How Substance Use Treatment Professionals Manage Organisational Tensions

A Web Survey and an Interview Study

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Abstract: *Aims:* The study examined how substance use treatment professionals managed problems and tensions in their work, and explored if the strategies varied by organisational features related to New Public Management (NPM). *Methods:* A total of 69 semi-structured interviews (2017–2018) with treatment staff in nine sampled local/regional areas formed the basis for constructing a web survey administered to staff across Sweden in 2019 (n=606). The means showed how often the different strategies were used. Regression analyses examined organisational differences, and central strategies were illustrated by the interview study. *Results:* Treatment professionals in general reported satisfactory freedom in their work. Staff in more NPM-like organisations were less likely to report autonomy and more inclined to report conflicting demands. When conflicts emerged, the staff used both passive strategies indicating adaptation or resignation, and active strategies including boundary spanning, protest, and liberty-taking. Some challenging strategies such as looking for other jobs or reporting one thing but doing another were more common in more NPM-like organisations. The opposite was found for customer orientation. *Conclusions:* While NPM features on customer orientation and steering methods appeared to create fewer problems, more NPM-like organisations appeared to be less favourable overall and should be applied with caution.

Keywords: Substance use treatment, staff, New Public Management, Sweden

Umgang mit organisatorischen Spannungen in Einrichtungen der Suchthilfe: eine webbasierte Umfrage und eine Interview-Studie

Zusammenfassung: *Ziele:* Es wurde untersucht, wie Fachleute, die in der Suchthilfe tätig sind, mit Problemen und Spannungen in ihrer Arbeit umgehen und, ob sich ihre Strategien hinsichtlich organisatorischer Merkmale im Rahmen des New Public Management (NPM) unterscheiden. *Methode:* Insgesamt bildeten 69 halbstrukturierte Interviews (2017–2018) mit dem Behandlungspersonal in neun ausgewählten lokalen/regionalen Gebieten die Grundlage für die Erstellung einer webbasierten Umfrage, die 2019 in ganz Schweden mit in der Suchthilfe tätigen Fachleuten durchgeführt wurde (n=606). Die Mittelwerte zeigen, wie oft die verschiedenen Strategien eingesetzt wurden. Mit Hilfe von Regressionsanalysen wurden organisatorische Unterschiede untersucht, zentrale Strategien wurden durch die Interviewstudie veranschaulicht. *Ergebnisse:* Die Befragten berichteten, dass die Freiheit, die sie im Rahmen ihrer Tätigkeit haben, im allgemeinen zufriedenstellend ist. Mitarbeiter in Einrichtungen, die eher nach den Regeln des NPM organisiert waren, berichteten, weniger autonom handeln zu können und sahen sich eher mit widersprüchlichen Anforderungen konfrontiert. Beim Auftreten von Konflikten, wandte das Personal sowohl passive Strategien, in Richtung Anpassung oder Resignation, als auch aktive Strategien an, die auch Grenzüberschreitungen, Protest und Freiheitsentzug umfassten. Herausfordernde Strategien wie die Suche nach einem anderen Job oder anders handeln als man vorgibt handeln zu wollen, waren in den NPM-nahen Organisationen häufiger vertreten. Das Gegenteil war in Einrichtungen mit einer eher kundenorientierten Haltung der Fall. *Schlussfolgerungen:* Während die NPM-Merkmale hinsichtlich Kundenorientierung und Steuerungsmethoden weniger Probleme zu schaffen scheinen, scheint eine eher NPM-ähnliche Organisation insgesamt weniger günstig zu sein und sollte mit Vorsicht eingesetzt werden.

Schlüsselwörter: Behandlung von substanzbedingten Störungen, Mitarbeiter, New Public Management, Schweden

Introduction

This article discusses how Swedish substance use treatment (SUT) professionals deal with problems in their work, and explores if different organisational features are associated with the chosen strategies for managing cur-

tailed discretion and conflicting demands. The background is the restructuring of the health and welfare systems that has taken place in many Western countries. Changes have included a move away from rule-based steering towards lean, market-oriented or business-like organisations. The shift started in the 1970s and has acceler-

ated since the 1990s when it became conceptualised by the loose term of New Public Management (NPM) (Hood, 1991). NPM may be regarded as a two-level phenomenon: as a general theory assuming that the public sector is improved by the introduction of business models or values, and as a set of related practices and organisational solutions (Pollitt, 2007). Such reforms have so far gone rather unnoticed in the SUT literature (Storbjörk & Stenius, 2019b).

The Swedish SUT system took a turn in the direction of NPM after the peak of the welfare state advances in the 1980s. It was during these years that the overarching framework laws for health and social services (which continue to regulate SUT) were enacted. SUT was primarily available within the public administration or non-governmental organisations (NGOs). Treatment and assessments offered great professional freedom, but public administrations were criticised for a lack of cost consciousness, and for being unstructured, bureaucratic, and paternalistic (Blomqvist, 2004; Harlow et al., 2013). The ensuing reforms also reshaped the SUT when the common NPM features were implemented: market mechanisms and greater competition (e.g., competitive tendering, private providers, term contracts); separation of functions (purchaser-provider splits); disaggregation of organisations into smaller and more specialised units; decentralisation of management authority ('flatter' hierarchies); explicit quality standards and emphasis on output control ('incentivisation'); private-sector management styles (performance-related pay); greater transparency in resource allocation; customer orientation; and cost-cutting (Hood, 1991; Pollitt, 1995).

At a national level, management-by-results was implemented in Sweden in 1988 (Sundström, 2006). Public procurement laws were enacted in 1992 and have since promoted competition also in SUT (Stenius & Storbjörk, 2020). Other national efforts to steer the SUT system and enhance quality include the implementation of evidence-based practices (EBP), statutory provisions on documentation requirements and quality assurance systems, and sharpened auditing by supervisory government agencies. Such overarching government is deemed necessary due to the long tradition of local self-government. SUT is highly decentralised, tax-funded, and primarily the responsibility of the 290 local municipal social services administrations and the 21 regions' health care systems. These public administrations, each governed by locally elected political assemblies, have great freedom to organise political functions and services as desired. The diversity in organisa-

tional solutions for offering SUT is therefore vast. Some areas adhere to traditional models by focusing on in-house public care provision. Others have implemented several of the above NPM features and may rely upon internal purchaser-provider splits, customer choice, or have transferred SUT onto the market by introducing competition and outsourcing. This expansion of market incentives and solutions at national and local levels has changed SUT. Many relationships become regulated by contracts, and private providers have become more important. The NGOs of the 1980s have by and large been replaced by for-profit companies and more recently by multinational corporate groups operating across national borders, and purchased on the stock-exchange market (e.g., Capio/Ramsay GdS, Ambea, Attendo, Humana) (Storbjörk & Stenius, 2019a). The advanced marketisation and local variations make Sweden an opportune case for studying potential organisational effects.

The quasi-marketisation, entry of new actors, increasingly complex organisations and incentives, and more standardised, specialised, and controlled treatment practices are most likely influencing the SUT working conditions in similar ways as they are changing the general occupations and practices of social work and medicine (Bejerot & Hasselbladh, 2013; Blomberg et al., 2015; Flodgren et al., 2011; Harlow et al., 2013; Hjärpe, 2017; Lauri, 2016; Meeuwisse et al., 2011; Tham, 2018). Unfortunately, the SUT research literature offers little advice in this regard. Research on NPM in SUT primarily deals with more sweeping matters. Bergmark (2010) has stressed the necessity of a market perspective for understanding the functioning of marketised SUT systems, as market aspects like competition clash with the theorised and desired rational and well-coordinated SUT system. A Norwegian SUT reform¹ in line with NPM has also been found to promote a fragmented system with bureaucratic procedures – thus standing in the way of such key system features as continuity, access, equity, and efficiency (Babor et al., 2008). Nesvåg and Lie (2010) have reported how staff have sought to facilitate care continuity despite the new obstacles, pursuing 'strategies for alleviating the negative treatment quality consequences of a system consisting of fragmented, linear transfer of responsibilities from one agency to the next' (p. 663).

While there is no clear link between NPM and treatment outcomes (Jones et al., 2018), studies have found that NPM may improve some process indicators (McLellan et al., 2008; Mendelson et al., 2017), customer choice may empower service users (Andersson & Johnson, 2020), and

¹ Introduction of a purchaser-provider model, new patients' rights/assessments, and a treatment responsibility transfer from regional to national level (Nesvåg & Lie, 2010).

user involvement largely corresponds with a professional logic (Storbjörk & Samuelsson, 2018). NPM may also create new career possibilities and increase the autonomy of lower-level managers as budget responsibilities often are decentralised (Berg et al., 2008). Management practices that enhance job autonomy, and coworker support have also been found to lower staff turnover, which may be high in many services (Roman et al., 2006). It clearly seems that the incentives embedded in different policies, management models, and funding schemes influence the functioning of the system and how staff may act (van de Ven et al., 2020). For example, the introduction of Payment by Results in England changed treatment access, completion, and discharge. There were no signs of 'creaming', that is, selection of service users more likely to be profitable (Jones et al., 2018). Other studies have found that systems of this kind may tempt the staff to act in ways that favour their funding situation or image (Lewiskin, 2018; Lu & Ma, 2006).

The importance of money cannot be ignored. Saving tax-based resources has always been central, but researchers also claim that practices like social work have changed from being needs-led to budget-led (Berg et al., 2008). Leppo and Perälä (2017) used the *logic of austerity* to understand how caring relations and SUT have transformed with the neoliberal regime. Cost-cutting, striving for economic efficiency, increasing treatment volumes, and understaffing due to competitive tendering that grants contracts to the lowest bidders may create frustration and job dissatisfaction (Blomberg et al., 2015; Bogo et al., 2011).

The only study (Lewiskin, 2018), to our knowledge, that has specifically scrutinised SUT staff experiences of NPM in the day-to-day practice presents experiences in line with those reported in adjacent areas (Astvik et al., 2019; Meeuwisse et al., 2011; Welander et al., 2019). Lewiskin (2018) noted that SUT staff and managers in New York handled increased demands concerning administrative tasks, tensions between productivity goals and treatment quality, and loss of professional autonomy. The strategies included: self-care to maintain health and well-being (e.g., set boundaries on overtime work); adjustment; cutting corners (e.g., not do paperwork, down-prioritise tasks); bending the rules, and demonstrating acts of resistance (e.g., 'fudge' numbers, commit to one's clinical values and exercise discretion regardless of agency requirements, speak up or argue for one's values). There were also examples of 'creaming', reporting one thing but doing another (i.e., 'organizational hypocrisy' (Brunsson, 1993)), and plans to leave the job.

Different dimensions of NPM appear to influence SUT differently. Some features seem to benefit staff and service users whereas others may hinder the prerequisites of good working conditions and good-quality services. We there-

fore analyse which strategies are used by Swedish SUT staff, and try to unravel the significance of various organisational features in this regard.

Methods

Design

A nationwide *web survey* was constructed based on a qualitative *interview study* in a sample of SUT administrations. The background, aims, setting, and methods of the entire research project are fully available in an online open-access report (Storbjörk et al., 2019). It describes in detail the sampling procedures, interview guide, web survey and its content, research participants, and procedures. The aims of the overarching research project were to examine the government of the SUT system, the permeation of various NPM solutions, treatment professionals' experiences thereof, and the handling of potential tensions in demands or logics.

The project used informed consent and received ethical clearance by the Ethical Review Board of Stockholm (EPN 2016/446-31/5).

Setting

For the *interview study*, six municipal administrations (social services-based SUT) and three regions (health care-based SUT), with accompanying contracted private providers, were selected across Sweden.

The *web survey* was distributed nationally and targeted SUT staff in municipal, regional, and private for-profit and not-for-profit organisations. State-run compulsory care and the criminal justice system were excluded.

Samples

Interview study: Purposive sampling was applied to select regions/municipalities across Sweden with variations in prerequisites (population size, wealth, political majority) and NPM permeation. Different organisational features were covered such as traditional in-house service provision, internal markets (purchaser-provider splits), high share of purchased private care, performance-based funding, and customer choice. Purposive and snowball sampling were applied in each area to reach interviewees that could offer a comprehensive understanding of the organisation from the perspective of SUT staff, managers, and elected representatives. A total of 69 semi-structured in-

interviews were conducted with 77 people (some interviews had more than one interviewee) between March 2017 and June 2018. No specific eligibility criteria were applied.

The *web survey* was launched on 5 April and closed on 2 June, 2019. It targeted SUT professionals in the health care system, social services, or other, non-public provider. Managers without involvement in treatment encounters or treatment decisions in individual cases were excluded. Different advertising and outreach strategies helped to reach staff across Sweden. A total of 606 valid entries were recorded by different professions (social workers, nurses, psychologists, treatment assistants, etc.). The number of SUT professionals in Sweden is unknown, but the distribution of participants across provider types resembles what could have been expected. However, it is not a random sample and we cannot assume that it is representative of all SUT staff in Sweden.

These aspects are further elaborated in Storbjörk et al. (2019).

Instruments and procedures

For the *interview study*, we developed a semi-structured interview guide based on the study aims and previous research. The guide was used as a checklist and was adapted to respondent and area specifics. It covered, among other things, views upon different NPM features in the organisation, development over time, pros and cons of the organisation, professional autonomy and administrative control, daily work, and national-level steering of SUT. Interviews (about one hour) were recorded, transcribed, and the 1900 pages of text were organised and coded in QSR NVivo 11.

Interview study experiences were translated into a *web survey* to allow for a wider portrayal and comparisons across organisations. It was constructed to chart central NPM features and cover experiences reported in the interviews. It was further informed by previous research. The web survey included questions on the respondents, their organisation (NPM features), everyday practices (experiences of professional autonomy and administrative control, pros and cons about the unit, coping strategies), and general attitudes towards market-oriented models.

Web survey measures

Strategies

What do you do when you experience problems in your work, e.g., if you experience incompatible demands, value conflicts, or different obstacles to doing a good job? How often do you do the following? 24 items (Table 1). Response categories: 0 never, 1 seldom, 2 sometimes, 3 often, 4 very

often, not applicable (n/a). N/a was recoded into 0, since it primarily reflected strategies that were rare in certain types of organisations and hence rarely applied. The multiple regression models controlled for provider type, and additional models run without n/a cases (not shown) did not change the findings significantly.

Autonomy scale

On the whole, can you do your client/patient work based on your professional knowledge and experience or do you feel overly steered and controlled? (From 10 very free to 0 very controlled).

Conflicting demands

Statements about possible good and bad aspects of your work situation. To what extent do you agree with the following? There are conflicting demands in my work (4 fully agree, 3 partially agree, 2 neither nor, 1 partially disagree, 0 fully disagree).

Provider type

We separated between staff in statutory social work (assessments/decisions by municipal social services), other municipal units (treatment, housing support, etc.), regional health care, and private providers. These have different tasks and are regulated somewhat differently.

NPM permeation

The analysis separated between conceptually different aspects of NPM. The item response categories were 0 not at all–6 completely, and 0 no–1 yes. The variables were rescaled (to 0–1) and included in three additive indexes rescaled to range between 0 (low) and 1 (high on NPM):

NPM customer orientation used two items: Patients/clients have high user involvement in my unit (0–6); The unit conducts recurring service user satisfaction surveys (0–1).

NPM steering and control included five items: My unit has clear goals for SUT (0–6); Uses a certain management model, e.g., LEAN (0–1); Uses a system for thorough planning and recording of time/work (0–1); Has performance-based/unit-price funding (0–1); Often provides up-to-date information to staff about finances or performance (0–1).

NPM organization covered internal market/purchaser-provider split; outsources SUT/entrepreneurial contracts; framework agreements with private providers; system of choice; civil society public partnership; other public procurement; highly specialized units, e.g., separation between assessment and treatment functions; SUT responsibilities are split across several political committees; for-profit provider; belong to a large corporate group (0–1 on all items).

Table 1. Autonomy–control, tensions, and strategies for tackling conflicting demands, indexes, items, and means (m) (n=606)

STRATEGIES	Mean
Passive index: Adaptation & resignation	1.48
Try to find ways to handle my frustration on my own	1.92
Try to justify to myself why the work is (organised) the way it is	1.56
Perform the work as the unit requires although I think it's wrong or could be done in a better way	1.54
Try to make the client accept our methods and interventions even if I don't agree	1.54
Down-prioritise tasks or clients even though I don't want to	1.37
Lower my quality requirements	1.29
Lower my commitment to the work and clients in order to cope	1.13
Active index: Fight, voice, & boundary transgression	1.29
Exert myself very hard to find good solutions/interventions for clients despite poor conditions/alternatives	2.57
Emphasise that health/social/compulsory laws must be obeyed if my needs-assessment/intervention is rejected by superiors/funding bodies	1.62
Try to convince the management or purchaser that we're doing a good job	1.62
Exert myself to get our providers/purchasers/collaborators to do a good job	2.26
Perform tasks that actually are someone else's responsibility/task	2.13
Work extra hours or more intensively to catch up	1.75
Protest against problems and suggest possible solutions to the management	2.54
Protest against problems and suggest possible solutions to policy-makers	.84
Liberty-taking: Do what I think is best for the client regardless of unit/manager demands	1.68
Exit: Look for other jobs	1.24
Ignore costs: Don't allow costs to prevent me from choosing an intervention I think best will meet the client's needs	1.52
Refusal: Refuse to take on more assignments or clients than I can manage	1.68
Unit refusal: Unit refuses to admit clients that don't belong here (e.g., too severe problems)	1.56
Unit adaptation: The unit adapts to contracts and purchasers' demands even if we think the work is best carried out differently	1.56
Hypocrisy: Report doing the work as demanded by the unit, but do in fact something else	.51
Avoidance: Avoid documentation work or tasks I've been assigned but find unnecessary	.64
Support: My colleagues and I support and help each other when the work situation is difficult	3.09
Procurement: Ignore frame agreement if it doesn't match client needs or wishes ^a	1.57
AUTONOMY–CONTROL, INCONSISTENCIES	
Autonomy scale	6.74
Inconsistencies in demands	1.94

Notes: ^a Asked only of those involved in statutory social work, n=169.

Other organisational features

We controlled for three additional organisational features or prerequisites that may influence the work. *Organisational instability* (0–1): My unit has high staff turnover; has a lot of consultants as opposed to fixed positions; is often reorganised (0–6 on all items). *My unit has a good financial situation* (0–6). *Area/population size* in 2017 was divided into units located in one of Sweden's three big city (most populous) areas; medium (big cities and high-density areas, > 41 inhabitants/km²); rural or other sparsely populated area.

Respondent characteristics

Sex; number of years mainly/partly been working with people with substance use problems; and holding a management role or not.

Statistical analyses

SPSS 25 helped to analyse the web survey data. Factor analyses guided a data reduction of the strategy items for further analysis. Two conceptually sound factors with eigenvalues >1 were distinguished (Principal Component Analysis, Varimax rotation). Missing values were first replaced by means, and the additive indexes were created and rescaled to range from 0 to 4 like the other items. *The passive index* (see Table 1) included seven items (Cronbach's Alpha .846). *The active index* had eight items (Cronbach's Alpha .717). Other items that did not fit into a factor were treated individually. The means for indexes and items are presented in Table 1. Multiple regression models were run (Table 2) for type of provider, NPM permeation, and participant characteristics (Models A). Next, we also controlled for additional organisational prerequisites (Models B). Linear regression was used to benefit from variances in responses. Logistic regression was used for highly skewed items (values > means were coded as 1).

The findings may not be generalised to the entire SUT staff population. Yet the ranking of means may reflect the relative importance of different strategies, and the regression models shed light on differences across organisational features. P-values (<.05 and <.10) were marked to indicate potentially strong associations.

Results

Web survey

Autonomy and inconsistencies

The staff felt, on the whole, fairly free in their work. Although there appeared to be some conflicting demands,

the mean value at just below *neither-nor* did not suggest that this was a large-scale problem (Tab. 1).

Interesting organisational differences emerged (Table 2). Lower odds for enjoying great *autonomy* were found for those in statutory social work (compared to those hired by other municipal units or by private providers), for those in more NPM-like organisations, and for those reporting higher organisational instability. Higher odds for professional freedom were found among staff working in units with greater customer orientation and with better financial situations. Experiences of *conflicting demands* were more prominent among those in statutory social work (compared to other types of organisations), in more NPM-like organisations, in organisations suffering from more instability, in the most populous areas, and among those with a management role. Such tensions were less obvious in organisations with more NPM steering and with more customer orientation (when controlling for additional prerequisites), and at units with better finances. It was thereby SUT staff exercising public authority and those in more NPM-like organisations that appeared to be more controlled and exposed in these respects.

Strategies

The most frequently used strategy was to *support* and help each other. *Liberty-taking* and *refusing* to take on more work than one could manage were also common. Staff were more prone to adhere to *passive index* strategies – adapting or resigning to the situation – than *active index* strategies such as boundary spanning efforts or speaking up for one's situation or work (Tab. 1).

Table 2 displays interesting differences across strategies and organisational features. The models were good at explaining the variance in the indexes and in the exit option. Both the *passive* and *active* indexes were more frequently reported by staff in statutory social work, and in more NPM-like and in more unstable organisations. These strategies were more seldom used by staff in units with stronger customer orientation and NPM steering, and in small administrations and units with good finances. The most extreme *exit* strategy of looking for other jobs was more often reported by statutory social work staff and staff in more unstable organisations, but was less often considered in units with stronger NPM steering or customer orientation, and in units with good finances.

The included variables explain a lower share of variance in how often SUT staff used some of the other strategies. The very common strategy of *supporting* each other occurred more frequently among women, in low populated areas, and in statutory social work (than in other municipal units). The results indicate a greater need for such support also in more NPM-like organisations. Organisational *hypocrisy* was rarely reported but occurred more often in

Table 2. Multiple regression. Ordinary Least Square models (Bs) and logistic regression Exp(B) (n=606)

	OLS									Logistic			
	Passive index	Active index	Liberty-taking	Exit	Ignore costs	Refusal	Unit refusal	Unit adaptation	Inconsistency	Autonomy scale	Hypocrisy	Avoidance	Support
MODELS A													
Public: Municipal [ref: statutory social work]	-.47*	-.41*	.02	-.19	-1.03*	-.03	.24*	.01	-.54*	2.93*	.98	.68	.61*
Public: Health care	-.21*	-.19*	.20	-.19	-.31	.17	.23	.30*	-.26	1.46	.87	1.06	.75
Private	-.61*	-.53*	.01	-.43*	-.52*	-.03	.64*	.36*	-.90*	3.02*	.93	.69	.87
NPM customer orientation	-.67*	-.58*	.06	-.79*	.02	.24	-.30	-.67*	-.73*	4.52*	.33*	.37*	.94
NPM steering & control	-.61*	-.53*	-.66	-1.17*	.50	-.04	.05	-.65*	-.93*	1.16	.80	.86	1.39
NPM organisation	.40*	.35*	.16	.60*	.14	.24	.11	1.35*	.60*	.19*	4.33*	1.91	1.45
Female [ref=male]	-.05	-.05	-.28	.04	-.08	-.12	.03	-.03	.19	.67	.97	.43*	1.67*
Boss	.00	.00	-.24	.03	.24	-.37*	.09	.00	.25*	.85	1.11	1.27	.80
Work experience 0–2 yrs [ref=3–5 yrs]	.05	.05	.07	-.08	-.21	-.13	-.08	-.32*	.09	1.00	.79	1.31	1.06
6–15 yrs	.06	.06	.41	-.17	-.11	.07	-.06	-.13	-.13	1.18	1.08	1.18	1.14
16+ yrs	-.17*	-.15*	.23	-.36*	-.30	.01	-.02	.01	.00	1.16	1.03	1.17	.94
Adjusted R ² (for OLS) and Nagelkerke R ²	.203	.203	.026	.116	.094	.031	.016	.058	.110	.151	.051	.081	.041
MODELS B													
Public: Municipal [ref: statutory social work]	-.35*	-.31*	.03	-.06	-1.01*	.00	.26*	.07	-.34*	2.36*	1.08	.78	.55*
Public: Health care	-.26*	-.23*	.15	-.22	-.25	.12	.21	.24	-.29	1.38	.68	.87	.89
Private	-.52*	-.45*	-.09	-.32*	-.46*	-.04	.66*	.31	-.69*	2.24*	.74	.59	.94
NPM customer orientation	-.43*	-.38*	.08	-.53*	.04	.28	-.28	-.54*	-.31	2.79*	.40*	.51	.79
NPM steering & control	-.45*	-.39*	-.64*	-.98*	.64	-.02	.10	-.58	-.69*	.74	.85	.92	1.38
NPM organisation	.10	.09	.03	.30	.31	.13	.11	1.10*	.15	.27*	2.09	.82	2.42
Female [ref=male]	-.06	-.05	-.28*	.03	-.09	-.11	.03	-.04	.17	.70	.98	.41*	1.65*
Boss	-.01	-.01	-.22*	.02	.27*	-.38*	.09	.01	.23*	.87	1.12	1.28	.82
Work experience 0–2 yrs [ref=3–5 yrs]	.05	.04	.09	-.08	-.18	-.13	-.08	-.31	.07	1.04	.80	1.32	1.07
6–15 yrs	.07	.06	.42*	-.16	-.10	.07	-.06	-.13	-.13	1.20	1.09	1.19	1.15
16+ yrs	-.12	-.11	.25	-.31*	-.23	.02	.01	.03	.06	1.07	1.05	1.17	.94
Unit has good economy	-.05*	-.04*	.04	-.07*	.04	.00	.02	.00	-.14*	1.26*	1.03	.93	1.01

Table 2. Multiple regression. Ordinary Least Square models (Bs) and logistic regression Exp(B) (n=606) (continuation)

	OLS									Logistic			
	Passive index	Active index	Liberty-taking	Exit	Ignore costs	Refusal	Unit refusal	Unit adaptation	Inconsistency	Autonomy scale	Hypocrisy	Avoidance	Support
Organisational instability	.99*	.87*	.45	1.03*	.85*	.25	.34	.64*	1.18*	.21*	3.30*	2.45	.59
Area/population size rural [ref=big]	-.25*	-.22*	.03	-.22	.56*	-.15	.02	-.16	-.49*	1.37	.45*	.33*	2.21*
Medium	-.10	-.09	-.15	-.14	.17	-.03	.11	-.20	-.21*	1.33	.58*	.50*	1.27
Adjusted R ² (for OLS) and Nagelkerke R ²	.293	.293	.033	.165	.117	.030	.016	.068	.205	.223	.087	.133	.062

more NPM-like organisations and more seldom in more customer-oriented units. Likewise, *avoiding* tasks experienced as unnecessary was seldom reported, more rarely in more consumer-oriented units, but was more frequently used by men, in unstable organisations, and in the most populous areas. As expected, those working in private units or performing municipal treatment were more likely to *refuse* admitting service users they did not think fitted their remit, whereas statutory social work is obliged to assess everyone. Likewise, refusals were rarer in units with a stronger customer focus. Private and health care *units more often had to adapt* to others' demands than was found in statutory social work. That was also the case for more NPM-like organisations, while units with a stronger customer orientation and NPM-steering more seldom had to adapt. *Liberties* were more often taken by more experienced staff and in more unstable organisations. It was less often used by females, managers, and in organisations with stronger NPM steering. As expected, *ignoring costs* was easier for those *not* performing statutory social work and making the actual decisions.

Interview study illustrations

This section offers interview study examples of professionals' experiences. On the whole, the interviewees were highly committed to their work with the service users. This was particularly evident among staff with many service user encounters. There were also managers and others who felt that a more NPM-like organisation helped them focus upon their assigned tasks. It could offer great autonomy and be 'a fun challenge' to be 'almost like a CEO for a little company' with a range of responsibilities and tasks [municipal manager; 38 (our interviewee ID number)].

However, this article deals with the handling of experienced problems, and there were many accounts of how the staff managed and negotiated professional and organisational boundaries and regulations, adjusted to or sought to resist demands, or sought to protect their autonomy, or gain professional legitimacy.

Passive strategies, such as adaptation, loyalty, or resignation are illustrated by an experienced social worker in statutory social work [36] who described how the work had become highly structured and the organisation so specialised that 'there's not much room left to be spontaneous'. Some jokingly said they had become 'assessment machines'. They sought to handle this by trying to 'let go ... accept this arrangement', accept their narrow role, and try and justify 'why am I doing this?', 'remember that we have a purpose', that predictability and equity are important for the service users. Because there 'isn't much I can control ... neither can I control our organisation or how we work' [see 18,22,35–36]. This interviewee [36] described negotiations with other providers and how s/he actively navigated such regulated relationships: 'I must choose whether I'll just back off, serve as a supervisor, a judge, or be the one signing the discharge decision. I know that some social workers find it difficult *not* to interfere with the actual treatment.' Another, less experienced, social worker argued that 'there must be room for professional judgement', but routines and checklists imposed on the staff meant that 'you must try to become even more efficient, and somewhere along the way quality will suffer' [40]. The treatment becomes less flexible and needs-based [18–20]. Professionals providing treatment presented a more autonomous situation but they also had to struggle to settle with 'good enough' despite higher quality aspirations when the organisation pushed for greater treatment turnover [47]. Treatment was more about scratching the surface

and offering tools for handling daily life instead of solving underlying causes [34,36,46–47]. One solution was to invite the service users to a joint effort to 'exit the factory as a new and fixed person' in the limited time allotted [34]. Potential quality reduction could also be imposed at the unit level (*unit adaptation*), e.g., when an employee was commissioned to implement a new evidence-based treatment method only to be told not to do it by the book as that would be too costly. The method was nevertheless displayed as EBP [34].

Liberty-taking and the active and boundary-spanning strategies involved a range of responses such as protesting or struggling to find good solutions despite a fragmented system, fixed or disrupted contracts, or budget cuts [42–45,48–49,54]. It could include arguing for one's case by invoking health/social laws in treatment rejections or times of austerity [12,15,17–18,39,42,45]. For example, a health care manager had set up a reporting system to demonstrate that the unit was doing a good job and that it was the reimbursement scheme that had to be adapted to reality [81]. A doctor had ignored the top-down implementation of a 'screening instrument that was to be used on every patient every day. I refused to do it and said that it had nothing to do with quality' [75]; a trauma therapist offered such care if deemed necessary despite being told *not* to, as that was the responsibility of another unit [47]; an outpatient provider made phone calls against the rules on behalf of statutory social work to speed up slow processes [15,34]; or treatment staff had sought to keep service users enrolled even if they had already had the approved number of sessions [34,68]. Staff could also give low priority to demands they perceived as pointless [13,18,21]. And while some skipped meetings and sought to set aside time for documentation [12,15,18,20,22,40,44,49], others admitted that they had become sloppy [22,36]. Generally, many demands were considered reasonable but impossible to live up to due to time and resource constraints.

For some, escape was considered the only solution to the dissatisfaction. 'I guess I have to move to another municipality' [36], 'I've had quite a lot of room for discretion, I think. But this is different and I'll retire earlier than I'd planned' [20].

Discussion

Our research project suggests that several of the reported organisational shifts in health and welfare systems are also reflected in SUT – e.g., standardisation/specialisation, marketisation, and strengthened control. The local variations in NPM permeation offer rich opportunities to study the consequences of such organisational features. The

findings may benefit an international audience by offering advice on which solutions appear more desirable than others.

SUT staff have for good reasons never experienced infinite freedom. A certain degree of (quality and cost) control is necessary. Yet professional autonomy is crucial for responding to individual and complex needs of the service users – hence framework laws allowing for professional judgement. Conflicting demands and curtailed discretion have been previously reported (Blomberg et al., 2015; Harlow et al., 2013; Leppo & Perälä, 2017; Lewiskin, 2018; Meeuwisse et al., 2011). Our web survey contributes to this knowledge by suggesting that staff in certain types of organisations are more exposed in this regard, that is, staff in more NPM-like organisations and in statutory social work (making treatment assessments/decisions and thereby also controlling the costs). Interestingly, health care SUT did not tend to differ from statutory social work, whereas private and municipal providers appeared to enjoy a more favourable situation from a staff point of view. NPM in the form of customer orientation seemed to better correspond with professional values. There were also indices that NPM-like steering could be beneficial – perhaps by offering greater clarity and transparency?

These findings were reflected in the strategies applied, with more frequent use of less desirable strategies like *organisational hypocrisy* and *exit* among staff in more NPM-like organisations. *Active* and *passive* strategies were also more prominent in more NPM-like organisations (and less prominent with stronger consumer orientation and NPM steering). It appears that such organisations, with competition, internal markets, contracts, and more diverse or fragmented systems, present staff with a greater need to actively handle difficulties (Nesvåg & Lie, 2010). Furthermore, other prerequisites, including austerity, organisational instability, and big administrations, were important (Leppo & Perälä, 2017). Yet the NPM permeation measures remained fairly stable also when controlling for such factors.

What is, then, the extent to which SUT staff seek to protect their professional autonomy and knowledge? This question remains partly unanswered due to uncertainties in the generalisability of the web survey. There were signs of liberty-taking for the sake of service users and good-quality care, particularly so among experienced staff, but passive adjustment or resignation were also common. Professionals' boundary work may indeed be of great value (Lamont & Molnár, 2002): Grell et al. (2019) found that boundary spanning and bending of formal rules created favourable conditions for helping relationships. Formal structures were bad for such relations and especially so for more complex cases. Perhaps treatment staff should speak up more in the controversy between autonomy and con-

trol? Other representatives do not appear to shoulder that role (Lewiskin, 2018).

A major limitation of the web survey is that it is impossible to judge its generalisability. It was more difficult than anticipated to recruit respondents from private and health care units (Storbjörk et al., 2019), but the distribution of participants across provider types appears reasonable. The agreement in findings between the interview study and the web survey strengthens our belief that our project contributes to the knowledge on daily practices and the significance of organisational features. The interview study did, for example, suggest more distrust and problems with fragmentation in larger and in more NPM-like organisations. Three of our sampled municipalities/regions with a long NPM history had therefore started to question the value of internal markets and purchaser-provider splits.

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