on the notion that the accumulation of research provides valid inferences demonstrated by a hierarchy of evidence, where randomised controlled trials (RCT) represent the only valid knowledge. Here, clinical interventions within a specific area are aggregated in systematic reviews. This approach and the critical appraisal model downgrade the reflective practice model and the consensus model (Harrison et al. 2002: 6).

---

18 In a review of Taylor’s work, Sangolt (2005) found that these ideals of standardisation, specialisation and job splitting have inspired modern versions of organisational concepts (Sangolt 2005).
These models can be said to represent four different epistemological approaches; however, I find it relevant to use the distinction between scientifically-based and contextual knowledge as a reference point in this study because these two different epistemological perspectives can contribute to our understanding of the contexts in which the CPs are studied, i.e. within the hospital and in locally based mental health care. Although there is no strict dividing line between these two perspectives, the fundamental understanding is that they have different consequences for the view of mental illnesses, the methods of treatment and organisation of the services. The scientifically based approach builds on natural science, being grounded in biological, neuropsychological or biochemical perspectives. This approach involves the idea that mental illnesses should be understood as objective phenomena, where the individual and the illness are the object of a search for explanation and diagnosis, with the aim of finding methods of treatment to fit the diagnosis. This long-standing traditional medical approach has high legitimacy and high status as shown in the ranking in the hierarchy of evidence-based terms (Ørstavik 2008). However, although professions use their expert knowledge, this will not always be scientifically based knowledge. I choose to refer to such non-scientifically based knowledge as contextual knowledge. A scientifically based approach is often expressed in the field of psychiatry within the specialist health services, while the contextual knowledge perspective is rooted in the locally based services (Hammerstad 2006, Karlsson 2008). These two modes of knowledge live side by side for users, professions and organisations within the system.

In the context of Harrison’s (2002) four models, I understand that reflective practice is related to contextual understanding and critical appraisal and scientific bureaucratic medicine is related to scientific tradition. Regarding his model of consensus conferences, I believe that this model has a place within both the scientific and contextual frameworks of understanding. Consensus conferences may be used in cases where there is little or contradictory evidence in a selected clinical area. And here, as in other situations with asymmetrical relations in the status of knowledge, we approach the question of the relationship between power and knowledge.

**Discursive Practice**

With his concept of “power/knowledge”, Foucault has attracted much attention by emphasising the fact that knowledge can never be value-neutral descriptions of reality, but a strategy that both constitutes and supports power relations. Foucault's ideas about discursive practice are linked to the relationship between knowledge and power and here medical knowledge is used as an instrument of power (Foucault,
Foucault’s term “discursive formation” explains how systems of thoughts are composed of ideas, attitudes, courses of action, beliefs and practices which together indicate the relationship between knowledge and power but also negotiations and the struggle for power (Foucault 1972). The “ADHD discourse” can according to Foucault’s ideas be seen in relation to power as it operates by rules of exclusion. The discourse is controlled by objects which can be spoken of; rituals, where and how one speaks, and the privileged who may occupy a special position in power-knowledge relations. Thus knowledge is both the creator and creation of power and as I interpret Foucault, these discourses through such interweaving of power and knowledge can influence language and norm formation.

2.3.2 Autonomy in the Perspective of Sociology of the Professions

There are various (and often contested) definitions of the term “profession”. However, one conventional definition is as follows: “Professions are occupations which have gained a professional status” (Molander & Terum 2008:17). With regard to the organisational aspect of the term of profession, Freidson’s (1970) observation is “...an occupation which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work” (ibid: xvii). With regard to performance (which is relevant to most of these definitions because professions are groups of occupations), we find profession referred to as “applying somewhat abstract knowledge to particular cases” (Abbott, 1988), or a “discretionary specialisation” (Freidson, 2001). Science has become the fundamental ground for legitimising professions and professional operations. Science constitutes the logic and rigour aspects of a diagnosis, and implies extensive academic knowledge based on the highest standards of rationality for the actual cognitive strategies to create jurisdictions. Many professional individuals and groups have come to believe that the knowledge they possess is essential for the work they wish to have a jurisdiction over (Abbott 1988).

Professions are associated with knowledge. They involve highly skilled workers with strong autonomy. Parsons (1951) was the first to introduce professions as the critical element in modern sociology and society in general, claiming that one cannot fully understand modern society without understanding the professions. Parsons’ structural-functional model describes the importance of functions in the various social processes and institutions that are part of society. The focus is from a macro-sociological perspective, regarding the institutions and structures existing in society as a whole, and Parsons claimed that the roles of professionals were in general strongly emphasised by relations of cultural traditions, institutionalised by a series of
conditions. As an illustration of some of the interrelations of the principal elements of the social system, he chose the then modern medical practice when he conceived the roles of the physician and the patient as complementary normative structures (Parsons 1951: 429). A couple of decades later, he presented the professional complex as a complex of occupational groups that perform certain rather specialised functions for others (“laymen”) in society, due to a higher level of specialised competence, with attendant fiduciary responsibilities. The other party is in need of the professional’s competence and therefore relies on this competence. Consequently, confidence with respect to the responsibilities of the professions is expected (Parsons 1978:40-41). Parsons’ professional complex and the term “fiduciary responsibility” imply a relation of power, as the professions have control over the knowledge and are in a position to make interpretations. Furthermore, the professions’ power increases because of their role as a “gatekeeper” of public welfare services (Molander & Terum 2008). Thus, the welfare state forms the basis for the power of the professions. In addition, the fiduciary responsibility answers claims of justification, and the course of action has to be properly clarified by the professions. This claim of rational reasoning is a basic cultural principle and a standardised normative procedure which needs to be reflected in all professional operations. The display of power requires legitimacy and a guarantee of no abuse of power. Therefore, different forms of internal and external control mechanisms are necessary (ibid 2008:14-15).

2.3.3 The “Profession State”

The history of Norwegian health policies is deeply related to professional knowledge, to the extent that the making of the modern welfare system led to what has been named a “profession state” (Johnson 1982, Freidson 1970). Here, the professions have a key role in the structuring of services and the implementation of health care in the Nordic countries, and these welfare states have thus been described as “profession states” (Byrkjeflot & Jespersen 2005, Eriksen 1996). The medical profession gained powerful influence over the making of health policies, and in mental health the psychiatric profession paved the way for the expansion of psychiatric hospitals since the origins of psychiatry in the 19th century (Slagstad 1998, Erichsen 1996). On the other hand, several scholars also label Norway a “municipal welfare state”, pointing to the decentralised structure of

---

19 The “profession state” idea reflects an integration of professionalism and state authority, in contrast to profession theories emphasising separation and conflicting relations between professions and state (Johnson 1982, Parsons 1951).
welfare service provision (Baldersheim (ed.) 1990). In many ways the references to these concepts illustrate the inherent complexity of, and contradictory approaches to, the Norwegian healthcare system, since it is both highly decentralised and strongly professionalised.

In the 1980s the influence of the medical profession on health services was redefined, being now regarded by political actors as a steering problem. The “dismantling of the profession state” was a political programme for successive governments from both left and right and the influence of the medical profession was challenged by new professional groups (e.g. nurses and social workers) and by critics of the welfare state as being too expensive and inefficient in service provision. A number of administrative reforms influenced by New Public Management ideas were initiated, and reforms in the legal system, e.g. the 1992 Local Government Act and the Hospital Reform of 2002, were heavily influenced by these ideas (Byrkjeflot 2006, Ramsdal & Skorstad 2004). The reforms within health care indicate that governments no longer accept the autonomy of professionals; rather a new societal ethos leads to attempts to restrict this autonomy (Jespersen & Wrede, 2009:151).

2.3.4 Professions are Subject to Control

New Public Management governance initiatives included the introduction of EBM and CPs, thus directing clinical performance in ways that are transparent, and therefore also potentially subject to political and managerial control. The idea was that CPs were introduced “to be obeyed rather than as navigational aids, directing rather than informing clinical practice” (Dent 2008:108). The expansion of EBM has developed on two axes, horizontally and vertically. By horizontal expansion, EBM is becoming the model for the search for “evidence-based” health and social work. The vertical expansion is now usually referred to as the emergence of “scientific-bureaucratic medicine” (Harrison et al 2002, Timmermans & Berg 2003, Dent 2008).

Freidson (2001) argues that during the past decades medical care has been seriously weakened with respect to competitiveness and efficiency. He acknowledges that the development of new technologies has contributed to making it considerably more challenging to dominate and restrict many of the occupations in the health division of the labour force. Still, he claims that medicine has not lost its prominent position in the official labour force, as discretionary notions of medical work are closely tied to significant medical knowledge. Professionals draw attention to the importance of moral as well as technical content, and they must therefore resist financial and
political restrictions (Freidson 2001). Others challenge this point of view, as they question the transparency and accessibility of the clinical pathway. They claim such concepts will undermine the exclusive knowledge on a macro level, and discretionary power will possibly still attenuate the need for standardisation (Timmermans 2005). Ackroyd et al. (2008) raise the question of whether sweeping structural changes derived from a state sponsored initiative have been a product of corporate usurpation of the healthcare system; this is reflected in a book chapter entitled “From Taylorism as Product to Taylorism as Processes” (Kipping & Kirkpatrick in Ackroyd et al. 2008).

2.3.5 Regulation Tools

Public policy instrumentation implies a set of problems posed by the choice and use of instruments that allow government policy to be made material and operational (Lascoumes & Le Gales 2007). Public policy instruments and instrumentation can be seen as “bearers of values, fuelled by one interpretation of the social and by precise notions of the mode of the regulation envisaged” (Ibid: 4).

Lascoumes & Le Gales (2007) made a typology of the observable elements in regulation tools by distinguishing between three levels: social institutions, the technique and the tool. Regulation tools are generally related to auditing and in a critical response to the audit explosion, Power (1994, 1997) referred to a distinction between programmatic practices (mainly normative and linked to the broader political ideas, objectives and missions) and technological practices based on operations in the world of practitioners (e.g. checklists, samples, methods). However, in order to identify the observable elements and connect them to the new state-owned bodies/agencies, I find it fruitful to combine the two typologies of Lascoumes & Le Gales and Power into a typology of distinction between broader political ideas, bodies and techniques/tools as micro devices. It should be possible to use this kind of typology in an international context; however, the observable elements will differ between countries simply because regulation mechanisms and especially the social institutions differ. To a certain extent, the same can be said of the techniques and the tools; however, CPs and many other health care techniques and tools are worldwide concepts, often initiated and established by the World Health Organisation (WHO).
2.4 Research Questions

As shown in the introduction, clinical pathways are a phenomenon with international resonance in the entire Western world and attempts at streamlining and rationalisation through standardisation are a theme which preoccupies both practitioners and researchers. CPs as a regulatory instrument are thus to be considered as a political idea initiated in an attempt to control the actions of professionals. The inductive approach of the present study brought changes in the main research question because it was clear early in the analysis that the professionals had a central role in the work of standardisation. Therefore I gave the study a distinctive emphasis on the “rulemaking” processes, i.e. the design processes for standardising. The main focus of this study is thus to explore the contexts in which “rule production” takes place, and my main research question in this thesis is thus:

“How do professionals standardise their own work”?

The design processes for standardising reveal how CPs as knowledge-based regulation tools are created through a number of activities and decisions which are not “pulled out of thin air” as generally the construction of the CPs is a work of translation, interpretation and appropriation of ideas, knowledge and devices already in circulation. Hence within this framework, three specific subsidiary research questions are outlined:

1. How was the clinical pathway for children with ADHD designed?
2. How was the clinical pathway for adults with ADHD designed?
3. What are the responses to the clinical pathway for children with ADHD among professionals working in the system?

The next chapter provides a description of the methodological considerations of the procedure used in data collection and analysis.
3 Methodology

The aim of this study is to understand what clinical pathways mean for professional work, hence in order to fulfil this objective and answer the research questions, explorative approaches based on the methodological principles of qualitative research have been used (Yin 2003, Andersen 1997, Jacobsen 2005). First follows a brief presentation of the two cases.

The research was undertaken in one Regional Health Enterprise and eight local authorities in one Norwegian county in 2008 and 2009; these were chosen as they have created a methodology for developing CPs during the past few years. The units of analysis are two CPs in dissimilar phases of production and implementation. The first is a CP for children with ADHD\(^\text{20}\) which was completed in 2006. Because of difficulties of implementation, especially in the local authorities, some actors in child and youth psychiatry were working on a revision in 2009. At the same time, the second unit of analysis, a CP for adults with ADHD, was nearing completion after a two-year production process. The latter CP was in the final process of being ratified by the management. These two CPs for ADHD are thus quite different pathways; they represent differences as to how the work of standardisation was organised and also with regard to objectives and scope, yet they were both developed within the Division of Mental Health at the same hospital.

3.1 Access to the Field

There were a number of welcoming and helpful people at the hospital who assisted me in gaining access to the field; these were people who participated in the work on the two CPs. This process started when I retrieved information about the project “Clinical Pathway for Children with ADHD” from the hospital website. When I then got in touch with the person listed there as a contact, I was able to meet several

---

\(^{20}\) The diagnosis of ADHD is officially defined by Norwegian health authorities. The symptoms of the disorder consist of attention and concentration difficulties, impulsivity, hyperactivity and physical restlessness. To satisfy the requirements for an ADHD diagnosis, the symptoms must have been present for a prolonged period, appeared under different circumstances, and created significant problems for the patient and/or immediate surroundings. Similar symptoms could however be associated with other conditions as well. Many people with ADHD face additional challenges, such as deviant behaviour or learning difficulties. Some children have trouble remaining focused without manifesting impulsiveness or hyperactivity. These children may have ADHD of the inattentiveness type, previously called ADD (Norwegian Directorate of Health, 2004).
people who had been key figures in this work. The choice of the two cases was thus based on a pragmatic approach. The CP for children with ADHD was one of the very first pathways developed in the hospital. Work on the design and implementation was organised as a project in the period 2003-2006, and the hospital website contained a great deal of information about the project. I had therefore relatively easy access to public information about the project idea and organisation, and not least to the actual CP tool\(^\text{21}\) as early as the initial phase of the study. There were also reports on the website that outlined which actors had participated in the project and how the project itself was organised. I wished to interview those who had helped to design this CP and the participants in the five regional teams were the relevant people to contact. I started off with the project report, where there was a list of all those who had participated in the project, primarily professionals working in Child and Adolescent Psychiatric Polyclinics (BUPP) and in the local authorities. In this county there are 5 BUPP offices, one for each region of the county, and the project was organised on the basis of these five regions. In practice this meant that the project would result in one CP for the whole county. Each of the five BUPP teams consisted of professionals from both the BUPP and from the local authorities in the region. I will return to these teams at a later stage.

Through my contacts at the hospital, I also gained access to the CP for adults with ADHD developed in the period 2007-2009, but the production of this CP did not take the form of a conventional project, but rather as part of the everyday operations in the ordinary line organisation within the Division of Psychiatry at the hospital. Here I also had a preliminary meeting with the same contact person, where I was informed that they were in the very last stages of the CP for adults with ADHD. I also learnt how they were organised and it turned out that this work was set up quite differently than in the case of the CP for children and adolescents. I had an interview with the contact person where we agreed that I would send a request to the participants in the team to attend and observe their meetings. This interview thus provided me with the opportunity to study what actually happened during the process of designing the CP for adults with ADHD.

\(^{21}\) At that time (in 2007) this was the only CP that was wholly available to the public. The other hospital CPs, both those completed and those in process were only available in their entirety on the hospital intranet.
3.2 Data Collection

Here, a triangulated methodology where the methods can complement, control and contrast with each other was used in data collection. This consisted of semi-structured open-ended interviews, participant observation and source investigation of documents. Here follows a description of the procedure used in these three methods of data collection.

3.2.1 Interviews

The interview sample consisted of participants in the project “Clinical Pathways for Children with ADHD”, which was completed in 2006. These were employees from the five regional BUPP offices and the local authorities in the county, working in e.g. the PPT, health centres and child welfare services. A list of suitable respondents (former project participants) was available in the public project report of 2006 (see the previous section). The list contained names of 39 employees from 14 of the county’s 18 local authorities and 5 regional BUPP offices (child and adolescent psychiatric polyclinic) and one representative from a client organisation. After some weeks of preparation for the study, which included informal meetings with key personnel at the hospital and in local services, I sent a request for participation in the study to all those listed in the five teams and received a quick response with written consent from nearly half of them, all of whom were working in local authorities and BUPP offices in the county. The professions represented here as informants/respondents in interviews were; psychologists, educationalists, a psychiatrist, health visitors, a social educator, nurses specialised in mental health and a physiotherapist, all in all 15 professionals.

There were in practice only four doctors (two of them working as GPs) on the list of project participants who were connected with one of the five teams involved in the design of the CP for children with ADHD. None of them responded to my request. One particular doctor had been very active in a team for a year and had now become a GP in one of the local authorities. I sent him a letter and tried to ring him several times. When we finally managed to arrange a meeting, this was cancelled because he had to visit a patient. Unfortunately, I was not able to proceed with this matter. The other doctor I spoke to was no longer working in the field, and had only been involved in some initial rounds of the project. Those who were interviewed about their experiences of the design process of the CP for children with ADHD are summarised here and consisted of the following actors:
Table 3.1 Professionals interviewed about the CP for children with ADHD

<table>
<thead>
<tr>
<th>Position:</th>
<th>Employed at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two Educational and Psychological Counsellors, local auth.</td>
<td>PPT</td>
</tr>
<tr>
<td>Three Clinical Psychologists, local authority</td>
<td>PPT</td>
</tr>
<tr>
<td>Clinical Psychologist, Child and Youth Psychiatry, hospital</td>
<td>BUPP</td>
</tr>
<tr>
<td>Child Psychiatrist, Child and Youth Psychiatry, hospital</td>
<td>BUPP</td>
</tr>
<tr>
<td>Health Visitor, local authority</td>
<td>Health Centre</td>
</tr>
<tr>
<td>Health Visitor, local authority</td>
<td>Health Centre/mental h.</td>
</tr>
<tr>
<td>Health Visitor/Manager, local authority</td>
<td>Health Centre</td>
</tr>
<tr>
<td>Educational Therapist/manager, local authority</td>
<td>PPT</td>
</tr>
<tr>
<td>Educational Therapist, Child and Youth Psychiatry, hospital</td>
<td>BUPP</td>
</tr>
<tr>
<td>Physiotherapist, local authority</td>
<td>Preventative care</td>
</tr>
<tr>
<td>Primary School Teacher, local authority</td>
<td>Primary school</td>
</tr>
<tr>
<td>Social Educator/mental health, local authority</td>
<td>Mental health care</td>
</tr>
</tbody>
</table>

Abbreviations:
PPT: Educational and Psychological Counselling Services
BUPP: Child and Adolescent Psychiatric Polyclinic

As mentioned, certain key figures in the two CPs have served to open doors for me to carry out this study. They have assisted me with access to the field, sent me relevant documents, and we had informal meetings and telephone conversations about their work with the CPs. These people did in fact take part in the meetings I observed, but with one exception, it did not seem natural to interview them.

After conducting some of the interviews with professionals with experience of producing the CP for children with ADHD, I wanted to grasp the hospital “recipe” for producing CPs at that time and therefore contacted an experienced chief paediatrician at the hospital and made an appointment for an interview. He had for several years promoted the idea of CPs, and was temporarily a so-called “BAL” (behandlingsansvarlig lege = Clinical Pathway Executive Doctor) for CPs within the Clinic. He had no experience of producing the CP for children with ADHD, but in this phase of data collection he provided useful information on hospital techniques of designing CPs. He also shared his thoughts about the challenges involved, especially the time consuming tasks of designing CPs and issues of quality measurement and control techniques.

I also twice conducted interviews with a facilitator/nurse who participated in the work of designing the CP for adults with ADHD during winter and spring 2009 before and after a meeting I observed (see below).
Table 3.3 Professionals interviewed about CPs in general at the hospital and the CP for adults with ADHD

<table>
<thead>
<tr>
<th>Position</th>
<th>Employed at</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Paediatrician</td>
<td>The hospital children’s ward</td>
</tr>
<tr>
<td>Facilitator/Nurse</td>
<td>The hospital department for substance abuse treatment</td>
</tr>
</tbody>
</table>

In total, the data were gathered from semi-structured/open-ended interviews of maximum one and a half hours conducted during autumn 2008 and summer 2009 with 17 professionals, all of whom had experience of at least one specific CP within the past two years as developers and/or users. These were 15 professionals with experience of the CP for children with ADHD, one professional with experience of several CPs within one ward at the hospital, and one professional/facilitator with experience of the CP for adults with ADHD. The informants were from two divisions of the specialist health services and eight local authorities.

The open-ended individual interview is characterised by the investigator and investigated (here respondent or informant) talking together as in a normal dialogue. This can be face to face, by phone or via the Internet. According to Jacobsen (2005), conversational interviews are most appropriate when:

- relatively few units are studied
- we are interested in what a particular individual says
- we are interested in how an individual understands and interprets a particular phenomenon (ibid: 142)

In my view it was appropriate to conduct interviews with actors who had participated in the project for children with ADHD, irrespective of whether they had a management function or been a member of the team, to enable me to gain an insight into their experiences of both the design of the CP and of how they felt the tool functioned in their workplaces. The interviews were mainly conducted at the workplace of the employees, lasted from one to one and a half hours and were in the form of a conversation. I brought a list of points to use as an interview guide (see Appendix 3.2). All interviews were audiotaped and transcribed by myself.
3.2.2 Participant Observation

In this study I was an observer in several different settings, such as seminars, three conferences arranged by the Regional Health Enterprise and several meetings. Three meetings were audiotaped and one was also videotaped. In the following I present my participant observation at these meetings in two different contexts; adult psychiatry and child psychiatry.

Adult psychiatry
- A group of employees (professionals and administrative staff) in adult psychiatry are completing the work on the CP for adults with ADHD. Here there is observation of one meeting.

Child psychiatry
- A group of employees (professionals and administrative staff) in child psychiatry are planning an evaluation of the CP for children with ADHD. Here there is observation of two meetings.

Observation of a Meeting in Adult Psychiatry

Through the interviews, I gained an idea of the retrospective reflections of some professional respondents around the design of the CP for children with ADHD. In order to understand how the CP makers actually constructed the CP I had to expand the data collection by participant observation of the interaction between the members of the CP team. But I had no data on the design context itself, i.e. specifically how the CPs were worked out in practice, so through one of my contacts at the hospital an informal meeting with a facilitator/nurse was arranged. This meeting provided information about the work of producing the CP for adults with ADHD, and I now had the opportunity to follow the design process of a CP much more closely by participant observation. The sketch below shows the physical environment in the context of the observation of this team meeting.
The professions represented in the observations were (clinical) psychologists, (chief) psychiatrists, a facilitator/nurse (also interviewed twice, see above) and an advisor (HR staff). The observations took place in a meeting room in a clinic for drug addicts. All the participants had given written consent to both video and audio recording of the meeting, and the use of both microphone and video camera did not seem to inhibit the participants to any significant degree. With regard to my participant observation at this meeting I was presented as a researcher before the meeting and thereafter took no part in the discussions. But I was physically present in a corner of the meeting room where I also operated a video camera.

The most interesting aspect of making a video recording of this meeting was the opportunity to study the non-verbal interaction among the actors, and between the actors and the technology (an IT tool for process modelling). Video recording of the meeting also enabled me to capture who was speaking at each point. Since there were quite a few actors who spoke (sometimes simultaneously), the video recording facilitated my transcription of the audio recording. Unfortunately, I only used video footage in one meeting, but to compensate for this, it was a meeting lasting three hours. The camera was mounted on a tripod in a corner of the meeting room, and I also moved it sometimes, so that I managed to film not only most of the interaction between the participants, but also much of their interaction with the screen.
Observations of Evaluation Meetings in Child Psychiatry

The project of the CP for children with ADHD was formally concluded in May 2006 and due to difficulties of implementation, especially in the local services, the agenda of the meetings was then to work on a revision in order to adjust the CP. I had the opportunity to participate in two of these meetings. Here I met three of the same people who were at the forefront of designing the pathway, i.e. the two representing child psychiatry, a psychologist in the BUP (Child and Adolescent Psychiatric Services) as well as an advisor working in the R&D Unit at the hospital. Two of their colleagues were also represented in the meetings; a specialist in pedagogical psychological supervision (“PP supervisor”) and a chief paediatrician.

The observations took place in a meeting room in a child psychiatric treatment institution. All the participants had given written consent to audio recording of the meetings. With regard to my participant observation, I was presented as a researcher before the meeting. I had made an agreement with the psychologist in the BUP that I would present my tentative analysis of the CP for children with ADHD, and this was organised as a separate sequence during the two meetings. Although I did not participate significantly in the discussions as they progressed during the remainder of the meetings, I was still present at the meeting table with the other participants.

Studying what the Participants Actually Do

Participant observation is very suitable for obtaining information about the behaviour of individuals or groups. Here it is appropriate to study what the team members actually do in a particular context (Jacobsen 2005: 159-163). According to Jacobsen (2005:160) but also Bryman’s (2002) reflections on participant observation (where he refers to Gold’s (1958) classification of the possible roles of a participant observer), I consider my role here as that of a participant observer. This role is essentially the same as if I was fully participating, but members of the social environment are aware of the person’s status as a researcher (Bryman 2002: 286). The participants were aware of my role as a researcher, and had given written consent for my participation in the meetings and also agreed to audio recording of the two meetings in child psychiatry and both audio and video recording of the meeting in adult psychiatry.
3.2.3 Recorded Data from Interviews and Participant Observations

All the individual interviews and observations from the meetings were recorded and transcribed. The table below shows the number of actors interviewed and observed in this study.

**Table 3.2 Recorded data: interviews and participant observation**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Interviews</th>
<th>Obs.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialist health services</td>
<td>Local authority</td>
<td>Specialist health services</td>
</tr>
<tr>
<td>Educational-Psychological Counsellors</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Clinical Psychologists</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Chief Psychiatrists</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Health Visitors</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Health Visitor/Manager</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Educational Therapist/Manager</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Educational Therapist</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Primary School Teacher</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Social Educator</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Chief Paediatrician</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Facilitator/Nurse*</td>
<td>1</td>
<td>(1)</td>
<td>1*</td>
</tr>
<tr>
<td>Advisor (HR staff)</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>PP Supervisor**</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total actors</td>
<td>5</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 3.2 Actors interviewed and observed. Explanations: *The facilitator/nurse was interviewed on two occasions and observed on one occasion, therefore the participant observation is in parentheses in order not to “count” this informant several times. **Specialist in pedagogical psychological supervision.

The table above shows the number of actors interviewed and observed in this study. In total 27 actors were interviewed and/or observed. 17 professionals were interviewed, of these 16 were interviewed once and the facilitator/nurse was
interviewed twice. A total of 10 actors were observed; 6 of these were observed on one occasion, 3 were observed twice and the advisor (HR staff) was the only one observed on all three occasions (the two evaluation meetings in child psychiatry and the one CP team meeting in adult psychiatry).

The data arising from interviews and observations are to be considered as primary data; they come straight from a direct source, i.e. a person or group of people. Secondary data on the other hand are based on information collected by others. The third method of data collection was source investigation of documents, such as minutes of meetings and reports; these are examples of secondary data.

3.2.4 Documents

With the assistance of several actors at the hospital, I collected documents, reports and minutes from meetings concerning the designing of the two CPs in order to explore the processes of “rulemaking”. In addition, policy documents, national strategy documents and hospital strategy documents were collected in order to explore the “packages” of CP ideas in a Norwegian context.

We can highlight three situations where source investigation is particularly appropriate:

- when it is impossible to collect primary data, i.e. information directly from sources
- when we want to understand how others have interpreted a certain situation or event
- when we want to find out what people have actually said or done (Jacobsen 2005: 165-166)

Experience shows that public administration has a strong writing culture (ibid), and in fact the hospital had documented its work on the two CPs with minutes, reports and presentations from the meetings. All these documents were sent to me by one of my hospital contacts. A review of the various documents would be of help in putting the elements of the two design contexts in chronological order. These were important sources of data to supplement the interviews and field observations.

In both cases I have had the opportunity to participate in hospital conferences and meetings and heard how the two CPs were presented; these presentations are also
important sources. As mentioned, the hospital has posted much information on the CP for children with ADHD on its website, making it possible to follow developments over time. Relevant documents were also obtained from the interviewees and from the support staff at the hospital who assisted me with practical matters for the study. I was allowed to copy two files from a BUPP office, which contained minutes from meetings and other notes from the entire project.

3.3 Analysing the Data

The methodological approach of analysing the data is to a certain extent inspired by Grounded Theory (GT) and the techniques of the concept-indicator model (Glaser 1978), in addition to the use of micro-sociological analyses of cognitive and linguistic models of interactional analysis (Måseide 2003, Atkinson 1995, 1999, Cicourel 1999). This integrated research design implies a methodological pluralism that enables the researcher to use different techniques in order to emphasise different facets of the same phenomena (Danermark et al. 2002). Further, the sourcebook of Miles & Huberman (1994) provided practical considerations of qualitative data analysis.

In the initial phases of analysing the interviews, the techniques were inspired by GT and based on the concept-indicator model, which is a form of coding to break down the empirical material into analytical units (Glaser 1978, 2004) and not least to manage the amount of data (Strauss & Corbin 1998). An inductive analysis strategy moves from data to theory and GT in its fullest meaning thus involves a movement from data to theoretical concepts, focusing on the significance of the concept formation. But a purely inductive analytical strategy without deductive elements would in my view be completely unrealistic and also inappropriate. An abductive approach is characterised by oscillation and interaction between one’s own empirical data and the search for a relevant theoretical framework to illuminate the data. According to Thagaard (2003), abduction may be linked to the researcher's theoretical background, which gives perspectives on the meaning of the interpretations (Thagaard 2003). Here I felt that a background of organisational theory influenced my own interpretation of the phenomenon being studied and also of literature I had read about CPs and the interpretation I had formed of the international “ADHD discourse”.

I was thus inspired by these analytical techniques, but I used them only in the initial interviews, and thereafter found a very pragmatic approach necessary with the aim
of using analytical techniques and methods more adapted to the purpose of the study.

In the analytical work I consistently used manual techniques in the processing and ongoing analysis of collected data. In practice, this meant reading through and making notes in the margins of the transcribed interviews, in addition to other notes, field observations, minutes of meetings and other written material. The design and development of visual tables and figures have inspired me throughout the analytical process. Many of these were developed and then rejected because they were too bizarre and complex and others have been used in different contexts and, although quite illustrative, were not nuanced enough or even perhaps somewhat unflattering for certain actors. But some models which show the relationship between knowledge and rules have been retained and developed during the process; this especially applies to figures borrowed from Fernler and Helgesson (2006) and then further developed based on the empirical findings in this study.

Below follow some examples of open coding (Glaser 1978, 2004), which finally resulted in the concept “prima facie knowledge” and the mechanism of “initiated ignorance”.

3.3.1 Examples of “Open Coding”

I had an initial presumption that making a CP for a psychiatric diagnosis would largely be a question of competition, negotiations and compromises between the various professional groups involved in the “production process”. Yet this was almost a “non-issue” in my data from the interviews. What however did emerge at an early stage was a strong common belief in a knowledge paradigm that seemed to be an important driving force in the design processes for standardisation; this manifested itself through certain exclusion, selection and defence mechanisms, which closed off the process to competition, negotiations and compromises. These mechanisms thus did not give space to the contradictory approaches which exist in the field, and which could have provided questions, discussions and academic debate. This gave me associations to the idea of “evangelism” in the early stages of the data collection. Here I developed concepts and ideas in figures and tables, one example being the “strategic distribution model” (later abandoned), linked to the spread of a knowledge paradigm that seemed to have a strong basis among the respondents I interviewed:
Excerpt from memo 24th September 2008:

Themes: beliefs, concepts: evangelisation, loyalty, power
After the interview today with the leader of a working group from BUPP, my associations are as follows: In the reference to us (who believe in Ritalin) and them (those who do not believe, e.g. colleagues, the child psychiatrist, and some psychologists at work) we see the different approaches and contradictions that lead to concrete practical challenges in relation to the CP. ... this actually involves more factors than the question of evangelism. ... a strong belief in something, not least loyalty to the prevailing treatment paradigm...

Code memo “Preaching”

Preaching as a concept can illustrate the process of convincing someone of a message that cannot be negotiated. The message is fixed and must be communicated. Missionaries have the role of communicators of the message and the recipient of the message has a passive role. A doubter is one who questions the message, but if the message is strong enough and there are few doubters, the doubter will not get anywhere with his views or hope for discussion.

Categories/empirical indicators:

Making an agreement: Who is involved, formalised or not, discussion process, decision making process, degree of importance (large/small)
Participants: Who participates, how they are recruited (selection of participants)
Organisation: Who chairs meetings, from which organisation, who speaks, where meetings take place (location)
Argumentation: Arguments presented, issues addressed, discussions, questions
Spreading the word: Information activities (what and to which target groups)
Influence: Who has/will get what influence?

The next example of open coding is a different but associated concept, namely that of “black Peter”\(^{22}\). Here is an excerpt from a memo:

Theme/concept: Black Peter:

3rd October 2008:
The psychologist used the “black Peter” concept twice during the interview; this is the idea/concept I have thought about since the very first interviews... Black Peter

\(^{22}\)“Black Peter” is a popular children’s card game, usually known as “old maid” in the UK. The old maid/black Peter is the card nobody wants, but somebody will end up with it and therefore lose the game.
may be a question of having no control over the tasks one has to perform. One is given tasks that were assigned to one in advance. One does not have any possibility of negotiating these tasks ... This is a concept/idea worth studying further; what does it actually mean?

Here I explored the literature of autonomy in the perspective of the sociology of professions and the discussion around a potential weakening of professional autonomy that was previously associated with a classical conflict perspective between professions and management, but here the black Peter concept illustrated attempts at internal control of professional behaviour. The fact that each individual professional within different organisations practises the CP in a different way drew my attention to the literature of the *logic of appropriateness* (March & Olsen 1989, March 1994:57) also named logic of appropriate behaviour (Christensen 2007:40) or the logic of following rules (Brunsson & Jacobsson et al. 2000), and also to the literature of standards, rules and norms.

The above memos are examples of open coding, but do not according to Glaser's (2004) claim “earn their way into theory by systematic generation of data”. I did not have “a minimum of preconceptions” required for this technique. Still I found the technique useful to “communicate” with my informants.

3.3.2 Micro-Sociological Analyses

In order to grasp the actual decision-making processes within the CP teams with especial attention to analysing the legitimacy of the different “modes of knowledge” in the work of standardisation, I used an inductive technique in studies of social interaction.

The data used for empirical analysis was collected from a video-recorded participant observation of a three-hour meeting in addition to documents from earlier meetings in the team. I was inspired by techniques of using micro-sociological analyses of cognitive and linguistic models of interactional analysis (Måseide 2003, Atkinson 1995, Cicourel 1999). Such analyses pay special attention to how the team can manage to standardise complex issues of mental health care embedded in the discursive and organisational context of the discussion, utterances and behaviour. Medical problem solving in this context is about standardising a number of activities for a specific group of patients. It can be labelled “medical discourse”, referring to interactional activities that accomplish medical problem solving. Discourse represents an integrated and often essential part of medical work in institutionally
focused settings (Goffman 1971 in Måseide 2007:613). The team in question have had regular meetings during the past two years, about once a month. The meetings always take place in the clinic where the initial idea of the CP for adults with ADHD started two years ago; therefore this team can be referred to as an institutionally focused gathering.

In the production of a CP, there are several processes of decision making within the CP teams and also decisions outside the teams; these processes are not individual acts. Decision making does not take place in a social vacuum; it is not shaped just by general norms and typification of medical knowledge but by the very organisation of medical work itself. The organisation of the work differentially distributes knowledge and interests between the professionals and each occupational group has a different set of everyday practices, which define the contour of information used in making prognostic judgement and decisions (Anspach 1987, Atkinson 1995).

“Voicing”

Different “voices” (metaphorically) distinguish contrasting orientation to the world and to the moral order. Voices articulate different presuppositions concerning language and reality, and have different implications for “avowals or attributions of agency and responsibility”. Each voice represents a relationship between the speaker and the world (Mishler 1984, Atkinson 1995:129). The distinction between knowledge derived from personal experience and from evidence-based science hints at the possibility of several voices. These modes of knowledge often appear in subtle and complex ways to express a variety of orientations with different sources and different grounds of legitimacy. They do not articulate a single life world: “they are cleavages and fault lines running through the culture of medicine.” For this reason it is important “to pay some attention ... to the distribution of knowledge and expertise within the complex social and technical division of labour” (Atkinson 1995:148). These voices co-exist and sometimes compete. The micro-sociological analyses of the discourse within the CP team are based on this approach.

Goffman (1981) developed the theory of “footing” regarding the changes in a participant’s alignment or set, posture or projected self. These changes are commonly linked to language as a structure which underpins changes in footing; it can vary from a word or a sentence to the most subtle shift in tone of voice (ibid: 128). Expressions of credibility and plausibility and of approximation and attributions are embedded in narratives in case stories (Atkinson 1995). When presenting a clinical history obtained from patients, the professional has two
options: to present the patient's story as facts or, alternatively and more commonly, to treat the patient's story as a subjective narrative consisting of statements and reports (Anspach 1988:368). The teamwork involved in designing the CP for adults with ADHD provided such narratives; I will return to these in the analysis of “rulemaking” for the CP for adults in Chapter 5.

3.4 Reflections on the Validity of the Study

All methods have both strengths and weaknesses. An interpretation-based approach should present a number of people's interpretations of the same phenomenon, in this case their experiences from participating as “standardisers” in designing the CPs. Based on a contextual understanding, the situation is context dependent, and meaning and understanding can only be achieved by placing the situation in its particular environment. The interviews reveal that in an everyday situation people have neither the time nor inclination to undertake a systematic and critical assessment of what is happening around them. Respondents have their own fixed perceptions of reality (Jacobsen 2005:215). It is known that the answers to research questions will depend on whom one asks, what point of view and experiences they have and how they express and interpret these. And of course it also depends on the researcher's interpretation and presentation of the data. Here, my professional background includes degree qualifications as a social educator and in organisation and leadership. Apart from one year as a social worker in a child psychiatric ward, I have worked in local authority social and child welfare services, both as a social worker and as a leader. I have also for some years been in charge of an office with child welfare and social services, health care and psychiatric services.

Another factor is that the validity also depends on whether I have obtained the most relevant respondents. The fact that I have interviewed people who were key actors in the introduction of CPs is a strength for the information, but a different picture would almost certainly have been revealed if I had chosen more peripheral actors.

Validation through Control with other Empirical Data and Theories

The data were collected at various stages of the study, at different venues and not least in cooperation with a variety of actors. All these factors have implications for
the validity of the data. During the investigative process, I gained progressively more knowledge about both the CP concept as a tool and more especially the design of the two CPs for ADHD. The study became more focused on knowledge, rule production and rule following, and personally I feel that some of the most interesting data have been revealed in the “backstage” decision making. Miles & Huberman (1994) argue that data gathered late in the collection phase are often the best, but the weakness here is that the researcher may have become blinded to any important new circumstances and factors.

With regard to validity through control, I have on several occasions presented tentative analyses during this study, at meetings and conferences in the field and to my research colleagues at conferences and in reports for the international network KNOWandPOL.

After having started with some interviews, I had the opportunity to participate in preparatory meetings for the implementation of a major evaluation conference on the CP for children with ADHD. Here I took part in several meetings with actors from the hospital, and together with a colleague I was given the opportunity to present the CP concept in an international context, and also importantly, I used this opportunity to provide information about the study and the initial analysis.

3.5 Summary of Methodological Considerations

This chapter introduced two empirical cases from Norwegian mental health care. I have chosen a qualitative methodology that provides an interpretation-based approach and the methods selected are individual semi-structured interviews, participant observation at meetings and document examination. This is an in-depth study, using a combination of descriptive and explorative design to seek an understanding of the experiences of CPs of certain actors. The analysis design is characterised by a combination of inductive and deductive approaches closely linked to the main approach, and illuminates the research questions both chronologically and thematically. Finally this chapter offered some critical reflections on the validity of the methods.
3.6 The Structure of the Four Empirical Chapters

As a conceptual framework, the processes of the production and implementation of clinical pathways can be divided into two interwoven phases:

- “Rulemaking”
- “Rule following”

Thus within this framework the first two subsidiary research questions apply to “rulemaking” and the third question applies to “rule following”. The analyses presented in Chapters 4-7 reflect this conceptual framework.

The data from interviews, observations and documents provide a basis for the first step of the empirical analysis, i.e. the descriptive analysis of “rulemaking” in Chapters 4 and 5, where the various activities in the design of the two CPs are described chronologically, covering respectively the research questions “How was the clinical pathway for children with ADHD designed?” and “How was the clinical pathway for adults with ADHD designed?”; thus, these two chapters provide an insight into the way the two CPs were produced. Chapter 6 analyses part of these empirical descriptions in an “analysis of rulemaking”, focusing on mechanisms in the design process for standardisation in ambiguous and controversial contexts. Chapter 7 deals with the third research question “What are the responses to the clinical pathway for children with ADHD among professionals working in the system?” followed by an analysis of “rule following” in the same chapter. Thus, the next four chapters explore how professionals standardise their own work and can be read as empirical analyses in a discussion of what CPs as a knowledge regulatory tool mean for professional work in mental health care.
Rulemaking for the Clinical Pathway for Children with ADHD

This chapter deals with the first of the three research questions; how was the clinical pathway for children with ADHD designed? Firstly, I would like to present the CP project for children with ADHD, showing how the design process was organised in the years 2003-2006. Here, those involved had to point out the coordination and quality problems in the system with a view to making improvements by standardising the services for these patients. Then I present the next problem the CP makers were facing: how they defined the knowledge used in the creation of this CP and how this knowledge gained entry into the CP.

Clinical pathways consist of rules based on one or more specific knowledge bases and thus the focus is on knowledge and in this case specifically the knowledge of ADHD in the design of CPs. I understand knowledge as a social construct, which means that knowledge is constructed and reconstructed by social groups in different cultural settings. Knowledge of ADHD is constantly being transmitted and distributed among the actors involved, which might give rise to distinctive views of ‘ADHD knowledge’, also termed ‘knowledge paradigms’ or ‘knowledge regimes’. Let us now consider how the design process was organised during the years 2003-2006.

4.1 The Design Process

In introducing the CP for children with ADHD, this section starts with a chronological description of events and activities considered significant during the years of its design.

We find ourselves in a hospital department of child and youth psychiatry, which provides comprehensive treatment at the level of the specialist health services. Such operations are spread throughout the county, serving a population of 270 000 in the region.

4.1.1 The Initial Design Process of 2003 and 2004

In the winter of 2003, several participants gathered to debate developments in the field of ADHD. Participants from specialist health services included the R&D Unit and the Child and Youth Psychiatric Unit at the BUP, the Division for Medicine
and the Division for Habilitation of Women and Children at the hospital along with the County Governor. The agenda of the meeting was to “brainstorm” the challenges involved in ADHD. In this context, ADHD was described as a “psychosocial and medical challenge that affects many families, and early intervention is important” (the report on the current situation and submission of a CP of 07.01.11, page 4).

The possibilities for a clinical pathway project were discussed and the participants decided to continue with the idea of developing a CP tool. A temporary working group of various actors from the meeting was established; these were working in the Units of R&D and Child and Youth Psychiatry. It should be mentioned that the participants in the meeting also discussed a research project called “EEG biofeedback in treatment of ADHD” headed by a chief psychologist from the neurological team of the BUP. This project is not further discussed here but was developed separately at the same time as the ADHD clinical pathway project.

**Kick-Off Seminars**

During the autumn of that year, the hospital organised two kick-off seminars on ADHD. The idea of a CP for ADHD was now put into production. At this time, the initial work on the CP formed part of the hospital's public health projects as the hospital was a member of the international network of Health Promotion Hospitals initiated by WHO. This preliminary work on the CP was also a part of the commitment to the National Escalation Plan.

At the kick-off seminars, a range of participants gathered to debate developments within the field of ADHD. Contributors from the specialist health services included the R&D Unit, the BUPP, the BUP and the Child Habilitation Service at the hospital along with contributors from local agencies such as the Centre for Health Information and Disease Prevention, the PPT, the Child Welfare Office, the Social Welfare Office and finally the County Governor. The director of the R&D Unit headed the meetings, although the overall initial idea emanated from professionals working within the BUP, particularly a chief psychologist in the neurological team at the hospital as the frontrunner in developing improved services for these patients.

Experience from professionals and patients, bottlenecks in the service system and suggestions for improvement were brought into the spotlight and discussed during these events. There were several lectures from the participants during these days, all stressing the local challenges for patients with ADHD in the county, as there were waiting lists, bottlenecks and a lack of coordination between the organisations in the system. By relating patient narratives, several of the lecturers pointed out that
patients and their relatives did not get the services they required. As a social worker from a local authority child welfare office expressed it, “the help these patients get depends on where they live and who they meet in the system, due to the fact that the various local councils in the county are organised quite differently”. Several contributors pointed out the lack of knowledge about ADHD everywhere in the system. These were professionals working in local authorities such as a health visitor, a GP, an educational-psychological counsellor and a social worker. There were also professionals working in specialist health services; a chief psychiatrist, a specialist psychologist and a chief psychologist reported from the field of ADHD. The problems were communicated based on these experts’ views from their own place in the chain of services. Thus, these lectures and reports can be regarded basically as “mood reports” from the field of ADHD in this region.

In order to exemplify what a concerned parent could meet in requesting help, a chief psychologist in the neurological team (one of the frontrunners in the CP) illustrated the problems of arbitrariness in the system regarding screening and assessment:

**Figure 4.1 Arbitrariness in the System:**

```
Concerned parent → Kindergarten/School → General Practitioner (GP) → Child Health Clinic* → Particular system or PPT → PPT, possibly BUPP, other PPT/GP, then possibly BUPP
```

* Centre for Health Information and Disease Prevention

As mentioned, the focus of these “kick-off” seminars was the coordination problems, and a number of lecturers demonstrated the arbitrariness and fragmentation within the system, but also the blurred organising of the services, as an educational-psychological counsellor working in the local authority PPT pointed out:

ADHD is a medical diagnosis; the condition is a neurochemical imbalance in the brain. In general, the PPT develop and implement relevant measures, apart from any medication. What this means is that most of the investigative work concerning these children is carried out by an organisation which has no responsibility for it!
This is a strange state of affairs.

(Report from the conference, November 3, 2003:3)

A further point she made was that the problems of the individual child automatically tend to be given a specific label according to which agency is dealing with the case.

A summary of the first seminar explicitly points out that little knowledge has been gathered as to how patients and their families must be helped further in the system:

A well-defined clinical pathway is what is needed in further work

(Report from the conference, November 3, 2003)

Thus, the initiators in the temporary working group wanted to develop a standardised tool to solve stated problems of coordination and quality in the system. This decision cannot be seen independently of the organisational and social context of the time, as the idea of developing CPs was already in circulation in Norwegian hospitals and SINTEF Health Research had recently started a study of the ADHD situation, the data from which was used in the Breakthrough Series for improving the ADHD situation. First I give a presentation of the SINTEF health study followed by a descriptions of the Breakthrough Series and its objectives.

SINTEF Health Research

During the same period as the work on the CP, a study by SINTEF Health Research in 2004 reported a lack of treatment facilities for ADHD patients in Norway, revealed by the discovery of problems of coordination and quality23, and thus the experiences from the kick-off seminars were strongly confirmed. This study, which was prepared on behalf of the Directorate of Health and Social Affairs, pointed out the key objectives of the Escalation Plan for Mental Health, namely to develop easily accessible, high quality services for children and young people. Yet several challenges remained, one of which was the need to increase assistance to certain special needs groups not covered by the ordinary measures. One such area was the assessment, diagnosis and treatment of children and adolescents with hyperkinetic disorders/ADHD. The main objective of the study was to “provide systematic information about the treatment options available for children and adolescents with hyperkinetic disorders/ADHD, and to provide new knowledge

23 National survey of the opportunities for diagnosis and comprehensive treatment of children and adolescents with hyperkinetic disorders/ADHD (Andersson et al. 2004)
about how the support system works for this group” (Andersson et al. 2004:1).

The SINTEF report revealed for example that the average time to wait for help (the period from when parents start to get worried until a diagnosis is made) was around four years. This report received great attention, and the Norwegian Medical Association used this information to establish ADHD as a part of the Breakthrough Series (in Norwegian: “Gjennombruddsprosjektet”).

**The Breakthrough Series**

The Breakthrough Series is the name of a working model for change in clinical practice. The method was developed by the Institute for Healthcare Improvement (IHI) in Boston, USA in 1995 and later translated and adapted for the situation in Norway. The Breakthrough Series aims to help health care organisations make “breakthrough” improvements in quality while reducing costs and one of the major ways to do this is via mobilisation of professionals as cited by a Senior Fellow of IHI, Paul B. Batalden: “The general aim is to prepare health professionals – as part of their useful professional formation – to lead the continual improvement of the quality, safety and value of health care” ([www.ihi.org](http://www.ihi.org)). Supported by the Norwegian Medical Association, the National Board of Health, several departments at the Norwegian Directorate of Health and the Norwegian Knowledge Centre for Health Services, the Breakthrough Series has been applied in a number of different fields since 1998. In brief, this method focuses on system and process improvements in selected health care services, and it turned out that mental health issues were to dominate the Norwegian Breakthrough Series (also called Breakthrough Project). The procedure in the Breakthrough Series is briefly: Firstly, areas for improvement are identified in the chosen field of study by a team of experts on the medical aspects of this field. Hospital departments and in some cases other organisations are invited to join the project. Local improvement teams are set up and guided by the process change advisors during a change period of about six months. During this time three improvement seminars take place, where the group of experts, advisors and improvement teams meet up and exchange experiences and ideas (Hammer & Torp 2006:8).

---

24 Paul Batalden was a guest professor at the University of Bergen and via Haukeland Hospital contact was established with the Medical Association, which linked the Breakthrough Series to its commitment to the project Total Quality Management (TQM). (from a presentation of the background and history of the Norwegian Breakthrough Series held by A. Fredriksen, head of the Norwegian Medical Association, at the Quality Conference on March 8th 2011).

The board of the Norwegian Child and Adolescent Psychiatric Association initiated this project, and it was organised by the Norwegian Medical Association in collaboration with the Child and Adolescent Psychiatric Association, the Norwegian Psychological Association and the Norwegian Nurses Association. The project was funded by the Norwegian Medical Association fund for standardisation and quality improvement in the specialist health services (Quality Assurance Fund II)\(^\text{26}\).

The Breakthrough Series “ADHD – Improving Assessment, Diagnosis and Treatment”, which took place in 2003 and 2004, started with the project steering committee inviting a multidisciplinary expert group appointed in cooperation with the Norwegian Child and Adolescent Psychiatric Association to identify appropriate areas for improvement. Physicians, psychologists, nurses, educationalists, a team of experts on hyperkinetic disorders/ADHD and the ADHD Association were represented in the expert group. Each agency involved then chose its own preferred areas from the list of areas for improvement.

A chief psychologist from the BUP and a chief psychiatrist from the BUPP at the hospital participated in this project; they were also frontrunners in the CP project. The specific objective for these actors was to cut the time from starting work on a possible ADHD case to clarifying the diagnosis and testing medication where applicable. The project used statistical methods where relatively small data sets are recorded and arranged along a time axis. Statistical Process Control (SPC) was the tool used; this is a well-known method, but has previously been little used in health care. In the Breakthrough Series there is a strong emphasis on training and use of this method, and it has been used by the working groups in the evaluation of results.

Standardisation of Work Processes Intended to Improve Waiting Time

One important goal of the Breakthrough Series was to improve referral, diagnosis and treatment of ADHD. The report from this project suggested that the four years' waiting time for a diagnosis was unnecessarily used to conduct a broad spectrum of diagnostics, which rarely focused on confirming the ADHD diagnosis. Instead, they suggested a new and much faster four-stage diagnostic process, which could be conducted in the course of a few hours or spread over three to five days:

---

\(^{26}\) The Medical Association Quality Assurance Fund is a joint funding committee (state and association of local and regional authorities) that allocates project funds upon application. Source: see footnote 24
An ADHD-focused assessment must be based on the knowledge that this is an organic brain condition, partly genetic, where other factors (...) are often important for the manifestation of the problems, but are not the main cause. Such an assessment can be carried out relatively quickly, freeing up time for treatment and follow-up.

(Norwegian Medical Association 2006:27).

We see here that the guidelines from IHI were adopted by the professional employee organisations, which together with a number of government agencies and the study by SINTEF Health played a significant role in the standardisation process. It is also clear that a certain group of professionals through the adoption of new methods and techniques was entrusted with the responsibility to solve specific challenges. I will return to this project in the next section because the way they defined the knowledge in this CP project influenced the design of this CP. First, a further presentation of details of the design process of the CP for children. The next event is an information letter.

The Information Letter

In spring 2004, the director of the Psychiatry Department and the director of Research and Development at the hospital sent an information letter to the political and administrative leaders of the eighteen local authorities in the county and to the divisions within the specialised services. The letter emphasised the need for making it easier for patients with ADHD and their relatives to find their way around the system of public services, both at local and specialised level:

Well-defined and coordinated services will be developed, independent of which local authorities the patients are living in.

(Information letter of 21.04.04:1).

Attached to the letter, a list of possible actors and their responsibilities and tasks in the diagnosis and treatment of children and young people was presented along with information on the diagnosis of ADHD/hyperkinetic disorder. The diagnosis is present in 3-5% of the child population and the condition is characterised by striking deviations in the areas of activity level, attention and impulsiveness. In the next section I will return to the content in this information letter as an empirical source for studying the knowledge used for rulemaking in the CP.
Mapping the Current Situation through Interviews

During 2004, the members of the temporary work groups (three advisors working in the R&D Unit at the hospital) conducted activities in order to map the current situation of ADHD in the county. The work group conducted interviews in a focus group of parents, relatives and professionals working in local child welfare offices, PPTs and health centres. The professionals interviewed were for example social workers, educational-psychological counsellors and health visitors. It was difficult to gather GPs to a meeting (there are approximately 200 GPs in the county), therefore they chose to interview thirteen of them by phone. The focus groups and the GPs were asked about their experiences with the ADHD diagnosis, how the services are organised, inter-organisational collaboration, the levels of knowledge of ADHD and areas of possible improvement. It would be too comprehensive to report all remarks from the interviews with the focus groups here; however, we may briefly state that during these events the actors involved reported diverse problems with lack of coordination within the system and arbitrariness in services. The experiences of the 13 GPs illustrate core dilemmas:

- The GPs’ role in clarification, referral, collaboration with others is unclear
- Great variation in knowledge of the ADHD diagnosis among the GPs
- They very seldom participate in collaboration on Individual Plans (IP)
- The services for these patients are variously perceived as ranging from “very bad” to “good”. Most of the GPs perceive the services to be “fairly good”.

These points provide information on how some GPs in the county interpret the ADHD situation. They confirm the problems of coordination; however, the notes also reveal the following areas of improvement suggested by GPs:

There are several tasks they could carry out, e.g. providing a medical evaluation in assessment and referral, participating in coordination meetings, taking over the prescription of medication under supervision of a specialist and taking part in courses or seminars on ADHD.

(Notes from meeting, undated 2004)

All in all, the CP makers note in a report that GPs have a positive attitude to the production of a clinical pathway, as such a tool can lead to improved collaboration, well-defined responsibilities and roles, simplification and improvements in services for these patients.

In addition to the interviews with the focus groups and the individual interviews of
the GPs, a team member in the temporary project working in R&D utilised the technique of process modelling.

A Flowchart Model of the Current Situation in a Particular Case

The model below illustrates the activities of screening, assessment and referral of children with ADHD in one particular case in a local authority. As mentioned earlier, there are eighteen local authorities in the county, or to put it in another way: there are eighteen different ways of organising the services within mental health care and the other services involved such as kindergartens and schools. The model below illustrates (with headings from left to right) the roles of organisations/professions, their activities and work tasks. The actors/agencies are parents, school/kindergarten, local council doctor/GP, clinic, child welfare services, PPT, BUPP, BUP and the neurological team. This “flowchart” model, demonstrated by the symbols and arrows, illustrates the patient’s “pathway” through the system. Here, the model demonstrates the various ways into the system and the number of ways to solve the processes of screening, assessment and referral within the same local authority.

Figure 4.2 The Flowchart Model

Figure 4.2 Flowchart model constructed through the technique of process modelling. Source: Østfold Health Trust (2005)
Along with the data from the interviews in 2004 and the lectures and input from the brainstorming meeting and the two conferences in 2003, the flowchart model was applied as a technical support to conduct an analysis of the current situation from the CP makers’ point of view. The document from the project established that it was essential to develop improved interactions and procedures, thus a CP in this context should deal with clarifying and concretising the notion of ‘who does what, and when’ in the process from the first suspicion of ADHD in children and young people, through referral, diagnosis and treatment, and finally to follow-up of the patients. Four members of the temporary working group presented a report on the current situation including the suggestion of a CP. At that time these members were working in the R&D Unit (three advisors) and within child and adolescent psychiatry (a chief psychologist in the neurological team at the BUP). In the report, they included a new model as a CP tool in order to solve the prevailing situation. This document can be regarded as central to the future project. Here, the draft of a CP was presented in written text. The focus in the report is on launching a tool for solving the defined problems of coordination and arbitrariness in the system.

To alleviate the problems of coordination and arbitrariness, the idea of developing a standardised CP tool was launched in the first brainstorming meeting and during the conferences. No analysis was conducted of the factors which might be causing the coordination problems and the arbitrariness in the system, neither were any alternative measures examined; rather the focus seemed to be fixed on the CP as a problem-solving tool. Considering the control signals pointing in the same direction in the form of a relatively strong focus on standardisation and quality improvement, a CP in the field of ADHD may thus represent a response to solve the stated problems in this area. The solution has therefore been outlined, but it is worth noting that general practitioners, who are intended to play a key role in this CP, have been very little involved in the rule production.

There was a gradual transition from when the initial work started in 2003 until the final result of this work became the project entitled “Implementation of Clinical Pathways for ADHD-Affected Children and Youth in the County”, launched in May 2005. This project was partly financed by the hospital and partly by external funding.

4.1.2 The Implementation Project during 2005 and 2006

We are now in the next stage of the design of the CP. The main goal of this project was to establish a proposal for a clinical pathway for children and young people
suffering from ADHD and put this into practice throughout the local authorities in the county. However, the CP was regarded as a proposal and therefore the tool needed to be confirmed and adjusted by the participants before it could be implemented in all parts of the system in the county. A project organisation was established, along with a steering committee, a reference group, a project group, and five regional local teams.

When the implementation project started in 2005, 18 clinical pathways were in production or under implementation in the hospital, but none of these covered psychiatric diagnoses.

The hospital used the following definition of the tool:

A clinical pathway is a standardised form of describing all initiatives necessary in order for an average patient to experience a desired benefit of a hospital stay. The clinical pathway must contain professional, economic, and quality aspects affecting the patient. These aspects must be made available to be reported as results.

(Report 7th January 2005:5)

This definition was produced by the specialist health services at that time and was broadly defined in the context of this particular project. The project management points out that interaction among participants is essential, and work conducted outside specialist health services, i.e. local council services, plays a highly significant role. The CP is described as:

A process plan for the entire clinical pathway chain, from interception, referrals, to clarification/determining a diagnosis, and further initiatives.

(Report 7th January 2005:5)

Referring thus to the above definitions, one intended result of a CP is benefits within the hospital setting. The emphasis on results in professional, economic and quality aspects implies control of these aspects, which requires suitable techniques for implementation of certain measures/suitable measurement techniques. As the CP for children was intended to cover the “entire” clinical pathway chain, the level of ambition for this CP can be seen as both higher and lower than the hospital’s definition. The ambitions are higher because the CP covers the overall chain of activities, and lower because the CP does not emphasise reporting of results in professional, economic and quality aspects. Hence, considering the fact that there are 18 different local councils involving several hundred people, one can assume that it will be impossible to envisage measurement of all the activities of interception, referrals, clarification, diagnosis, etc. in addition to further initiatives,
therefore toning down the “result part” seems appropriate. Consequently, coordination of activities in the overall chain can be seen rhetorically as important to emphasise, but extremely difficult to obtain.

A Submission for a CP in January 2005

The report on the prevailing situation of children and young people with ADHD in the county, including the draft of the CP, was sent to all involved organisations for a submission. The report included 26 pages of description of the prevailing situation and proposals for improvements. The main result of mapping the situation is referred to above, where we see there is too little knowledge of ADHD, great variations within the county and unclear roles of the agencies during the activities of referral, diagnosis and treatment. The submission of the CP proposed goals and measures relevant to the activities of all those involved in the system, “but it should be noted that the implementation of this is not a part of the project”:

\[
\begin{align*}
\text{It is a primary goal that children and young people with ADHD in (County), and their families, should receive necessary assistance from a coordinated support system.} \\
\text{(Report 2006)}
\end{align*}
\]

Under the main points concerning screening, referral, assessment/diagnosis and the responsibility for actions, there is a description of who is responsible and which tasks should be performed. It is emphasised that:

\[
\begin{align*}
\text{. the responsibility for follow-up and the necessary framework conditions must be clarified.} \\
\text{(Report 2006)}
\end{align*}
\]

These were also factors in much of the input received. A chief psychologist presented some of the main aspects of the consultations from the neurological team, but it is difficult to summarise these statements as they differ widely. This is quite natural when many agencies and professional groups give their opinions on such a broad field, but I shall return to some of these views later in this chapter.

The County Conferences on ADHD in January and February 2005

A wide range of participants from the field attended two conferences during the winter of 2005. In the conference in January, the draft of the CP was presented along with information on background, aims, and experiences so far of the CP project for children with ADHD.
The ADHD seminar in February was dedicated to a prominent local paediatrician. 350 participants from the field took part in the seminar, which included lectures and reports from the field of ADHD including diagnosis, use of medication, brain research and co-morbidities. Here no alternative treatments or questions about the ADHD diagnosis seemed to be aired by the speakers or the participants.

During the breaks at the seminar meeting a poster of the draft version of the CP for ADHD was presented. Here, a new model illustrated the proposals as to goals, activities and the agencies’ responsibilities, obtained from the 26-page report mentioned above:

**Figure 4.3 The draft version of a CP for children with ADHD**

The draft version of the CP describes goals and responsibilities in the activities of screening, referral, assessment/diagnosis and actions which can be regarded as ambitious, for example the goal of “general agreement on the responsibilities of the various agencies”. The “tangible outputs”, i.e. the manuals describing step-by-step instructions of care and treatment for each service agency, had at that stage not yet been produced.
On the same poster, a model of a brain illustrates the ADHD diagnosis. The text on the poster outlines the way forward:

- The implementation of a similar project for adults should be considered.
- It is important to follow up the proposals for clinical pathways. A collaborative project between the local authorities in the county and the specialist health services at the hospital would be appropriate.

(Poster, 2nd February 2005)

The poster was presented by two of the members in the project from the R&D Unit; the contact person on the poster was the chief psychologist in the neurological team. As this draft version was presented to 350 participants from the field, the CP idea was probably spread to a good number of actors and agencies.

An Intention Agreement between the Hospital and 18 Local Authorities

During spring of the same year, a formal agreement was drawn up in collaboration between the hospital and representatives from some of the eighteen local authorities in the county. This agreement was formally linked to legislation in health and social services in addition to the recommendations of the National Strategy for Quality Improvement in Health and Social Services 2005-2015: “And it is going to get better!” The agreement was confirmed politically by the local councils and signed by the mayor of each council and the director of the hospital. It must be pointed out that this was a general collaboration agreement which did not only apply to this project. However, this agreement is cited in the following conferences and in the documents of the project, therefore it can be regarded as significant for the future work. A member of the project who at that time worked in the R&D Unit of the hospital emphasised it in this way:

This agreement was crucial in tying down the local authorities.

(Memos, October 2008)

This comment is interesting because this intention agreement seems to be the only formal written agreement between the local councils and the specialist health services during the design of this CP. Here, it is important to mention that the CP was the first of its kind to have the ambition of involving the entire system in the county.
The Mandate of Discussing the Proposals in the CP and Suggesting Local Challenges

The organisation of the project describes a model of five regional teams participating in the CP design. They are inter-organisational ad-hoc groups representing actors from specialist health services (BUPP) and local authorities (sometimes these groups will be referred to as “CP makers”, although they are not the only decision makers in the design process). Each of the teams was headed by a professional working in the BUPP, since the organisation of these teams reflected the BUPP's five regional sections in the county. Thus two psychologists, an educational therapist, a clinical social worker and a chief psychiatrist headed the five teams respectively. The heads and members of the teams were partly recruited on request by the project management or they received an open invitation through their place of work. These teams were constituted prior to a two-day workshop in September 2005.

At this time, the intention agreement was signed and the hospital management had approved the implementation of the project. Information meetings had been arranged in the BUPPs and among local coordinators of mental health care in addition to a meeting with heads of the local PPTs at the county governor’s office. The project organisation was established and the emphasis in the September seminar was on the future work of the CP teams. The mandate of the teams was to discuss the proposals in the report and suggest local challenges; they should have an opinion about “Who are doing what - when”. Thus, in the process of creating the CP, selected individual professionals within mental health care formed multi-professional working groups, which thus consisted of high-level expertise assigned to decision-making. However, it is worth noting that clear guidance was given at the outset by means of the previously mentioned SINTEF Health Report and not least the Breakthrough Series.

The establishment of the five regional CP teams entailed an expansion in the number of CP makers from very few initiators into a total of approximately 35-40 professionals. Here, I had the opportunity to meet the professionals participating in the work groups and through individual interviews I could explore how these “external actors” involved in CP making interpreted the design process, including their individual views on ADHD knowledge. They worked either in local or in specialised services and participated in inter-organisational CP teams during 2005 and 2006.

A further look at the teams’ mandate of discussing the proposals in the CP and suggesting local challenges regarding goals and measures brings us to an
examination of how they experienced this mandate. As the implementation of the CP in the overall system was formally not a part of the project, it was important to stress that the local groups should suggest local challenges and report these challenges to the project management via the heads of each of the five teams. Thus, these local suggestions can also be seen as initial implementation in various organisations in the county. The possibilities of implementing the mandate were interpreted differently by the various team members, and there were some problems involved, which I will discuss later, but first some considerations of the teamwork.

A psychologist working in a BUPP is the head of one of the five teams. She has a relatively small work environment in the division of child and youth psychiatry and felt she was able to discuss the CP at her workplace at the hospital and she had also support from the manager and colleagues. When I asked her if she felt the team had any influence on the design of the CP, she pointed out an important side effect of the teamwork.

Researcher:
Did you feel that you and the others in the work group had any influence on what form the CP would take?

Psychologist:
Yes, I did. Definitely. When I was working on this, we had those local meetings and then I thought it was... it was... well, one thing was the project itself, that we'd achieve something. And the other thing was building relationships, getting to know one another.

(Interview with BUPP Psychologist 2009)

This view is shared by the other team members as they through the interaction in the CP team were able to get to know each other and build inter-organisational relationships. When the CP makers held team meetings, each of the members had the opportunity to impart his or her views and convey experiences of the specialised field of ADHD and possible ways of organising the services. They understood each other and were dedicated and eager to help the children by the best option they could offer, thus the team meetings seem to strengthen the relations between the actors.

However, the extent to which the CP teams had the opportunity to influence the design of the CP was experienced in different ways. As a health visitor in a Centre for Health Information and Disease Prevention expresses it:

When I joined that process, the clinical pathway was more or less laid out. What we were supposed to work on there was what we should do at the local level. …And we were supposed to… do those things…. And we felt that we neither had the
capacity nor the right people locally to do it, at that time. So it was kind of a bit frustrating in a way. And as I said, we were in BUPP’s arena, and we couldn’t. There was no chance to discuss professional aspects either.

(Interview with Health Visitor 2008)

Here, the informant is emphasising that she more or less felt that the CP had already been completed. The context of the BUPP arena interfered with the possibility of discussing the proposals in the CP from a local council point of view. The teams’ mandate was also to suggest local challenges regarding goals and measures, and, as a number of informants experienced from the work in the teams, the recurring discussions very often concerned the need for courses and follow-up for families in addition to the topic of the various actors’ responsibilities and tasks during referring, clarification and diagnosing. The latter topic involved mainly GPs, PPTs and the BUPP, and here there was a need for a standardisation of all the tasks and activities to counteract the arbitrariness in the county. Because each CP team included actors from several local authorities in the same region, considerations of “who does what and when” were difficult to manage in practice. The difficulties of implementing the mandate had numerous causes, and the most obvious reason, pointed out by several informants, is that all the local authorities are organised in different ways in addition to the range of complexity in the services and the number of professions involved. The CP proposed activities and tasks for each of the professions regarding what instruments and tests were needed for referral and diagnosis, and the lack of representation of professions was experienced as a major problem. GPs, for example, did not have representatives in all teams although this profession is assigned a vital role in the CP. Consequently, an absence of GPs made it difficult for the team to discuss this part of the submission, or rather; the CP team problematised the absence of GPs, but did not have the possibility to make suggestions on this aspect of the CP and took for granted the proposals in the CP showing responsibilities and tasks for GPs. Another problem regarding the CP teams’ mandate of discussing the proposals in the CP and suggesting local challenges in goals and measures was, as several informants also pointed out, the absence of managers in the team. With just a few exceptions, the leaders from the various services did not participate in the teams at all, and this was seen as a problem by a number of those interviewed. A psychologist elaborates the implications of this for the progress in the CP design:

Psychologist: Well, the thing was that the various members didn’t have direct influence as leaders where they worked, and that because of that.. er – it was a bit up and down how much their leaders knew about the clinical pathway..
There were extra rounds of communication which were difficult, or which.. well, maybe made implementation difficult, at least it was a challenge to get the implementation done. And this was mentioned several times by different agencies. That if the leaders had been involved, if the people in charge of child welfare, PPT, and even the head nurse at the clinic had been involved and got more familiar with it from the beginning, the implementation would have been easier.

So that.. they missed not having their leaders involved in the clinical pathway right from the start.

Researcher: Yes.
Psychologist: That they, the ordinary team members, had to come and.. make it work.
Researcher: Hmm.. but how has it been in practice?
Psychologist: Er, I think it’s varied a bit. Er.. in fact it depended a bit on each person’s work situation and personality and.. yes. Many factors I think are involved in how we worked on it. Hmm. So it varied a bit.

(Interview with BUPP Psychologist 2009)

Several informants support this statement as they describe vulnerability in the organisation of the CP teams. The individual actors in the team had the responsibility to communicate information on the project to their organisations, discuss the CP at work, bring responses back to the team and, last but not least, ensure financial support for new measures.

We have now seen how these CP makers interpret the design process in the work of the teams. The mandate was to discuss the proposals in the CP and suggest local challenges regarding goals and measures, but there were clearly defined problems, which made this mandate difficult.

The tangible “output” of the project was to be the procedures of tailoring work tasks and treatment sequences to each service agency, such as the local PPTs, GPs, BUPPs, schools, kindergartens and Centres for Health Information and Disease Prevention. The CP was made into an electronic version in order to make it available to all involved parties in the system and this distribution of the CP also had an iterative learning aspect. Manuals outlining such procedures were available from June 2006, in both electronic and hard copy formats. In the electronic version, one can navigate through the manual by clicking on hyperlinks such as “National Guidelines for Clarification and Treatment of ADHD”. In practice, the CP for children with ADHD should include all the organisations involved, including all the
GPs in the entire county; consequently standardisation of all the activities and work tasks in the “chain” of services represented a substantial effort. The project was formally concluded in May 2006. The model below is the final electronic version available on the hospital website and is translated in its entirety.

The Electronic Version of the Clinical Pathway for Children with ADHD

This clinical pathway has been developed by (name of hospital) in collaboration with the local authorities in (name of county).

Model 4.4 “Who does what, when?”

<table>
<thead>
<tr>
<th>Screening</th>
<th>Referral</th>
<th>Appraisal/Diagnosis</th>
<th>Follow-up, actions, treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>GP</td>
<td>GP</td>
<td>GP</td>
</tr>
<tr>
<td>PPT</td>
<td>PPT</td>
<td>PPT</td>
<td>PPT</td>
</tr>
<tr>
<td>BUPP</td>
<td>BUPP</td>
<td>BUPP</td>
<td>BUPP</td>
</tr>
<tr>
<td>Parents</td>
<td>Parents</td>
<td>Parents</td>
<td>Parents</td>
</tr>
<tr>
<td>Kindergarten/school</td>
<td>Kindergarten/school</td>
<td>Kindergarten/school</td>
<td>Kindergarten/school</td>
</tr>
<tr>
<td>Clinic</td>
<td>Clinic</td>
<td>Clinic</td>
<td>Clinic</td>
</tr>
<tr>
<td>Child welfare office</td>
<td>Child welfare office</td>
<td>Child welfare office</td>
<td>Child welfare office</td>
</tr>
</tbody>
</table>

- About the ADHD clinical pathway project in (name of county)
- General information about ADHD
- What’s happening in (the name of county)?
- Contact us
- Video talk about the ADHD clinical pathway by project manager (name) (18-minute video film. NB! Large file = 32 MB. The PowerPoint presentation from the talk can be downloaded [here](#))
- Views on the (name of county) ADHD clinical pathway from various actors involved (5-minute video film – 8MB)

Below you will find complete manuals for the clinical pathways for children and young people with ADHD in (name of county). The manuals are in PDF format and can be downloaded and printed.
### Supplementary material to the manuals

Published: 12.06.2006  
Last updated: 17.08.2006

**Figure 4.4** Who does what and when, Clinical Pathways for Children and Young People with ADHD

This final version of the CP is available on the hospital website and describes and visualises all the interventions and treatments in order to control the actions and interactions of the various actors and organisations. The complex inter-organisational structures within and between the organisations have been replaced by a uniform organisational structure and a streamlined standardised approach in order to reduce variation and arbitrariness in the system, problems of waiting lists, bottlenecks and lack of coordination between the organisations.

I will now return to the knowledge of ADHD used in the CP as it is presented and mediated through documents and interviews. This is empirically noteworthy because the production of CPs to a large extent represents production of specific ADHD knowledge or ADHD discourse communicated in different contexts of mental health care.
4.2 Knowledge in Use

We have seen how the CP makers solved the quality and coordination problems by giving them due consideration and deciding to develop a CP as a knowledge regulatory tool and as a course of action. The next problem the CP makers had to solve was to decide on the knowledge for use in the CP. The first view or understanding of ADHD knowledge that is highlighted here is in the SINTEF report of 2004:

Stimulants have been used to treat hyperkinetic disorders/ADHD in children and adolescents for over 60 years (Gillberg, 1998), and are now part of the overall treatment of children and adolescents. There is scientific consensus that medical treatment with stimulants has a positive effect on most children in relation to motor skills, social and cognitive functioning (Zeiner et al., 1999; Groholt, 2001). The long-term effects, however, have to a lesser extent been clarified or documented.

(Andersson et al. 2004:26)

The next view or understanding of ADHD knowledge is recognised in the report from the Breakthrough Series by the Norwegian Medical Association in 2002-2003. As mentioned, the frontrunners working in Child and Youth Psychiatry at the BUP and BUPP participated in this project. Here, the authors establish ADHD as an organic brain condition, as the text below demonstrates, but they also point out the controversy about medication:

ADHD, which 20 years ago was called MBD (minimal brain dysfunction), entered the scene in Norwegian child and adolescent psychiatric work in the early 1980s. Understanding this condition, and not least acceptance of it as an expression of organic brain pathology, has had a very difficult birth. It took almost 15 years before the majority of those involved in the field (in all the professions) and the cooperating agencies (PPT, child welfare) were able to reach a fairly unanimous view of the explanation, expression and treatment of the condition. The use of stimulants has contributed particularly strongly to the difficulties in accepting ADHD as a diagnosis.

(Report from the Breakthrough Series, Norwegian Medical Association 2006:7)
In addition to establishing that ADHD is caused by an organic brain condition, the quotation above illustrates the ambiguity and the difficulties involved in getting acceptance for this diagnosis.

The previously mentioned information letter which was sent from the project management to all the agencies in 2004 provides an explicit understanding of how to diagnose and treat these patients, as the letter points out the need for a system to safeguard detailed diagnostics, differential diagnostics and medication. Here is an extract from the letter:

ADHD or hyperkinetic disorder is present in 3-5% of the child population. The incidence in adults is believed to be about half as much. The condition is characterised by striking deviations in the areas of activity level, attention and impulsiveness. The symptoms must have occurred before the age of seven, have continued for some time and create significant difficulties for the individual and/or his environment in order for the diagnosis to be made. A subgroup known as ADD has attention disorders without notable impulsiveness and hyperactivity. Additional problems such as learning difficulties, clumsiness and not least behavioural disorders are common. The combinations of ADHD and severe behaviour disorder and ADHD and depression increase the risk of substance abuse considerably.

(Information letter, 2004)

With regard to the repertoire of treatment facilities, the information letter points out that there is a professional consensus on a broad-based treatment of ADHD as most children and young people will need extra help in school and there is a great need for guidance and support for parents. Further, the letter indicates that treatment with stimulant medication (usually Ritalin/Concerta) will form an important part of a package of measures for many ADHD children:

This medication will be effective or very effective for about 75% of children and young people with the diagnosis. It has however no curative effect, and must usually be taken for some years. Common side effects are reduced appetite and sleep disorders. Such medication appears to be able to reduce the risk of subsequent drug problems. Medication is not effective in all cases; some individuals experience unpleasant side effects and others are very reluctant to use psychotropic drugs on children.

(Information letter, 2004)

Furthermore, the letter states that against such a background there is a need for complementary and alternative methods of treatment of the primary symptoms of
ADHD and that psychosocial and pedagogical measures mainly seem to be able to help the additional problems but have limited impact on the basic symptoms.

At that time (in 2004), national guidelines for ADHD had not yet been published and there were no references to studies or literature attached to this letter; these texts more than hint at the biomedical knowledge paradigm. There are a number of RCT studies of the biomedical paradigm as stated in the previously mentioned report from the Breakthrough Series in Norway:

In a broad perspective, nationally and internationally, ADHD as a condition has had considerable significance for the development of knowledge and also for a shift in basic thinking in child psychiatry. No condition has been researched more than ADHD in the field of child and adolescent psychiatry, and it has therefore become an example of an evidence-based approach to assessment, diagnosis and treatment and research continues to give us new and better grounded knowledge.

(Report from the Breakthrough Series, Norwegian Medical Association 2006:7)

The report refers to a number of prominent RCT studies; however it would be too lengthy to refer to all these. Here, medication is the cornerstone in the “package” of treatment.

The proposal for the CP in 2005 (presented by three advisors in the R&D Unit and a chief psychologist in the neurological team at the hospital) used the knowledge referred to above in the presentation of the ADHD diagnosis in the drafted version of the CP. At this time, the number of CP makers expanded from very few into 30-40 employees from the 18 local authorities and BUPPs as members of one of the five CP teams. Thus, a variety of workplaces was represented in the design of the CP as there were professionals working in PPTs, in Centres for Health Information and Disease Prevention, in primary schools and in mental health services and also a few GPs along with BUPP staff. Thus, the majority of the participants in the CP teams worked for a local authority. But the expansion also included the number of professions, as there were now e.g. nurses, psychologists, psychiatrists, special needs teachers and GPs. Does the biomedical knowledge paradigm also apply to these members of the five local CP teams? When interviewed, nearly all the CP makers in this study express the same attitude towards the biomedical paradigm and medical treatment as the best option for children with ADHD. The informants state that the CP teams hardly ever discussed the use of this knowledge for rulemaking (the drafted version of the CP). Methylphenidate (e.g. Ritalin and Concerta) is a
stimulant drug and a number of RCT studies show that medication can help reduce 
the symptoms of hyperactivity, inattentiveness and impulsivity in children with 
ADHD. However, the medications can produce adverse side effects in some 
children, e.g. sleep difficulties, reduced appetite and emotional problems. These side 
effects are well known, but as many informants assert, the positive effect of the 
medication on the children outweighs the side effects. One distinctive trait of the 
CP makers is the enthusiasm they demonstrate for having the potential to improve 
the quality of life of these patients. As one educational therapist working in a BUPP 
put it:

I am witnessing the significant improvement of some children being treated with the 
correct level of Ritalin or equivalent.

(Interview with educational therapist, BUPP, 2008)

One experienced special needs primary teacher has been helping children with 
special needs for many years and her workplace has a well-developed system for 
such support. Regarding ADHD children, she says that there is on average one in 
each class, but the number is constantly increasing. Nearly all of them are boys, and 
even though she has had her suspicions sometimes, and they have tried to find girls, 
she finds this striking. She sees a pattern in that children are diagnosed earlier and 
earlier, and now they have pupils at the school who were diagnosed in kindergarten:

Researcher: What’s your opinion about the diagnosis?  
Teacher: …….I think it’s actually a serious diagnosis, that’s my opinion. But I 
also think it’s very important for children to get the diagnosis. Because children have said to me “Now my heart’s asleep” and “Now my legs can sit still”. They have been sitting holding on to 
them… their legs have been jumping up and down… But we feel we 
need to reassure parents about everything in the media and so on.  
We see these scare tactics all the time…

(Interview with primary school teacher, 2008)

Children who receive medication must have been diagnosed with ADHD first. Here 
the diagnosis is automatically linked to the use of stimulant medication, which is 
natural as long as this is the form of treatment used in the vast majority of cases 
among specialists. She also says that she struggles to give explanations to parents 
and reassure them, but she does not shy away from recommending to parents that 
they try out the medicine in conjunction with other necessary measures. She believes
that the medication is vital for the children’s learning at school. Like the other informants, she says there was no discussion of the diagnosis itself in her CP team.

Consequently, being convinced of a common view of ADHD knowledge, the CP makers did not feel any necessity to argue for alternative methods of treatment, as the biomedical treatment appeared indisputable. Alternative paradigms of treatment for children with ADHD seemed to be out of the question in the local CP teams. On some occasions, the topic was introduced by way of maintaining loyalty to the biomedical paradigm. The angle of discussion of the topic was the scepticism and doubts of the prescription of Ritalin which had recently been raised in society by e.g. media, parents, teachers and GPs. The debate in society was brought into the teams as the team members had to argue to defend their views, primarily to ascertain the advantages of biomedical treatment. A number of CP makers experienced that their colleagues at work expressed reservations about biomedical treatment, mentioning the well-known side effects of Methylphenidate, and it seems that these reservations were neither discussed nor taken into account in the team.

4.2.1 “These ADHD Discussions”

One informant who participated in designing the CP represents the biomedical approach, although she acknowledges the following:

Those children entering the system and having the diagnosis determined are undergoing a process in which they are benefitting from the medical treatment. Yet, it is obvious that this sector still suffers from disagreements, and emerging discussions will argue for and against these….. ADHD discussions….

(Interview with educational therapist, BUPP, 2008)

As an example of the varying perceptions of the diagnosis, she mentions in the interview the Swedish child psychiatrist Christopher Gillberg, who was on trial for scientific misconduct\textsuperscript{27}, but was held in very high esteem here in Norway. She also

\textsuperscript{27} He was convicted in Gothenburg District Court of scientific misconduct in 2005 for refusing to hand over his research material about ADHD after a prolonged battle in which sociologist Eva Kärfe and pediatrician Leif Elin Cederlund had questioned his research for several years, demanding the release of his data (see Kärfe’s critical book Brain Ghosts. D.4MP and the threat to public health (2000)). It goes with the story that the Swedish Church of Scientology strongly opposed amphetamine treatment of children (see the Committee for Human Rights, www.kmr.nu).
states that he was an advisor for the so-called “Bergen Survey”\textsuperscript{28}.

\textit{Doubts and Uncertainties}

As we have seen, nearly all of the CP makers I interviewed supported the biomedical paradigm, and shared the view that medication of children with ADHD is the best treatment available and is considered safe, with reference to a number of RCT studies. Thus the meetings in the CP team and the conferences were opportunities for collaborative sharing of ADHD knowledge. In these sessions, lectures on studies and reports from the field were welcoming topics as the conferences contributed to a mutual understanding of knowledge about diagnosis and treatment of patients with ADHD. Some speakers at the conferences were “heavyweights” in the field, and if any participants (contrary to expectation) were basically sceptical, they experienced an overall convinced attitude to the biomedical approach. However, not all participants were convinced throughout the long period of designing this CP. One psychologist who joined a CP team was sceptical to the idea of what he termed a “fast lane” for one group of patients and also to the number of children diagnosed and medicated, although his experience from the conferences was that the other participants were quite convinced. He tried to express the doubt he felt, but his uncertainty and questions met stony ground. He felt the attitude of the other CP makers was to keep up with the work and move forward and he did not want to “throw a spanner in the works” and therefore refrained from attempts at further discussion of these topics at the conferences or in the CP team. The other participants probably noticed these expressions of doubt and uncertainty, but he felt that the conferences and later the team meetings were arranged in a context which did not allow for sceptical feelings and alternative contributions. However, he stated that it was fruitful to participate in the CP team in order to discuss complementary measures and plan local services to support the families after the diagnosis was made by the BUPP. Here, the team focused on concrete measures, e.g. planning parent support courses.

This paradigm of knowledge appears esoteric, as it is restricted and mostly understandable in the context of the group of CP makers; nevertheless, they repeat

\textsuperscript{28} A screening of 9000 children in the city of Bergen; (Posserud, Jindevold and Gillberg, 2006. \textit{Autistic features in a total population of 7-9-year-old children assessed by the ASSQ (Autism Spectrum Screening Questionnaire).} \textit{Journal of Child Psychology and Psychiatry,} 47, 167–175).
their comments and remarks in public and at work. During the interviews I asked
the informants whether they discussed alternatives to the conventional biomedical
paradigm, but none of them could remember having done so. However, alternative
forms of treatment were aired in conversations with parents and sometimes at work.
Also, the previously mentioned report of the Breakthrough Series illustrates the
ambiguity and the difficulties of getting acceptance for this diagnosis, mainly
because of medication of children. The “strangers” to this CP were found outside
the project of designing the pathway, and particularly a number of GPs questioned
the diagnosis and the use of medication. They are assigned a vital role in the future
CP, although several of the informants mentioned that some family doctors
preferred to have reservations about the medication of children:

It is an agent acting on the central nervous system, a narcotic drug. If it was not, this
would have been a whole lot easier. Doctors make this objection. It is narcotics. It is
strong.

(Interview with educational therapist, BUPP, 2008)

Scepticism and sometimes resistance to the CP as an idea and to the biomedical
knowledge paradigm were stronger in the local authority services than in the BUPP.
The informants have already hinted at some reasons for this, but I will return to this
topic later in the discussion.

Finally, here is a manual in the CP stating:

Medicating patients is considered a safe form of treatment with few side effects.
Appropriate medication is not addictive. A number of prominent studies have
revealed that there is a reduced risk of developing drug substance abuse problems
when patients suffering from ADHD have been medicated.

(CP Manual 2006 p.2)

Another important factor is that the ADHD diagnosis, since its origin in North
America, is the fastest growing diagnosis of the last decade. At the same time as the
design of the CP for children, an international debate on the issue was taking place,
revealing a disputed and controversial diagnosis. The debate and disputes were
centred on a number of basic points such as “ADHD is a diagnosis versus ADHD
does not exist”, “the cause is congenital versus the cause is social”, “amphetamine is
not dangerous versus amphetamine is dangerous” (Brante in Hallerstedt 2006). The
controversies about ADHD in society caused a consortium of international
scientists to sign an International Consensus Document on ADHD, confirming the
existence of the diagnosis, its biological foundation and the benefits of medicine.
As an introduction to the consensus document, the authors stated the following: “We are deeply concerned about the periodic inaccurate portrayal of attention deficit hyperactivity disorder (ADHD) in media reports….we fear that inaccurate stories rendering ADHD as myth, fraud, or benign condition may cause thousands of sufferers not to seek treatment for their disorder. It also leaves the public with a general sense that this disorder is not valid or real or consists of a rather trivial affliction” (Barkly et al. 2002). The debate continued under opposing headlines such as “ADHD is best understood as a cultural construct”29, which underlined the disagreement of other professional groups (Timimi & Taylor 2004). In the same year, the 16th IACAPAP World Congress 2004 affirmed the diagnosis as “the biggest controversy in the history of child and adolescent psychiatry” (Riedresser 2004, Brante in Hallerstedt 2006).

Also relevant here is a literature review30 which reveals several distinct paradigms of ADHD knowledge at the same time but in different contexts. A number of RCT studies focus upon a biomedical approach with prescription of medicine (Amphetamines, e.g. Ritalin) which acts on the central nervous system, and this has led to an increasing number of children being treated with such medicine31 (Åsheim et al. 2007). This approach is in line with the knowledge paradigm in the production of the CPs, in addition to the fact that the Norwegian Medical Association used this knowledge paradigm to establish ADHD as a part of the Breakthrough Series. However, if we search international studies, we find that this is not the only treatment paradigm. After consulting relevant RCT studies identifying the advantages of a diet based on fatty acids (Richardson 2005), the same year a Swedish research group demonstrated the effect of a training programme claiming that the programme had the same level of influence on ADHD as medication (Klingberg et al. 2002). From the literature review, we can here identify at least three treatment paradigms that, according to RCT studies, are recognized as the “best” option for children with ADHD. The first approach is based upon a “conventional” biomedical paradigm as we have seen in the design of the CPs, the second is represented by the fatty-acid diet paradigm and the third by a memory training programme. In addition, there are other approaches to treatment; several combine

29 Timimi et al. (2004) published a critique of the statement together with 33 co-endorsers.
30 Databases: PubMed, ISI Web of Science, PsycINFO and Cochrane Database of Systematic Reviews.
31 Figures from the Prescription Register show that in the period 2004–2009 the number of users of the medicine from 0-19 years doubled in Norway. While there were 8543 users in 2004, the number had risen to 16788 users in 2009. More than seven out of ten were boys, and most stimulant users were in the age group 12-15 years. It is not yet known for what length of time the patients are treated with this medication.
psychosocial treatments and ADL training, often in combination with medical treatment.

4.3 Summary: The Design of the CP for Children with ADHD

This chapter has considered the organisational and social contexts during the three-year design process of a CP for children with ADHD. The overall initial idea emanated from professionals working within the child and youth psychiatric services, particularly a chief psychologist in the neurological team in the BUP and a chief psychiatrist in the BUPP who both participated in the Breakthrough Series. The SINTEF Report and their own practical experience indicated that something had to be done to remedy the problems of poor coordination in dealing with children with ADHD. Those representing child psychiatry considered that the solution to these problems was to create a clinical pathway that would serve as a regulatory tool for professional practice to ensure that ADHD patients were detected as early as possible and to prevent arbitrariness and discrimination in the system. The fact that the hospital participated in the Breakthrough Series by the Norwegian Medical Association in 2002-2003 seems to have had a strong influence on the approach of streamlining the services. Implementation work started as soon as the five local teams were established and at this stage the actors from child psychiatry were still in the driving seat in the planning and organisation of activities. It was also the professionals especially those few actors from BUP and BUPP who in practice determined the content of the CP, since the management did not take part in its design.

The biomedical knowledge paradigm of ADHD was conveyed and transmitted as a natural state of affairs during the CP design process through the activities and events in the project. However, some of the CP makers expressed doubts about the CP as a general idea and to the biomedical approach, especially in the medication of children, but these doubts mainly emanated from intermediate discussions among colleagues at work. Such doubts are in line with the international debate on ADHD with its disputed and controversial diagnosis.

As I interpret the data, this organisational context limits the opportunities both for those involved to reflect on what this tool can mean in practice, and also for a critical review of the relatively complex issues that exist in the organisations and workplaces. The absence of such analyses is in fact a recurring tone in my data, and this appears to be an important mechanism in enabling the creation of the pathway for children with ADHD. Through mechanisms of exclusion and ignoring doubts,
uncertainty and alternative knowledge bases, scientific biomedical knowledge was included in the CPs in order to create a “firm” knowledge base. Throughout a design process involving standardisation, these are important mechanisms in order for standardisation to take place at all. It is thus quite natural to exclude potential expressions of doubt and uncertainty about the ADHD diagnosis and alternative treatment options to the biomedical model. A core question here is whether the professionals as “standardisers” had any choice at all as to the possibility of organising the design process differently. As mentioned, the framework for the standardisation work was the Breakthrough Series developed by the Institute for Healthcare Improvement (IHI), with strong support from the Norwegian trade unions and also government pressure for standardisation and quality improvement. I will return to this topic in the analysis of rule production. The following chapter investigates how the CP for adults was designed.
5  Rulemaking for the Clinical Pathway for Adults with ADHD

This chapter deals with the second of the three research questions; how was the clinical pathway for adults with ADHD designed? The chapter is divided into three sections: The first section shows how the design process was organised from the CP makers’ point of view. In respect of the CP for children with ADHD, some individual professionals from the hospital faced quality and coordination problems and therefore initiated the development of a similar tool for adults in order to make improvements. This section concludes with considerations at a board meeting in June 2009, when it was decided to adopt this tool, followed by an overview of the CP as it was presented on the hospital website in March 2010. The next section takes a further look at how those involved defined the knowledge used in the design of this CP, with particular focus on knowledge of diagnosis and treatment. I also explore how knowledge is distributed in the CP team and which basis for legitimacy the different modes of ADHD knowledge have in collaborative decision-making. The third section provides a brief summary of the findings. But first let us look at a project completed in 2006, two years after the Norwegian substance treatment reform was launched. We find ourselves within the Division of Psychiatry at the same hospital as for the production of the CP for children with ADHD, but now in the units providing services for adult patients.

5.1  Internal Coordination Problems are Identified

The project “A procedure for comprehensive follow-up monitoring of substance dependants with ADHD problems” was carried out by professionals at the clinic in the Department of Substance Abuse Treatment. The professionals represented several professions; psychologists, a social worker, a social educator, family therapists, a psychiatrist and a physiotherapist. The Regional Centre for Co-Occurring Disorders of Substance Abuse and Mental Health32 had provided project funding which focused on follow-up monitoring of substance abusers with ADHD in the county. The goal of this project was to create a procedure manual for the

---

32 In 2005 the regional health administration for Eastern Norway (Helse Øst) gave the Division of Mental Health Care at Innlandet Hospital Trust the task of establishing a regional centre for co-occurring disorders of substance abuse and mental health. The main reason for establishing the centre was the need for the coordination of services and development of expertise for a group of patients which has had difficulty in finding such benefits within the health system. (www.dobbeldiagnose.no).
monitoring of a clearly defined target group, namely patients who have both ADHD and substance abuse problems. The procedure would describe how the Hospital Clinic, as part of a unified chain of measures, should define its duties more precisely, and would also involve external partners through the use of Individual Plans, and thus achieve cooperation in the areas of:

- Diagnosis
- Interventions (psycho-educative measures, substance abuse treatment and perhaps medication)
- Socialisation measures (housing, work, education, leisure, etc.)

It is basically the District Psychiatric Centres (DPS) which are responsible for the treatment of adult ADHD patients, but the target group for this project is in contact with several departments at the hospital. By focusing on the holistic aspect of the treatment for this group, certain deficiencies and ambiguities were identified at the level of the specialist services (within the Division of Mental Health Care) in relation to who is responsible for the different stages of the monitoring process:

The collaboration between the departments of substance abuse treatment and mental health is characterised by so much confusion that we have clearly seen patients passed around like a ball between the various agencies. Both assessment and treatment are unnecessarily cumbersome, and the division is incapable of looking after the patients effectively. We have also questioned whether it is ethically correct to begin an assessment process if we are uncertain whether the process can be continued satisfactorily. (For example: How appropriate is it to start a screening for ADHD if you are unsure whether the rest of the diagnosis can be made?).

(Without date, final report from the project “A procedure for comprehensive follow-up monitoring of substance dependants with ADHD problems”; the authors were both psychologists)

The main goal of the project on comprehensive follow-up monitoring of these patients was thus not reached, but the above-mentioned report states that the staff at the Clinic feel that expertise has increased, treatment and planned follow-up have become better organised and the services have become more predictable. Two

---

33 District Psychiatric Centres (DPS) are responsible for general mental health care for the adult population. Inpatient departments provide treatment plans and some polyclinics also offer individual or group treatment plans. DPSs have emergency teams to visit those in need of acute mental health care.
important results of the project were the diagnostic guidelines “Drug Problems and Suspected ADHD - the Way to Clarify the Diagnosis” and an internal compendium “Adults with ADHD and Substance Abuse – the Condition, Diagnosis and Action”.

5.1.1 The Idea of a Clinical Pathway for Adults with ADHD

In connection with the above-mentioned project, the hospital divisional director decided that the hospital would develop a clinical pathway for adults with ADHD (A presentation was held by two psychologists involved in the project at the Experience Conference 2007 organised by the Regional Centre for Co-Occurring Disorders of Substance Abuse and Mental Health on 26.09.07).

At that time, the CP tool was defined by the hospital as:

an expected patient progress based on medical evidence, in connection with an efficient exploitation of resources and measurable results.\(^\text{34}\)

(Hospital website 2006)

As we shall see later, it eventually turned out that the team had trouble dealing with this definition. First, some considerations on how the design process was organised during 2007-2009, and here I focus on certain episodes and activities I consider important in enabling us to understand how the CP for adults was developed.

5.2 The Design Process of 2007-2009

The procedure of developing the CP for adults with ADHD did not take the form of a conventional project, but rather as part of the everyday operations in the ordinary line organisation within the Division of Psychiatry at the hospital. The departments mentioned in the clinical pathway for adults with ADHD are:

- District Psychiatric Centre (DPS) 4 regional offices, in/outpatient facilities.
- Long-Term Treatment Unit (substance abuse and mental health)
- Department of Substance Abuse Treatment, Clinic
- Sociomedical Polyclinic (SMP), 5 regional offices

\(^{34}\) In Norwegian hospitals, a number of different definitions of CPs exist. The definition cited is taken from the Regional Health Enterprise in 2006 and by 2010 was still in use in the hospitals in the region.
Additional units in the Division of Psychiatry for adult patients are the Emergency Unit, Psychiatric Assessment Unit and Psychosis Treatment Unit.

5.2.1 A Clinical Pathway Executive Doctor and a CP Team in Place

Not surprisingly, the Divisional Director appointed a chief psychiatrist from the Department of Substance Abuse Treatment to the position of Clinical Pathway Executive Doctor as he was a vital actor in the aforementioned project and was a very experienced psychiatrist. The first regular meeting in the CP team took place at a two-day conference in March 2007. The participants at the conference were the clinical pathway executive doctor, a specialist psychologist working in the same department (Sociomedical Polyclinic/SMP), a specialist psychologist working in a psychiatric day clinic at the DPS, an advisor working in the HR department and finally, as a “bridge” between the CP for adults and the CP for children with ADHD, the chief psychologist working in the neurological team in the BUP. I will return to the content of this conference meeting a little later.

The minutes from the following meeting show that the working group had now been expanded to include a psychiatrist (senior doctor) from the DPS, and the hospital’s expert on the use of the process modelling tool itself would also be involved in the work.

Thus, regular team members consisted of professionals (psychologists and psychiatrists) working in the Psychiatric Intermediary Ward, District Psychiatric Centre (DPS) or the Department of Substance Abuse Treatment (ward and polyclinic). In addition, a representative from a client organisation was a regular team member during the last year of the design process. Furthermore, two facilitators took part in the team, both of them working in the R&D (HR) Unit at the hospital. One of them was in charge of handling the process modelling tool, but after moving to another position at the hospital, he was replaced by a new facilitator who worked as a professional development advisor/mental health nurse in the Department of Substance Abuse Treatment. The other facilitator was the team’s secretary, who also participated in the work on the CP for children with ADHD. The clinical pathway executive doctor (BAL) and members of the team decided on the person in charge of representing the team, and during the next two years a few

35 The role of a BAL is to “head the clinical pathway in general”.
36 The minutes of the meetings indicate that this person thereafter did not participate in the meetings, but was kept informed about the work.
members were replaced. The team worked on the design of the CP in regular meetings as often as once a month.

Guidelines for the Work

The duties of the team involved defining major tasks for the clinical pathway, and identifying areas in need of improvement. Notes from the first meeting in the CP team outline the idea:

The CP for adults with ADHD in the county uses the same model as the CP for children and young people. Adults are defined as those aged 18 and above. This enables the transition from childhood and adolescence to adult life through this clinical pathway to be more satisfactory and secure in the service system too.

(Minutes of the meeting on clinical pathways, 27 and 28 March 2007)

The CP for children with ADHD had been launched one year previously, and thus in order to improve coordination between the Department of Child and Youth Psychiatry and departments of adult psychiatry, this new CP was meant to represent a continuation in the services for the ADHD diagnosis independent of the patient’s age.

At the very first meeting it emerged that it was important to clarify the internal division of labour in the specialist health services in terms of screening, assessment, intervention and follow-up (e.g. compared to the front line services), not least in relation to treatment such as psycho-educative measures and medication.

5.2.2 In-House Clean-Up First of All

It was determined at an early stage that the CP should include all patients diagnosed and treated for ADHD within the four departments of adult psychiatry at the hospital. These were the Psychiatric Emergency Ward, the Psychiatric Intermediary Ward, the DPS and the Department of Substance Abuse Treatment. Local authority health services in the county and other organisations would only be included after the specialist health services had dealt with the matter internally. There was thus a considerably lower level of ambition compared to the CP project for children with ADHD; however, considering the problems of internal collaboration revealed by

37 Structured psychosocial intervention with a focus on information and mastery
the previously mentioned “procedure project” and not least the characteristics of this group of patients (co-morbidity is relatively common especially with regard to other psychiatric diagnoses, i.e. not only substance abuse), the ambitions of standardising the services by designing a CP can be regarded as reasonably high. Let us now return to the initial phases of the design process. At the third meeting the organisation of this work is in place, but it is also clear that the efforts to make a CP for adults with ADHD involve some special challenges; who exactly are the patients, how are the work tasks distributed and what should be the scope of the CP?

*Who are the Patients?*

An early attempt to define a potential pool of patients and how many patients the CP should account for proved difficult due to the lack of ICD38 coding and access to fundamental patient data in the administrative systems. The team stated that historical figures indicated that approximately 2-3% of the adult population suffers from ADHD, according to ICD-10. The number of ‘new’ patients seeking help or who are admitted to the support system every year could not be quantified. The Clinical Pathway Executive Doctor emphasises that these patients have high symptom pressure and that they may well be camouflaged under other diagnoses, so that the numbers from the DPS may not be representative. He elaborates on the problem of not knowing the numbers, and sees this in relation to planning and resources:

So how much resources should we actually assign to get a... ehh... a good initiative for adults with ADHD... then we need to know how many patients are affected. There were no figures on this... and neither were there any rough figures internationally or nationally... in relation to psychiatry ehh. Figures from substance abuse suggest about 25% in different studies, but it’s never been examined within the specialist health services, so we started up a couple of projects to find out.

(Participant observation, Psychiatrist 1/BAI, CP team meeting, May 2009)

The team therefore made a decision to launch a study to investigate this number further, possibly using the ASRS Self-Report Scale as a support tool for mapping and clarification.

---

38 The International Classification of Diseases, ICD-10, was approved at the 43rd World Health Assembly in 1990 and came into use in WHO member states from 1994.
That's where the cross-sectional study comes in, it's a research project that emerged from the start of the work on creating the clinical pathway. Because the question that came up was: “How many are there?” No one had a clear idea... it was like... if you’re going to make a CP, then you have to know... the extent, what we can expect in terms of the steps we have to take..

(Interview with facilitator/nurse, July 09)

Here the clinical pathway executive doctor and the facilitator raise the issue that the number of patients for the CP cannot be quantified, which in turn can cause problems in planning and dimensioning services for this population. To obtain some idea of how many patients this could be, a project called “Cross-Sectional Study I” was set up, which would collect the ASRS (Adult ADHD Self-Report Scale) from six hundred people.

Distribution of Work Tasks

The question of “which agency does what” in the processes of screening and assessment was presented during spring 2007 as the BAL gave a PowerPoint presentation in which flow charts provided a starting point to discuss further details (see Appendix 5.1). Issues that emerged in this presentation included e.g. the right to health care according to the Patients' Rights Act and the Priority Regulations, and the BAL demonstrated the patient’s “flow” through the system of local services and specialist health services. All these services conduct screening in the preliminary evaluation whether the patient suffers from ADHD or not. If there is no indication of ADHD, then the procedure ends. If an agency suspects ADHD, the specialist health services are responsible for assessment, but which agencies should conduct the assessments?

These questions were topics for discussion in the future work as the way forward was set out in the model: “When we suspect ADHD – the way we want to go about it” (see Appendix 5.2).

Here, the ideal model illustrates a distribution of work tasks in two separate tracks: straightforward ADHD and ADHD and co-morbidity. There is no description of which agencies should handle these tasks. It was made clear at an early stage that the team should initially work out forms of treatment that did not already exist, to bridge the gap between substance abuse treatment and psychiatry.
The Scope of the CP: Inclusion and Exclusion Criteria

When the team created the CP, they performed a simulation based on their experiences of various issues related to a selected case, e.g. “An average adult, simplex ADHD, not yet captured, assessed and diagnosed”. Here the team used flipchart sheets spread over the tables and put words to various actors on sticky notes, showing who does what and when at the key points:

- Screening
- Referral
- Assessment, diagnosis
- Treatment, actions and follow-up

The starting point for the team was a “simplex ADHD” in the flowchart with links/branches to various co-morbid disorders. Here they concentrated on the first key points along the process and the flowchart for the healthcare services. They based their work on how they experienced the current situation, but they had difficulty in not moving on to actions needed for improvement (which were to be added later). After the meeting, the BAL and the facilitator were to start modelling, i.e. creating the flowchart in the CP tool, to be available for the CP team on the hospital intranet.

At the next meeting they did the same with a typical “complex ADHD,” which refers to individuals with multiple, complex mental disorders. This process was also examined and posted on flipchart sheets with sticky notes. Here they discussed the various roles of the specialist health services in connection with potential “complex ADHD” patients. It also emerged that it might be beneficial to standardise the assessment and diagnostic tools, but that there was a need for training and that it was important that the expertise in assessment and diagnosis of ADHD was of satisfactory quality (minutes from meeting, 26th October 07).

The Process Modelling Approach

The CP team used the technique of process modelling and developed flow charts with the aid of flipchart sheets, determining the names and duties of the actors on post-its, and the timing of tasks within the main key point. Initially, the main process was defined, and areas for improvement were identified. Simple diagrams
with a set of graphical elements comprised the modelling in the software computer system. As shown later in this section, the team agreed to base the design of the CP on a simplex ADHD flow chart, and create links to various conditions of comorbidity, in order to focus initially on the key points in the process and the flow chart for the specialist health services. This was incorporated into the hospital’s clinical pathway tool, allowing read access for team members. Comments during the process were communicated either by e-mail, by telephone, or addressed at the next meeting. Besides these team meetings, small work groups of participants were also arranged with the goal of solving specific tasks. The CP team would ensure the quality of the work carried out. There would have to be a clear distribution of tasks between the members of the work group. Professionals were to be responsible for the professional aspects of the work, and facilitators responsible for modelling, structure and considering the CP from the point of view of non-professional users. The process should be seen as a kneading process. This means that the group first considers proposals uncritically, and then critically (minutes of meeting, 31.10.07).

The layout and appearance of this CP would be made very similar to the clinical pathway for schizophrenia completed in autumn 2007. That pathway provides a structured and detailed description of assessment, diagnosis, treatment and follow-up of patients with suspected schizophrenia or psychosis. It is a CP that the team has studied in the course of its work, but as we shall see later, the layout is somewhat different because the dimensions of client role and client information are more apparent in the CP for adults with ADHD.

We have seen that it was clear that the efforts to make a CP for adults with ADHD involved some special problems; the planners did not know how many patients there were and therefore launched a study to investigate this. Further, areas for improvement were identified regarding distribution of work tasks, by performing simulation activities of “who does what and when” based on their experiences from their daily work. The next problem to be solved was the question of which units should be in charge of assessment and diagnosis. At that time there was a senior doctor at the Clinic who assessed and diagnosed his substance abuse patients when ADHD was suspected. The Psychiatric Intermediary Ward (Ward 16) also did so, often in conjunction with a differential diagnosis.

*Who should be in Charge of Assessment and Diagnosis?*

Here they based their discussion on the various units within the Division of Mental Health Care; the following is an excerpt from the minutes:
We know there is considerable waiting time for assessment and diagnosis and clinicians express the desire that those involved should be well qualified and that they should put in enough effort to give satisfactory and effective results. This task basically belongs to the DPS. Who will be involved, and where, must be clarified from this perspective.

(Minutes of meeting, 11th February 08)

The CP team holds the view that there must be enough professionals and it must be clarified where and at how many locations in the county assessment and diagnosis should be carried out. There was a need to clarify this formally, and it is an example of what the CP team called “cleaning up their own act.” The team members were asked to consider possible solutions.

At this meeting, a project manager of a regional professional centre\(^\text{39}\) for people with ADHD, Tourette’s syndrome and narcolepsy attended and presented important ideas on further work on the use of standard screening and a “diagnostic kit” (minutes of meeting, 11th February 08).

This topic of who should be in charge was raised again at the next meeting, and now the issues were whether the DPSs had staff who performed assessments and diagnoses, whether it was necessary for every DPS to have such people and where the expertise was located geographically. It was further questioned whether it is suitable for the Department of Substance Abuse Treatment to perform these tasks for its patients when there is a suspicion of ADHD, and whether it would be desirable and appropriate for the Department of Psychiatric Assessment and Intermediate Treatment\(^\text{40}\) to continue with such cases as they deal with at present. It was also emphasised how important it was that the team has a clear idea of the content of the assessment and in what part of the Division it should be carried out (minutes of meeting, 7th March 08).

**All Relevant Units in Charge**

The minutes do not provide clear answers to the questions raised, but it was still important to specify the questions. The clinical pathway executive doctor clarified this with the management of the Division. It was decided that assessment and

---

\(^{39}\) One university hospital within the regional health enterprise (Helse Sør-Øst RHF) was asked to develop a regional professional centre for people with ADHD, Tourette’s syndrome and narcolepsy. A survey was conducted on selected aspects such as incidence, treatment, current expertise, the need for further expertise, collaboration and research and development for e.g. ADHD.

\(^{40}\)“Intermediær behandling”
diagnosis should be performed at the patient's point of entry into the Division, whether it is a DPS, SMP or a ward (minutes of meeting, 16th May 08). This meant in practice that the tasks of assessment and diagnosis previously reserved for a small number of units (mainly DPSs), would now be performed by all the relevant units in the Division of Mental Health Care.

It does not seem that any other circumstances regarding this fundamental decision (that assessment and diagnosis should take place at the point of entry into the Division) have been the subject of discussions or conflicts in the team. In practice, a couple of units have previously had assessment and diagnosis of this patient group as their “domain”, and by way of the clinical pathway, management has now decided to entrust this responsibility to all five affected units in the Division.

Lack of ADHD Expertise

The management’s decision that all the relevant units in the Division of Mental Health Care should perform assessment and diagnosis created a need for an internal training programme. Lack of ADHD expertise amongst the clinicians had already been considered in the context of the small number of patients registered with the ADHD diagnosis in the code system (ICD 10). In order to study precisely the question of expertise, the CP team had surveyed staff competence in assessing and diagnosing ADHD based on the criteria in the national guideline IS-1244. The results of this survey were disheartening:

There was virtually no expertise in ADHD with regard to assessment. And as for diagnosing ... There was some in the DPS, nothing in the SMP... and little in the wards or polyclinics...

(Interview with facilitator/nurse July 09)

The facilitator goes on to describe the consequences of professionals lacking knowledge of assessment and diagnosis of this patient group. In her view, many patients come to the clinic with a history of symptoms from childhood, but these patients have never been captured. She is therefore keen that knowledge of ADHD should reach all staff by being accessible on the Internet. The problem of patients not being captured and diagnosed can be illustrated by the following deep sigh from Psychiatrist 2 (senior doctor in the Psychiatric Intermediary Ward) at a CP team meeting, in connection with the fact that certain ADHD patients are misdiagnosed:
They've been through the whole system and they're people as old as 30 or 40 who have completely classic symptoms of it (ADHD) and haven't been taken seriously anywhere... they've had most of their adult life messed up... because no one has seen it...

(Participant observation, Psychiatrist 2, CP team meeting, May 2009)

The clinical pathway executive doctor and one of the group members took responsibility for the development of an internal training programme. The team received financing internally and from the Ministry to fund a well-coordinated “diagnostic team” as they called it, also referred to as “Cross-Sectional Study II”. This was the start of a comprehensive training programme implemented at a later date, namely to train the 40 psychiatrists and specialist psychologists from various departments in the specialist health services (e.g. SMP and DPS) in the entire county, who in turn could train their colleagues41. This training programme took place at about the same time as the implementation of the CP in the Division.

Below I present a translated version of the CP as it appears on the hospital website. All text that is underlined indicates that one can click there to get information about the current procedure.

41 It was a three-day training programme in collaboration with the Bergen Clinic in autumn 2009.
CLINICAL PATHWAY FOR ADULTS WITH ADHD IN (COUNTY)

This clinical pathway has been designed for adults with ADHD.
By following this pathway, the patient and family will get the best treatment, care, information and instruction, based on knowledge-based medicine and best practice.
If you have any queries about the clinical pathway, please contact:
(Name of BAL) Senior Doctor, Clinic at: (e-mail address BAL)

Treatment Path

Documentation and Descriptions

Objectives, Actions and Follow-up of Results (for internal use, not available on the website)

Registration form (short version) or individual plan

Follow-up of registrations/measurement

Objectives and actions 2008

Administrative information

Background information on adult ADHD

Links and documentation

On the top row, the “treatment path” indicates the key points in the “flow”, except for the first two arrows. Here, the CP team, led by the facilitator/nurse, have
inserted information for the patients in the first arrow and for the GP in the second arrow followed by three arrows based on core “value chain” ideas. This sort of “hybrid chain model” can be explained in several ways. Firstly, as mentioned earlier, this CP is not merely for professionals; the team also wants an information tool for patients in order to support and strengthen client involvement. In this respect the CP symbolises the important role of patients and their relatives; this was a result of a representative from a client organisation being an active participant in the team.

The above does not apply to the key points for doctors; here a flowchart has been produced for GPs to use, but this group has had no representative in the team. Since I have only considered the three key points for specialist care, I have chosen not to examine the content of the material for doctors. The pathway is only meant for actors in the specialist health services and the manual for GPs is merely advisory. But as I will demonstrate shortly, the management was concerned about this matter. I will return to this in the next section.

This final version of the CP is at the time of writing (summer 2011) available on the hospital website and it describes and visualises all the intervention and treatment activities in order to govern the interactions of the various actors in the Division of Psychiatry. The complex inter-organisational structures within and between the organisations are replaced by a uniform organisational structure, i.e. a streamlined standardised approach in order to reduce variation and arbitrariness in the system, problems of waiting lists, bottlenecks and lack of coordination between the organisations.

The Hospital Board Meeting in June

After two years of production, the CP was presented at a board meeting in June 2009; here is an excerpt from the minutes of the meeting:

ADHD in adults is often under-diagnosed. This applies especially to co-morbid conditions including substance abuse. “Ownership” and professional responsibility in relation to these patients need clarification. We must also develop expertise and guidelines for screening, assessment and treatment, and more research is needed. The divisions must have a holistic approach in response to the patient's complex needs. The clinical pathway for ADHD adults was presented at the meeting and is now available as an “electronic quality manual”, with the status “under development” and “for review”.

(Minutes of the board meeting, 17th June 2009)
Further, the minutes describe work tasks for the CP team and others, including e.g. coordination with NK (Norwegian Competence Centre for ADHD, Tourette’s Syndrome and Narcolepsy), development of psycho-educative measures, implementation measures, knowledge dissemination in the divisions and to local authorities/GPs, examination of resource needs and economic consequences. Here the CP was approved by the director of the division, later to be given final approval by the hospital director. In the interview with the facilitator after the board meeting, she explains her interpretation of what was discussed in the leader forum, especially the topic about the use of resources. Here are some aspects that were not recorded in the minutes of the meeting:

Well, I mean... they were very... they went in for it... and they were quite obviously positive about it... what they weren’t sure about, was... what were the economic consequences of the pathway... ...will it have economic consequences? Will we need more beds... as a result of the pathway... ?

(Interview with facilitator/nurse, July 09)

Another matter raised at the meeting was the financing of the implementation work itself. This pathway is certainly an internal matter, but it will require a considerable effort to get it implemented in all five units in the Division of Mental Health Care (or rather twelve units if the SMP and DPS offices are included). Training in the diagnosis of ADHD has already been discussed, but it is also necessary to involve GPs in the implementation, as they refer the patients. The referral procedure is also described in this CP. This has been the subject of several meetings of the CP team, and it was also a theme when the pathway was to be approved:

When we took up the matter of implementation, then... it was... “See if you can get some government funding”... because they’d got... one million... from the Ministry or the Directorate of Health for the CP for children. And had quite a bit of money for the implementation process.

(Interview with facilitator/nurse, July 09)

We have already seen that the Division had a limited repertoire in the treatment of ADHD patients. When the pathway was presented in the leader forum, they discussed this question. The facilitator elaborates:

Because when we presented the pathway, in relation to the existing treatment for the patients we now want to diagnose... ...At present it is mostly medication treatment... ...no psychoaudicative treatment. And that was the idea we tried to pass
around... Is that something the hospital wants to... ...spend money on? As a project... I mean like... can we put it in... in our hospital as well... And then the discussion went back and forth about whether perhaps it was a matter for the DPS. For example... or the SMP... that is... maybe the DPS... a kind of... yes, they could take charge of that.

(Interview with facilitator/nurse, July 09)

I have no data from what happened after the hospital board meeting. The CP was published on the hospital website in March 2010.

Here follows a temporary conclusion of this analysis as a summary of how the CP for adults with ADHD was created, before I proceed to examine the knowledge which was applied and how this knowledge was distributed in the CP team meeting. We have seen that the divisional director’s decision to develop a CP for adults with ADHD originated from a professional environment in substance abuse treatment which had revealed internal collaboration problems within the Division of Mental Health Care, namely between psychiatry and substance abuse treatment. The problems they were facing were connected to the fact that patients with ADHD and a substance abuse condition were normally in contact with a number of departments within the Division. Planning and coordination of the operations were not at a satisfactory level, resulting in the possibility of patients not receiving the kinds of treatment to which they were entitled.

An important principle made by the Divisional Board was the decision that the screening and diagnosis of ADHD patients should be conducted in the location where the patient is first admitted. The first priority was thus to achieve a good internal cooperation model in the specialist health services, after which the front line service would be involved. Regarding the actual work of designing the CP, certain organisational steps were taken during the process:

- The CP should be limited to certain parts of the Division of Psychiatry.
- When it emerged that the number of patients had not been satisfactorily recorded, a separate mapping project was set up.
- When it emerged that there was a lack of ADHD expertise in assessment and diagnosis, a separate training project was set up.

During the design process, the CP team initiated various organisational measures intended to help solve the problems, and here the divisional leader took the fundamental decisions.
We have seen that the CP team conducted simulation activities of expected patient progress in the system: “ADHD simplex” and “ADHD complex”. A very important precept for the standardisation appears to be the simulation activities. Simulation activities enable the team to make more informed decisions on how to formulate the CP proposal. These activities are in line with the hospital’s definition of a CP tool. The implementation of statistical analyses of the “here and now” situation does not seem to have been completed, which may be due to the small number of patients registered with the ADHD diagnosis in the system. We will now return to the design process itself, but this time with a particular focus on the type of knowledge introduced into the pathway.

5.3 Knowledge in Use

This section takes a closer look at how the CP makers defined the knowledge used in the design process, with particular emphasis on knowledge in two of the four key points of the CP: “Assessment and diagnosis” and “Treatment, action and follow-up”. It is important to point out that the team, consisting of psychologists, psychiatrists, a specialist nurse (“facilitator/nurse”), a human resources consultant and a client representative, possesses a great deal of knowledge in the field of psychiatry. Such professionals, who are the main focus of this study, each have expert knowledge in the ADHD field acquired through many years of education and work experience. Now this knowledge is to be applied in the production of rules and guidelines; it will materialise into a tool to be used by others. We can reasonably assume that each team member defines the knowledge on the basis of his or her professional viewpoint.

The team has to define a knowledge base for the CP, but as we have seen, they face problems because of ambiguities about who the ADHD patients actually are and they therefore started a study to investigate this. There was a lack of ADHD knowledge among the clinicians in the Division, and in connection with the decision that all units in the Division would be responsible for assessment and diagnosis, a training programme was planned. The next problem to be solved was to find a standardised tool for assessment and diagnosis.

Which Tools should be Used?

This is a recurrent theme in the meetings and the CP team was challenged to identify standardised assessment and diagnostic tools that could be used in all units regardless of professional affiliation.
It is psychiatrists and psychologists who assess and diagnose, and here the professional's own sphere of knowledge is being challenged. Diagnosis itself can be said to be an area characterised by a high degree of uncertainty; even though it is based on its own classification system, different assessment and mapping tools are used, some examples of which I will present below. The facilitator sits on the CP team as a methodology consultant, but she is also a psychiatric nurse, and explains that it was difficult for the group to arrive at a standardised tool:

We have had many discussions... about tools, choice of tools... And that's because all the people in the group have different experiences and different... some like this tool better and some like that tool... And some are working more with substance abuse problems and others more with psychiatric problems. And then it's natural to use different tools.

(Interview with facilitator/nurse, January 09)

She goes on to say that they still have some way to go, but as she interprets it, they have achieved a fair degree of consensus about the assessment and mapping tools to be used. They have accomplished this because the team members have a common interest in this patient group, they are passionate about the welfare of the patients and they know the patients' problems at different levels, as she relates. In fact it was decided early in the process that the group should follow the national guideline on the diagnosis and treatment of ADHD.

But there have been many discussions in the team and in the working groups outside the team in order to arrive at a common set of standardised tools. And as I will demonstrate shortly, disagreement was not always resolved by consensus. I will use sequences from a particular meeting in the CP team, where they discuss the proposal for the CP in this context. I also consider aspects of problem solving and decision-making in the team. There are several factors that distinguish this analysis from the previous one and primarily the emphasis in this section is on knowledge production on a micro level, where we consider patterns in the interaction activities. Let us now introduce the context of the meeting and the actors involved.

**Problem Solving in a Team Meeting**

After a two-year design process, the team is now in the latter stages of the CP for adults with ADHD, and on a specific date some weeks ahead the clinical pathway executive doctor as the chair of the team is going to present the CP to the section management. Thus, since the team have been functioning as a temporary working
group, this is the last ordinary meeting, and the agenda is to finish the drafted electronic version of the CP. The team are to confirm the procedures demonstrated by the flowchart on the screen regarding various activities involved in the treatment of ADHD patients. There were nine participants in the meeting; four psychologists, three psychiatrists, one psychiatric nurse and one HR/staff member, in addition to myself as researcher. Chief Psychiatrist 1 works in the Department of Substance Abuse Treatment and heads the team as Clinical Pathway Executive Doctor/BAL. Chief Psychiatrist 2 is employed in a psychiatric day clinic. Chief Psychiatrist 3 works in assessment and the temporary ward. Specialist Psychologist 1 also works in the temporary ward and Specialist Psychologists 2 and 3 both work in psychiatric day clinics, but in different ones. There is an Advisor working in the HR Department in the hospital, who is also the secretary of the CP team. Finally, there is a Psychiatric Nurse who works in the Department of Substance Abuse Treatment with the BAL and is also a facilitator of the CP team.

The meeting was held in a large room on the first floor of the Clinic. All participants work in the same organisation but in different departments and they seem to know each other except for Chief Psychologist 2, who was recently recruited to the team.

The participants were served coffee while the BAL introduced Chief Psychologist 2 and the researcher to the team. I soon became aware of the great amount of expertise in the room. There was a positive atmosphere but also some stress and tension in the air, as they had to finish the drafted version of the CP during the meeting and make it presentable.

In the introduction, the usual ritual activities such as reading and commenting on the notes from the previous meeting lasted about half an hour. Chief Psychiatrist 1 as chair of the team, and the Advisor as the secretary, dominated the talk during this sequence. Then the facilitator/nurse (after some start-up problems) got internet access, and the attention of the team members turned quickly from Chief Psychiatrist 1 and the Advisor to the facilitator/nurse who was demonstrating the website of the CP with flowcharts and documents on the screen. She reported status by showing the CP tool, asked structured questions and gave “homework” to the participants, supported by Psychiatrist 1.
We are now in a final discussion on which tools should be assigned to one of the key points on the treatment path, which looks like this:

If one clicks here, the various assessment and diagnostic tools to be used will appear, divided into two columns: “Basic Assessment” and “Additional Assessment”. There is another column called “Performed by” and here one can click into a presentation of the four units in the Division of Mental Health Care, which will be responsible for these tasks.

Under “Basic Assessment” there are links to procedures for:
- Somatic Examination
- MINI
- SCL-90-R
- Semi-structured interview for adolescents and adults
- WURS (Wender Utah Rating Scales)
- Interview with relatives (where possible)
- ASRS V1.1, 18-point

Here the team considered the entries in this key point. The team members had various comments and views, and here is a comment from one of the specialist psychologists at the DPS regarding one of the tests, which she believed should not be linked to “basic assessment”:

Psychologist 1: But…. Was it supposed to be linked up… as a basis? ....hmmm… because it has….

Psychiatrist 1: (Interrupting Psychologist 1) That was an alternative, because if you look at what’s written, it says “Mini” is an option, so it…

Psychologist 1: possibly mini-screen.

42 At that time there was a version “under construction” which formed the basis for discussions in the CP team. The text shown above is the final version of the CP.
Fac./Nurse: plus SCL-90-R.
Psychiatrist 1: Yes, because you didn’t quite agree in the group…. ha-ha
Psychologist 1: No, ok.
Psychiatrist 1: Ha-ha… some people swore to one thing and some people to another. So that’s why it ended up… instead of fighting with you, we made a compromise…

(Participant observation of CP team meeting, May 2009, pp. 38-39)

“We” in this context most probably means the doctor himself as BAL (Psychiatrist 1) and the facilitator/nurse. The way of working in fact often involved the team discussing and making proposals in the meetings and sending the proposals with documentation by e-mail to the facilitator/nurse and the BAL. The facilitator/nurse then added these to the CP tool, and demonstrated them at the next meeting. Let us now return to the topic raised. Many team members were enthusiastic, all talking at the same time about tests, patient interviews and anamneses from different clinical perspectives, but also about the fact that the display gave the messy impression that everything was equally important in carrying out a basic assessment; here the comments are more related to the information technology itself. The apparent controversy about these tests now reappears. The team members are enthusiastic and Psychologist 2 from the DPS, who is new to the team, also joins in, but ends up in a dialogue with the BAL about one of the tests. Then they are interrupted by Psychologist 3, who works at a different DPS. He was a member of the previously mentioned working group:

Psychologist 3: But (says the first name of Psychatrist 1), if we now start to discuss…. then it’ll all start again….
Psychologist 1: But I thought that….
Psychiatrist 1: But what I mean is that… we’ve based it on the suggestion you made.
Several voices: Yes, yes.
Psychiatrist 1: And it’s true what you say, it’s messy, ok, then we’ll find a solution next time round.
Fac./Nurse: That could be the next time we do a revision, for example.
Psychiatrist 1: Yes.

(Participant observation of CP team meeting, May 2009, pp. 38-39)

This sequence from the meeting shows that the specialist psychologist in the group who was a new member of the team had questions that “interfered with” what had already become part of the pathway and had been decided upon by the BAL. Psychologist 3 seems a bit irritated; it is important to move on. The team has almost
completed work on the CP, and thus, with the support of the BAL/Psychiatrist 1 and the facilitator/nurse, the question was ignored and the team moved on to the next procedure.

I would like to put particular emphasis on three issues from this sequence of meetings. Firstly, we see an example that representatives from the same profession, i.e. psychologists involved in similar work but in different departments, have not managed to agree on what tools to use. Each of the assessment and diagnostic tools can be said to represent genuine knowledge within a specialised psychiatric field and the team must constantly select and reject tools for use in the pathway. Statements such as “some people like this and others like that” demonstrate the autonomy of the individual psychiatrists and psychologists in the choice of different assessment tools. Secondly, the clinical pathway executive doctor has realised that it is a question of “finding the happy medium” if standardisation is to be at all possible, and he creates procedures he considers to be a compromise, which can be changed in a later revision. Ignoring new suggestions can be seen as a necessary rational decision in order to proceed with the process descriptions. The BAL, by dint of his authority both as a psychiatrist and as team leader, can compromise and make decisions without significant protest from the rest of the team. Thirdly, by operating the computer system, the facilitator/nurse became a person in charge along with the BAL.

Evidence?

I have previously suggested that the team found it difficult to relate to the hospital’s definition of clinical pathways. This definition of a CP states that the expected patient progress should be based on “medical evidence in connection with an efficient exploitation of resources and measurable results”. Let us start with medical evidence as we now consider the next key point along the treatment path with entries concerning treatment, action and follow-up care of patients and not least, how the CP team arrived at the actual contents of this box.

If one clicks here, the three columns: “Treatment, action and follow-up” emerge, and here one can click into procedures of medical treatment and information sites about e.g. Individual Plans. The column “follow-up” leads to links to the client
organisations ADHD Norge and Mental Health and a link to “create a responsibility group with the coordinator of the local health services”.

In the minutes of a meeting at an early stage in the production of the CP, the following question came up: “What treatment services do we have and what shall we plan?” The BAL of the CP had earlier stated:

Medication is no treatment, but is often a good tool. Psycho-educative interventions, cognitive measures and specially adapted programmes for this patient group: do they exist in our system? Will it be necessary to develop psychotherapeutic interventions?

(PowerPoint presentation, 06.09.07)

The minutes of the meetings reveal that a great deal of attention in the CP team was directed towards the organisation of the assessment and diagnosis aspect, which tool should be used etc., and it seems that these initial questions about the treatment did not receive much attention.

With regard to the background information and evidence used in the creation of the pathway, the CP team clearly stated that the national guideline for the diagnosis and treatment of ADHD was vital (minutes of meeting, 3rd September 07).

The treatment of ADHD is described in the manuals as follows:

The main goals of the treatment are to reduce ADHD symptoms, improve daily functioning and prevent or limit the development of additional problems. It will usually be extensive and involve the use of psychological/psychiatric, medical, psychosocial and special educational interventions. Individual plans will be a necessary aid, cf. the Regulations on Individual Plans and the Guidelines for the Regulations.

(Norwegian Directorate for Health and Social Affairs, 2007:15).

But the national guideline emphasises the following:

International and national research and clinical experience are the basis for our knowledge of causal factors and treatment efficacy in children with hyperkinetic disorder/ADHD. However, there are few studies on treatment efficacy in adult patients.

(Norwegian Directorate for Health and Social Affairs, 2007:3).
The team had a sideline view of the knowledge base when the clinical pathway for children was created, but there was much less research in the case of adults with ADHD. Now let us take a closer look at the rather roundabout way the team planned to work on this key point, despite the fact that there is little evidence in this area.

In June 2008 came what seems to be the first specific discussion of the issue of what should be included in this key point. That spring there had been some changes in the composition of the team. There had been a change of facilitator (the nurse became the new facilitator) and a client representative from the organisation ADHD Norge had joined on a permanent basis. At this meeting “procedures for the prescription of stimulants to patients with drug addiction as co-morbidity” was examined more closely, but here the only information available is that the client representative had made suggestions about these procedures. The following meetings during the autumn have this issue on the agenda, but it is not mentioned in the minutes, except to state that the client representative sent a summary of information from NAV (The Norwegian Labour and Welfare Organisation) about various support schemes, which could be progressively added to the pathway. The minutes from the December meeting state that the leader and facilitator will delegate to sub-groups the work of preparing proposals for information at this point along the pathway:

This is a big, important area of work that requires a high degree of coordination because it is divided between specialist health services, local authority health services and other actors.

(Minutes of meeting, 28th November 08)

The facilitator/nurse explains the available treatment options after the patients have been given a diagnosis:

As of today, the way it’s done in the specialist health services is that it’s generally medication. Not much in the way of other types of treatment... there’s some at some DPSs... Alternative approaches or groups. But otherwise it’s mainly the interest organisations that offer other treatment... So there we... we’re not good enough... in the hospitals...

(Interview with facilitator/nurse, January 09)

She tells of an active client representative in the team who helps the staff view the pathway from a client perspective. And this implies an expectation that as a patient, when you get a diagnosis, you should also be told what the treatment is. There is a
free choice of hospitals, so you can consider treatment elsewhere, she continues. But in this county it’s a bad situation, that is, the alternatives to medication treatment. She goes on to share experiences from her practice:

They come in, get an assessment, a diagnosis, start the medication, and usually it’s... stimulants. And what does that do to the person? Who looks after them afterwards? No, then they’re discharged from us, then, after starting up and stabilising the dose...

(Interview with facilitator/nurse, January 09)

Ethical aspects of medication without satisfactory follow-up are clearly visible here, but this quotation can also be read as a concern that the repertoire of interventions for patients is inadequate. She goes on to talk about psychoaudicative treatment, where the patient learns about himself, his own situation and how he can cope with his illness, including discussion groups and anxiety groups. Today it is mainly voluntary organisations that offer such treatment.

At the next meeting (January 2009), it emerged that the team discussed an initial paper about medication for ADHD adults, which had been prepared by the leader. It was decided to start new procedures for medication prescription and evaluation. The contents of this paper (which referred to the type and amount of medication) were discussed at a meeting in March. Here it was revealed how important it was for the doctor in charge to follow up the effect of the medication, and that it has a very positive effect on most people with this diagnosis in terms of concentration and relaxation, but that they often experience a kind of depression after some weeks.

What emerged at this meeting was a concern expressed by one of the senior doctors in the team about the division of labour regarding not only assessment and diagnosis but also treatment. In fact it appeared that the Department of Psychiatric Assessment and Intermediate Treatment might be the object of reorganisation and possible closure. It became clear that neither the DPSs nor the SMPs have the expertise to take over this special function (minutes of meeting, 13th March 09).

Here we enter an area that does not concern the hospital's lack of treatment options, but rather a looming threat that an entire form of treatment will disappear. It was agreed that the BAL would send a so-called “expression of concern” to the management on this matter. The outcome of this does not appear in my data.

43 In Norwegian the term “psykoaudikativ” is in use, referring to autodidactic treatment.
We are now returning to a new sequence of the meeting I myself observed. I would like to start by returning to the topic of what should be included in the key point “treatment, action and follow-up”. This was the last meeting before the CP was submitted for approval at a management meeting. The team members look at the flowchart and review the forms and procedures relating to medication. Here they see that there is only medical treatment in the pathway, but as many argue, it is treatment for anxiety or depression, and there is no special treatment for ADHD patients:

The Advisor (secretary in the team) looks at Psychiatrist 1 (BAL) and turns to Psychologist 1:

Advisor: But wouldn’t it be an idea if you just added some stuff about alternatives to … medication?

Psychologist 1: Or that we just go and look at that text which… was there (points at the screen) before.

Psychiatrist 1: The patient manual? (In Norwegian: Pasienthåndboken)

Psychologist 1: Yes, because there it actually said psychotherapy before medication treatment. It does look like medicine is the only treatment option, and that’s a bit scary, even though we don’t have anything good there… so it’s not right.

They continue to discuss this for a while and the discussion then moves towards the idea that they should have an additional text that mentions this:

Psychiatrist 1: Yes, it’s true you know, the pathway will be very one-sided if we don’t take into account……

Psychiatrist 2: It rather looks like you get handed a prescription with a “now you’ve been treated, goodbye”.

Psychologist 1: And it doesn’t have any effect on certain people, so what are they supposed to do? It’ll be… (looks at Psychiatrist 3)

Psychiatrist 3: And people have such huge expectations as well.

( Participant observation of CP team meeting, May 2009, p. 57)

The conversation on this subject ended with Psychologist 2 suggesting that the text could say something like “for example psychotherapy, counselling, psycho-educative treatment”. He was asked to formulate something along those lines, preferably with some links and send it to the leader and facilitator. Any comments made were not visible in the CP at the time it was published on the hospital website some months later. However, we find a point under “treatment and
actions” called “psycho-educative treatment” but here there is only an empty box, i.e. just a heading, and it is therefore not possible to click on this for further information. While we are in this area, I will present a short excerpt from the text under “medical treatment”:

Experience of medication of adults with ADHD still suffers from insufficient documentation with regard to types of medication, dosage and efficacy. The experience we have from the medication of children is not necessarily relevant for adults.

Here it is confirmed that there is insufficient evidence regarding medication. It is also stated that:

Proposed medication for adults with ADHD should be considered as recommendations based on clinical experience, and not necessarily strictly followed.

("Medication of ADHD Adults” undated, page 1)

The clinical experience referred to is the knowledge of the professionals in the team, and we shall shortly see more examples of this knowledge. First let us return to the inadequate treatment repertoire:

As Psychologist 1 points out, the Patient Manual recommends that psychotherapy should be considered before medication, but the team is concerned that there is no specific psychotherapy treatment for ADHD patients in the county. Visualisation through flow charts is a good example of the transparent effect of the tool. Here the inadequacy of the treatment options is quite obvious. The team should ideally present best practice, but there is a contradiction between what they as professionals want to offer and what the hospital as an organisation can offer. This was almost a moral dilemma for the team, and expressions added to the text such as “e.g.” and “etc.” do not solve the problem of the lack of treatment options, but the bias of the pathway towards medical treatment becomes less obvious. There is thus no correlation between the wishes of the professionals and what the Division can really offer patients. As we have seen, this very matter was raised in a hospital management meeting where the use of resources was discussed. Thus, the pathway as a visual representation may serve as a catalyst for discussion between the professionals and the management on the introduction of new options.

CPs are based on scientific knowledge from leading RCT studies. However, as demonstrated in the previous section, this is not the only knowledge base in mental
health care; there are alternative modes of knowledge and interests which do not fit into the CP. Although professionals use their expert knowledge, this will not always be evidence-based knowledge. I choose to refer to such non-scientifically based knowledge as contextual knowledge. This distinction between the professional “know-how” (contextual) and evidence-based science hints at the possibility of several modes of knowledge. Here we have observed sequences that show the difficulties that arise when the professional’s knowledge and interest regarding alternative therapies are selected out of the production process because of the lack of suitable treatment options. But there are also other modes of knowledge and interests that are not allowed access into the CP. This brings us to the next section in this chapter, where we focus on the distribution of knowledge in interactional problem solving and decision-making within the CP team: what basis for legitimacy do the different modes of knowledge have in decision-making? How are those involved coping with the uncertainties and managing to create and determine a “firm” knowledge base? What kinds of knowledge are certain knowledge and what kinds are uncertain knowledge? Furthermore, is it possible to convert uncertain knowledge into certain knowledge so that it can fit into a clinical pathway?

5.3.1 Firm Knowledge?

We have seen that the team initiated certain organisational measures to eliminate the uncertainty regarding the patient base and the way the experts would deal with ADHD. We have also seen disagreement about the tools to be used for assessment and diagnosis, and here the team leader cut short the discussion and made the decision. There are few scientific studies on adults with ADHD receiving medication, which fact resulted in this part of the CP being described as “a recommendation based on clinical experience”.

We are still at the key point “treatment, action and follow-up”, and now the team was considering the links there and the procedures of medical treatment. Most of the conversation was dominated by a general exchange of information about the different sites in the CP: links, treatment and the measures to be taken. These comments followed a standardised pattern, such as: “My experience of ADHD medication is...” or described client perspectives, such as e.g. “If I had a daughter with ADHD...” and similar.

*The Narrative of Psychiatrist 3*

This conversation sequence is an extract from the end of the meeting and the team members have been sitting in the room for over two hours with no break. For the
first time during the meeting, one of the professionals presents a subjective narrative report from her practice. The sequence is started by Psychiatrist 3 from a psychiatric day clinic who tells the group that they occasionally get questions about pregnancy, ADHD and Ritalin. The team started a brief discussion of this topic in a general manner when they were viewing the written procedures on the screen, and ended up discussing the topic of the Norwegian Board of Health Supervision’s\textsuperscript{44} authorisation regarding new restrictions on getting a driving licence for people diagnosed with ADHD. Psychologist 1 had some recent written information and made an agreement with the BAL, the chair of the team, to send the documents by e-mail to the facilitator/nurse and BAL, for them to upgrade the temporary procedures. Just as the facilitator is moving on to the next procedures in the CP, Psychiatrist 3 starts to speak:

Psychiatrist 3: I am not giving up completely on pregnancy. I have a well-functioning young woman with an uncomplicated form of ADHD, with no record of substance abuse. (Speaks quietly, looking mostly at Psychiatrist 1). She is currently prescribed Ritalin, and she has become pregnant. I have almost stopped seeing her, and she is being followed up by her GP. But she has been told... both by the GP and her gynaecologist... that she can continue taking Ritalin. She tried for a while to stop using it completely, but this was not very successful. For her. She was then told that she could continue on a low dose... So I don’t agree that all of this is as accurate as you claim (looking at Psychiatrist 2)... in practice. So... she came to me during her 20th week, and told me they advised her to start treatment with me again. I tend to claim (looking at Psychiatrist 2) that during pregnancy one should stop using it completely (all the team members are quiet, listening). But she had been told otherwise, and she finds that this works out the best for her.

Psychiatrist 2: In that case I believe those people bear the responsibility. And... she does have a GP and a gynaecologist. A couple of those I mentioned that were using this have got discoloured legs (gesticulates with one arm, looking at Psychiatrist 3). This is calcium and Ritalin. But ehm... I am thinking about that situation... (indistinct talk) It’s exactly the same...

Psychiatrist 1: Yes, that is ... correct. But yes, this is all right, (says the first name of Psychiatrist 3). We can surely include a point on

\textsuperscript{44} This is a public organisation which supervises health and social services.
pregnancy and ADHD as well, if you have anything to add. Submit this to us... Because... we do have a section on women and ADHD, and this could be incorporated into this segment. We can describe some of it there.

(Participant observation of CP team meeting, May 2009, p. 48)

The starting point is a client narrative concerning a patient who needs Ritalin medication during pregnancy. Psychiatrist 3 is the intermediary for the story and recounts her professional experience from practice; she is situating the contextual knowledge, giving an individual patient “a voice”. Both the patient’s GP and a gynaecologist support the legitimacy of the patient’s need. Psychiatrist 1, the chair of the CP, invites her to write something about it and then he seems to think that he wants to publish the comments she would send, depending on what she writes. The story could end here, potentially resulting in a comment in the CP. However, the topic of medication attracts the attention of Psychiatrist 2 who had a different understanding of Ritalin and medication during pregnancy. She did not complete the story of “blue legs”, which was not necessary because her professional voice was supported by the voice of science regarding the Norwegian Pharmacopoeia. 

Psychologist 1: But isn’t it the Pharmacopoeia that should be consulted, for guidance? (looking at Psychiatrist 2)
Psychiatrist 1: Yes, the Pharmacopoeia is completed.
Psychiatrist 2: And can we DO anything during pregnancy......? (looking at Psychologist 1)
Psychologist 1: No, we cannot start mixing up this. Doing anything beyond what is mentioned in the Pharmacopoeia could be risky. If we (looking at Psychiatrist 1 and pointing towards the screen) begin to advise on medicine that is not mentioned in the Pharmacopoeia, it would all be a little...

They claim that it would be risky to add some information that is not mentioned in the Pharmacopoeia. The first hint of moral order entered the discussion.

Advisor: We can include some of this......

45 Felleskatalognen is a national consolidated catalogue of pharmaceutical compounds marketed in Norway, intended for doctors and other health care professionals. Its descriptions are based on those approved by the Norwegian Medicines Agency. A private company publishes the Felleskatalog each year.
Psychologist 1: Hmm? (looking at the Advisor)
Advisor: THAT THERE IS SOMETHING MENTIONED REGARDING THIS (numerous participants talking, the Advisor is talking loudly, the talk among the others continues)
Psychologist 1: (approaching Psychiatrist 3). But do YOU want to be responsible for this, in the context of a clinical pathway (pointing towards the screen), and spread this information? (looking at Psychiatrist 3)
Psychiatrist 3: I don’t know. I don’t have anything in writing on this as of now. But I am thinking this should be a point, because it may be….. a question that we will be asked from time to time.

The question from Psychologist 1 about whether Psychiatrist 1 would be personally responsible for this was followed by Psychiatrist 2 who stressed the aspects of evidence:

Psychiatrist 2: When connections are made to research proving that this works out well.
Psychiatrist 1: Yes.
Psychiatrist 2: And if there are no studies supporting this, it isn’t really important, I think.

Moral order thus broke into the discussion with full force, and Psychiatrist 3 is in doubt, as she has no scientific evidence to support her professional contextual knowledge. Psychiatrist 2 from the ward maintains the claim of scientific evidence concerning pregnancy and Ritalin, which is now supported by Psychiatrist 1, the head of the CP.

Psychiatrist 3: But I can write something about this.
Psychiatrist 1: Yes, please do. Otherwise... Otherwise it is a good idea to make a point out of the issue of pregnancy and ADHD.

He is now picking up on the previous suggestion to write something about the topic and asks Psychiatrist 3 to make a summary and recommendations. The Advisor (the secretary) and the facilitator (the nurse) support his question by suggesting making a kind of written text describing “experience in the county”:

Advisor: (speaking quietly with Psychiatrist 1). Who will submit this..... about..... pregnancy? (holding up his pencil)
These ways of talking can be interpreted as caring or considerate towards Psychiatrist 3, but can also be interpreted as a compromise: “Let’s meet halfway and now move on”.

**Psychiatrist 3:** And it is also, from experience, that I have realised how pregnant woman do quite well without any sort of medication... much better than those... before and after... For some reason (smiling).

**Psychiatrist 2:** hmm

**Facilitator/Nurse:** But if... the only thing we can do, is like this... and whether there are any studies conducted on the topic. One may question if we can take it so far as to make a formal write-up of “experience... thus far in the county”. In this case one must base it upon a general notion of the empirical data, and consequently make a statement regarding this. As in...

**Psychiatrist 1:** But this is, as Psychologist 1 mentioned, if we include several aspects in this section, we will also be responsible for what we publish... which is why I would, so to speak, take into account what is included in the clinical pathway. But ehm... this part of referring to external sources... which are... in locations abroad, consequently passing by other regulations... but we could make a link to this specific place. So people can read about it... But I don’t want to include this in the pathway if I cannot be personally accountable for the content.

The head of the CP reiterates the moral order as he states that he is personally accountable for the content in the CP. However the Advisor and later the CP leader Psychiatrist 1 still want to include ADHD and pregnancy in the CP:

**Advisor:** Either way, this should be a statement with a more general perspective. Because it is, in reality, quite an essential point. Therefore, it does not have to say... do this... or do that... but there should still be a reference to the topic of ADHD and pregnancy.

**Psychiatrist 1:** Yes. That is absolutely correct. That is... your assignment. .... Yes (turns towards Psychiatrist 3)
The session ends with Psychiatrist 3 being assigned the task of finding supporting scientific material on medication during pregnancy.

Psychologist 2 and Psychologist 3 are not participating in the talk in this sequence, but are still taking part in the interaction. They are partly looking at the participants during the discussion and partly looking down at the table. Psychologist 3 nods sometimes when Psychiatrist 3 is talking while he writes on a piece of paper. The nodding can be interpreted as that of a satisfied listener; he seems to support Psychiatrist 3’s dilemma.

It is part of the story that some months later the CP for ADHD was published on the hospital website. In the treatment manual for the professionals, one cannot discover any comments or remarks about the use of Ritalin during pregnancy.

My data appear to suggest that the various actors present themselves as more than just representatives of their professions. This was evident in Psychiatrist 3’s narrative, where her rather unusual and subjective report met with resistance, mainly arising from moral concerns first expressed by the psychologist and then by the two psychiatrists. It was a matter of adding something to the pathway, which represented the professional know-how or contextual knowledge, but this knowledge was not allowed into the pathway. This sequence thus illustrates a core dilemma in standardising medical work and in particular mental health care. By saying to her colleague in the same profession: “I don’t agree that all of this is as accurate as you claim in practice”, she is implicitly airing the question: “Does one size fit all”? The contextual knowledge of Ritalin during pregnancy conveyed by the psychiatrist’s narrative is legitimated in her practice in her daily work with individual patients, but the knowledge has no legitimacy when standardisation is the agenda. There is no room for patients’ narratives in standardisation; attempts at negotiation, discussion and problem solving based on such contextual knowledge could not possibly solve the problem within the context of standardisation.

5.4 Summary: The Design of the CP for Adults with ADHD

This chapter examined the organisational and professional frameworks during a two-year design process of a CP for adults with ADHD. The organisational framework implies the organisation and implementation of the work involved in
producing the pathway, whereas the professional framework is here primarily related
to professional interests and knowledge paradigms and especially to social norms of
how knowledge and interests are applied in rule production. The organisational and
the professional framework go hand in hand and provide opportunities but also
restrictions in the work of standardisation.

The organisational framework of rule production focused on clear leadership,
clarification of the participants' tasks and roles, a fixed meeting structure, written
notice and minutes of meetings, creation of ad-hoc groups, simulation activities and
the use of process modelling techniques. The professionals were in the driving seat
in designing the CP, and they were familiar with the patients' needs. Problems that
arose were either referred to the management for a decision or solved by the team
itself.

The professional framework of rule production shows that the team has developed
social norms for standardisation. These norms were created on the basis of the
context; the team was to make rules intended to prescribe what other professionals
in the Division should do. In order to standardise, the team members have had to
cope with the uncertainty of various factors, but the concept of uncertainty has
different dimensions. They could do something about the uncertainty regarding the
number of patients, but nothing about the uncertainty regarding the lack of
scientific knowledge of ADHD treatment. Not surprisingly, the scientific knowledge
has high legitimacy; the narrative of Psychiatrist 3 is an example of this. The
sequence illustrates the contradictions between contextual knowledge and
rulemaking, but also the importance of moral order in standardisation.

The data shows that competition of knowledge and interests do not coincide with
the professional groups, here psychologists, psychiatrists, a facilitator/nurse and
advisor: the organisational context provided opportunities to act irrespectively of
any potential dividing line between the professions, as the team seems to have
established a collaborative community.

In the sequence of compromises about diagnostic and assessment tools,
professional autonomy had to be weakened in order to standardise. The example of
the new specialist psychologist in the team for the first time questioning a procedure
may indicate that some knowledge (through selection and compromise) is
considered as certain knowledge by the other team members but uncertain by the
new member. Is it then possible that uncertainty can be eliminated over time by the
creation of new common professional norms? In that case, a time dimension is
added to the rule production in the team.
The empirical data in this chapter are the subject of later discussion. The following chapter analyses the two processes of rule production with particular focus on the relation between knowledge and rulemaking.
6 An Analysis of Rulemaking

The relation between knowledge and rulemaking in mental health care can be viewed as a rather sophisticated process. This chapter argues that there are powerful forces outside the organisations that exert pressure or push in the direction of streamlining mental health care, and for this reason the rule production itself is not only linked to legitimacy-creating mechanisms, but equally to the fact that an entire “CP package” aims to encompass the scope for action of the rulemakers during the design period. As a prelude to a discussion of where this might lead for professional practice, this chapter therefore starts by looking in more detail at the steering framework of the standardisation process itself before I consider more closely the knowledge that gained a foothold in the CPs.

The two previous chapters gave us an insight into how the two clinical pathways were produced. This chapter analyses parts of these empirical presentations, and will, together with the analysis of empirical data in the next chapter (rule following), form the basis for the final section of the dissertation, which discusses the significance of clinical pathways as knowledge-regulating tools for mental health care professionals. Although the two pathways apply to the same diagnosis, it is difficult to compare them primarily because of the considerable difference in the design context. The availability of empirical data and the subsequent level of analysis also differ. I would still argue that the two cases complement each other, but also contrast with each other in a way that enables us to see an empirical pattern of the relationship between knowledge and rules.

As we have seen, there were actors who chose to address the coordination and quality problems by taking prompt action: standardisation was thus the key to improving the situation and the clinical pathway idea was launched. The empirical data demonstrate that mental health care provides ambiguous contexts and the field of ADHD in an international context is characterised by controversy about e.g. what causes the diagnosis, various forms of treatment, medication of children, etc., but also a number of additional challenges. The informants had to cope with these controversies and complexities throughout the two years of designing the two CPs. What can explain the fact that these two clinical pathways could be produced under such potentially difficult circumstances? In order to create an understanding of this question, it is fruitful to look at what creates legitimacy (Scott et al. 2000:236, Scott 2001, Deephouse & Suchman 2008). Thus, the arguments used to legitimate the CP concept depend on the discourses available and on current trends and
interpretations of what it means to legitimate. Rule production has to be studied in the light of the organisational contexts (Ahrne & Brunsson 2004, Fernler & Helgesson 2006) and I would claim that the ideas involved in the design of the CPs for ADHD are inextricably intertwined with ideas of what is considered a “modern and fashionable” way of organising the health care system. Foucault’s “discursive formation”, which explains how systems of thoughts are composed of ideas, attitudes, courses of action, beliefs and practices (Foucault 1972, Motion & Leitch 2007), represents a kind of “backdrop”, as the data from the two chapters on rulemaking are primarily analysed from a neo-institutional perspective.

6.1 The Influence of the NPM Ideology

New Public Management can be regarded as a central theoretical and practical starting point for the development of new regulation tools (Pons & van Zanten 2007). Organisations tend to select reform elements that are popular at any given time in order to provide themselves with legitimacy; one example is the influence of the NPM ideology, focusing on effectiveness and modernisation of the public sector (Røvik 1998, Christensen & Lægreid 2001, Christensen et al. 2004). Hospitals as organisations do not create new instruments in a vacuum; rather, the NPM-based idea of streamlining health care services found fertile ground, and the growth in the number of CPs can indicate further rich fertilisation of this idea. As standardisation is often explained in terms of new needs or as a part of organisational strategy (Brunsson & Jacobsson et al. 2000), the idea of developing CPs for ADHD met with approval within the hospital; the management of the Division of Psychiatry took the necessary decisions, since the development of this tool fitted the hospital’s steering logic like a glove. Furthermore, during the years of designing the two CPs for ADHD (2003-2009), the number of other CPs developed in the hospital was also continually increasing. The definition that CPs are “based on medical evidence, in connection with an efficient exploitation of resources and measurable results”, can be considered as a prescriptive and instrumental mode. We have seen that this definition was broadly interpreted in the context of the two CPs for ADHD, especially regarding the extent of efficiency measurement, but the two CPs were also included as part of the general priority of the hospital. The hospital strategy of developing clinical pathways in order to offer high quality and cost-efficient service provision demonstrate that the legitimacy of these organisations is inextricably connected to whether they are effective or not (Røvik 1998, Scott 2003). From the point of view of Suchman (1995), the hospital’s actions seem to reflect moral legitimacy through normative perceptions of clinical pathways as an appropriate solution to the problems.
But there is another factor, stressed by several informants, that appears to have been important for the hospital in the decision to create these two pathways for ADHD: it is “good publicity”. Therefore, convincing stakeholders within the overall system, be it politicians, the Regional Health Enterprise\textsuperscript{46}, other hospitals, top hospital management or client organisations, might be just as important or more so than effective rulemaking. Following this approach, the creation of CPs seemed to increase the hospital’s legitimacy rather than improving coordination (DiMaggio & Powell 1991, Scott & Meyer 1994, Brunsson & Jacobsson 1998, see also Scott 2004b and Fernler & Helgesson 2006). One way to achieve this is that the very idea of adopting a CP (with the subsequent standardisation design processes) is disconnected from the practice field. But here it is worth noting that this disconnection takes place parallel with leading ideas of employee involvement in continuous efforts at improvement.

6.2 Decoupling, Professional Involvement and Legitimacy

“Organisational decoupling” of the CP idea is an important mechanism in producing the two CPs. Decoupling refers to the creation of gaps between formal policies and actual practices; it is a pervasive organisational phenomenon. Meyer and Rowan (1977) claim that decoupling enables organisations to gain legitimacy with their external members. This approach can partly explain how organisations adopt recipes in considerations of legitimating and keep these new recipes decoupled from the field of practice in order to avoid conflicts and loss of legitimacy (Meyer & Rowan 1977:340, Brunsson & Jacobsson et al. 2000). In fact it frequently occurs that a standardisation process is disconnected from the practice field, i.e. from the professionals to be managed. But here it is interesting to consider decoupling in connection with the idea of professionals standardising their own work. Let us first take a closer look at the constraints involved.

\textsuperscript{46}The 2002 Hospital Reform underpinned this tendency by reorganising specialist health services and implementing new management principles for hospitals; the Enterprise model is an example of this (White Paper 5/2003).
6.2.1 Professional Involvement and Continuous Improvements

There is a clear emphasis on continuous improvements in work processes through employee involvement, enthusiasm and teamwork in terms of best practice and “learning organisations” both at the hospital and in Regional Health Enterprise seminars on clinical pathways. The very first idea of using CPs in these contexts was from the Breakthrough Series “ADHD – Improving Assessment, Diagnosis and Treatment”, which took place in 2003 and 2004, organised by the Norwegian Medical Association in collaboration with the Child and Adolescent Psychiatric Association, the Norwegian Psychological Association and the Norwegian Nurses Association. The unions are thus here strongly involved in a new form of steering of the health services, which without a doubt provides the project with legitimacy. This legitimacy is reinforced by the fact that the project was financed by the Norwegian Medical Association Quality Assurance Fund II, a joint fund allocated by the state and the association of local and regional authorities. The idea of professionals’ “creative involvement” is promoted here by Paul Batalden of the Institute for Healthcare Improvement (IHI): “as part of their useful professional formation – to lead the continual improvement of the quality, safety and value of health care”.

These ideas are in line with the lean concepts of “continuous improvements” where employees’ “goodwill and creative involvement” will ensure a gain in efficiency. This rhetoric is not only used in the promotion of concepts in the private sector, but such solutions are also being strongly introduced into the public sector. When the Breakthrough Series ended, it seemed natural to continue this new form of management in a particular project for the county, i.e. the CP for children with ADHD and at a later stage the CP for adults with ADHD. These projects fitted in well with the hospital ideas of employee involvement and teamwork. Here we see an example of high-level political steering signals regarding the streamlining of health care being transformed into a regulatory tool for professional practice from governmental level via employee unions and down to work environments.

6.3 Innovative but Limitless Work

The idea of the two clinical pathways for ADHD thus represents an ideal example of good intentions about implementing political objectives, where the idea gains legitimacy through its implementation being based on employee involvement and

47 A presentation at several hospital seminars of the introduction to the CP strategy was headlined “Teamwork is dream work”, directing attention to the idea of “champions” in order to create responsibilities and implementation capacity within the CP team.
participation. Viewed in this light, adopting the CP concept may help to strengthen legitimacy, but such an approach is in my opinion without substance, being only a kind of varnish which the organisation uses to please its surroundings. I view this as a simplified description that reduces the opportunity for critical reflection on the crux of this matter. There are various political signals, reforms, new government agencies, new advisors and new techniques being employed; this would suggest that as a whole these are relatively powerful constraints that set limits for the standardisation process to the extent that we can empirically observe the substantive changes taking place, which in different ways may affect professional practice. These professionals who have now been assigned to lead the efforts to design the CPs are parties in a contract with management to perform innovative but limitless work. This is the focus of this analysis, namely to consider – from a certain distance - what challenges this may bring to the professionals as standardisers.

6.3.1 Lack of “Responsible Leadership”

The lack of management involvement and responsibility during the CP design process is striking. It astonishes me that management was not more involved in the process, especially in the pathway for children and adolescents with ADHD. The organisational framework of the design of the CP for adults seemed to focus more on responsibility in leadership than in the case of the CP for children; this can be explained partly by the production context and partly by the lower level of ambition since the CP for adults was created as an internal CP within the Division of Psychiatry.

In the initial phase of the design process of the CP for children with ADHD, the project management seemed to be aware of the importance of their involvement and commitment as they drew up an intention agreement, confirmed politically by the local councils and signed by the mayor of each council and the director of the hospital. The agreement was formally linked to the recommendations of the National Strategy for Quality Improvement in Health and Social Services 2005-2015: “And it is going to get better!” However, in the case of this pathway, leader involvement, on the part of both the hospital and the local authority, seems to stop here, since it evolved that this was the only written agreement between the organisations to be involved in the clinical pathway. Leader involvement appears to be far stronger in the creation of the pathway for adults with ADHD; we have seen that the leader took part in important fundamental decisions. But it is worth noting that the team dealt with only one leader and one group of leaders, since this was an internal clinical pathway limited to one division in the hospital. The lack of leader involvement in the design of the clinical pathway for children can possibly be
explained by the fact that this was the very first pathway developed by the Division of Psychiatry at the hospital. This may therefore have helped to create legitimacy for the idea that it is also possible to standardise in this field. Thus management involvement in working on these CPs in fact just seems to be a minor part of the rulemaking process. It may also appear that the management's lack of involvement could be associated with the ideas of professional involvement and creativity in connection with one of the reform elements in NPM. Such an approach can create expectations that the professionals familiar with the patient group can replace the traditional authoritative top-down decision-making with entrepreneurship and consensual “bottom-up approaches” (Pollitt & Bouckaert 2004). These ideas may partly explain the loss of management involvement (especially in the CP for children with ADHD) during the design process.

6.3.2 The “Standardisers”: Professionals Supported by Techno Staff

We have seen how the two clinical pathways for ADHD were produced in a setting with a great need for improved coordination. Professionals working in respectively Child and Adolescent Psychiatric Services and the Department of Substance Abuse Treatment were those most aware of these challenges, probably because they had focused on these problems for many years and were apprehensive about the lack of efficiency, quality and coordination of the services. Thus, dedicated professionals were strong driving forces in developing the CP tool to solve coordination and quality problems within the system. According to Brunsson and Jacobsson, such actors assigned to decision making can be characterised as “standardisers” as they are directly involved in the design process, transforming knowledge and interests into rules presented for utilisation by professionals in their work (Brunsson & Jacobsson et al. 2000). The professionals who sit in the driving seat, such as psychologists and psychiatrists, are “right up close” to the patients; they are proactively seeking to develop CPs as knowledge-based regulatory tools. But they do not do this single-handedly; as we have seen, they were assigned to do the work in line with relatively strong constraints around ideas of professionals’ “creative involvement”. The standardisers I interviewed can thus be viewed as being in the driving seat - as drivers - but the roads they take are already set out by the constraints mentioned above.

We have seen that decoupling in the standardisation design process resulted in a displacement of responsibility from the management to the professionals and it was thus left to the professionals to solve problems that arose in the field of practice. However, decoupling in this case may seem less important since a central part of the
concept was precisely the idea that professionals themselves should be responsible for the actual work of designing the two CPs. And here it is a natural consequence that the professional standardisers should encounter problems, since the actual idea which had emanated from the Breakthrough Series was not introduced in the many organisations to be affected by the CPs. The idea of employee involvement in rule production contributes to the legitimacy of the idea, but it seems to be an assumption that this is not connected to organisational practice. Here, therefore, the standardisation work is based on the rulemakers’ interpretations and understanding of the problems to be solved in the field of ADHD in the county. This in fact applies to the creation of both pathways but because the pathway for children was so comprehensive, there were very special challenges here. The production contexts with teams led by the BUPP meant that there was no discussion of any issues that local authority actors may have wished to raise. The responsibility to ensure involvement and commitment appears to have been left to the rulemakers. In the case of the CP for adults with ADHD, the pilot project that preceded it seems to have helped to establish a relatively close link between idea and field of practice, but there was also a much lower level of ambition here than for the pathway for children and adolescents with ADHD. Nevertheless, rule production appears to rest on the shoulders of the professionals. What has this meant for practical considerations? First we will consider in more detail the actors and how important they were in the standardisation process.

“Medicine” and Management Hand in Hand

The hybridisation between the professional role ("medicine") and management is demonstrated by certain actors, especially the BUPP psychiatrist and the BUP psychologist who participated in the Breakthrough Series, whose role was to adopt management values and techniques. However, as we have seen, other staff, e.g. advisors, the hospital secretary and facilitators had various roles during the design process, e.g. writing a report with the BUP psychologist in the early stages of the CP for children; the secretary and facilitator also took part in the team which designed the adult CP.

The facilitator is intended to play a neutral role in encouraging dialogue within the CP team without taking sides in the argument, particularly when trying to reach a consensus. The facilitator also operates the ICT decision support system, as in performing the process modelling on the computer by asking questions to the group.
Such people are officially advisors and analysts, however despite their lack of formal authority, they reveal considerable informal power in standardising other people’s jobs (Mintzberg 1983, Mintzberg & Glouberman 2001). Here, they are providing the CP teams with valuable ideas and techniques of process modelling of the patient “flow”, and are thus transmitting ideas associated with efficiency and high quality services for these patients. With their professional and technological background, these standardisers contributed to increasing the legitimacy and authority in the context of rule production (Brunsson & Jacobsson et al. 2000, Tamm-Hallstrøm 2000). And they had considerable responsibility as they decided on the content of the manuals for each of the professions regarding what instruments and tests were needed in referral and diagnosis. They had a clear goal of determining the actions of other professionals; they were also dedicated to working towards this goal. The CP for children with ADHD provided a model of a trans-organisational horizontal control regime as it involved all the 18 local authorities, whereas the CP for adults did not have the same level of ambition as it only involved internal departments within the Division of Psychiatry at the hospital. There are thus different types of clinical pathways giving different potential challenges; this will be discussed later.

Like the administrative advisors, the professionals have no formal authority or positional power in the organisation, yet they have considerable power in the standardisation work by dint of their functional authority, as their knowledge in the field gives them expert power (Abbott 1998). The standardisers are here assigned a role that could represent a hybridisation between the professional role and management role in that they make use of management techniques. They thus have a position of power in the standardisation work as experts in their fields of knowledge, but without a portfolio of formal authority or positional power in the organisations that could potentially be affected by the clinical pathway. According to my data, this is something that applies to the production of both pathways. We have now seen that the standardisers were professional experts with support from hospital staff, and here they met with a variety of problems, e.g. how to deal with the complexity of the standardisation process. Were they in fact, in the absence of a formal power portfolio, marginalised by virtue of being standardisers?

---

48 In an organisational configuration perspective we may discern the role of Mintzberg’s ‘techno-structures’, as analysts that developed and designed the hospital’s approach to the CP concept seem to have an important role at these seminars. We have here seen the facilitator’s role in the CP teams along with the support staff (the secretary of the teams).
Managing without Portfolios

In the design of the CP for children with ADHD, the procedures of referring and clarifying a diagnosis involved consultations with a number of organisations and several hundred professionals. The extent of the complexity thus gave the CP makers an enormous challenge in the decision-making process in order to standardise these activities. The wide definition of a “process plan for the entire clinical pathway chain, from interception, referrals, to clarification/determining a diagnosis, and further initiatives” is not only ambitious but also extensive in organisational scope, including a wide range of complex services at specialist and local levels. Here, a clinical pathway encounters a complex organisational structure where agencies often have several tasks and the patient group related to the pathway of ADHD is but one of many groups of patients. The actors working in the specialist health services assessed the problems from their particular point of view, thus in order to achieve rationality in the problem-solving process they gave limited attention to the complex issue of causes, one of which is the fact that the 18 local authorities in the county are organised in different ways. They therefore did not manage to involve all the organisations, management and professions in motivation and commitment. Although most of the CP makers were enthusiastic when they worked within the CP teams, they did not fulfil the need for commitment in the organisations involved. They did not have the opportunity to consider all the potential pitfalls and had to make a number of rational and limited decisions. Here, the professionals acted according to what they considered appropriate (March 1994:58). This makes sense because considerations of the complexities in the involved organisations evoke uncertainty that may hamper the decision rationality. To a certain extent this also applied to the actors who designed the CP for adults. In this case they created an internal CP within the Division of Psychiatry at the hospital, which at the outset did not involve the same level of complexity, but the data still demonstrate complexity and controversy in various aspects, making it difficult to standardise here also. Members of the organisations involved are limited in their knowledge and in their capacity to learn and to solve problems (March and Simon 1958:156, Brunsson & Jacobsson et al. 2000). This means that rationality in decision-making cannot be seen independently of the decision maker’s frame of reference, which is determined by limitations in his knowledge. In light of the way the production contexts are organised, they cannot have the necessary overview and knowledge to influence such issues. They have thus been subject to external control,
so they had very little influence over the knowledge to be included in the CPs because this was predetermined even before the standardisation work started.

Absence of Reflections on What this Tool will Mean in Practice

It is often taken for granted that organisational decisions should be based on knowledge (Feldman & March 1981). In the design of a regulatory tool, there is a need for knowledge in how to standardise work processes within and between organisations, and more specifically the CP makers in this study need particular knowledge of the complexities of mental health care. Most organisations spend substantial resources on collecting and analysing knowledge, but the knowledge of what causes problems is driven by the organisational and social contexts (March 1994). Part of the explanation of why there seemed to be little knowledge about standardisation as a coordination mechanism may be found in the fact that it was the professionals themselves who designed the tool. In this respect, my data show that the two clinical pathways were produced in two different yet very limited contexts, and the recurrent tone was an absence of reflection and analysis as to what this tool could mean in practice. Professionals possess expert knowledge in their field (Abbott 1988). But this expert knowledge is not the same as knowledge of how standardisation can be a coordination mechanism within and between organisations. Thus it is in no way strange that the assumptions for the standardisation work could not be met, as it is well known that professionals represent a clinical and therapeutic culture, while advisors and facilitators represent the technical aspect with process modelling and structuring of the clinical pathway tool itself. And these actors naturally do not relate much to discussions and potential conflicts around resources, budgets and organisation. However, to a certain extent, the CP makers used decision support tools in different ways during the work of standardisation, which turned out to provide them with some remedial support.

Before we examine the clinical pathway tool, let us first consider Statistical Process Control (SPC), which is used to focus on improvement of waiting time for referral and diagnosis in the Breakthrough Series. It eventually turned out that this method was not used in the design of either of the CPs, but it is of interest to study this tool because it is extensively in use at the hospital. This method can be seen as a technical feature of lean thinking (Stewart et al. 2009) and is promoted and recommended by the Norwegian Knowledge Centre (see Appendix 1.1).
A Statistical Method in Process Modelling

Some of the actors involved (the chief psychiatrist from the BUPP and the chief psychologist from the BUP) had participated in the Breakthrough Series for change in clinical practice, and had thus been trained to work with improvements in referral, diagnosis and treatment of ADHD by the use of statistical methods. Statistical Process Control (SPC) is a measurement tool whereby data is arranged as a time series in order to examine how a process changes over time. It is thus a recognised statistical method used in the hospital in connection with the production of clinical pathways, but it was not used during the production of the two pathways for ADHD. The interpretations made of the hospital's definitions of clinical pathway also imply that efficiency measurements were toned down. But it is possible that this method could (at least) have provided statistical analyses of bottlenecks, waiting times, etc, to enable a closer link between the pathway idea and the field of practice. This applies especially to the pathway for children with ADHD, but later, when the CP for adults was designed, SPC as a method was not used either. With the exception of the report from the Breakthrough Series, the data show that the actors paid no attention to the use of this tool. This lack of attention could perhaps be explained by the fact that the rulemakers were not familiar enough with its use, but it may also be because statistical analysis was not considered appropriate in this field. However, there is another support tool that has been used, and that is the hospital's web-based process modelling tool for clinical pathways.

Use of the Hospital Tool for Clinical Pathways

As we have seen in the data of the CP for children with ADHD, the advisors at the hospital demonstrated a flowchart of roles, tasks and decisions regarding referral and clarification in one particular case. The model illustrated the roles of organisations and professions, their activities and work tasks. This “workflow” model, demonstrated by the symbols and arrows, illustrated the patient’s “pathway” through the system. The model demonstrates the various ways into the system and a number of methods of solving the issues of screening, assessment and referral within the same local authority. This particular flowchart appears to be a “homemade” model and is thus not based on the hospital's tool. The tool used by the hospital may not have been sufficiently developed at that time, as far back as 2003. During the years of designing the CP for children (2003-2006), this kind of decision support tool was not used further; however during the creation of the CP for adults (2007-2009), this support tool for decision-making was extensively in use within the team.
Information and communication technology (ICT) represented by the computer system is an important factor in producing the CPs. The technological decision support system provided “quick fix” solutions as the standardised procedures of how to treat patients were structured by the flowchart in order to obtain an efficient and evidence-based sequence of activities “ready to use” by professionals in their daily work. The problems seem to be solved the moment the activity is described through the process modelling system as being ready for the next step of modelling. This is also related to the mechanism we shall consider shortly, namely “initiated ignorance”, and here this “quick fix” is especially linked to the knowledge allowed into the pathway. This was evident in the sequence from the meeting about selecting the mapping tools. It appears that technology supports efficient problem solving, where the complexity and uncertainty that exist in this field seem to be eliminated in the process of allowing entry into the pathway. The facilitator transmitted this technological “participant” in the meetings; the (human) participants viewed the screen while speaking, pointed at the screen and had it as a sort of common reference point during the meetings. Thus, technology creates opportunities and restrictions regarding the distribution of knowledge and has its own logic in enabling the participants to visualise the steps in the flow charts, but it also disrupts and restricts the discussion. Decision support tools are intended to transform the “art” of medical decision-making into a science, making medical practice more rational, uniform and efficient (Komaroff 1982, Berg 1997). As demonstrated in the data of the CP for adults with ADHD, the process modelling tool provided transparency of the actors’ roles and responsibilities during the activities in the “chain of services” within the hospital, and here as for the CP for children with ADHD, the “tangible” outputs of the standardisation work were step-by-step instructions of care and treatment for each service agency. The CP tool will also provide an information system within an iterative learning framework and allow for the circulation of knowledge. However, the ideas of the two CPs stem from defined coordination and quality problems; problems of confusion, patients passed around like a ball between the various agencies, cumbersome assessment and treatment procedures, waiting lists, etc. All these problems are emphasised in the policy documents, the SINTEF report, the Breakthrough Series and in the reports from the two CP projects. Use of decision support tools, such as SPC or any similar technique, could perhaps have contributed to revealing the causes of e.g. bottlenecks in the system, and questionnaires for patients and parents could for example reveal aspects of service quality. But none of these decision support techniques were used; the absence of such forms of analysis was a recurring tone in the data of the CP for children with ADHD, but also partly in the CP for adults. This could be because the concept of “scientificisation” through the use of
statistical analytical tools may seem inappropriate in this field, but I will not consider this matter further here, as my data have not addressed this issue particularly.

As we have seen, there were relatively powerful constraints regarding the streamlining of health care that characterised the standardisation design process. It appears that decoupling is a necessary element of the CP concept by its very nature, and therefore also an integral part of this recipe, first and foremost because ideas of professional involvement led to the professionals standardising their own work by taking on all the standardisation themselves. If the clinical pathway idea had not been decoupled from the practice field, we would have witnessed the emergence of a number of potential conflicts around the distribution of tasks and responsibilities between the organisations, including the power relations between local authorities and the hospitals. This would have made standardisation difficult, indeed almost impossible. Keeping the design process of these CPs decoupled from management and from the field of practice was an important mechanism in order to maintain legitimacy of the CP tool in an ambiguous and controversial context. Now let us consider more closely an important mechanism in rule production, namely initiated ignorance – “in a straitjacket”.

6.4 Initiated Ignorance – “in a Straitjacket”

The reasoning in the first part of the chapter showed that there are powerful forces which together represent a steering framework for the standardisation process. The practical considerations of the design processes had to be solved by the rulemakers in constrained production contexts, as they had to shoulder all the standardisation work themselves. This was especially true of the design of the pathway for children with ADHD. Now let us examine more closely the knowledge that gained a foothold in the CPs.

The definitions of clinical pathways in the literature take for granted that there already is scientific evidence-based knowledge for the diagnosis and treatment of a particular patient group, which can provide a stable, objective and unambiguous knowledge base. This is also the case with the data from the rulemaking, as there were a number of prominent studies in the field of children with ADHD. The team who created the CP for adults with ADHD had a sideline view of this knowledge base, but there was little evidence in the case of diagnosis and treatment for adults with ADHD, which necessitated a rather roundabout method of rule production.
6.4.1 Prima Facie Knowledge

My data not surprisingly demonstrate quite clearly that those who sit in the driving seat as rulemakers are the ones who determine the conditions for the knowledge base in line with the steering framework. The biomedical hegemony is maintained and the CP confirms this knowledge as the only valid knowledge. The rulemakers had very little influence on the knowledge base for the CP for children and young people. I earlier questioned whether the rulemakers had any possibility at all to organise the design process differently. The basis for this question is strongly linked to the fact that the knowledge and techniques conveyed by the state control signals via the SINTEF Report, the Breakthrough Series for ADHD and the ADHD guideline specify such strict constraints that the immediate conclusion must be that they had no choice. And in fact this was not necessary for the standardisation work.

The CP for children in particular was shaped in organisational contexts which left little or no room for scepticism. It is a question of pro or contra – either you believe or you do not believe in the relevant knowledge base. Just one informant (the psychologist who participated in the design of the CP for children with ADHD) questioned the biomedical knowledge paradigm and had moral qualms, but his reservations met stony ground. This is because the actors who sat in the driving seat naturally applied the range of treatments they were familiar with (Abbott 1998), i.e. the available treatment repertoire within child and youth psychiatry at the hospital. Rulemakers’ decisions are generally not “pulled out of thin air”; the design of the CPs was a work of translation, interpretation and appropriation of ideas, knowledge and devices already in circulation. The data shows that evidence-based knowledge in the form of the traditional biomedical model of understanding was an obvious choice: it was “prima facie knowledge” for the rulemakers. They had an overview of the international literature on potential improvements that could be adopted in the local context and in this way they acted as knowledge mediators, bringing their knowledge into a local context by proposing ways of applying it there. The Breakthrough Series and the SINTEF Report had already given biomedical knowledge high legitimacy in this professional environment, and it gained further legitimacy when it was presented through conferences, the information letter, and in the drafted version of the clinical pathway. Eventually the CP makers also received further support from the state, for the knowledge introduced into the pathway can be said to represent “official ADHD knowledge” according to the national guideline published by the Directorate of Health and Social Affairs in November 2005 (Veileder i diagnostikk og behandling av AD/HD, 1. version 2005). This knowledge thus became institutionalised in the field of ADHD, i.e. the biomedical knowledge
paradigm represented by leading evidence-based RCT studies (see for example Barkley et al. 2000) is now an institutionalised knowledge paradigm within child and youth psychiatry at the hospital. Before we consider further the knowledge base introduced into the pathway for adults with ADHD, we shall now look at a simplified model that specifies the relationship between knowledge and rules. The figure below outlines an instrumental rational model of the relation between knowledge base, knowledge production and rule following.

Figure 6.1 A basic model of the CP design as a “rational rulemaking” process

![Figure 6.1](image-url)

Figure 6.1 A basic model of the CP design as a “rational rulemaking” process (Original source: Fernler & Helgesson 2007:36).

This traditional view of the relations between knowledge and rulemaking stem from an implicit understanding that a stable and unambiguous knowledge base has already been created for precisely the question the rulemakers are dealing with. The rulemakers produce a CP founded on this knowledge base, which constitutes a standard for professional work: a rule to follow (Fernler & Helgesson 2006:36). And here there was no need to choose, since the knowledge to be used in the pathway was already institutionalised as the “correct” knowledge in this professional community. Although the data suggest that biomedical evidence-based knowledge is institutionalised in this professional community as “prima facie knowledge”, this knowledge base has first and foremost its origins in and association with the traditional medical view of illness. This is entirely in line with the government guidelines in the SINTEF Report and the Breakthrough Series and later in the government guideline for ADHD.

Those in contact with ADHD children in local mental health care services, whether at the PPT, clinic or school, consistently expressed more scepticism of the biomedical approach. This is primarily related to the medication of children and adolescents. This is probably because these people are increasingly exposed to scepticism and resistance at work, although they in fact share the knowledge that can be said to be based on the traditional medical understanding. Furthermore, they relate to a greater extent with the child and the child's family over a longer period of
time and also meet them more in everyday situations than do professionals in child and adolescent psychiatry. A final but important point is that the local actors had not been exposed to the strong steering signals to the same degree as the actors in child psychiatry. Here there is in fact little focus on the debate that exists “out there”. One perspective on the ADHD debate can also be linked to Foucault's ideas of discursive practices - and this brings us to the relationship between knowledge and power. The various discourses create particular perceptions of ADHD as e.g. an illness and, as in this case, medical knowledge is used as an instrument of power (Foucault 1972). Also relevant here is Berger and Luckman's statement that “knowledge is sealed to processes of legitimating at different levels” (Berger & Luckman 1967).

Multi-Professional Independence

This biomedical evidence-based knowledge paradigm appears esoteric and this is a key characteristic of professions; they depend upon close solidarity between each member of the profession (Hughes 1984:376). But the data in this study demonstrate that the esoteric biomedical knowledge paradigm provides for close solidarity between the CP standardisers in a kind of “multi-professional independence”. According to March (1994), inter-organisational or inter-professional teams can give individuals a stronger identity with those actors outside, rather than those within, their own organisations or professions (March 1994). This demonstrates the important position of knowledge, but in this case the knowledge base was thus protected against intruders, i.e. alternative knowledge paradigms that could challenge the institutionalised biomedical knowledge paradigm in competition for entry into the CP. Here Abbott points out an interesting state of affairs, i.e. that it is precisely by competing for knowledge that professionals can retain a monopoly on a particular field and also protect this field against intruders (Abbott 1988). Within these communities there are demands for what Foucault refers to as “control principles of discourse production” (2008). We find such control principles in the contextual frameworks of the design of both CPs. Academic knowledge is reserved for special groups of intellectuals to be developed, preserved, disseminated, discussed and processed (Abbott 1988). I will return to this in more detail in the discussion. What is interesting here is that the knowledge that apparently works for “the initiated” in the ADHD professional community in this county becomes much less esoteric through its inclusion in the CP. This is a natural consequence of standardisation; abstract knowledge is demystified by being introduced as a knowledge base in the CPs. As I understand Abbott (1998), abstract esoteric knowledge (which is precisely what characterises professions) is in danger of being
compromised if the knowledge becomes too concrete. It would thus diminish the possibility of legitimating the professional group (ibid 1988:103-104). But the data show that the CP makers through their inter-professional community have formed over time a multi-professional independence, creating a common identity through a knowledge base that cuts across professional boundaries, for there are psychiatrists, psychologists, special needs teachers and health visitors: almost all respondents seem to share the same knowledge which is naturally included in the pathway. This knowledge may be considered esoteric (for the “initiated”), but by gaining entry into the pathway it becomes exposed in the public domain and becomes transparent, concrete and thereby generally comprehensible. This is logical; it is in the very nature of standardising. We will now examine another model which shows that the relationship between knowledge and rules is not so straightforward in practice. And this is largely due to the fact that the knowledge base which gained entry into the CPs has to some extent been exposed to competition.

6.4.2 Competing Modes of Knowledge

According to the international literature of the ADHD discourses, “ADHD knowledge” is not stable and objective knowledge, rather the field can be labelled “uncertain, ambiguous and controversial” and multiple modes of knowledge differ in equality and legitimacy. In line with Fernler and Helgesson (2006), the rulemaking process emphasises the need to make the knowledge base “firm”, by “initiated ignorance” where ambiguity and disagreements over the knowledge base are reduced or eliminated (ibid). Thus it is here scarcely necessary to make any adjustments in order to achieve standardisation; the knowledge used was the knowledge most suitable for standardising, being evidence-based and highly ranked in the hierarchy of evidence. It is thus stable and secure knowledge for standardisers. However, the ADHD discourse testifies to alternative understandings of ADHD, and this is particularly where certain informants expressed doubts.

In practice, the diverse knowledge bases within the system of mental health provide uncertainties and ambiguities, thus the relation between knowledge and rulemaking in mental health care can be seen as a rather sophisticated process. This is mainly related to the very nature of mental health care, but also to the controversies about the ADHD diagnosis in society. Not all knowledge is treated as equal, the knowledge has different sources, different weight attached to it and may be regarded as more or less warranted (Atkinson 1995:127). In order to understand the relation between knowledge and knowledge production, the model of rulemaking below provides an analytical conceptual fram...
Figure 6.2 Claims for knowledge - A model of rulemaking (adjusted from an original source: Fernler & Helgesson 2007:37-39).

Based on data from the design of the two pathways, this model (albeit highly simplified) is intended to serve as an analytical framework to illustrate the types of knowledge introduced into the pathways, where the powerful forces outside the organisations exert pressure or push in the direction of streamlining mental health care. Here these forces are illustrated from left to right in the box “CP packages”; the Breakthrough Series representing the external expertise from the Institute for Healthcare Improvement, the SINTEF Report, the ADHD guideline, but also the tools used, such as the hospital's IT system for clinical pathways. Overall, this model indicates what was included, evaluated and then excluded, and what types of knowledge were not even evaluated for possible inclusion.

Not surprisingly, biomedical evidence-based knowledge supported by moral order was claimed for entry into the CPs. Contextual knowledge was considered but excluded. Evidence-based alternative knowledge was not considered at all in the CP for children; it was considered but excluded during rule production in the CP for adults because of a lack of suitable treatment options.
This model of rulemaking illustrates the multiple knowledge fields involved in understanding mental health care, and reveals that only one mode of knowledge has legitimacy in making a claim for knowledge in rulemaking. The biomedical evidence-based knowledge paradigm is supported by moral order. It appears on the basis of this model that the standardisers had no choice; they had to adhere to evidence-based biomedical knowledge. This is basically correct and it was not even necessary to adjust this knowledge to fit it into the CP; it had its natural advantages and was therefore included. But this knowledge base can create problems insofar as the CP is also intended for professionals who work for local authorities, since these actors are far more strongly exposed to the ongoing controversies surrounding diagnosis and treatment of ADHD.

The mechanism of initiated ignorance was actively in use in the team to reduce the problems connected to standardisation; the team was almost “in a straitjacket” in order to achieve this. The “straitjacket” refers back to the steering framework for the standardisation work. We shall now examine evidence-based forms of knowledge, ethical questions and contextual knowledge. Here it is worth noting that one never excludes the other. Professionals relate naturally to the scientific knowledge base in their field, but also at any given time to their own contextual knowledge. I will now explain the distinctions between evidence-based biomedical knowledge, moral order, evidence-based alternative knowledge and contextual knowledge.

**Evidence-Based Biomedical Knowledge**

The characteristic feature of standards and standardisation is abstract knowledge, which is general and de-contextualised in space and time (Brunsson & Jacobsson et al. 2000:41). Knowledge here is a set of “disembodied, neutral, reified facts about the world” (Hellström & Raman 2001:139). A CP as a knowledge-based regulatory tool follows the logic of objectivism; there is no room for patients’ narratives in designing a CP, only for evidence-based biomedical knowledge. In decision making, the teams have to establish certainties by the use of scientific knowledge, as this mode of knowledge is the logic of the CPs. This is no surprise; rather it is in the nature of standardisation. Science has become the fundamental basis for legitimising professions and professional activity. Science constitutes the logical and rigorous part of a diagnosis, and it implies extensive academic knowledge based on the highest standards of rationality for the actual cognitive strategies to create jurisdictions (Abbott 1988); this topic will be discussed later. What is not surprising
is that not just any scientifically based knowledge is allowed into the CP, but traditional biomedical RCT knowledge.

Moral Order

We have seen that moral dilemmas are revealed in various ways in the standardisation work. In the creation of the pathway for children with ADHD, informants state that their colleagues at work have moral reservations about giving children psychotropic drugs, but most informants also indicate that it is immoral not to give medication to sick children. In the creation of the pathway for adults with ADHD, further nuances of moral dilemmas are revealed; this is probably related to the level of analysis, since these data are based on participant observation. We have thus seen the importance of moral issues in relation to an insufficient treatment repertoire, but also in relation to the legitimisation of evidence-based knowledge. Moral order is therefore emphasised as having high credibility attached to it as supporting scientific knowledge in the context of rulemaking. Moral issues are thus related to the problems experienced by professionals in work with patients and clients, but also to the knowledge base incorporated into the standardisation work. Based on Goffman's (1971, 1981) vocabulary of morals, Måseide (2006) refers to a broad meaning of the term, as morals represent problems facing medical work, but may also represent recourses for institutionally adequate solutions to medical problems at hand.

Evidence-Based Alternative Knowledge

There appear to be several evidence-based resources within the field of mental health care. In an international context there is a variety of professional viewpoints as to the best treatment of children and adolescents with ADHD, and we only have to go as far as Sweden to find a research group claiming that a training programme has the same level of influence on ADHD as medication (Klingberg et al. 2002). It should be noted that this is just one study, not a meta-study. But I include it because it in fact shows that there are various alternative treatment paradigms which are not allowed entry into the CP, but which are the subject of discussion in other professional environments. According to the data, other potential evidence-based knowledge paradigms were not discussed in the CP teams for children with ADHD. However, we have observed sequences that show the difficulties that arise when the professional's knowledge and interest concerning alternative therapies are selected out of the production process because of the lack of suitable treatment options in the CP team for adults with ADHD.
The contextual knowledge base as an epistemological feature is denied, reduced and excluded in the design of the CP. The CP team for adults with ADHD tried to solve the problem addressed by the experienced psychiatrist although attempts at negotiation, discussion and problem solving were doomed to fail within this context. This contextual knowledge does not fit into the standardisation process; it cannot be standardised by its very nature. Here, Harrison (2002) draws on Argyris and Schön's “theory in practice”, pointing out the importance of personal experience as the main source of valid knowledge (Argyris and Schön 1977: 90-91).

In order to explain in more detail how I understand this concept of contextual knowledge, I draw on a study conducted in a psychiatric ward (Skærbæk 2004) and a literature review (Nicolini et al. 2007). The first study was conducted in a new psychiatric ward in Norway with multidisciplinary professional staff. Skærbæk investigated how knowledge and competence were expressed, recognised and developed in the ward during a period of two years. It was not surprising that biomedical knowledge overruled all other knowledge in spite of the ideology of the ward that everybody should be heard and listened to. In my view the most interesting finding is that irrespective of the professional background or “discipline” of the staff, they were all unable to identify and recognise as equal the embodied, situational and contextual knowledge at play in relationships and interactions (Skærbæk 2004). And precisely this study may help to explain how I understand the concept because a competence conflict linked to an established understanding of the medical hegemony may inhibit the creation, sharing and use of contextual knowledge, especially since such knowledge is by nature difficult to express. The contextual understanding usually cannot be quantified, as it is neither codified nor research-based. It is a form of personal knowledge that the professional acquires through experience in his profession, related to various situations and contexts in everyday clinical encounters with patients and clients. In the work on the CP for adults with ADHD, contextual knowledge was considered but excluded. And here I will move on to the next study, a literature review which reveals this complex understanding of knowledge in the face of an evidence-based treatment paradigm.

With the purpose of reviewing the current literature of knowledge management (KM), Nicolini et al. (2007) identified the distinctive ‘nature of knowing’ in the health care sector as one of three overarching themes. Here, drawing on several studies showing the importance of local contexts, they draw attention to a study by Clarke & Wilcockson (2002) who suggest that healthcare professionals value and pursue local and tacit knowledge in a distinction between knowledge for practice
(distal knowledge) and knowledge from practice (proximal knowledge). Proximal knowledge is derived from within a specific practice and depends on contextual issues which do not meet the criteria used to judge the quality of care, i.e. the explicit and codified knowledge. “Evidence and distal knowledge may be a tool…. but it is the proximal knowledge that allows practitioners in health and social care to know whether it is the right tool for the job, whether it is the right knowledge for the needs of their service users”. Consequently, “clinical decision making is located, or ‘situated’ in the context of proximal knowledge changing as that contextual knowledge fluctuates in time and between place and person” (Clarke & Wilcockson 2002:398 in Nicolini et al. 2007:249).

6.5 Summary of Rulemaking

The CP for children with ADHD was intended to be an instrument to regulate the relationship between organisations in the specialist health services and in the local authority services. The clinical pathway for adults with ADHD was intended to regulate the relationship between the departments in the same division. The steering framework of the design processes for rulemaking was interconnected with ideas of streamlining health services promoted in policy documents, by the SINTEF Report and the official guideline for ADHD, but first and foremost influenced by powerful forces in the Breakthrough Series supported by the employees’ union (especially in the case of the CP for children with ADHD). The mechanism of decoupling the CP idea from practice in the combination of “professional involvement” and “continuous improvements” resulted in the standardisers shouldering the standardisation work without the involvement of management. In order to handle the design processes for standardising they adopted management values and techniques thus forming a hybridisation between the professional and management roles. However, it turned out to be relatively easy to produce both the CPs because the decoupling from the field of practice outside the specialist health services and from the management in addition to constrained production contexts meant that the complexities that existed outside the professional environment were not taken into account.

The analysis shows further that in rule production there are connections between biomedical evidence-based knowledge and moral order and contradictions between these paradigms and contextual knowledge and alternative evidence-based knowledge. This is no surprise, neither is it surprising that contextual knowledge has weak legitimacy, having no place in standardising. Scientific knowledge is the core of
standardisation, providing high legitimacy as a secure, stable and reliable base for the production of rules. When this knowledge is then introduced into a knowledge-based regulatory tool in the form of explicit rules laid down in the CP manuals, it acquires a substantiability which can be viewed as trans-professional power; clinical pathways were meant to be a regulation tool for several professional groups, and this applies to both of the pathways for ADHD. Now let us consider responses to the CP for children with ADHD among the professionals in the system.
7 Rule Following - Responses to the CP for Children with ADHD

This chapter deals with the third research question: what are the responses to the clinical pathway for children with ADHD among professionals working in the system?

We have seen that the previous chapters described how the clinical pathway for children with ADHD was created in a setting with a great need for improved coordination, and how dedicated professionals along with some other employees shouldered the work of standardisation. Yet they did not have a free hand; they were assigned to do the work in line with relatively strong constraints around ideas of professionals’ “creative involvement” and the streamlining of health services promoted in policy documents, by the SINTEF Report, the Breakthrough Series and the official guideline for ADHD.

The clinical pathway has now been created, yet in 2006 it was merely a tool “in theory” describing and visualising all the interventions and treatments to control the actions and interactions of the various actors and organisations through a uniform organisational structure in order to reduce variation and arbitrariness in the system, problems of waiting lists, bottlenecks and lack of coordination between the organisations. The tool is posted on websites, brochures and manuals have been sent to all local authorities, general practitioners and departments of the specialist health services and now it is intended to be used by hundreds of people in the entire county: How do the professionals react to the pathway? How do they interpret this tool and how does it function in the workplace?

Most of the people I have interviewed about these experiences during 2008 and 2009 were members of one of the five teams to provide input to the proposals for the CP. They are thus basically “standardisers” or “rulemakers”; by virtue of their expert knowledge as psychologists, psychiatrists, health visitors and counsellors, they participated in various ways in the creation of the pathway. Since these rulemakers are professionals themselves, the tool will not only control other professionals, but also their own actions in the areas of screening, referral, diagnosis and treatment of children with ADHD. They had thus contributed to standardising their own work.

For analytical purposes it is possible to identify some specific issues connected to the question of the responses of professionals working in the system. In contrast to the three previous chapters, this chapter starts with views of knowledge in this CP.
The first section investigates the professionals' interpretation of the diagnosis of ADHD, including reflections on the streamlined approach. The next section looks at responses to the redistribution of workload and presents the concept of suboptimisation. The third part explores the status and role of the CP: do the professionals regard the CP as a standard or a directive? The chapter concludes with some reflections and afterthoughts conveyed by the frontrunners of the project, and finally a brief analysis of the findings and a summary.

A Comprehensive Pathway

The clinical pathway for children and adolescents with ADHD is very comprehensive, containing four key points along the treatment path (screening, referral, appraisal/diagnosis and follow-up/actions/treatment) and seven manuals, one for each of the different groups of actors involved. Apart from the manual for parents, this pathway intends to regulate the work of six different professions within the four key activities. I have therefore chosen to examine in more detail elements of two of the key points along the CP: referral and appraisal/diagnosis. Here, examples from the manuals are used as a background for analysing professional responses, and I will start by presenting some reflections on a characteristic hallmark of mental health care, namely that this field involves a great deal of diagnostic uncertainty.

7.1 Knowledge Ambiguity of ADHD Diagnosis and Medication

There are general difficulties in diagnosing within mental health care, as one child psychiatrist expressed:

Mental health is more fluid. If you suffer from a physical health condition, you can determine your condition by taking an X-ray, but for mental health, one will need to consult with different sources.

(Interview with BUPP child psychiatrist, December 08)

All diagnosis is basically uncertain, but through different kinds of assessment carried out by various agencies and professional groups, we gradually build up certainty as to whether a child has the ADHD diagnosis or not. The clinical pathway sets out the division of responsibilities for the diagnostic work:
The normal procedure is accordingly that the BUPP determines the formal diagnosis, based on their own examinations and material submitted by the GP and PPT. Make sure that essential information has been made available by the referring agency - obtain missing pieces if necessary. Functional specifications, differential diagnostic assessments, and assessments of additional difficulties are all incorporated in the diagnosis.

(CP Manual for BUPP, 2006, p.5)

We will now take a closer look at the reactions of professionals to the content of the clinical pathway at this point, taking as our basis the manuals for the PPT, GP and BUPP.

7.1.1 Coping with Uncertainty in Diagnosing

With a view to creating an overall picture of the information to be provided by the professionals as a whole, we show here a model constructed on the basis of the manuals for the PPT, the GP and the BUPP. As the symbols indicate, the ideal workflow in the pathway is that the PPT starts the assessment and forwards it to the GP who then refers it to the BUPP for final diagnosis. Many of the points below cover instructions for the use of specific standardised instruments for diagnostic clarification (text in bold).
### Table 7.1 Checkpoints in clarification of ADHD diagnosis

<table>
<thead>
<tr>
<th>PPT</th>
<th>GP</th>
<th>BUPP</th>
<th>END</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Development</td>
<td>Make a Quick Screening of ADHD Symptoms</td>
<td>Information from GP</td>
<td>END</td>
</tr>
<tr>
<td>General Psychosocial Functioning</td>
<td>Brief Medical Anamnesis Case History</td>
<td>Information from PPT</td>
<td>Plan for Clarification</td>
</tr>
</tbody>
</table>
| ASEBA | Medical Examinations | Consultation(s) with Parents | PPT
| Learning Assumptions/Ability Profile: WISC-III | Blood Tests: HB, ASAT, ALAT, Gamma GT; Thyroxin, TSH, Ferritin, Folic Acid, Coeliac Disease, MCV, MCH, MCHC, Urine Stix Test | Anamnesis Case History | Examination/Testing of the Child: (Conner's CPT)
| Educational Functioning: Pedagogical testing | Assessment of Somatic Symptoms and other Comorbidity/Differential Diagnosis | Information from Teachers/Preschool Teachers (School interview) | BUPP
| Consider other Testing that can Determine the Child’s Challenges and Abilities | Contraindications for Treatment with Psycho-Stimulants | Assessment by BUPP Doctors | BUPP
| Important Factors in the School Environment/Kindergarten | ADHD Criteria: KIDDIE-SADS, DAWBA, others | ADHD Criteria: KIDDIE-SADS, DAWBA, others | BUPP
| Strong Points, Interests, and Abilities of the Child | Differential Diagnosis: (Clinical interview) | Resources and Interests | BUPP
| Make a Judgement of Whether the Symptoms of ADHD seem to be Present: ADHD-RS, ADDES, ASEBA, 5-15, other checklists | Information and Comments | Information and Comments | BUPP

Table 7.1 Checkpoints in clarification of ADHD diagnosis

The evaluation and clarification of the diagnosis of ADHD are based on various standardised instruments used by psychologists and educational-psychological counsellors in the PPT, by GPs, and finally by educational therapists, psychologists and psychiatrists working in the BUPP. There may be discrepancies between these medical judgements because of the difficulties of interpretation of the sets of symptoms. The individual assessments of the young patients’ bodily experiences (often passed on by parents, teachers and others) can also show discrepancies. Collaboration with others in gathering information will depend on the age and the situation of the child, e.g. kindergarten or school, or contact with e.g. the child.
welfare office or a physiotherapist. The use of different sources implies different views and perspectives from professionals, managers, parents, children and others. How do the professionals cope with all this? All informants in this study expressed uncertainty about these activities in different ways; here I present some statements:

A psychologist working in the PPT put words to it. He is concerned about the fact that it is difficult to make diagnoses, in spite of various diagnostic tools available, and he is especially sceptical of early childhood diagnosis:

I would say it is extremely difficult for even the specialist health services to determine with certainty whether a preschool child has ADHD. In some cases it is relatively easy, but in many of those who later turn out to have ADHD, it would have been very difficult to make the diagnosis so early, I think.

(Interview with PPT Psychologist, October 08)

An educational-psychological counsellor who works at a different PPT centre provides a contrasting picture as she states that she is responsible for conducting these tests at her work. She expresses confidence in the various assessments, which is probably because the tests outlined in the pathway are consistent with the way she has always worked:

There I think our experience coincided very well with what the project group proposed. For example, we always use the WISC test, we've always used it.

(Interview with a PPT educational-psychological counsellor, September 08)

She goes on to talk about the various tests and concludes with a laugh, saying that they have used the Barkley and Aseba questionnaires since “times immemorial”.

I have little data on how the general practitioners themselves experienced this part of the pathway. According to the manuals, the GPs should conduct medical examinations and check for possible somatic comorbidity or differential diagnosis, but the diagnosis itself is made by actors in the BUPP.

Virtually all the informants I have spoken to have perceptions of the GP's role in the assessment. This is not so much a question of how far they follow what is prescribed in the “doctor's manual”, but rather frustration at the fact that many doctors simply refuse to accept these patients for assessment, with the consequence that the patients have to find a new GP to perform the assessment. As previously mentioned, several informants indicated that this may be because GPs are wary of
medicating children, but it may also be due to other factors which I will return to later in this chapter. The manual specifies the role of the general practitioner:

GPs will generally obtain information from health centres. The GP’s most important role at the clarification stage is to consider other, primarily medical (somatic) reasons for the child’s challenges, or whether such conditions can contribute to escalating the child’s difficulties. Due to medical treatment being appropriate for a large number of patients, potential contraindications for such treatment should be considered.

(CP Manual for GPs, 2006, p.4)

We will now consider some reflections of participants in the BUPP system. In one interview, a child psychiatrist constantly returns to the points that there is pressure for a speedy diagnosis, there are so many patients, and they have a waiting time guarantee of three months. In this way the assessments may be almost just “filling out a form”, which she does not consider ethically acceptable:

But I think .. you can get stuck in a rut and the assessment gets very mechanical…you do all the right things, you have the right questionnaires.. but as I said, you hardly see the parents or the families.

Interview with BUPP child psychiatrist, December 08

The informant’s statement presents a picture of her reservations about the standardised diagnostic procedure. It should be mentioned here that this child psychiatrist was one of two from child and adolescent psychiatry who a few years previously had participated in a local workgroup in the Breakthrough Series together with the psychologist from BUP (whom we shall meet later in this chapter).

An educational therapist from another BUPP centre says that she works well with the PPT in the assessment of cases, but cites a number of examples of internal disagreements at the centre, both about the medication of children and about the length of time it can take to diagnose:

Educational Therapist: …And it took nine months before she (the name of the BUPP doctor) had completed all the examinations she thought were necessary for that child...

Researcher: After the diagnosis was made?

Educational Therapist: Yes, after we’d said this was an ADHD boy. And I don’t think she disagreed herself. Then there were some other things she
wanted to make sure it wasn't first. But what I say is: "Why on earth couldn't we have tried out Ritalin first and taken the other things later?" Because I can't see that those things are so connected. But she's the one who's a doctor (laughs).

Researcher: But when you consider the fact that there are several professions at the centre, did she have support for her view, from her professional perspective, from other colleagues of yours?

Educational Therapist: A number of the psychologists are kind of sitting on the fence. Because psychologists are really supposed to do therapy. So they'll "therapise" them better. But you can't do... therapise children better, who have these kinds of problems. But basically there was not always agreement about it.

(Interview with a BUPP educational therapist, September 08)

Here we see clear professional differences in terms of both diagnosis and treatment. She describes three professional groups at the same workplace, each of which defines knowledge from its own professional perspective and thus uses the kinds of treatment it masters. The doctor and psychologists have a monopoly on diagnosing and the doctor has a monopoly on prescribing medication. The informant is the only professional at the centre who is not qualified to make diagnoses or prescribe medication, but she was certain the child had the diagnosis and wanted the matter to proceed quickly so that medication of the child could begin.

7.1.2 Ethical Reservations about a “Fast Lane” and Medication

Some of those involved were dissatisfied with the idea of following a streamlined process in light of the peculiarities of mental health. We have already had a glimpse of the reflections of the child psychiatrist on a standardised diagnostic procedure. Another issue is whether the CP leads to a “fast lane” in the system for a particular group of patients. The opportunity for the PPT and BUPP to take a case out of the waiting list and give it priority is an issue which was discussed in several places, and my impression was that this is connected to personal contacts between actors in the PPT and BUPP. A PPT psychologist is concerned about this:

For me it's a bit of an ethical concern. And then a new clinical pathway will come soon... I'm sure there's a new pathway in the pipeline.. then they'll be taken out as
well... What about those ones then, the ones who end up in the big bag labelled “undefined”, the ones who don’t belong to any pathway, they’ll just have to wait, will they? ….. So there’s a danger there..

(Interview with PPT psychologist, October 08)

This informant was one of the few who were sceptical to the idea of a “fast lane” but as described previously his reservation met stony ground in the rulemaking context. His words seem to demonstrate a professional concern about the standardisation of work, but he also shows resistance to the very idea of a clinical pathway for certain groups of children. He emphasises the number of children the PPT is in contact with, who are all waiting in line for services.

If you want Help, it is very Useful to Have a Diagnosis

Many informants point out the advantages of having a clinical pathway for children with ADHD. Visibility and knowledge dissemination help to increase the legitimacy of the diagnosis in society, but as the informants have already demonstrated, there is a relatively high degree of controversy in the field, especially regarding the medication of children.

As we have seen, medical treatment is explicitly mentioned in the manual as an appropriate treatment in line with a number of prominent studies and the steering framework of the SINTEF Report, the Breakthrough Series and the official guideline for ADHD. The biomedical knowledge base dominates; no other forms of treatment are mentioned in this part of the manual.

The manual states the advantages of a set diagnosis:

When a clear psychiatric element is not present, there is no reason to make a BUPP referral. In such situations, it is also important to weigh the advantages of a formal diagnosis. Certain benefits and valuable information are linked to a set diagnosis, and medical treatment is ruled out with no diagnosis. In quite a few instances, one may realise that the effects of educational and psychosocial efforts are limited when medication is not applied.

(CP Manual for PPT, 2006, p.4)

The benefits of obtaining an ADHD diagnosis are on the systemic and organisational level (as this diagnosis may cut costs in addition to the individual medication of Ritalin). Here we move into an area which I would call “the power of diagnosis”. An experienced health visitor specialised in mental health care shares her
thoughts on the advantages of a CP for children with ADHD, but is concerned about the disadvantages of a set diagnosis:

Health Visitor 1: At least we've got a strong argument to put forward, that it's important.
Researcher: Yes, about the diagnosis.
Health Visitor 1: Yes, that it actually is a disability, that's what it is. That it's not a kind of in-fashion diagnosis or, well, because you come across that.
Researcher: Do you often come across it?
Health Visitor 1: Yes, on occasions.
Researcher: Well, what form does it take then?
Health Visitor 1: It's what I'm saying, grown-ups who don't see the point of this, and there are some teachers who think there's too much hype about this or that there's kind of too much focusing on it, and "does everything have to have a diagnosis". So it's maybe a bit that ideological idea that you shouldn't diagnose everything. But that's the way the system is. If you want help, it's very useful to have a diagnosis. That's the disadvantage, putting labels on people, yes. It's a kind of, a bit that kind of ideology almost. Other disadvantages... I mean this is, looking at it that way you can imagine making an illness of almost normal variations... or people must be allowed to be different, and if they get a diagnosis, they can... I do see that point. If you diagnose a child... who's a bit naughty (in Norwegian: at man diagnostiserer Emil i Lønneberget) ...it makes him... more ill...

(Interview with Health Visitor 1, September 08)

As the health visitor points out, there are various comments and remarks about the diagnosis, and she is not the only one to make reflections on the advantages of a set diagnosis. Her reflections give the impression of the introduction of a steering system that advocates the diagnosis of children in order to receive help. She is not familiar with this, but otherwise she seems to accept the way the system is.
7.1.3 “You Have to Take What you’ve Got”

We see that the diagnosis is very readily connected to the testing of medication, which is the dominant form of treatment here. Several informants are concerned about the pressure from various quarters for diagnosis and subsequent medication, and one child psychiatrist says that parents sometimes insist, but it also happens that parents do not want their children to be medicated. This informant emphasises that they do not put pressure on the parents if they do not want the child to be medicated; it is in fact the school that tends to put pressure, as she says:

Because the children are supposed to sit still at school, and not disturb the others... so I think something can be done here.

In her experience, the medication has a positive effect on the vast majority of children, but she also feels there should be fewer pupils in a class and more teachers:

But that’s not the reality.. so then ..I’m quite sure many children could benefit from having smaller classes... and.. or having two teachers in the class.. where the teacher could keep an eye open, so then I reckon you have to take what you’ve got.

(Interview with BUPP child psychiatrist, December 08)

Here we see an example of how organisational determinants such as school organisation and resource use put pressure on the diagnosis and subsequent medication of children.

In this section we have seen how various professionals respond to the biomedical knowledge paradigm in the CP. Several of them express doubts about diagnosis and medication, which may be said to be in line with the long-standing controversies about ADHD. The next section in this chapter takes a closer look at the responses to the redistribution of the workload and the idea of suboptimisation.

7.2 Redistribution of Workload

We have noted the content of the manual regarding the types of assessment to be performed, and this section focuses more closely on the principles for a division of
responsibilities. The CP led to a shift of tasks away from the BUPP, primarily to the GPs and the PPT.

7.2.1 “What can be Completed Locally should be Completed Locally”

The manual states that the CP is designed to have GPs and PPTs conduct the basic analysis of the child, prior to involving the BUPP:

… This is because anything that can be completed locally should be completed locally. Family doctors and PPT have the expertise to make such clarifications at the local authority level. Yet these professionals depend on information, observations and judgments from parents, public health centres, kindergartens/schools, and others.

(CP Manual for PPT, 2006, p.3)

These statements describe a rule which has not yet been fully implemented by GPs and PPTs. In the previous section we saw that the manuals stated that the normal procedure was that the BUPP determines the formal diagnosis, based on their own examinations and material submitted by the GP and PPT. Here are instructions from the manual for the PPT underpinning this rule:

The PPT has performed most of the clarification process in several ADHD related cases. As the diagnosis is formally determined in the Specialist Health Services, it is customary that the PPT in their reports use wording such as ‘behaviour compatible with the ADHD diagnosis’.

(CP Manual for PPT, 2006, p.4)

This text in the manual for the PPT establishes the BUPP’s domain in diagnosing and points out the dividing line between the specialist health services and the local services.

The issue of the redistribution of workload between specialised and local services made professionals from the latter generally sceptical to the effects of the CP on their work. As a PPT psychologist explained:

Psychologist: … the diagnoses had to be determined at an early stage in order for the patients to be treated as soon as possible…. the patients were also to be medicated as soon as possible, and consequently discharged…
At the time of the interview, the PPT was in a stressful work situation, with many groups of children with great needs. He had difficulty with the idea that it would only focus on one of these groups. In his view, the local authority would be left with much of the workload since all children who were detected would be assessed by the PPT.

The child psychiatrist working in Child and Youth Psychiatry confirms these reflections:

The entire concept (of CPs) was designed in order to avoid some work … there is no point in having us (in the specialist services) spend a lot of time doing the job of the local services. This would lead to a greater accumulation of tasks as we would have to complete the basic clarification, anamnesis, and so forth, to then finally produce the diagnosis.

Another informant in the specialist services says that there were several tasks that the local services now had to do that they previously did themselves. A psychologist in the BUPP explains:

Researcher: Discharged from what?
Psychologist: From the Specialist Health Services.

(Interview with PPT psychologist, October 08)

Researcher: At the time of the interview, the PPT was in a stressful work situation, with many groups of children with great needs. He had difficulty with the idea that it would only focus on one of these groups. In his view, the local authority would be left with much of the workload since all children who were detected would be assessed by the PPT.

The child psychiatrist working in Child and Youth Psychiatry confirms these reflections:

The entire concept (of CPs) was designed in order to avoid some work … there is no point in having us (in the specialist services) spend a lot of time doing the job of the local services. This would lead to a greater accumulation of tasks as we would have to complete the basic clarification, anamnesis, and so forth, to then finally produce the diagnosis.

(Interview with BUPP child psychiatrist, December 08)

Another informant in the specialist services says that there were several tasks that the local services now had to do that they previously did themselves. A psychologist in the BUPP explains:

Researcher: What’s missing there then?
Psychologist: Yes, we used to do the whole assessment package more often than we do now. I think so, yes. And the latest referrals I’ve had of the little ones, very good thorough work has been done there, following the pathway just the way (unclear). the whole thing, it’s just the bit with the doctor that’s missing then.

Researcher: But that’s not supposed to come to you, is it?
Psychologist: No, it has to go via the doctor, but these things haven’t been done according to the pathway, he hasn’t done that.

Researcher: Do you do it then, or what?
Psychologist: No, that’s when I try to send them back with a copy of those brochures, that they have to start a medication evaluation like this and so on. Through the doctor first.
The psychologist’s example is one of several ways to deal with this. She keeps strictly to the pathway, and commends the local PPT centre for also doing so. But according to the manual, the GPs should complete the medication evaluation and then refer to the BUPP. She therefore sends the case back to the doctor. Others I have talked to solve this in different ways, and since some GPs refuse to have anything to do with these patients (especially regarding testing of medication), the BUPP can then begin testing without the patient having been to the GP. Another alternative is that the GP in collaboration with the parents refers directly to the BUPP. The BUPP refuses the case because there has been no basic assessment from the PPT. The parents are then referred to the PPT, where the child is put on a waiting list for up to six months before the assessments start. After this, the case goes back to the GP, who then refers the child to the BUPP. It is interesting to note, however, that the BUPP manual encourages certain flexibility on this point, stating that the BUPP sometimes must deal with incomplete referrals, but there is considerable variation in exactly how these activities are carried out.

Here the informants point out that the shifting of responsibilities can help to free up resources in the BUPP, but this shifting will naturally depend on someone “taking over” the tasks as prescribed in the CP manuals. I will return to this subject later. The streamlined model outlined in the CP therefore (not surprisingly) encounters a more complex reality with a variety of different organisations and professionals with different approaches.

Reflections on the diversity in organisational solutions are described as follows by a very experienced PPT psychologist:

Psychologist: .. I think there are just as many models as there are educational psychological services.
Researcher: Hmm, I think so too!
Psychologist: I think that’s a bit of a problem for the users then. You never know what you’ll get but that applies to BUPPs.. the profile and design and so on… so it’s not like buying chocolate… well, there too, you know.. chocolate tastes different.. so.. it is a bit of a problem that.. depending on the person and the system…

(Interview with PPT psychologist, December 08)
The informant emphasises precisely why I have limited this chapter to a consideration of the professionals’ response to the two key points of referral and assessment/diagnosis in the clinical pathway. But most importantly, the quotation stresses the problems of standardising these activities. However, in fact the professionals find a variety of ways to solve this matter.

“The Department of Creative Referrals”

The professionals care about the patient's best interest and are creative in referring to the BUPP in such a way that patients are given priority and do not end up in the waiting list queue. The PPT manual states that the PPT can ask the BUPP for help with the basic assessment under special circumstances, thereby dispensing with the procedure. Where there is good cooperation between the PPT and BUPP, these activities take the form of a joint project and here several informants mention that this was in line with “the way they have always worked together”. In such cases there are often personal contacts between the two centres. If there are no personal contacts among the actors, another time-saving example given by the informants is arranging for parallel PPT and BUPP assessments.

7.2.2 Professional Boundaries and Jurisdiction of a Field

PPT now has more tasks than before and several of the PPT staff react to the fact that they have less contact with the BUPP than previously. One psychologist says that they have had a big discussion at the centre about one of the points in the pathway, which concerns getting feedback on referrals:

…they weren’t obliged to do it. They were only obliged to send the letter to the GP... The GP was supposed to be a kind of kingpin in all this.

(Interview with PPT psychologist, September 08)

Here the GP is given a key role in referring to the BUPP, but if the PPT had received a copy of the letter that the BUPP routinely sent the doctor and the parents, they could have received confirmation that the case had arrived. Now they see that something they had before is missing. Health visitors I talked to also feel overlooked with regard to referral and assessment. Very often, they conducted various clarification activities in collaboration with the children’s family, followed by
contact with the clinic doctor to sign the referral to the specialist health services. This agreement had been established as a norm for collaboration with the doctor at the clinic, but also with professionals at the BUPP. The CP brought about a change:

Health Visitor 2: and, and we had discussions about it here and.
Researcher: What was it about?
Health Visitor 2: It’s been about the fact that we at the clinic previously did a lot of the work which the GP was now going to do. We’ve referred to the BUPP, we’ve referred to others, we’ve had the talks, and now we couldn’t do this any more. Now everything had to go via the GP. And we’ve gone many rounds on this, and we’ve missed it. We miss in a way being in charge, knowing about the family, that the families are using us and we haven’t got, it’s even led to us not getting discharge summaries from the BUPP. We’re not involved in the families the way we were before when we could make referrals and they contacted us to get that help.

Researcher: Is it caused by, or is it a consequence of, the clinical pathway?
Health Visitor 2: Yes. I would say so. Or not entirely. We got that GP scheme. That came before. But they were so very, it was maybe not exactly in connection with the clinical pathway, but the BUPP changed its routines, and wanted us to go via the GP. And not the clinic doctor like before.

(Interview with Health Visitor 2, September 08)

Here the health visitor points out an important factor, that they had actually lost a position with regard to following up the children who needed it. The close contact they had with doctors at the clinic was in any case undergoing a change at this time as a result of the General Practitioner Reform of 2002. The children who come to the clinic are seen by both the clinic doctor and their GP. All children have their own doctor, which means that health visitors have a large number of doctors to relate to. The GPs are most frequently involved in e.g. the collection of anamnesis data, meetings with the patients and their families and somatic clarification and less in interprofessional collaboration with other actors in the system. They are relatively little involved in the chain of services of treatment and interventions and many of the informants emphasise the peripheral role of GPs in referring to the BUPP. The health visitors lost an important aspect of responsibility, namely the contact with GPs and they also lost the contact with the BUPP. The displacement of domains is confirmed by nearly all the informants; here an experienced health visitor specialised in mental health care describes the GP’s role:
Researcher: Do you notice that the clinical pathway makes for any change in the way you organise your work tasks? …

Health Visitor 1: Yes, I've already said a bit about that, the role of the GP. That's all well and good, but it's made them less available, I think quite a lot of children aren't getting the help they should have had, because they're referred to a GP and are dependent on the GP's understanding of the case. It depends on the parents' ability to describe it. A GP has little time, it's person dependent, there are many factors, so well, you easily lose control of it then. And it's also to do with the fact that I think the nurses can almost get a bit sulky. When those GPs don't want to cooperate with us, well, we don't want to cooperate with them. Are we supposed to sit writing a referral, and then he's the one who gets paid for it? So we don't get anything back? You can call it sulky all right, but it's a question of a bit.. it's difficult to follow up a family, if there's no interaction. On the other hand I think it again raises the point that we actually have to spend more time on these families. You have to give them priority; you can't do them in 10 minutes...

(Interview with Health Visitor 1, September 08)

The two health visitors' statements indicate a power shift between two professions, public health nurses and GPs, where the nurses have lost a position to the doctors. The CP states that referral and diagnosis are largely a question of activities in the interaction between the PPT, doctors and the BUPP, which results in a division of responsibilities which may give the nurses a more peripheral role. Doctors often rely on nurses providing partial reports in diagnostic work, but the health visitors are now reluctant to do so. It is interesting to note that the shift in duties prescribed by the CP also involves shifts of power; not only between the specialist services and local services, but also between actors at the local level. As I interpret the nurses' statements, the criticism is directed at the doctors and their role in the interaction (which many other informants have expressed opinions about) but there is little awareness that it is the CP as a regulatory instrument that prescribed this distribution of responsibilities. Now we will take a closer look at the possible role of the GP in this context.
7.2.3 Reflections on Suboptimisation

As previously mentioned, the project of the CP for children with ADHD was formally concluded in May 2006 and due to difficulties of implementation, especially in the local services, the agenda was then to work on a revision in order to adjust the CP. I had the opportunity to participate in some meetings with two of the same people who had taken the initiative to create the pathway, i.e. those representing child psychiatry and HR, and two of their colleagues. The topic under discussion was a revision of the pathway, and the participants included a paediatrician, a psychologist, a specialist in pedagogical psychological supervision (“PP supervisor”) and an advisor from the HR department. The psychologist participated in the Breakthrough Series some years ago and is still the head of the CP.

An extract from a meeting illustrates an open-minded attitude among the professionals. As a number of GPs are resisting the CP, the (former) CP makers are in negotiation with the GPs. As for the role of GPs, an experienced paediatrician states:

Paediatrician: Yes, and that it won’t be one of the many things.. that the GPs get annoyed about, all the directives they get from the specialist health services. As we gradually scale down and save money. And.. then it will.. for years we’ve been doing it in the specialist services and then one day: “No, now we have to save money”.. “Now we don’t have time any more” and.. “Over to you”. And the GPs experience one thing after another, paperwork, they’re sitting down every day for hours with paperwork, applications, sick leave notices, meetings as you say, more and more things they’re obliged to attend a given number of hours and at the same time earn a few pennies for their staff and themselves and preferably more than that. It’s not easy to be a GP. I really have great respect for them.

(Psychologist interrupts, Paediatrician continues)

Paediatrician: “Here you are, here’s the plan”, you have to use it, you must understand that.. the GPs in (County) ought preferably to be a collective body. Which says, “This is a good idea.”

Psychologist: But we must build on the principle that things go from the specialist health services and back again.. otherwise..

Paediatrician: Yes, yes, but it mustn’t mean that if we pick out two doctors in the county, three doctors in the county, then we sit down and make a clinical pathway. And then it’s sent out to all the doctors. Who
haven’t done it before. Then you have.. well, I don’t quite know.. but if you have one body for all the GPs in the county then.

Psychologist: Yes.

Paediatrician: And they elect their representatives at some meeting or other (bangs the table as he speaks), an annual meeting or something.

Psychologist: Yes.

Paediatrician: To be involved in that plan.

Psychologist: Yes.

(Participant observation, status meeting, August 09)

The specialist health services at this time generally had a focus on cost containment, and at the same time a reduction of waiting lists, since the government had decided on a “waiting list guarantee” policy for all patients. This issue resulted in conflicts between specialised and local services, and undoubtedly the CP was expected to reduce the pressure on specialised services, as seen from their perspective. The paediatrician puts words to the hospital’s demand for optimisation, saying that GPs are getting too many tasks piled up on them. He is the only doctor in this meeting and he clearly represents his own professional group. But he represents an important voice in this evaluation, since GPs play a significant role in the clinical pathway. We have seen that doctors faced conflict concerning the division of responsibilities at the local level (health centre) but here we find further signs of pressure on doctors in the form of an optimisation paradigm involving an increasing number of tasks to deal with. Here, the paediatrician also puts words to an unintended result of the design process, namely the lack of involvement of GPs in the creation of the CP; this was rather problematic because the GPs have no collective representative body. The status meeting concludes that they can return to the topic when they get to the question of revision.

Such aspects of the hospital’s cost containment strategy lead to a certain suboptimisation of the mental health care services. The agenda of “not doing what others can do” provides a logistical and rational justification for making a CP for ADHD. It is also in the spirit of the principle of the “lowest effective care level”. However, the locally based services were not ready to perform new tasks, and several local authorities were in addition ill equipped as they already had many children waiting in line for clarification before referral. An example is the PPT where there is no waiting time guarantee and children sometimes wait for months for clarification. Let us now consider the informants’ interpretations of the status of the CP.
7.3 Different Interpretations of the CP: a Directive or a Standard?

One important question raised in my data is about the status and role of the CP: should the tool be considered as a directive or a standard? On this rather crucial point, disagreements and ambiguity among professionals working in the field and other actors were observed. The formal status of the CPs in this aspect was unclear for nearly all the informants in the study. Some of those involved regarded the CPs as a directive, and any deviance from the regulations at the level of individual professional performance was considered as a breach of the rules that would blur the anticipated process. Others considered the CPs as “advice”, or guidelines that had to be confronted with the logic of appropriateness in individual cases when a patient met with the professional.

Even those who were in the driving seat during the design process do not agree entirely on this point. The following sequence was taken from a status meeting I attended with participants from child and adolescent psychiatry (the same meeting as above). The extract from the meeting starts with a sequence where I as a researcher report from the study, followed by a team discussion where they air their thoughts about the tool:

PP supervisor * And maybe the word’s wrong, I’ve thought that sometimes. But that’s another discussion. That the clinical pathway tool can’t so easily be used like that.
Psychologist: As coordination, you mean?
PP supervisor: Yes, maybe more like an advisory plan or.. some kind or other.. like that.
Paediatrician: That’s not what it is.
PP supervisor: No, but it’s some word or other I haven’t got right now. But it’s still very useful if you could get it to work, I think.
Several: Hmm.. yes.

Participant observation, status meeting, August 09

* Specialist in pedagogical psychological supervision

This sequence illustrates the ambiguity of the term “clinical pathway” used in this setting. The PP supervisor is not comfortable with the term, whereas the paediatrician says it is not an advisory plan. They did not continue on this track, but went on to talk about the various challenges in implementation, which I shall return to later. Here it is important to note that this meeting took place three years after this CP was completed, and that this pathway was the first to be based on a psychiatric diagnosis. During these years the hospital has focused quite strongly on
the clinical pathway concept and has initiated several new pathways, including others in mental health.

One child psychiatrist also discusses the actual concept of a clinical pathway. She is concerned that there are such huge differences in the various districts of the county, and that there is so much difference between other kinds of patients and those they come into contact with:

       Psychiatrist:  .. if you look at the pathway like pathways for somatic complaints… you often have one thing.. you have ulcers.. and bang bang bang… and here you have… in a way it’s… this clinical pathway is sort of not a proper clinical pathway because there’s so much in it, I feel. So in a way it’s not a clinical pathway, it’s a way of working with ADHD. In a pathway you have clear steps.  
       Researcher:  Do you?  
       Psychiatrist:  And it’s different in this case. And I think that makes.. that makes it in a way… in a way it’s very good. I mean, it’s good publicity, but the implementation isn’t quite as intended, because it’s not the same.  

(Interview with BUPP child psychiatrist, December 08)

It should be mentioned that this informant is easily recognisable as one of the two professionals who participated in the Breakthrough Series.

It is perfectly natural that not everyone understands the rules of the pathway in the same way; in fact it would be surprising if everyone had done so. In my data, there is a clear distinction between those who feel that the pathway represents an explicit standard based on existing norms (this is how we do it today) and those who feel that it represents a break with these norms. This has been an important theme for the professionals. Those who work in child psychiatry and those who say that they cooperate well with the people who work there belong to the first group. On the other hand, those people who have felt they were outside the process of creating the pathway and who are sceptical of the knowledge base belong to the second group. This group relates to other rules and norms than the ones proposed in the pathway. However, what creates a problem is when two or more parties have to cooperate on a case, e.g. an assessment. One considers the pathway as a standard, another considers it a directive, and a third party does not relate to the pathway at all, i.e. he or she relates to other rules. The logic of appropriateness reveals itself as a mechanism here, but I shall return to this in the concluding part of this chapter.
7.3.1 Afterthoughts of the Project Management

I will conclude this analysis by moving on to some of the previous rulemakers’ reflections in the second status meeting in the specialist health services. No resources have been set aside to organise the work of revision or adjustments or to keep the CP tool “alive”. It has been three years since the CP was produced and the same BUP psychologist (who was in the driving seat in the design of the CP) is still mentioned as the contact for this CP. Here his colleague puts words to this, but this seems to be too big a topic to address for the rest of the group.

“A Much Bigger Piece of Work”

Paediatrician: That’s what I mean by the difference in clinical pathways. what there is. within specialist health services, the work they do there. like the first bronchiolitis, for example, to do it right and count the number there. it was in. (unclear 28:03) but an ADHD clinical pathway is special because it. it involves the council apparatus. and it. it’s a much bigger piece of work

Several: Hmmm

Paediatrician: ...and much more complicated. And that means. if you’re to evaluate and all that, then you must have other partners. so this Coordination Reform is a great tool to. to give it a firm basis. There’s cooperation out there. including external things related to the client and it’s obvious that things will work properly then. not just within the BUP system. so. this coordination which is being examined and the identifying and so on. so there must be something dynamic there. That. that costs money, I should think. To run it, to get people involved and (speaking a little louder) I’m just saying. that if you’re going to keep on doing it, during working hours. then it must have a kind of official basis. and also in the coordinating bodies which exist between the hospital and the local health services. then it must be. then one can impose. i’d almost say practice coordinators and others who. are supposed to be good at this and get things to work together. But it. it has to sort of start at the top as well.

Psychologist: Yes, I think so, to really ensure continuity. we did in fact go through it in the minutes of the meeting. there was quite a bit of debate about the one part then. And. (clears throat, laughs a little) if we keep to the agenda then. because that’s been said. then we
can draw a few conclusions along the way instead.

Participant observation, status meeting, September 09

This sequence shows how these professionals describe the complexity of this CP compared to the internal CPs in somatic health care. It demonstrates the professionals’ sense of responsibility for this CP and the paediatrician’s statement that “it has to start at the top as well” indicates that the management is not involved in this work. The professionals produced the tool without management involvement and there are no resources to evaluate it, which was in fact a major problem for future revision work on the CP. The reflections shared in this group show that it is still the professionals (especially the psychologist who is still the contact person for the CP) who have to shoulder this work with little support or resources from management.
7.4 An Analysis of Rule Following

On the question of what might explain the various responses by the professions to the pathway for children, I assume that the data speak for themselves. The presentation in the first part of this chapter includes several dimensions of standardisation and rule following which deserve a thorough analysis; some elements of this analysis receive a sketchy treatment here, but I shall return to these in the discussion chapter of this thesis.

In the data on rule following, we have had a glimpse of the varying responses of professionals to this clinical pathway. Standardisation is based on expectations that some organisations and actors will adhere to the standard concerned, or at least that they will consider following the standard, since the main theoretical framework for understanding the data of rule following is the logic of appropriateness (March & Olsen 1995, March 1994:57, Christensen 2007:40, Brunsson & Jacobsson et al. 2000). The professionals will act according to what is considered appropriate in a given situation (March 1994:58), i.e. “a match of behaviour to a situation” (March & Olsen 1995:39). And that is exactly what these professionals do; they relate to the CPs to the extent that they find appropriate. The professionals are by no means unfamiliar with procedures, manuals and guidelines; these form part of their everyday work. As Knudsen and Vinge point out, it is important to affirm that professional work in health and social services is to a great extent already structured, systematised and standardised through various regulatory tools (Knudsen & Vinge 2003). Nevertheless, the pathways studied here represent rules that specify interdepartmental or inter-organisational regulation between the actors in the system. As argued by Perrow (1986), conflicts appear when different professions with different backgrounds and preferences compete for power and autonomy regarding resources and positions within and between organisations (Perrow 1986:132).

Another rather unusual aspect of this CP is its scope. There is an obvious correlation between the extent of the CP and the challenges mentioned by the informants; I shall return to this in the introduction to the discussion in the next chapter.

7.4.1 Regulation of Professional Practice

Given the fact that this CP only applies to a certain group of patients, it would seem reasonable to conclude that it represents a regulation of professional practice in only
a very small proportion of everyday work. And this is in fact quite correct. However, I would still argue that professional practice can be influenced by the new steering framework with its ideas on streamlined services and not least by the fact that these professionals have been in charge of the standardisation. The data reveal actors who find the CP appropriate through their expressions of commitment, engagement and loyalty, and other actors who find the CP inappropriate, expressed by withdrawal, denial and even hostility. These findings are in line with Ackroyd and Thompson’s (1999) conceptualisation that ‘distinct forms of organisational misbehaviour are the characteristic artefacts of distinct managerial regimes’ (1999:75). I refer to this quotation from Ackroyd and Thompson (1999) since the CP as a knowledge-based regulatory tool represents an inter-organisational control regime for professional practice. Although there is a danger in this approach of simplifying a relatively complex phenomenon, I have chosen to base the following analysis on such a division. It is difficult to make clear distinctions between the different types of reactions, but I present below some reactions from certain professional groups and individual actors that I find worthy of particular attention.

7.4.2 The “Followers”: Commitment and Engagement?

The heading is in the form of a question because there are many who follow the CP manuals but still find alternative solutions in cases where they consider the manuals inappropriate. These “followers” were mainly working in child and youth psychiatry (BUPP) as psychologists, educational therapists and a psychiatrist, but also in local authorities, mainly at the PPT. The actors involved in designing the clinical pathway confirm that most parts of the tool in fact made rules by formally validating the activities they are actually performing on a daily basis. These actors find the CP natural and legitimate and the rules matched closely with their professional identity. The data show that these professions such as psychologists, health visitors and psychiatrists through their common view of the potential for streamlining the services have shaped a common identity based on the biomedical knowledge paradigm of ADHD, i.e. the prima facie knowledge. In interviews, several informants working in local health care services expressed stronger identity with professionals working in specialist health services (child and youth psychiatry) than with colleagues in their own profession and in other professions in their own organisation. Thus, in a pluralistic view, these actors can possess multiple identities because of their multiple institutional memberships (March 1994). Here, a common identity led to commitment and engagement in rulemaking, but also loyalty to the instructions in the CP manual. Following the logic of appropriateness, these actors act upon institutional rules and do their best to fulfil the obligations inherent in their
institutionally determined identity. Rules are followed because they are seen as natural, rightful, expected and legitimate (March & Olsen 2004). To act appropriately is to follow collective practice of what are (often tacit) mutual understandings of what it is right or natural to do. And here they develop good practical collaborative solutions for these children, even if their work does not always represent a rigid adherence to the CP.

7.4.3 Those “Left in the Lurch”; Withdrawal, Denial and Hostility

These informants were working in local councils but also in specialist health services; in interviews and the two meetings they convey their own and their colleagues’ views of the CP. Here, the CP was felt to be dysfunctional in relation to practical everyday work, but they also had reservations about the idea of streamlining the services for these patients.

As demonstrated in the analysis of rule production, some informants were concerned that they did not have the potential to influence the content of the CP; in particular, this is related to their experience that the pathway was almost finished when the five teams were established and of course the fact that the doctors did not participate in the design process. Not being listened to or taken seriously is perceived as unfair, and this may influence the outcome (Leventhal 1980), i.e. the decision to adhere to the pathway manual or not. This has similarities with the logic of appropriateness, but here, the question of loyalty to the pathway appears to be related to the informants’ feelings of being “left in the lurch”. This is particularly true in cases of loss of duties and responsibilities, as for health visitors. But it also seems to be the case where the actors were given new tasks and more responsibility. This applies especially to those working at the PPTs, and not least to GPs. The latter professional group was scarcely involved in the design process and my data reveal clearly that many GPs do not relate to the clinical pathway at all. This was a well-known problem, which is evident in the sequence from the evaluation meeting in child and youth psychiatry. March and Olsen (2004) provide an understanding of the importance of actors’ involvement; “The key democratic institution for ensuring rational adaption of rules is free debate where actors have to explain and justify their behaviour in public through reason based argumentation within a set of rules defining appropriate debate and arguments” (March & Olsen 2004:12). Of course we do not know what impact it would have had if doctors had been involved in the standardisation work. They had a central role in the CP, but based on the interviews with the other actors it would seem that the doctors’ presence might have resulted in “upsetting the applecart” for the standardisation implementation. It is well known
that doctors distance themselves strongly from this CP. But in fact it seems that they still have to relate to it, because when the BUPP receives a referral from a doctor who has not followed the manual, it can be returned to the doctor with an instruction to act according to the manual. It is thus problematic that professions - by virtue of their autonomy - can simply refuse to use the manual, because here the CP may lead to professionals controlling one another. And in this case it is the BUPP which dictates to the doctors with the help of the CP as a regulatory tool.

We have now seen various reactions among the standardisers from one of the five teams. Finally I will draw attention to those who sat in the driving seat, although the road was already decided. Through the Breakthrough Series and the subsequent standardisation of the CP for children with ADHD, certain actors represented a hybridisation between medicine and management, especially the BUPP psychiatrist and the BUP psychologist, but also the advisors from the hospital. However in the absence of a formal power portfolio throughout the design process and now during the revision of the CP, these actors still shoulder the work alone. Particularly the observations of the two revision meetings give the impression of a certain powerlessness in the effort to get this CP up and running.

These actors took the task upon themselves with strong support from the state, and thus in a way they entered into a contract to carry out quality and development work. The BUPP child psychiatrist who took part in the Breakthrough Series and led one of the five CP teams is one of the “followers”, but expresses at the same time clear reservations about the streamlining of work with these patients, as also mentioned by several of the more peripheral players. This clearly suggests that several key players no longer sympathise with the form of steering behind the whole idea of making this CP, and we are now far removed from the idea of “the professional's involvement and creativity”.

A question I feel it is pertinent to ask is whether such expressions of doubt can be understood in light of the fact that the standardisers themselves have been marginalised when they have to relate to a form of steering that they may not approve of.

7.5 Summary of Rule Following

The CP for children with ADHD is very comprehensive, containing four key points along the treatment path (screening, referral, appraisal/diagnosis and follow-up/actions/treatment) intending to regulate the work of different professions.
within these four key activities. For this reason, I limited my detailed examination to two of the key points along the CP: referral and appraisal/diagnosis.

We have seen a variety of different reactions to the clinical pathway for children with ADHD launched three years ago. The foundation for this CP is strongly linked to the biomedical evidence based knowledge and techniques conveyed by the state control signals via the SINTEF Report, the Breakthrough Series for ADHD and the ADHD guideline. There were thus powerful forces representing a steering framework for the standardisation process. In the first part of this analysis, the informants reveal that standardisation did not eliminate the uncertainty that characterises (and always will characterise) mental health care, and the clinical pathway did not remove the uncertainty in the field of ADHD.

Based on what the professionals say (most of whom have two years’ experience from the standardisation process and three years’ experience of using the tool at work), the data demonstrate that the CP as a knowledge based regulatory tool influences the professionals’ role in different ways as the emergence of various potential conflicts around the distribution of tasks and responsibilities between professions, agencies and the hospital is revealed. The CP regulates the domains of certain professions and organisations by clarifying and sometimes altering the division of responsibilities for assessment and diagnosis between the organisations; nurses feel they have lost some duties, the PPT has gained duties and GPs are assigned a key role in assessment but had a reserved attitude. Such an attitude may be put to the test because the tool enables professionals to control each other’s work performance.
8 Towards Scientific Bureaucratic Medicine in Mental Health?

This chapter discusses the question of whether the institutionalisation of “evidence basing” represents a new form of governance of professions, considered here in light of the emergence of “scientific bureaucratic medicine” in a regulatory landscape. The starting point for the discussion is that I view clinical pathways in a broad sense as “regulatory instruments, intending to bring actors to think or do something they might not otherwise do” (Salamon 2002, Lascoumes & Le Gales, 2007). As an introduction to the discussion, the first section presents the findings from the study in a table showing different forms of clinical pathways and potential challenges/responses. The second section discusses “training for certainty” by evidence basing and the third section outlines the findings in the model of “circulation of evidence based knowledge” showing how the institutionalisation of “evidence basing” indicates a new form of governance of professions. The fourth section considers the pragmatic mix of “old and new” governance followed by a discussion of “soft bureaucracy” in the fifth section.

8.1 Different Forms of Clinical Pathway and Potential Challenges

This section starts by presenting the findings from the study in the form of a table that shows different forms of clinical pathways and also reveals the potential challenges of the two different CPs in mental health care. In the table below, variations in the status of the knowledge base and the area of application are combined.
Table 8.1 Different forms of clinical pathways and potential challenges/responses

<table>
<thead>
<tr>
<th>Knowledge base/area of application:</th>
<th>“Certain” - based upon one diagnosis</th>
<th>“Uncertain/controversial” – based upon several diagnoses or comorbidity with one diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Internal”</td>
<td>“Simple” (I) “Internal guidelines”</td>
<td>Multi-disciplinary collaboration (II)</td>
</tr>
<tr>
<td>Confined to one or a few hospital departments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Complex”</td>
<td></td>
<td>CP for adults with ADHD</td>
</tr>
<tr>
<td>Several hospital and local authority agencies</td>
<td></td>
<td>Complex, multi-disciplinary collaboration, management models – (IV)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CP for children with ADHD</td>
</tr>
</tbody>
</table>

Table 8.1 Different forms of clinical pathways and potential challenges/responses. Adjusted from original source: Ramsdal & Ramsdal (2007)

*Internal Multi-Disciplinary Collaboration*

The CP for adults is placed in Square II in the table above. Uncertainty in the knowledge base for adults with ADHD was based upon comorbidity with the diagnosis, often a combination of ADHD and substance abuse, as there were only a few studies showing the effect of medication or other treatment (compared to the number of studies of the effect of medication on children with the same diagnosis). Here, the empirical research carried out on the CP for adults with ADHD showed the uncertainties the CP makers had to cope with during almost the entire production period. But here they could receive help from the leader to decide on important fundamental clarifications along the way, and the CP makers even took some steps themselves to reduce the uncertainty. The CP for adults was confined to a few departments within the Division for Psychiatry at the hospital. The organisational and the professional framework went hand in hand and provided opportunities but also restrictions in the work of standardisation. There are yet no empirical data on the implementation of this CP.

*Complex Multi-Disciplinary Inter-Organisational Collaboration*

The CP for children with ADHD is placed in Square IV in the table above. Uncertainty and controversies about the knowledge base combined with the
extensive complexity of the service system included in the CP makes implementation problematic. Here, the empirical research on the CP for children with ADHD carried out in the hospital trust dealt with inter-organisational pathways between hospital and local authority services, concerning (potential) patients with symptoms of deviant behaviour which were vague, but related to ADHD diagnoses. Here, there is even a stronger need for explicit formalisation of the processes involved, since the lack of clarity of the system boundaries is greater and the number of professionals involved is higher. Furthermore, loyalty to the knowledge base underlying the CP cannot be taken for granted, and the complexity of the implementation system easily makes other considerations and actions outside the CP procedures more likely to disturb implementation.

I would like to emphasise that evidence-based medicine with scientifically grounded studies is in itself a very important source of knowledge for professionals, including those in mental health care. We will now examine whether evidence basing can help reduce the degree of uncertainty in clinical work.

8.2 Training for Certainty by Evidence Basing Mental Health Care?

Mental health care is characterised by a relatively high degree of uncertainty, and within medical sociology and especially in the evidence debate there are differing views on whether standardisation using evidence-based medicine can help to reduce the degree of uncertainty. According to Atkinson (1995), there is a potentially complex set of attitudes and relations concerning knowledge and practical activities and it is unwise to try to capture them all under the rubric of uncertainty (Atkinson, 1995:110-115). However, I still believe it is relevant to discuss this topic, because when a field is uncertain, it is natural to express a need for tools to help reduce the uncertainty and many researchers argue that evidence basing is an appropriate tool for this purpose.

On the one hand, the CP concept stresses the logic of certainty and objectivity in the knowledge base in order to standardise. On the other hand, mental health care is characterised by ambiguities and uncertainties in the knowledge base, which suggests incompatible logics. Mechanisms of “initiated ignorance” and “being in a straitjacket” showed that it was possible to eliminate the uncertainties “in theory”, but can training for evidence basing provide certainty in mental health care?

Based on an in-depth analysis of paediatricians participating in two training programmes, Timmermans and Angell (2001) argue that managing uncertainty develops along with what they call “evidence based clinical judgement”
One might argue that examples from medical training programmes are distant from everyday practice in the profession, but what they show strengthens Atkinson’s point of view when he elaborated the notion of *training for certainty* rather than training for uncertainty (Atkinson 1984). Thus they suggest here that evidence basing has the potential to help reduce uncertainty in medical work.

Both the scientific bureaucratic medicine model and the critical appraisal model seem to undermine personal professional knowledge in the field (Harrison 2002). However, the critical appraisal model focuses on ensuring that professionals can be trained in these skills. However, I have my doubts as to whether “training for certainty”, using evidence-based solutions, can help reduce the uncertainty that exists in the field of mental health care. It is certainly important that clinicians gain expertise through studying relevant research, but the very nature of mental health care often implies a high degree of uncertainty in the knowledge base, and this cannot be eliminated. However, with regard to the degree of discretion, which is the cornerstone of professional work (Freidson 2001, Grimen 2009), evidence-based solutions may help to complement or inform this discretion. In this respect contextual and evidence-based knowledge go hand in hand in professional practice.

Let us now examine a model that shows how the CP concept helps to institutionalise evidence-based knowledge.

### 8.3 The Circulation of Evidence-Based Knowledge

Here we discuss indirect state steering through the creation of a number of agencies, guidelines and tools that help to institutionalise evidence-based knowledge. And here sociology of the professions is linked to political sociology of policy instruments and instrumentation. Here, the findings from this study of CPs for ADHD are placed in a diagram demonstrating the circulation of evidence-based knowledge.
The explanation of the model is that one starts with “Steering tools” and follows the arrows from left to right. “Steering tools” is the substantial state control initiative via the SINTEF report, the Breakthrough Series and the national guideline for ADHD. As we have seen, it was actually an international management institute which was the initial impetus for standardisation in the field of ADHD. Scientific knowledge is the prima facie knowledge. The mechanism of initiated ignorance was actively in use in the team to reduce the problems connected to standardisation; the team was almost “in a straitjacket” in order to achieve this, referring back to the steering tools for the standardisation work but also the ideas of standardised services and the high quality optimising paradigm.

Clinical pathways help to justify scientific bureaucratic medicine in mental health care. In a macro perspective, CPs fit New Public Management ideology, focusing on effectiveness and modernisation of the public sector, as streamlining health care services met fertile soil within the hospital; as the policy document points out,
standardisation plays an important role in coordination and quality improvement. At the same time as the streamlined approach, a “tailored” service in mental health care is emphasised as important in addressing the issues of normalisation, integration and empowerment. Knowledge acquisition and dissemination are key spheres of activity in NAPHA (The Norwegian Knowledge Centre for Mental Health Care, see Appendix 1.1). The ideology of tailored services is antagonistic to the ideology of a “one size fits all” approach. I shall now bring evidence-based knowledge into the discussion on the emergence of “scientific bureaucratic medicine”. Here I start with the institutionalisation of prima facie knowledge to demonstrate that evidence basing is linked to steering and control of employees.

8.3.1 Institutionalising Prima Facie Knowledge

Prima facie knowledge was the knowledge that gained entry into the two CPs. Let us now turn to the question of how far CPs can help to institutionalise evidence-based knowledge in mental health care. Here, the discussion is related to Scott’s (2001) normative pillar emphasising the importance of collective values and norms, with particular reference to what is perceived as legitimate for the production of clinical pathways in mental health care, not least because normative conceptions of the status of knowledge in mental health are closely related to the type of knowledge perceived as legitimate. In the model above we see that the important standardisation effort in the CPs helps to institutionalise evidence-based medicine. Here it was in fact an American international management institute (IHI) that was the original driving force behind the standardisation in the field of ADHD. IHI represents an expert group with support from the Norwegian Medical Association in collaboration with the Child and Adolescent Psychiatric Association, the Norwegian Psychological Association and the Norwegian Nurses Association. State financing gave further legitimacy to the launching of the CP for children with ADHD, but also initiated the establishment of a national ADHD guideline. This was produced with support from prominent researchers in this area and indicates a distinct knowledge base (with the exception of certain areas that apply to adults with ADHD, where there was little research compared to children with ADHD). A more indirect expert group for these two CPs but one which is very influential in the promotion of evidence-based medicine is the Norwegian Knowledge Centre. They advocate the CP concept and its tools, such as training in the use of statistical process control (SPC), which is a well known lean tool. All in all, these elements consist not merely of individual instruments, but a complete governance system - a “CP package” - which promotes the ideology of streamlining through tools and instruments that help to institutionalise evidence basing also in mental health work.
These findings are in line with Grimen’s (2009) recognition that evidence basing undermines the professional hierarchies, that it shifts power from the professions and that this power is mainly transferred to new expert groups. Let us now consider evidence basing related to these new disciplinary techniques.

8.4 A Pragmatic Mix of “Old” and “New” Governance

The introduction of CPs should be regarded as a strategy within the loosely defined new governance perspective, even though healthcare policies in this country are characterised by a pragmatic mix of “old” and “new” governance (Byrkjeflot & Neby 2008). Fournier (2002) refers to this perspective as “responsibilisation”, which could be understood as a new disciplinary technique “inculcating an internalised self-discipline, based upon a bargained legitimation of the (scientific) knowledge base” and the “articulation of knowledge around the notions of efficiency and technical competence” (Fournier 2002).

The emphasis is now primarily on New Public Management (NPM) related governance, and strategies to subordinate professions to state managed systems of surveillance known as “Governance I” (Dent 2008). This refers to the fact that scientific bureaucratic medicine was embraced by the medical profession as a response to a loss of legitimacy and public confidence. New Public Management governance initiatives included the introduction of EBM and CPs, thus directing clinical performance in ways that are transparent, and therefore also potentially exposed to political and managerial control. The idea was that CPs were introduced “to be obeyed rather than as navigational aids, directing rather than informing clinical practice” (ibid:108). By “horizontal” expansion, EBM is becoming the model for the search for “evidence-based” health and social work. From its origins in somatic medicine, evidence-based medicine has expanded into social work (Vindegg 2009), and more generally into welfare state professional work (Konnerup 2009). And, as this study of clinical pathways in mental health care shows, EBM has also expanded into child and youth psychiatry and a number of local authority mental health care services. By “vertical” expansion EBM has become a model of evidence-based management (EDMAN) (Rousseau 2005), and there are those who argue for evidence-based organisation of healthcare systems and political governance of the health services. The vertical expansion is now usually referred to as the emergence of scientific bureaucratic medicine (Harrison et al. 2002, Timmermans & Berg 2003, Dent 2008). According to several authors EBM represents “the positivist gestalt-switch” which focuses on the content of work
processes as implicated by professionalism (see for example Ekeland 2004, 2009). Here the role of knowledge, no matter how disputed and contested, must be presented as a firm basis in order to become a baseline for standardised guidelines. “Evidence-based knowledge” therefore will need to be strongly legitimated within the “knowledge society” to which guidelines or clinical pathways belong (Johannessen 2004).

“Governance II” refers to the “knitting together” of guidelines for the different professional groups involved along a common timeline with the aim of delivering effective and efficient care. This is regarded as the next stage in the erosion of medically controlled clinical autonomy. The “Governance I/II” border has been crossed, between professionally autonomous systems of clinical governance and inter-professional and state-managed (or at least state-guided) systems of prospective management of patient care and treatment.

The difference between the Governance I and II approaches to CPs seems, however, difficult to determine regardless of (national) contexts and the organisation of health care systems (Dent refers primarily to UK experience). With regard to the two CPs studied here, there is little doubt that the governance model of the "CP package" represents Dent’s term Governance II as demonstrated in Table 8.1.

Bejerot and Hasselbladh (2008) use the term “institutional transformation” in the discussion of the emergence of a trans-organisational governance regime in the Swedish health care sector. Here they demonstrate a regulatory landscape that traverses organisational boundaries and exerts influence on this professional field through normative and regulatory practices. There is thus little reason to doubt that governance of the professionals is strongly exposed to various forms of regulatory action, and I will therefore in the following discussion focus on the question of whether this form of steering constitutes a kind of "soft bureaucracy".

8.5 Towards “Soft” Bureaucracy?

The empirical analyses showed that there were professionals in the driving seat, but they did not have a free hand in driving as the way had already been marked out during the standardisation process, which makes it pertinent to discuss to what extent the introduction of clinical pathways may represent a development towards what Courpassion (2000) and others (see for example Gray & Harrison 2004 and
Dent in Muzio et al. 2008) describe as “soft bureaucracy”. We have seen the design of the two CPs mostly subject to local processes but strongly influenced by a steering framework of defined governmental policies where employee involvement and responsibility in the work of standardisation ensured loyalty to the idea.

8.5.1 The Professions’ Goodwill and Creative Involvement?

I will now draw attention to the fact that the professionals have been assigned to standardise their own work based on the words “as part of their useful professional formation – to lead the continual improvement of the quality, safety and value of health care” (Batalden, www.ihi.org) and lean slogans such as “employees' goodwill and creative involvement”.

As I understand the concept of “soft governance”, the self-management of professions is a key element, characterised here by the fact that the professionals themselves are the rulemakers, taking responsibility for the development of CPs within the steering framework for the standardisation. They thus maintain and expand control over their domains, as the pathway helps to legitimise the knowledge that they use in their daily practice (Abbott 1998). The self-management of professions may thus constitute a horizontal form of control, which is consequently less based on conventional hierarchical management principles. What is interesting here is that the streamlined approach met a fertile breeding ground even among those professionals whose organisational identity is with local mental health care. Thus, standardisation is not limited to just a few experts in one field, but to several different professional groups and administrative staff in various organisations, and furthermore, as in the production of the pathway for adults with ADHD, a client representative was also present at the meetings. We see here a combination of actors, techniques and knowledge during the standardisation process allowing for the formation of collaborative communities. In order to cope with external and internal pressures on professionals for greater accountability, quality improvement and an intensification of cost reduction, new forms of professional collaborative community are taking shape in the organisation of professional work in response to these pressures (Adler, Kwon & Heckscher (2008: 370-371)). In this way the teams over time can not only “manage themselves” but they also represent a collaborative community that, via the knowledge community, can contribute to the development of an

49 See also the ideas of new forms of professionalism in terms of collaborative interdependence (Silversin and Kornacki 2000a).
interdisciplinary professional identity rather than their own professional identity. But they are dutiful to the state, and this identity seems primarily to be linked to hybridisation through the use of the governance techniques which were available to the standardisers as they remain loyal to this steering framework. In my opinion this is quite sophisticated in the sense that it helps to increase the legitimacy of the standardisation work among the professionals. Here we also see Foucault’s (1972) ideas of knowledge used as an instrument of power in the acknowledgement that the design processes for standardising can contribute to positioning the knowledge of the “standardisers” closer to the power because the CP tool is a regulatory tool providing rules for professional practice. But it is not merely during the standardisation process that we see a coupling of medicine and management where certain professionals are in charge of carrying out the standardisation work, i.e. regulating their own and others’ work. In fact the professionals’ management of each other does not stop when the CP has been produced; this tool enables professionals to continuously control one another.

8.5.2 Professionals Control Each Other

Coherent patient pathways might be seen as a “species of bureaucratic rule, (reflecting)… a transition … to… neo-bureaucracy, in which… clinical activity has become the subject of surveillance and/or incentives and sanctions aimed at securing compliance with the rules” (cited from Harrison and Smith (2003:249) in Dent (op.cit: 104). Courpasson (2000) understands these developments as aspects of a new rationalist discourse, which is not one of direct managerial control, but more a case of soft bureaucracy where control is exercised through the imposition of performance targets and other output measures, and thus this new form of regulation represents a complex mix of hybrid soft bureaucracy. The empirical analyses in this study do not however reveal management control of the output. Rather, this control is related to possibilities for professionals to control each other by checking whether the manual’s instructions for the pathway are being followed. The professionals can thus use the CP manuals as a lever for management and control of each other. In this way a core group of professionals can position themselves in relation to other professionals in a division between those who govern and those who are governed (Freidson 2001). The autonomy of the professionals who are governed may thus be threatened, but even though the standardisation activities represent a hybridised professional role, this work is also controlled. We will conclude with a closer look at this issue.
Using hospital doctors as an example, earlier studies show that certain doctors who adopt management values and economic perspectives constitute a hybridised form of medical expertise. An example of this is a study of the Finnish NPM reforms by Kurunmaki (2004), who argues for the “hybrid profession”. However, as Martiniussen and Magnussen (2011) found in a study of Norwegian hospital reform, almost 50% of the doctors were critical of the reform, and only some parts of the medical profession seemed to adopt management values and tools. Thus, these physicians represent subgroups of the medical expertise resulting in a polarisation rather than hybridisation between physicians (ibid 2011). We have also seen here that those who were assigned to standardise their own work express a certain marginalisation in the sense that they experienced considerable limitations in the standardisation work and also afterwards, as we saw in the revision of the CP for children with ADHD. I will return to this topic in the next (and final) chapter in a brief summary and concluding remarks.
9 Summary and Concluding Remarks

9.1 Summary

By presenting the empirical findings and analysis of certain actors’ experiences and interpretations of the design processes of two different clinical pathways for ADHD, the aim of this study was to understand what CPs mean for professional work in mental health care.

The research was undertaken in one Regional Health Enterprise and eight local authorities in one Norwegian county in 2008 and 2009; these were chosen as they have created a methodology for developing CPs in recent years. The units of analysis were two CPs in dissimilar phases of production and implementation; a CP for children with ADHD which was completed in 2006 and a CP for adults with ADHD completed in 2009; they represent differences as to how the work of standardisation was organised and also with regard to objectives and scope, yet they were both developed within the Division of Mental Health at the same hospital.

The theoretical frame of reference focused mainly on key aspects of a neo-institutional organisational framework and outlined perspectives on health care in a section labelled “Scientific Bureaucratic Medicine”. The methodological approach was an in-depth study using a combination of descriptive and explorative design and the data collection included individual semi-structured interviews with 17 professionals, participant observation at seminars and meetings and document examination. The analysis design is characterised by a combination of inductive and deductive approaches.

The main research question was “how do professionals standardise their own work?” The first and second subsidiary research questions were “how was the clinical pathway for children with ADHD designed?” and “how was the clinical pathway for adults with ADHD designed?”

Here, the findings of rulemaking are:

- The standardisers were professionals supported by techno staff but they did not have a free hand in their work; the standardisation effort was linked to a
steering framework, “the CP packages”, representing external expertise, the guideline for ADHD and the tools used, such as the hospital’s IT system for clinical pathways.

- The practical considerations of the design processes had to be solved in constrained production contexts, as the CP makers had to shoulder all the standardisation work themselves, which seemed to be related to a combination of decoupling the design processes from practice and ideas of “professional involvement”. This was especially true of the design of the pathway for children with ADHD.

- The mechanism of initiated ignorance was actively in use in the team to reduce the problems connected to standardisation; the team was almost “in a straitjacket” in order to achieve this. The “straitjacket” refers back to the steering framework for the standardisation work.

- Not surprisingly, biomedical evidence-based knowledge supported by moral order was claimed for entry into the CPs as prima facie knowledge. Contextual knowledge was considered but excluded. Evidence-based alternative knowledge was not considered at all in the CP for children; it was considered but excluded during rule production in the CP for adults because of a lack of suitable treatment options.

The third subsidiary research question was “what are the responses to the clinical pathway for children with ADHD among professionals working in the system?” The findings were:

- CPs influence the professionals’ roles in different ways as the emergence of various potential conflicts around the distribution of tasks and responsibilities between professions, agencies and the hospital is revealed.

- CPs regulate the domains of certain professions and organisations by clarifying and sometimes altering the division of responsibilities for assessment and diagnosis between the organisations.

- The tool enables professionals to control each other’s work performance.

In the discussion, the model “circulation of evidence based knowledge” shows how clinical pathways help to justify scientific bureaucratic medicine in mental health care, implying a new form of governance of professions in mental health.
9.2 Concluding Remarks

The professions’ different and sometimes contradictory approaches to diagnosis and treatment constitute a relationship between knowledge and rules that did not seem to be very prominent in the debate on the introduction of clinical pathways. And this is where I would argue that this study not only sheds light on instruments and their use (or lack of use), but also considers them in the context of the processes taking place during the standardisation work itself.

9.2.1 Hybridisation in a Joint Project with the State?

This study has shown that professionals take responsibility for remedying the stated problems of coordination and quality, but it has also shown that the professionals had sole responsibility for the standardisation. As I see it, these actors have taken the political intentions most seriously and entered into a kind of joint project with the state to solve the problems. In order to handle the design processes for standardising they adopted management values and techniques thus forming a hybridisation between the professional and management roles.

The knowledge base of the tool reflects institutionalised evidence-based knowledge, which was readily recognised by the actors in the forefront of the standardisation work since their organisational identity was primarily with the specialist services. So here we see a dynamics between professional autonomy and accountability leading in the same direction. Professions play a key role in the structuring of services and the performance of health care work in the Nordic countries as these welfare states have been described as “profession states” where professions and state are closely intertwined through joint involvement (Johnson 1995, Eriksen 1996, Byrkjeflot & Jespersen 2005), in contrast to the classical conflict perspective between professions and state (see for example Clarke & Newman 1997, Freidson 2001).

Thus these findings may contribute to an understanding of a revitalising of the “profession state” in the Nordic countries, but now within the framework of NPM approaches. And this in fact does not lead to less conflict between professions and state; rather there is much to suggest that the conflicts are now more covert as the form of governance has become more sophisticated. This may well result in dilemmas for the professionals and other actors.
9.2.2 “Soft” Control and Contextual Knowledge

What concerns me is that the institutionalisation of evidence-based knowledge may in the long term degrade contextual knowledge. This is because a competence conflict linked to an established understanding of the medical hegemony may inhibit the creation, sharing and use of contextual knowledge, especially since such knowledge is by nature difficult to express as it cannot be quantified, codified or research-based. Evidence-based medicine may help to complement or inform professional discretion but as demonstrated in the circulation model evidence basing has become institutionalised. Evidence basing can thus lead to a downgrading of contextual knowledge as clinical pathways as knowledge-based regulation tools along with the “packages” of evidence basing imply regulation of knowledge, which in turn means regulation of professional autonomy.

The new form of governance is strongly linked to a coupling of medicine and management where certain professionals are in charge of carrying out the standardisation work, i.e. regulating their own and others' work. Here these professionals as “standardisers” had no choice at all as to the possibility of organising the design process differently. They were also controlled and there are indications that they were marginalised by virtue of being standardisers.

The professionals’ management of each other does not stop when the CP has been produced; this tool enables professionals to continuously control one another.

Thus, professional autonomy is threatened in an insidious and sophisticated way: by “CP packages” which institutionalise evidence-based knowledge in combination with professionals who standardise and control their own work. Through “soft” control professional autonomy is controlled by knowledge – from “the inside”.
References


Helsedirektoratet (2005) "Og det skal bli bedre!" ("And it is Going to Get Better!") (National Strategy for Quality Improvement in Health and Social Services 2005-2015)


Rechel, B. et al. (2009). Hospital capacity planning: from measuring stocks to modelling flow. WHO Bulletin Volume 88:2010 (printable version, downloaded 10.08.10)


Riedesser P. (2004). ADHD - the biggest controversy in the history of child and adolescent psychiatry. Presentation at the 16th World Congress of IACAPAP


Right Place and the Right Time”). Tilrådning fra Helse- og omsorgsdepartementet av 19. juni 2009

Stortingsproposisjon nr. 63 1997-1998: Opptrappingsplan for psykisk helsearbeid


List of Illustrations

List of Figures:

Figure 3.1 Video observation of a team meeting in adult psychiatry
Figure 4.1 Arbitrariness in the System:
Figure 4.2 The Flowchart Model
Figure 4.3 The draft version of a CP for children with ADHD
Figure 4.4 Who does what and when, Clinical Pathways for Children with ADHD
Figure 5.1 The electronic version of the CP for adult ADHD
Figure 6.1 A basic model of the CP design as a “rational rulemaking” process
Figure 6.2 Claims for knowledge
Figure 8.1 The circulation of evidence-based knowledge

List of Tables:

Table 3.1 Professionals interviewed about the CP for children with ADHD
Table 3.2 Recorded data: interviews and participant observation
Table 3.3 Professionals interviewed about CPs in general at the hospital and the CP for adults with ADHD
Table 7.1 Checkpoints in clarification of ADHD diagnosis
Table 8.1 Different forms of clinical pathways and potential challenges/responses

List of Appendices:

Appendix 1.1 Agencies/Bodies and Tools in the “Packages” of CP ideas
Appendix 3.1 Approval from the Norwegian Social Science Data Services
Appendix 3.2 Information letters sent to local authorities and the hospital
Appendix 3.3 Interviews with professional about the CP for children with ADHD
Appendix 5.1 “Clinical Pathway for ADHD”
Appendix 5.2 “When we suspect ADHD – the way we want to go about it”: 
Appendices

Appendix to Chapter 1, Introduction

Appendix 1.1 Agencies/Bodies and Tools in the “Packages” of CP ideas

The core of evidence-based thinking is quality control of the knowledge to be applied in professional practice. Quality control of knowledge is not new, but what is new is that its extent, methodology and control are institutionalised in particular organisations based on a political mandate (Grimen 2009:216). In recent years the Directorate of Health has established state-owned agencies/bodies who promote evidence-based knowledge and new diagnostic classification tools have also been implemented. However, there is one new official body promoting the “contextual” knowledge of mental health care; this is NAPHA. First, a look at bodies and techniques which promote and distribute the CP idea: The Norwegian Knowledge Centre for the Health Services, The Norwegian Patient Register, InnoMed and KITH along with certain tools as micro devices.

The Norwegian Knowledge Centre for the Health Services

The Norwegian Knowledge Centre for the Health Services (NOKC) was established in 2004 and is organised under the Norwegian Directorate of Health. Presently the NOKC is regarded as the most important advocate of EBM in Norwegian health administration, making a significant mark on political decisions on the organisation and performance of health work in the country (Byrkjeflot & Aakre 2008). It is the foremost institution of evidence-based knowledge in Norway, explicitly embracing the idea of the hierarchy of knowledge, which is adopted from the Cochrane Protocols (Grimen & Terum 2009).

The Norwegian Patient Register

The Norwegian Patient Register (NPR) is one of Norway’s most important health registers and is administered by the Directorate of Health. When patients are referred to or treated in a hospital, a polyclinic or specialist health care, a great deal of information is registered, and selected parts of this information are sent to the NPR. The objectives are outlined in the Norwegian Patient Register Regulations § 1–2 (in force since 2009).
InnoMed - Innovation in Health Care

InnoMed is a national network for needs-driven innovation in the health sector. InnoMed was established by the Directorate of Health on behalf of the Ministry of Health and Care Services. The Directorate of Health is responsible for the activities of InnoMed, which are aimed at both local and specialist health services. In the 2007 strategy memo, the following action is mentioned:

To explore how the idea of clinical pathways linked to patient records (process tools) has been developed in the Eastern Norway Regional Health Authority and whether it can be transferred to other regions or even new projects.

(“InnoMed, ICT and Health; Role and Strategies of InnoMed” Poppe 2007)

The South-Eastern Norway Regional Health Authority is also to take part in a development project, Evicare, funded by the Research Council of Norway and also involving the Norwegian University of Science and Technology (NTNU) and the Norwegian Knowledge Centre for the Health Services. EviCare and the South-Eastern Health Authority have commissioned a related project funded by Innomed, aimed at developing a national online tool for clinical pathways, professional procedures and interaction.

KITH – an organisation for the development of standards and classification systems

The Norwegian Centre for Informatics in Health and Social Care (KITH) is a non-profit company owned by the Ministry of Health and Care Services, the Ministry of Labour and the Norwegian Association of Local and Regional Authorities (KS). The main goal is to enhance electronic collaboration between service providers in health and social welfare (Nystadnes 2009). Thus in KITH’s plan for 2008-2013, the main strategy is to strengthen standardising and coordination by use of information and communication technology in the health care system and contribute to increased benefit for all actors in the system. Norway uses a number of international classification systems, for example ICD 10, ICF and ATC (see the next section). The Norwegian policy for several years has been to adopt European or international standards when possible, and KITH has been responsible for codes, classification systems and terms in the health and social welfare system and plays an important role in dissemination of these standards to the health care organisations.
The tools as micro devices

We have already seen some examples of tools promoted by the Norwegian Knowledge Centre.

As shown in the introduction to this thesis, the use of the CP concept started out in the mid-1980s as a response to an initial implementation of Diagnosis Related Groups (DRG) in hospitals. DRG is a method which aggregates patterns of treatment for similar health conditions, resulting in payment structures that are based on medical diagnoses instead of the nature and type of treatment provided (White Paper, Department of Health, 2003). However, the DRG system has not been implemented in psychiatry, but NCPM registrations are compulsory for adult psychiatry. NCPM/NCSP is a classification of medical procedures which has been compulsory in all divisions of the specialist health services since 2006. Within child and youth psychiatry (BUP and BUPP), the procedures used for diagnosis such as the ICD-10 multi-axial classification system became compulsory from 2008. This instrument has a particular objective, namely the registration of the diagnosis of all patients, leading to more cost-effective health care.

In health care the dominant classification system is the physicians’ diagnostic tool called ICD (International Classification of Disease). This is a global tool developed by the World Health Organisation (WHO) encompassing all classifications of disease. In preventive health care, medical diagnoses are attributed less importance, while measurements of functioning, activity and environmental conditions have been increasingly emphasised. Classification systems grounded on evidence-based knowledge are a national strategy (Feiring, 2009).

An alternative classification system, “International Classification of Functioning, Disability and Health” (ICF) has been developed by the WHO to register the activities and functioning of populations with regard to daily activities and general participation in society. The introduction of ICF has implications for how future statistics will have to be produced for the local authority health services. Among other things it forms the basis for IPLOS, which is a new individualised system for nursing and care statistics. ICF has also had implications for the content of the Individual Plans, which are currently being used by a number of support services, not least within psychological health services (Feiring, 2009).
The Norwegian Knowledge Centre is promoting and holding courses in Statistical Process Control (SPC) and I found a great many recommendations and useful links on their website.

**Statistical Process Control (SPC)**

This method was used to focus on improving the waiting time for referral and diagnosis in the Breakthrough Series, yet it turned out that this method was not used in the design of either of the CPs. Key aspects of this tool are the focus on continuous improvement and the use of control charts and designed experiments. SPC is a measurement tool whereby data is arranged as a time series in order to examine how a process changes over time. SPC was developed in the 1930s by Walter Shewhart as a method to monitor and control processes in the telephone industry in the US. He and others had discovered that they had little use for general statistics for this purpose. By performing a time series analysis of the data, they could distinguish between natural variation and special variation that warranted closer study. It was not until the mid-eighties that SPC began to be used in health services, first in the US and after some years in Norway. SPC can be used for:

- Monitoring and analysis of small statistical material
- Control of performance level (in accordance with good practice/good quality)
- Control of variation (stable and predictable services)
- Control of improvement (to ensure that improvements are documented)
- Facilitating understanding and communication of processes through graphical presentations
- Decision support, especially by "balanced monitoring" with several indicators

Some examples of elements that can be monitored and analysed with SPC:

- Waiting times
- Discharge summary time
- Duration of procedures, treatment time, etc.
- Goal achievement/programme performance
- Resource use
- Quality measured by e.g. rating forms, such as referral quality, discharge summary quality
- Activity, e.g. the number of consultations or admissions per time unit
- Patient satisfaction
Here follows an example of SPC in a Norwegian psychiatric hospital ward:

**Deming’s circle**

SPC can be seen as a technical feature of lean thinking (Stewart et al. 2009). Another tool (or rather approach) connected to lean thinking is Deming’s circle (the term stems from the American Edward Deming who contributed to the development of Toyota’s quality system in the Japanese car industry after the Second World War).

*Figure: Deming’s circle*
The Norwegian Knowledge Centre promotes this approach for improvements in health care. The centre does not use the term “lean” but as the examples demonstrate, ideas, terms and techniques from lean thinking are in use.

**Lean hospitals**

We have seen a great interest in the lean approach in hospitals and there is a strong connection between clinical pathways and lean thinking. A number of Norwegian hospitals have in recent years arranged kick-off seminars and presentations and minutes from the CP seminars are available on the hospital website. In the documents and minutes from the meetings and conferences aimed at developing clinical pathways, there is frequent stress on continuous improvements of work processes by employee involvement, enthusiasm and teamwork in the context of “best practice” and “learning organisations” in terms of Kaizen, the lean values chain, flow, elimination of “waste”, MUDA, Taguchi methods and the Six Sigma (Sort, Stabilise, Shine, Standardise and Sustain).

Neither the policy documents nor the hospital use the term “lean hospital” but in the planning of a new hospital in Norway, the vision and solutions for clinical operations are based on the challenges of “fewer beds for a bigger population”:

- Work processes are fully digitised.
- All requisitions are handled electronically.
- Treatment is carried out according to the principles of clinical pathways and lean thinking for 80% of the patients; buildings and planning are adapted to this.
- All equipment and resources are marked and can immediately be retrieved electronically.

**NAPHA**

As a counterpart to the new bodies promoting evidence-based knowledge and a streamlined approach, NAPHA is a national competence centre for adult mental health care at local level, funded by the Directorate of Health, from which it receives various tasks by means of assignment letters and management meetings. The Centre is organised as a department of NTNU (The Norwegian University of

---

Science and Technology). Knowledge acquisition and dissemination are key spheres of activity in NAPHA. The Centre has a clear goal of being of benefit to local authorities. Effective measures in one locality can be developed further and spread to others. Examples and experiences are disseminated on the website napha.no, in the knowledge base Psykiskhelsearbeid.no and through various networks. Informing professionals of relevant research is also an important task for NAPHA. In addition, the Centre aims to maintain strong links to client organisations and ensure that client perspectives are incorporated into the development of knowledge. NAPHA is active in promoting client participation at all levels.
Appendix to Chapter 3, Methodology

Appendix 3.1 Approval from the Norwegian Social Science Data Services

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Mona Jerndal Finseth
Avdeling for beveg- og rentefag
Hospitalet i Oslofjord
1737 HALDEN

Ved dato: 25.08.2008
Ved ref: 14667 / 2.1.1
Dato dato: Denne ref.:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, motenr 04.07.2008. Meldingen gir per prosjekt:

19967
Behandlingsområde: Behandlingsområdet om overfølgelse av samordningsmodell
Hospitalet i Oslofjord, ved sitt aksjonsett av enEarnet leder
Mona Jerndal Finseth

Personvernombudet har vedtatt prosjektet og funnet at behandlingen av personopplysninger er medbøylig i henhold til personopplysningsloven § 31. Behandlingen utføres under kravene i personopplysningsloven.

Personvernombudets vurdering fører derfor til at prosjektet fremkommer i tråd med opplysningene gitt i meddelsesbrevet, korrespondansen med ombudet, eventuelle kontrakter samt personopplysningslovens/helseregisterlovens forskrifter. Behandlingen av personopplysning vil here tts i gang.


Personvernombudet vil ved prosjekts avslutning, 01.08.2011, sette en henvendelse angående status for behandlingen av personopplysningene.

Vennlig hilsen

Odd Henrik Olsen

Kontaktperson: Lisa Tunsleid tlf: 55 58 33 77
Vedlagt: Prosjektorvaretting

1550: Norsk universitet, Oslo, Norge.
1650: Norsk universitet, Oslo, Norge.
Personvernområdet for forskning

Prosjektvurdering - Kommentar

Personvernområdet finner opplegget for gjennomføringen av prosjektet tilfredsstillende. Videre finner vi skrevet godt utformet.

ENDRING AV FORSKningsprosjekt

Vi viser til endringskjemaet mottatt 09.05.2009 og informasjonskrav til utvalget mottatt 12.05.2009, gjeldende prosjektet 19957 Behandlingslinjer somLovfislig anvendbarmodell

I endringskjemaet opplyses det om at man ønsker å utvide utvalget til å også omfatte profesjonelle arbeidspartnere/teams. Arbeidspartnere i enkelte grupper også deltar fra kommunale virksomheter. Hensikten med arbeidspartnere er å utvide en generisk samordningstnavtell for henvisning, utredning og behandling av definerte pasientgrupper, det som kalles en behandlingslinje. I enkelte arbeidspartnere inspigerer de representanter fra bruksorganisasjonen, disse representerer de bruksgrupper og ikke enkeltindivider.

Hensikten er å få ytterligere kunnskap om samhandlingssprocessene mellom aktører.

Man ønsker også å gjennomføre både gruppentervju samt fellesbevisninger under mester. I tillegg til tydelig er det også ønskelig å finne arbeidspartnere med dataavsmidlingen.

Ombudet finder vedlydende informasjonskrav til utvalget vist satt mer tilfredsstillende, men nemner om at utvalget også har informert om at det er viktig å delta og at de når som ledet i løpet av prosjektperioden kan trekke sitt samtykke tilbake og få opplysninger som de har gjort skjer eller anonymisert.

Endringen har ingen konsekvenser mht. ombudets opprettende vurdering og tilsetting av prosjektet, jf. brev fra ombudet dater 25.06.2009.

Vennlig hilsen

[Undertegnede]

Perilla Bolltun

Anbefalingerhjem / Advice Office

ERD: VEN, Universitetsparken 35, 0371 Oslo, Tlf: +47-22-46-52-11, nsd@nsd.no

KRETSBEHÅRER NSD: 1. Byen, Øvre- og Nedre Teitman, DNB Bank, Tlf: +47-22-45-19-07, byen@teitman.no

PRIS: NSD: 036, Byen, Øvre- og Nedre Teitman, DNB Bank, Tlf: +47-22-46-52-11, nsd@nsd.no

208
Appendix 3.2 Information letters sent to local authorities and the hospital

Informasjon og forespørsel om deltagelse i studien;

Behandlingslinjer som en iverfaglig sanningsmodell

Jeg er ansatt som stipendiat på Avdeling for helset- og sosialfag ved Høgskolen i Østfold. I
samarbeid med , har jeg med en del av dem som har erfaringer med "behandlingslinjer for barn og unge med ADHD i".
Intervjuene skal gjennomføres denne høsten og vinteren.

Hovedformålet med projektet er å bidra til å videreutvikle kunnskap om
behandlingslinjekonseptet som en standardisert iverfaglig sanningsmodell.

Jeg skal nå gjennomføre empiriske studier som skal undersøke hvordan behandlingslinjer
innenfor psykisk helsearbeid forstås, og hvordan arbeidet med å utforme og implementere en
behandlingslinje foregår. Videre skal jeg se på i hvilke grad og på hvilke måder behandlingslinjekonseptet
 gir innsikt på arbeidets organisering og muligheter for
sannordning av de ulike tjenestene.

Denne undersøkelsen er en del av mitt doktorgradsprosjekt ved Universitetet i Karlstad, der
professor Lena Gonset er hovedvelede og domst Helge Ramsdal ved Høgskolen i Østfold er
velede. Prosjektet har en varelighet fra 1. august 2011.

Rent praktisk legges det opp til 1 - 1½ times individuelt intervju, gjerne på et kontor eller
masteren på arbeidsplassen ditt. Det undres en samtykkeerklæring før intervjuet starter
opp. Spørsmålene vil være delvis strukureret rundt de temaene som er nevnt over. Det tas
lydopptak under intervjuet, som jeg straks etter hvert skriver ut på papir og koder, slik at atning
som eventuell gjengivels, ikke kan knyttes til en bestemt person. Lydopptakene opphevares på
lydfile som er innfelt, og det er kun jeg som har tilgang på personidentifiserbare data. Jeg er
underlagt taushetsplicht, og data behandles konfidensielt. Lydfilene slettes straks de ikke
lengre er nødvendige for prosjektet, og renet ved prosjektstart den 1. august 2011.

Data som innhentes kan underevises i prosjektet om ønskelig bli hentet av BUPP til
evalueringer og forbedringer av behandlingslinjen for barn og unge med ADHD, og disse
dataene er også alltid presentert i en anonymisert form.

Til slutt vil jeg nevne at deltakelse i dette prosjektet er frivillig, og du har muligheter til å
trekte deg når som helst uten å begrense årsaken til det. Jeg håper allikevel at så mange som
mulig har anledning til å stille opp på intervju, og ber deg fylle ut samtykke-erklæringen og returnere i den vedlagte konvolutten. Jeg tar så kontakt med deg over telefon for nærmere avtale.

Dette prosjektet er meldt til Personvernombudet før forskning, Norsk samfunnsvitenskapelig datatjeneste AS, og har prosjektnummer 19567.

Ta gjerne kontakt med meg for kommentarer eller spørsmål på: mona.j.fincide@biof, eller ring meg på kontoret 69 30 30 80 eller mobil 41520750

Med hilsen

Mona Jendsdahl Finicide
Stipendiat

Riv av denne og legg i ferdig frankert konvolutt som ligger vedlagt.

..............................................................................................................................

Samtykkeerklæring:

Jeg har mottatt informasjon om studien av behandlingslinjen for barn og unge med ADHD, og ønsker å stille på intervju.

Namn: ______________________________________

Vårenhet: ______________________________________

Telefonnummer: ________________________________

E-post: ________________________________________

Signatur: ........................................

210
Informasjon og forespørsel om deltagelse i studien;

Behandlingslinjer som en overflakkkelig samordningsmodell

Jeg er ansatt som stipendiat på Avdeling for helse- og sosialfag ved Høgskolen i Østfold. I særskilt med - , henvender jeg meg nå til deltakerne i arbeidsgruppens "Behandlingslinjen for voksne med ADHD", med forespørsel om å gjennomføre feltobservasjoner under møtene.

Denne undersøkelsen er et ledd i mitt doktorgradsprosjekt ved Universitetet i Karlstad, der hovedformålet er å bidra til å videreutvikle kunnskap om behandlingslinjen konseptet. Professor Lena Gausa er hovedveileder og dennes Helge Rasmøl ved Høgskolen i Østfold er bid- veileder. Prosjektet har en variabel fra 1. august 2011.

Jeg har til nå gjennomført intervjuer med ansatte i kommunene og i BUP som har erfaringer med behandlingslinjen for barn og unge med ADHD, og vil nå imøtekomme data som kan gi mer kunnskap om profesjonelles tømming og samhandlingssyringer for behandlingslinjen i det lages. Her er tidspunktet og "like-vernhane" uttrykkser som sentrale elementer, liknende bruk av datamerkjet der de bruker. Det arbeidet deres kan gjort kan betraktes som foregangsverk, og således et meget interessant forskningsfelt.


Til slutt vil jeg nevne at min deltakelse under møtene er avhengig av at alle deltakerne samtykker i dette. Da har muligheter til å reservere deg når som helst uten å begrense ansaen til det. Jeg gjør oppmerksom på at om enkelte reserverer seg fra bilderekspor, tas kun lydopptak under møtet, og om enkelte reserverer seg fra at det tas lydopptak, tas kun notat eller under møtet (døg av min erfaring at det fort "glommen" kameraet som står i høyst og oppkasten som står på bordet). Uansett, vil du reservere deg, må du ikke nøle med å ta kontakt med meg, da helst innen dagen før møtet.
Dette prosjektet er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS, og har prosjektnummer 19567.

Ta gjerne kontakt med meg for kommentarer, spørsmål eller reservasjon på mona.j.fineide@hiof, eller ring meg på kontoret 69 30 30 80 eller mobil 41520750

Med hilsen

Mona Jerndahl Fineide
Stipendiat
Appendix 3.3 - Interviews with professional about the CP for children with ADHD

**Introduksjon og bakgrunnsopplysninger**, erfaring med denne, andre behandlingslinjer?

**Utforming av behandlingslinjen**, motivasjon for å delta i prosjektet, hvordan rekruttert, praktisk organisering, hvorfor ble den akkurat slik, faglige diskusjoner i teamet/arbeidspllassen?

**Implementering av behandlingslinjen** på arbeidspllassen, endringer i organiseringen/oppgaver? jobber du annerledes enn du gjorde før, nye oppgaver, har andre fått nye oppgaver, formelle og uformelle normer) Hvordan bruker du brosjyrene/manualene, hvilke funksjon og hvilke betydning har de? Er det noen som sjekker/kontrollerer om du følger manuane)?

**Betydning for oppgave- og ansvarsfordelingen** mellom de ulike virksomhetene, eksempler på at innføring av behandlingslinjen har gitt noen praktisk betydning på oppgave- og ansvarsfordelingen mellom personer/virksomheter? (eks. fastlegen, PPT, barnevern, forholdt mellom kommuner og BUPP. Eks. hensvisning, diagnostisering, oppfølging av barna – hvordan var det før, hvordan er det nå)?

**Om koordinering og samordning**, hvordan jobber du i dag rundt barn og unge med sammensatte behov? (eks. deltar i fagteam, uformelle kontakter, IP?) Er det spesielle virksomheter/yrkesgrupper det går lettere/vanskelligere å samarbeide med? Hvorfor? Opplever du at behandlingslinjen bidrar til at barn og unge med ADHD og familiene får mer koordinert hjelp, støtte og behandling? På hvilke måte i så fall? (er det mulig å konkretisere, eks. ventetid, hensvising, epikriser, bruk av IP, andre)
Appendix to Chapter 5, production of the CP for adults with ADHD

Clinical Pathway Executive Doctor (BAL): “Clinical Pathway for ADHD” presented on 30th May 2007:

Appendix 5.1 “Clinical Pathway for ADHD”
Appendix 5.2: “When we suspect ADHD – the way we want to go about it”:

(Clinical Pathway Executive Doctor (BAL): “Clinical Pathway for ADHD” presented on 30th May 2007, my translation)
Controlled by Knowledge

Standardisation of professional work is a major policy concern to ensure quality and efficiency of services. A number of hospitals are now focusing on the use of clinical pathways as an important tool to standardise their work. This study sheds light on the processes set in motion when notions of standardisation meet local practice. In order to gain insight into what clinical pathways mean for professional work in mental health care, the focus of the study was to explore the contexts in which standardisation by “rule production” takes place.

Two empirical cases from Norwegian mental health care show how dedicated professionals are in charge of carrying out the standardisation work, strongly influenced by a steering framework of defined governmental policies where employee involvement and responsibility ensured loyalty to the idea. Along with a “package” of ideas, new bodies and techniques, clinical pathways contribute to the institutionalisation of prima facie knowledge in demonstrating that evidence basing is linked to steering and control of employees.

Thus, professional autonomy is threatened in an insidious way: through the institutionalisation of evidence-based knowledge as prima facie knowledge in combination with professionals who standardise and control their own work. The thesis therefore concludes that the control of professional work has now become a complex and sophisticated process where professional work is “controlled by knowledge”.


ISSN 1403-8099

DISSERTATION | Karlstad University Studies | 2012:19