When research and development comes together – Experiences from working with the Frequent service user model

1. Introduction

This text is about the Frequent service user model, a model to identify systemic barriers in the addiction-related health and social care, and the work of Fou-Södertörn to develop and implement it.

The model focuses on services targeted to the individuals (patients/clients) who are the most health-care consuming, people who have many (care) contacts with different actors and might be given different services without overall planning. Despite major resources are directed towards these individuals, their needs for care are seldom satisfied. Evaluations and/or follow-up activities of different services are often carried out from the perspective of the care-givers. But how does the addiction-related health and social care as a whole function for these patients/clients? Where are the gaps in the system? And is the provided care relevant to the problems and needs of the target group?

By conducting a comprehensive survey of the health-care interventions (from different providers) a group of clients/patients receive in a year, and by analyzing how different interventions contribute (alternatively: fail to contribute) to help the client/patient, a picture of how the overall health-care system actually works is obtained. A central part of the survey is a detailed interview with the patient/client around his/her experiences of various interventions.

---

- Åsa Bringlöv and Jouko Lindgren are research fellows at the Research and Development Centre of Southern Stockholm (FoU-Södertörn). Martin Börjeson is associate professor in social work, research director at the Research and Development Centre of Southern Stockholm and lecturer at the Centre for Municipality Studies (CKS), Linköping University.
The Frequent service user model is supposed to be a tool to acquire knowledge about how health care system's components interact and how the efforts meet individual needs. The model is one of three methods of monitoring and evaluating activities related to dependence care as part of a three-year national commitment in knowledge-based treatment of substance abuse and addiction.

1.1 Support for implementation

An often overlooked aspect of implementation and development are the learning processes which are necessary for successful implementation. I.e. how the experience of monitoring/evaluation will be utilized, become part of practice and lead to the development of services (Svensson et al 2009). Often the results and the collection of information are not used in further development work (Lindgren 2008).

Within this project, Research- and Development (R & D) units have been given a role to support implementation. The idea is that support can make the monitoring process more systematic and also create better conditions for knowledge use in developing services. A number of R & D units are retained to support the implementation of a monitoring and evaluation method in their own counties. FoU-Södertörn has been commissioned to hold together the work to implement the method/model and guide these R & D units.

As many other R & D units, FoU-Södertörn work with interactive research and evaluation to support the development of social work. Our approach in the current development project has been inspired by research on conducting change management, including ongoing evaluation. In the ongoing evaluation theories about the use of knowledge and organizational learning has influenced our perception of change (Svensson et al 2009). An important question is what managers and participants can learn from development work during the process. This includes making practice (politicians, managers and staff members) involved in both knowledge and learning processes, rather than, as often happens, consider them as consumers of knowledge and results (Svensson et al 2009, Uggerhøj 2011).

** The R & D units we are referring to are organisations that have been established in relation to the social service sector within local municipalities, and their objective is to work with research and development from a local social service-perspective. Most often these R & D units are run by a group of local municipalities (or counties), and the often work in cooperation with regional university colleges. Today, there are approximately 30-35 R & D units of this kind in Sweden.
In our paper, we describe our attempts to make research and practice interact within the framework of local development work. We will focus on two points. The first is our work structure, where R & D units are given an intermediate role in the development. The second is the learning processes that is expected to be the result of the use of the Frequent service user model.

2. New structure for the implementation and development?

2.1 Implementation as collaborative learning

The first problem we faced was that there was not any model that was 'ready' to implement. What existed was a model that had been used by one group of researchers in numerous studies (but in a different field of activity – care for the elderly). The results from their work seemed so promising that the SKL, supported by the state, wanted to launch it as a general model for local monitoring and evaluation. But this model was not described, nor developed for the use of local monitoring in other fields of activities. The fact that the model was not “ready to be implemented” had the consequence that the different elements in implementation – that traditionally is looked upon as different phases – has been carried out simultaneously. As a consequence of this has meant that the boundaries between the development, monitoring/evaluation and learning has been "rewritten".

A number of counties had already taken the decision to implement the method and begun preparations for it, and they waited impatiently for the instructions for use and implementation of the model. But the necessary adjustments proved to be so extensive that the implementation was likely to be delayed. We decided to carry on the work to develop the model at the same time as the counties began preparations to implement it. As a result, we have designed the work as a pilot where we involve the participating counties in the work of further developing the model.

In traditional approaches to implementing new methods, an important part is to make sure that the method is used exactly as stipulated by existing guidelines and manuals (Fixsen et.al. 2005). It is an approach that has been criticized for not taking the local context into consideration. Here we have chosen a slightly different approach. Our ambition has been not to make this mistake and instead, provide the local context space and to encourage the implementing counties to find solutions relevant to them. Here we support the idea that there is a need to contextualize knowledge and that knowledge actually will become more useful if
developed in dialogue between research and practice (see eg Svensson and Brulin 2011 and Uggerhøj 2011). One conclusion was therefore that our work with developing the model should allow to test many different approaches and forms. For our part, this has meant that we have drafted a model (based on experiences from earlier attempts to use the model) – and that model now is being tested and developed in collaboration with the six counties involved.

But such an approach also requires that there is someone who can take take charge of, and to safeguard, experiences gained; to disseminate these further, and perhaps also to synthesize them. Accordingly, we have considered it an important task for us to continuously monitor the process, to look at experiences of the work and to continuously reconnect experiences with practice. Therefore, we organize regular workshops and exchanges, and try to have a continuous dialogue with local R & D units. We also try to share these experiences and to use them in further development of the model.

Our role is therefore in many ways the role of an intermediarie (Brulin & Smith 2011). Such intermediaries can have a cohesive and supportive role in the development and they can create conditions for joint knowledge development/activities (Svensson and Brulin 2012). A way to incorporates knowledge into everyday work of practice is to enable participants to reflect upon their experiences (Ellberg 2009, Svensson et al 2009). These procedures deal on dialogue, on continuous feedback of experiences and collected data and a common discussion and analysis of these, for example in the form of feedback and analysis sessions (Halvarsson & Öhman, 2009).

There is also a need for cohesive and proactive efforts to support local development. The process of local development involves a number of actors. In this project, we have worked together with local R & D units in the first place. These R & D units have in turn established local project teams where different actors have been represented. Exactly how they have been formed have varied between counties, but in all counties practice is represented in these project teams in different ways. They also include representatives of various authorities - social services, healthcare /county, prison/probation, and sometimes also user organizations.

In order to make the development work sustainable, all significant actors needs to be involved from the beginning.

We have also seen it as an important mission to support the work of local R & D units by establishing an arena for reflection and exchange of experiences on local development work – and on the role the R & D units can play in this work. For example, at one of our joint
seminars we invited a researcher who gave a lecture on how to pursue long-term development work – and this is supposed to be a recurring theme in the workshops/analysis workshops that will be held during the project. These will hopefully help to bring about discussion and reflection on the progress of work, what can be learned from the experience and problems that occur, and what needs to be changed for the work to be successful (Ellström 2009).

2.2 Learning through case studies

The aim of the Frequent service user model is used to obtain a description of the care processes and of the care system as a whole. The idea is to map the care provided for the group of individuals that are the most health- and social care consuming. This is a rather small group, but a group that have many health care contacts and receive extensive services from various actors. To get help in one area can often be a prerequisite for services in other areas to be meaningful. However, services are delivered in different places and in different orders. The interdependence between the various activities in the healthcare context is not always directly observable/obvious to those who work there, and staff do not always see the consequences of their own actions (Lindberg 2002).

Here, case studies play an important role to describe the complex reality, and such descriptions are an important part in the systematic and structured approach that can be described as the core element of the model. The idea is to describe how the health care system is based on detailed descriptions of a number of concrete cases. The model is based on case studies of about 20 individuals, who are selected from the relevant population.

Different data sources (medical records, social acts, drug records) are used to identify healthcare services received by the individual during the previous 12-18-month period (and also: the costs of these services). The user experiences of the care process is documented by interviews. The interview tries to identify the problems and needs that led to different efforts and follow the results of these – and what they in turn lead to. Was the care given as a result of an initiative from the user? What was his/her experiences of the care given? In retroperspective, was the care adequate? Could anything have been done in a different way? Has the problems been solved?

These studies are conducted by project groups (where local R & D units have been commissioned). The results are fed back to practice: to professionals in various organisations, to management and to politicians.
How should the results be presented, and how should the case studies be used? In his "Making Social Science Matter" (2001) Flyvbjerg devotes a chapter to the role of case studies in the social sciences, noting among other things that "Atypical or extreme cases often reveal more information because they activate more actors and more basic mechanisms in the situation studied" and continues "Random samples emphasizing representativeness will seldom be able to produce this kind of insight; it is more appropriate to select a few cases chosen for their validity. "(p.78) Through the use of case histories in this way, we touch on a more general level Flyvbjergs concept of phronetic social science as".. explores historic circumstances and current practices to find avenues to praxis. The task of phronetic social science is to clarify and deliberate about the problems and risks we face and to outline how things may be done differently, in full knowledge that we cannot find ultimate answers to these questions..."(ibid s.140)

The case descriptions can be used in workshops with actors involved in the care for frequent users. The case descriptions can serve as "common map images" (Gurner et al 2010) in efforts to identify systemic barriers to health-care system relevant to the individual. They can help to concretize the abstract care process (the care pathway), identify - and not least illustrate moments where different parts of practice are dependent upon each other. They can also be used to create an understanding of what is happening in other parts of the system and describe/demonstrate how the actions of an actor has consequences for another. To follow the patient's path through the system in this way, one may contribute to a shared process of knowledge, and form the basis for reflections on how to find solutions to problems (Lindberg 2002).

3. Conclusion

Our work with the Frequent service user model began in 2011, and as we have stated earlier, it was necessary to put significant time and resources into the development of the model itself (rather than implementation of a fully developed model). The model have not yet generated any results, and consequently, that it is not possible to evaluate its significance. What we can say is that there has been considerable interest from practice to participate in the work. Obviously the aim of the Frequent service user model - to get an overall picture of the functioning of the care system's role (and not just of its separate parts) is considered to be important. For us as researchers, this project has given us an opportunity to study the
conditions of local change, and how empirical results can be used. It is of course also in our interest to develop models / methods that make it possible to monitor social practice.

In this paper we have described how we, in working with the model have distanced ourselves from how implementation processes traditionally have been carried out. It is, due to reasons stated earlier, still too early to judge whether we have been able to avoid the pitfalls that characterize traditional work. What we can report is primarily how we've looked upon in our mission, and how we have tried to develop approaches that are better suited to deal with the problems that typically arise in the implementation context.

The table below is an attempt to summarize the traditional view of implementation, the problems often associated with this - and how we tried to find ways to deal with them. The integration of local research and development (including ongoing evaluation) and practice is a central component in achieving these goals.

<table>
<thead>
<tr>
<th>The traditional view on implementation</th>
<th>Problem</th>
<th>How we are trying to avoid the problems related to traditional implementation processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research expertise develops the model</td>
<td>Context becomes a problem</td>
<td>Reversing established hierarchies</td>
</tr>
<tr>
<td>Management implements the model</td>
<td>Rejection of the model/Unwanted changes of the original model</td>
<td>Establish new roles and ‘job sharing’</td>
</tr>
<tr>
<td>‘Foot soldiers’ use the model</td>
<td>Lack of participation</td>
<td>Reduce boundaries between different phases of work, break up the linear process</td>
</tr>
<tr>
<td>Researchers analyse the use of the model</td>
<td>Development is not taking place</td>
<td>Shifting the focus: The goal is change, not the model itself</td>
</tr>
</tbody>
</table>
References


