Room for action? How service managers in three Scandinavian cities experience their possibilities to develop their services

OLE NÆSS & STÅLE OPEDAL & SVERRE M. NESVÅG

ABSTRACT
BACKGROUND – The study is based on the ongoing public debate concerning a limited scope for local service development in alcohol and drug treatment-related services – and that the main cause of local “paralysis” is to be found in health policy micromanagement of these services. It is argued that business management models place too much emphasis on financial control and performance measurement and that this leads to less interest in quality improvement in the provision of services. DESIGN – 23 interviews with service managers in three Nordic urban municipalities, Stavanger, Umeå and Aarhus. RESULTS – The article documents comprehensive local service development, demonstrating that the main conditions for innovation are management commitment and interdisciplinary co-operation in the practice field. CONCLUSIONS – In all three municipalities the services develop in a hybrid innovation model that combines New Public Management-inspired solutions with technical co-operation in horizontal networks. Results show that NPM-inspired solutions to alcohol and drug treatment services do not necessarily hinder the consideration of local professionalism and flexibility in the development.

KEYWORDS – service development, alcohol and drug treatment services, innovation, co-operation, quality improvement

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Introduction
Alcohol and drug treatment services in the Nordic countries are under increasing pressure to develop and co-ordinate services better for the users. The services should meet not only the more complex needs among users, they must also adapt to new government control signals, reforms, academic progress and to more squeezed municipal finances. It is in the balance of political, professional and economic expectations and considerations that drug services must find their future form.

This article focuses on the driving forces behind the development of alcohol and drug treatment services. Based on experiences in three Nordic cities, Stavanger in Norway, Umeå in Sweden and Aarhus in Denmark, the article highlights the scope of service development and which factors are pushing innovations in alcohol and drug treatment services. All three urban municipalities are part of the Scandinavian health system which, in international comparisons, is classified as a decentralised National Health Service (NHS) system. The health services are tax-funded and provided mainly by public providers. The content of alcohol and drug treatment
services offered in the three countries has many similarities. The service shall be universal and meet needs regardless of the user’s place of residence, gender and socio-economic status. Alcohol and drug treatment in the Nordic countries has clear similarities in the composition of both health personnel and user groups, and the services developing are driven by many governmental similarities (Edman & Stenius, 2007).

In the debate about implementing New Public Management (NPM) into alcohol and drug treatment it has been argued that this may compromise service quality and that the market is not a good way to distribute services between clients with different levels of information, varying degrees of real choice and varying possibilities to correct wrong choices. It has been argued that NPM cannot substitute the political decisions that will distribute services to all those who need them (Stenius, 2011). This and other similar positions may be interpreted as the services having become unwilling and resigned subjects of governmental health policies. This article assumes that quality comprises three organisational principles: i) the services shall be available, ii) the services must be adapted to each individual, and iii) services (collectively) should be able to provide continuity of treatment (Nesvåg & Lie, 2010). We examine in particular whether local service development stakeholders have the scope to develop services that support the principle of continuity. We understand the principle of continuity as a proposition that an individual’s treatment should last as long as the client needs it, but it is equally important to apply the principle of continuity to ensure that the services offered are linked to other services that the user receives (coordination).

It is argued that NPM-inspired models to a large degree “reward” quantifiable aspects of services and that this leads to less interest in development focusing on the quality of care (Twaddle, 2004). Alcohol and drug treatment services often involve services from many providers that, as a whole, must have the ability to identify individual and co-ordinated courses of treatment. NPM-inspired models are claimed to lack elbowroom for horizontal professional co-ordination of services (Twaddle, 2004). This article poses the question as to whether the practical field in alcohol and drug treatment services lacks the necessary freedom from central control to pursue local development.

**Background**

Research on service development has traditionally been based on top-down approaches which concentrate on political/administrative decisions and subsequent implementation in practice. There is a general lack of systematic studies of the effects of NPM reforms (Christensen & Lægreid, 2007; Lægreid, Opedal, & Stigen, 2005). It appears that the link between structures (reform) and effect is weaker than we have been led to believe. Organisational responses to reform are affected both by historical context and situation (Christensen, Lægreid, Roness, & Røvik, 2009). The more recent years have advocated a reform break in the alcohol and drug treatment services. Alcohol and drug treatment services are especially unsuitable to utilise the NPM-inspired market models (Stenius, 2011). NPM-inspired organisation leads to frag-
mented alcohol and drug treatment services while market thinking requires enlightened and informed users, which substance users, by virtue of their condition, cannot always manage (Ankarloo, 2012).

With this in mind, we will examine the scope for service development in the local practice. Leeway is defined as the space that local developers have at their disposal after the legal requirements have been adhered to. The practice field can, in our study, be defined as public providers of alcohol and drug treatment services. By local service development we mean small and large locally-initiated changes to service organisation and task management, based on locally arisen challenges. The term service development expresses an opportunity to develop a more favourable relationship between the use of resources and co-operation for public welfare, and the services that are provided and perceived as results (output). This may entail improved work processes, new technologies or a new combination of services or products. In addition, the development of services in the public sector also includes service experience. Service experience or service is all about the user and citizens’ subjective experience of the service (Bason, 2010; Godø, 2009; Hovlin, Arvidsson, Hjort, & Ljung, 2011).

Our focus is on service development seen from the service management standpoint. We are not concerned with the objective freedom of action as represented by the formal organisation, but with how the local service development stakeholders themselves perceive their opportunities to pursue service development. The service development stakeholders in our study are individuals who have the formal authority to undertake small or large changes in service design.

We are primarily concerned with what is referred to as knowledge-based intensive service development. New solutions occur jointly between people who have expertise in this area. This form of development is incremental and interactive in nature, suggesting that development rises from the experiences of daily work (Grabher, 2004; Hipp & Grupp, 2005; Lyons, Chatman, & Joyce, 2007; Robertson, Scarbrough, & Swan, 2003; Sarvary, 1999; Skjølsvik, Løwendahl, Kvålshaugen, & Fosstenløkken, 2007; Starbuck, 1992; Toivonen & Tuominen, 2009). Employees (employee-driven innovation), but also users, citizens or research (user-driven innovation) contribute input, knowledge and experience that gives rise to knowledge-intensive service innovation. This form of innovation usually happens in networks characterised by power symmetry between the stakeholders.

Local service development can also happen because the state or local political-administrative leadership say so. This is a form of asymmetrical power between those who require service development and those who implement the adopted amendments. The development is driven from the top of the organisation while the professional communities are reactive. Our assumption is that service development can best be understood in the intersection between the central control signal and the local exercise of professional judgment. We assume that this intersection provides sufficient leeway to develop alcohol and drug treatment services of high professional quality. Where this intersection occurs – between central control and
local professional freedom – will vary with the chosen theoretical approach.

**Theoretical framework**

The literature on innovation and service development points to several types of conditions that must be in place to stimulate innovation (Koch & Hauknes, 2005; Potts & Kastelle). Emphasis is placed on attitudes among management and employees that promote creativity and risk-taking. It is alleged that risk aversion is more prevalent in the public sector than in the private sector. It is also claimed that the public sector does not have the same understanding of crises as the private sector, and that this inhibits innovation and creativity. Furthermore, a systematic approach to innovation in local government requires an extensive interaction between participants. For example, experiences of interdisciplinary co-operation in the health field suggest that professional groups will often be able to stand in the way of such co-operation (Rice et al., 2010). Professional autonomy and self-interest thus act as a barrier to increased collaboration and development of new solutions, as shown in the field of welfare (Alm Andreassen, 2011). Research also shows the importance of conscious leadership that can create enthusiasm and room for trial and error (Bason, 2010; Sørensen & Triantafillou, 2009). However, this is not just a question of leadership and culture but is also related to whether the public sector is able to create organisational frameworks promoting innovation.

This article has one such organisational theory perspective. We are committed to professional freedom as a condition for creativity and innovation. Such an approach does not mean that the absence of overall leadership and management are necessary to promote the development of services in the practice field, but senior management must balance their leadership against the need for professional leeway for innovative trial and error in the professional communities.

Research indicates that over the last decades there has been a movement in Scandinavian public administration from the detailed governing Weberian bureaucracy toward organisational solutions inspired by NPM. NPM reforms were intended to create clearer vertical and horizontal tasks and responsibilities as well as better management internally between elected officials, administration and professional communities. In recent years, the emergence of network-inspired solutions claimed to be a backlash against service fragmentation created by the NPM (Christensen & Lægreid, 2007). Examples of such networks are the outreach treatment team in Stavanger (Oppsøkende behandlingsteam Stavanger – OBS) and the alcohol and drugs reception (Alcohol och drogmottagningen) in Umeå, where employees from different agencies share budgets and premises in a single unit. Umeå plans to create a Centre for Dependency Disorders (Beroendecentrum) where tight integration between government levels is a key objective.

The Norwegian Co-operation Reform (Samhandlingsreformen) aims to strengthen co-operation between municipalities and the hospital level so that the services are viewed as seamless. In Aarhus, where the bulk of alcohol and drug treatment services are placed at the municipal level, we also see different forms of network models emerge, but on the same administrative
level (Youth Centre, Centre for alcohol treatment, Centre for substance abuse treatment). In Aarhus the main goal is strengthening integration and collaboration between entities on the same administrative level. Increasingly, the alcohol and drug treatment services work with complex problems where multidisciplinary and cross-sectorial perspectives are crucial for successful solutions. These are issues that cut across different sectors. They cannot be resolved through, for example, standardisation or more resources alone (Holmen, 2011; Røiseland & Vabo, 2012).

Theoretically, we assume that local service managers’ leeway is controlled by an external organisational framework. Typically the outer framework varies with the choice of service development model. Three models form the basis for this article: bureaucracy model (service development as centralised management), NPM model (service development based on a combination of decentralised and centralised control) and network model (decentralised service development based on vertical and horizontal co-operation).

Service development in classic bureaucracy
In accordance with the classic model of bureaucracy, staff is a value-neutral tool for the implementation of elected representatives’ decisions. The focus is on managing the relationship between overarching drug politics, administrative management and the professionals in the drug services. The users’ role is to be passive recipients, whereas employees follow orders (Jacobson, 2012).

This model is based on a high degree of centralisation and a hierarchical organisation of service development with decision-making power carefully restricted by a set of common rules. All employees are responsible to management for overseeing that decisions are in accordance with the resolutions and regulations. Detailed inspection will ensure that similar cases are treated equally. The model provides for a high degree of top-down management, leaving little scope for local service development based on professional judgments.

Service development in an NPM model
New Public Management is a generic term for the reform wave that has swept over the public sector over the last 20–30 years. Public administration in Scandinavia has to balance some very conflicting considerations: contradictory political signals, various academic considerations, legal rights demands, equal treatment and predictability for all as well as taking into consideration the interests involved. With a strong focus on cost, NPM can therefore be too one-dimensional to manage and balance conflicting interests (Christensen, 2010). Where traditional public administration emphasised the distinctive nature of public administration and also limited public employees’ discretion to ensure maximum possible predictability and political loyalty, NPM points out the similarity between the public and the private sectors, thereby allowing professionals and service developers more flexibility and more choice.

Behind NPM’s overall focus on economy are two opposing tendencies: more control and more autonomy at the same time. Hiding behind the desire for more superior control is a certain centralising tendency where management wishes to govern the provision of services through incentives
such as by “making the managers manage”. Conversely, we see that the desire for decentralisation entails a dismantling of hierarchical authority. Behind the desire for more local flexibility is an admiration of the private sector that points in the direction of decentralisation and delegation, where the slogan is “let the managers manage” (Christensen, 2010).

The model comprises both centralised control and decentralised professional freedom. Goals and performance requirements are stipulated at “the top”. The operations’ results are managed by measurement indicators and are evaluated by senior management. Freedom of agency in the NPM model is to be able to choose the instruments that provide the best outcomes. It is in relation to the measures that academic communities have the freedom to pursue local service development.

Service development in a network model
In response to NPM-inspired solutions we have an increasing emergence of network organisations (Christensen & Læg-reid, 2007; Farsund et al., 2010). Network organisations are self-regulating and aim to help solve problems that cannot easily be put into traditional public hierarchies (Boyd, 2010). Vertical and horizontal co-ordination shall ensure that cross-sectorial issues and tasks are solved. Post-NPM reforms of this kind represent a third form of government that is neither a classical hierarchy nor an NPM-inspired goals-and-results-driven response. The network model operates several ideals side by side in a hybrid combination (Farsund et al., 2010). The various forms of networking solutions create mutual adjustment between stakeholders, tasks and needs. Employees can still be managed on goals and results, but various forms of networking solutions encourage organisational flexibility based on dialogue and negotiation. This type of solution will ensure that users receive continuous services (seamless services). The local scope of action (leeway) includes both external and vertical co-ordination through the establishment of partnerships and transverse forums.

Data, methods and setting
The three Nordic urban municipalities in this study are part of a health care system that, at a general level, has many features in common. The cities were chosen because they are larger urban municipalities that face challenges different from those in smaller municipalities, indicating that the regulatory framework for service development has many similarities. They are also exposed to many of the same organisational fashions, which may indicate that they choose many common solutions for their local service development. Through these three urban municipalities, we will discuss which model(s) they have selected for service development.

Stavanger, Umeå and Aarhus are rapidly growing cities and are considered to be at the forefront of innovation and development of drug-related health and welfare services.

Stavanger is the third largest urban municipality in Norway, with 130,000 inhabitants. The city is an “oil capital” and is growing rapidly, with consequent pressure on the housing market. Stavanger municipality has overall responsibility for monitoring individuals with alcohol and drug problems before, during and after treatment. The municipality is also responsible
for ensuring that users have shelter, clothing and food. Multidisciplinary specialised alcohol and drug treatment services (TSB) give citizens the right to reviews, assessments and treatment. The treatment is offered as outpatient/ambulatory or via residential or day care. Medically-assisted treatment and detoxification is also included in the TSB.

The 2002 hospital reform led to county-managed hospitals transferring into a state health model (Opedal & Stigen, 2005). With extensive administrative decentralisation of functions and power given to the regional and local health management, the reform placed political control at an arm’s length from the management and operation of Norwegian hospitals. In 2004 the county municipal alcohol and drug treatment services were transferred to the regional health authorities and were placed side by side with psychiatry and general medicine in TSB. Alcohol and drug treatment services thus became a hospital task. In order to increase the capacity of alcohol and drug treatment, the regional health authorities enters into contracts with private and non-profit organisations.

The Swedish municipality of Umeå has 120,000 inhabitants and is similarly growing vigorously. The municipality is located in Västerbotten County. Umeå municipality is responsible for follow-up and treatment of people with alcohol and drug problems. County councils (Landstinget) supplement with specialised research, especially for people who have co-morbid conditions (substance use disorder and mental disorders occurring in combination) and persons receiving medically-assisted treatment (MAT).

In March 2011, the Swedish parliament decided on an overall strategy for alcohol, drugs, doping and tobacco policy (ANDT). The general goal is a society free of drugs, doping and tobacco, as well as a reduction in the medical and social harm of alcohol. Two other important strategies for developing alcohol and drug treatment services are the regulatory guidelines of 2007 and the government’s alcohol and drug report of 2011. The latter suggests that hospital level (hälso- och sjukvården) be given primary responsibility for treatment and that municipalities be given responsibility for psycho-social support programmes (Blomqvist, 2013).

Like Norway, Sweden has decentralised health and welfare services in favour of NPM-inspired solutions. During the last half of the 20th century, Sweden halved the number of municipalities. Responsibility for health and welfare services is distributed among three levels of government: municipal, county councils and state (Dellgran & Höjer, 2005).

Aarhus, with around 315,000 inhabitants, is the fastest growing municipality in Denmark and the second most populous municipality in the country. Aarhus municipality is the largest of the 19 municipalities in Midtjylland Regions. Overall, the whole region has about 1,250,000 inhabitants. In Aarhus, alcohol and drug treatment services are primarily a municipal responsibility. The region is responsible for persons with serious co-morbid conditions and for certain inpatient services.

The municipal reform (structure reform) in 2007 reduced the number of municipalities in Denmark from 271 to 98. Meanwhile, the 13 counties were abolished in favour of five officially elected regions. The
regions’ primary task is to run the nation’s hospitals. The reform led to alcohol and drug treatment services being transferred from the counties to the municipalities. Before the reform Aarhus Municipality had already made arrangements with the counties to operate alcohol and drug treatment services. The structural reform led to specialised hospital tasks being placed in fewer organisational units. The purpose of the reform was to create the framework for a comprehensive treatment and rehabilitation chain across the different sector areas in the municipalities. The overall objective of the reform was to ensure a clearer division of responsibilities and to consolidate the decentralised Danish model where, as far as possible, decisions are made locally and as close as possible to the individual citizen. Danish municipalities and regions have introduced organisational models that draw on elements of concepts – agent, provider, performance management, results and decentralised management (Indenrigsministeriet, 2013).

The differences between the three cities included in this study are primarily organisational in nature, particularly for conditions that have to do with tasks and responsibility. In Aarhus the municipality has almost the sole responsibility for alcohol and drug treatment services. In Umeå the tasks and responsibilities for alcohol and drug treatment services are divided between municipalities, county councils and state, while in Stavanger the responsibilities and tasks are distributed between local authorities and local health enterprises. Despite differences in organisation the services are essentially the same in all three cities in the sense of how they understand the phenomenon (alcohol and drug) and how they deal with alcohol and drug problems in their daily work (Edman & Stenius, 2007).

The article is based on 23 interviews with managers of alcohol and drug treatment services in Stavanger, Umeå and Aarhus. These managers are all experienced in what they do (more than 10 years of service). Almost all of them had started their careers as clinicians before becoming managers. Except for one (political scientist), all respondents were either doctors, psychologists, social workers or nurses. Sixteen of the interviewees were women. The interviews lasted between 60 and 90 minutes. Our starting point was to examine the scope for service development in the three Scandinavian cities in light of the Nordic welfare model. We chose an exploratory design to gain a deeper insight into the factors that have an impact on local service development. We formulated a partially open interview guide. The interviewees were selected so that we covered key enterprises in alcohol and substance abuse-related health and welfare services at all levels. Interviews were held in the interviewees’ offices and were conducted between November 2012 and March 2013. Following these interviews, we made some preliminary analyses and drew some conclusions that we presented in April 2013 to two informants from each city at a gathering in Stockholm. The purpose of the gathering was to achieve a joint reflection on our preliminary findings that could help us to take the research process further.

Based on the interviews, the meeting in Stockholm and documentary analysis of national/local conditions, we carried out a multiple case analysis. Data from the in-
Interviews and the Stockholm meeting were transcribed and divided into categories: organisation, co-ordination, impetus, policy signals, resources and local freedom of action.

We were looking for factors that might tell us something about the local freedom of action that occurs after the requirements as formulated are met (“objective room to manoeuvre” understood as formal legal, financial and organisational issues). NVIVO 10 was used as an aid in this phase.

The Nordic welfare model gave us access to three relatively similar cases (Edman & Stenius, 2007). Multiple case design is well suited for analytical generalisation, creating an opportunity to identify factors that are not taken into account in the choice of theory (Yin, 2009). The final formulation of research questions, selection theory and hypothesis formulation is done after the data has been processed. The resulting combination of strategies increases the likelihood of developing relevant research questions and subsequent robust conclusions (Yin, 2009). The study aims to draw conclusions that are common to all municipalities and to point out the general terms for alcohol and drug treatment service development in larger urban municipalities.

Results
All three urban municipalities provide us with examples where the services have taken the initiative to further develop the services themselves. Stavanger has created several collaborative projects between many stakeholders. An outreach treatment team is a collaborative project between local TSB and Stavanger municipality. The team is staffed with personnel from both organisations. The reason for the co-operation was recognition that this specific client group was the responsibility of both organisations and that the patient services would be more robust if the patients were visited at home by personnel from both the municipality and the TSB. The team is organised as a separate unit, reporting jointly to their respective organisations via a steering group.

In Umeå an Alcohol and Drugs Reception has been established as a low-threshold service that is staffed and organised in a similar way to the outreach team in Stavanger. The Centre for Alcohol Treatment in Aarhus has taken inspiration from England to develop a comprehensive academic model that forms the basis for the services at the centre. These three examples are not exceptional, but join a long line of small and large local initiatives to address the superior objectives that are provided through traditional management relations between the government level and local level.

The alcohol and drug treatment services in Aarhus and Umeå have had their budgets reduced in recent years, while the Stavanger region has seen their budgets increase. None of the interviewees pointed to legal, organisational or financial conditions as a particular limitation on service development. Several informants in fact believed that economic cutbacks could be an opportunity to “tidy up their own activities” (Denmark). The result of these processes is described as “We are clear on what we should be doing and what we should not be doing” (Denmark).

Not surprisingly, according to our results the informants think that services they manage have moved from classic bureaucracy toward various forms of NPM-
inspired solutions. This is evident primarily in terms of increased reporting and increased focus on finances. The interviewees’ main concern is the time spent on various forms of reporting that comes with NPM thinking. Often, the same reports are given to several agencies. This work comes at the expense of time that could be used to develop better services. The information on what the reports will be used for is perceived as inadequate. Informants are asking themselves whether the information being reported affects service quality: “Only numbers matter, no one cares about the quality of what we deliver” (Sweden).

Some informants in Norway were critical of competitive tendering and tender proposals: “We spend a lot of time and effort on submitting tenders in accordance with detailed specifications. This means that whoever gets the tender does not have much room left to carry on with things that have not been in the tender”.

The general picture is that in recent years urban municipalities have experienced increased attention from central government to strengthen and improve alcohol and drug treatment services. Our results indicate that the informants have a high degree of loyalty to the control signals from local and national government: “we are very loyal, of course” (Sweden). A comprehensive transformation of public control signals is taking place at the local level so that they fit into a company’s profile. Informants spend a lot of time with their staff to interpret control signals. Several informants pointed out that such signals often are vague and non-specific: “we always check out the main objectives before we decide how we specifically have to perform” (Denmark). All our informants claim to have developed a treatment philosophy that is rooted in policy documents and research. The results indicate that the development of this philosophy can just as easily happen retrospectively. “We believe in our profession, although it is characterised by a lack of certain knowledge; it is important that we believe in something. But we always formulate our measures and methods in a manner that does conform to research and policy” (Denmark).

We find that local service development is driven by a combination of encouraging local management that gives professional communities creative leeway and local groups that are inspired by research and organisational fashions. It appears that the most important motivation for local change is the need to improve coordination between the services and the desire to provide good-quality alcohol and drug treatment services. Quality improvement challenges the services in all three urban municipalities. Governments in all countries offer various forms of quality guidelines. These types of guidelines are, to some degree, lacking in the necessary legitimacy with the local academic communities, which in turn leads to “limp implementation” (Norway). The centre for alcohol treatment in Aarhus is the drug service where the consequence of divergent knowledge about effective treatments is evident. According to the interviewees, the drug services in Aarhus have been successful in implementing internal systems and a common professional ideology in all phases of treatment. Furthermore, the interviewees argue that there is full support for the treatment philosophy from all the staff employed at the centre. While this is a locally developed treatment philosophy,
it is not unlike the Danish government’s general goals for alcohol treatment.

We find that local development is most successful where alcohol and drug treatment services combine overall professional guidelines with locally appropriate solutions. Our results demonstrate that where one does not succeed as well as they do in the centre for alcohol treatment, the alcohol and drug treatment services are unsure of how to solve their tasks.

The services seem to have an ambivalent relationship with general guidelines. “The problem is when we get standardisation of multifactorial issues” (Sweden) and “Recovery is nice enough, but it just does not suit our services, and no-one has asked us what we need either” (Denmark). “We are a little bit lacking in methods in our work within addiction treatment” (Sweden). “We’re not good enough at bringing structure to the treatment” (Norway) and “we need to get better at following up what experience and research tells us leads to results” (Denmark). The services that fail to combine overall professional guidelines with locally appropriate solutions end up not having any treatment philosophy at all, and “this leads to everybody having their own methods” (Denmark).

It appears that organisational affiliation is superior to professional affiliation in judging what good treatment is. It is not that everyone with the same education feels the same about a particular phenomenon. It seems that work affiliation determines academic perception of a particular phenomenon, which is most evident in connection with medically-assisted treatment or MAT. According to the interviewees, professional social work staff who work in a business that offers MAT are overwhelmingly positive about this type of treatment. The same profession has the opposite view if they work somewhere that does not offer this treatment. At the same time, our results show a consistent willingness to refer to another party, “it’s the hospital’s duty to perform that treatment” (Norway) or “the (name of institution) has that type of follow-up in their service” (Denmark).

In all three cities there is contact between research and the field of operation. The cities’ size and the legitimacy of the professional environment also mean that there is contact and dialogue with the central authorities. Development stakeholders are thus constantly updated on research in the field. The professional environment is also in a good position to be in dialogue with the authorities. The proximity of research and politics is highlighted as positive. Our informants believe that smaller regions, which are not in the same position, have greater challenges associated with development of services: “both in terms of access to money, science and politics, I would think that smaller regions have a tougher life than we have” (Norway).

According to the interviewees, professional environments in the surveyed urban municipalities are keen to find good tools to executing their work. Agencies use systematic search and learning processes to identify optimal therapies for their user groups. “We have internal and external workshops with our partners in order to calibrate our services to others and to be sure we meet the needs that are out there” (Norway). Our results show that managers involve their employees in the service development process: “Some staff are very
dedicated. They have attended courses and classes, etc., where they get ideas that they can present in the office when they return to work. A lot of the office’s development takes place in this way” (Sweden).

All three urban municipalities face challenges associated with the provision of co-ordinated and comprehensive courses of treatment. “Our services are not as integrated as we wish” (Sweden) or “You can tell Norway and Sweden that merging services does not necessarily ensure that users get a comprehensive course of treatment” (Denmark). There are two conditions that present clearly in our material: i) alcohol and drug treatment services are organised in a way that creates unnecessary breaks in the treatment for some service users, and ii) service managers and other key employees are constantly striving to address these challenges. This is done in several ways. Service development stakeholders put substantial resources into identifying relevant partners. They place great confidence in the strength of creating relationships with others as a means of solving large and small co-ordination challenges. Most informants spend a lot of time in meetings, “Meetings are my way of working. And e-mail. Oh, and the phone of course” (Norway). What characterises many of these meetings is that development stakeholders themselves have initiated them to address specific tasks. Mandatory meetings to implement direct control signals are in the minority. There is extensive information exchange between the agencies: “We are highly assertive” (Norway) or “if we are going to succeed, we need to work in co-operation with others” (Denmark).

The field of alcohol and drug treatment services comprises several professions, which we will get back to later. Interdisciplinarity is perceived solely as positive. Several agencies have adopted interdisciplinary skills, allowing users to receive comprehensive treatment. Several agencies are working systematically with issues relating to children, housing, employment, networking, training, diet, etc. as an integral part of the overall treatment: “We have always thought that way, but it is only in recent years we have implemented it into a system this way” (Denmark).

Service development stakeholders “create” new (formalised) services, not because it is a legal requirement, but because the staff find it necessary to solve the tasks in a new and improved way. Currently the possibility of a further merging of services across governmental levels is being considered, and “we believe that formal co-operation in this manner can be part of the future solution” (Denmark). We find several examples where the alcohol and drug treatment services work on each other’s “levels”. At present management is looking into the possibility of therapists having regular office days at other professions’ premises. Hospitals recruit staff, municipalities create and manage institutions, therapists establish themselves in offices at a health centre in town, as “we become less and less concerned with how we work, and more and more concerned about what we’re working on” (Norway). In Aarhus, we find examples of co-operation between the municipality and the private organisation Alcoholics Anonymous (AA): “there are AA groups that meet here in the premises and it is quite groundbreaking in Denmark. People who are in treatment with us can also have their sponsor from AA into the meetings”.
There is no discrepancy between the objectives at government level and practice level. Our results show that service development stakeholders are experiencing a large degree of leeway in terms of choice of methods: “To be successful it is essential to consider that the finder is the winner, and if you detect a problem then you are a participant in it” (Denmark). The practice field’s freedom is used by local service development stakeholders to implement development that is characterised by what is, at any time, seen to be good practice.

**Discussion**

Alcohol and drug treatment services are managed mainly in accordance with the overall objectives formulated from “the top”. In all three municipalities a management relationship has developed between the authority level and the practice level which has a clear understanding of NPM. In all municipalities the way ahead for how objectives will be achieved is largely left to the local alcohol and drug treatment services themselves. Inspiration for service development is drawn from practice and research. Service development is inspired by a combination of encouraging leadership which gives the professional communities flexibility and groups inspired by research and organisational meetings. In summary, alcohol and drug treatment services are driven by a desire to provide services of high professional quality.

The outreach treatment team in Stavanger and the Alcohol and Drugs Reception Centre in Umeå are both examples of local leaders from the municipality and health authority seizing a common challenge and creating new forms of organisation whose main objective is to solve challenges in the “grey zone” between administrative levels for specific client groups. The centre for alcohol treatment in Aarhus shows how drug services that use systematic search and learning processes drive locally based qualitative treatment methodologies with both internal and external validity and legitimacy. Such examples are not unique. They are three initiatives selected from among many that demonstrate how the drug environments have great local professional autonomy to improve services. And their motive? A solid desire to provide services of good quality.

An important principle for good quality is that the services are interconnected (seamless services). Bureaucracy and NPM models are essentially level-specific. The models do not capture the challenges associated with cross-sectorial issues, as they are often experienced by organisations working with alcohol and drug problems. We see a movement toward various forms of networking, not only in terms of public reforms, but also used as a local means of reaching overall goals of integrated treatment courses.

Alcohol and drug treatment services are essentially little controlled by pure administrative (hierarchical) rules. However, in matters concerning citizens’ rights, we still see characteristics of personal, procedural and substantive administrative rules. This is especially true in conditions that govern the assignment of rights. Where hierarchical models manifest themselves we see that service development stakeholders have little leeway in terms of both methods and goals. Variations in the bureaucratic model are therefore unlikely to explain the main picture of what regulates the local scope for service development.
Critics of NPM-inspired solutions argue that NPM hinders academic autonomy and local self-government. This statement is only partially correct, which this study demonstrates by reference to a number of locally arisen schemes that have been prepared after initiatives in the practice field. NPM’s overarching goal is that budget discipline and cost cutting allow managers to lead through decentralised decision-making and management autonomy. On the other hand, NPM does, through incentives, promote gains for a specific conduct and can therefore seem to be centralised and managed from the top. NPM does not mean that politicians give up all power over each policy area. Rather, it demonstrates a desire to control from a distance. Our study shows that both these principles prevail. An organisation’s tasks are to some extent controlled through various performance-related reward systems and reporting procedures, which restricts the authorities’ freedom of action. On the other hand, freedom of action for service development will be greater in the choice of measures for task management. The service development stakeholders adjust and modify means of achieving agreed goals. This happens locally, and often the background is an identified local problem.

When the authorities are faced with professional or organisational obstacles, it is a common strategy to establish various forms of internal evaluations based on their own clinical practice. This method is being actively used when the starting point is that something within the service should be changed. The evaluation methods also take opinions from clients and partner services. Alcohol and drug treatment service is an interdisciplinary field. Teachers, social workers, physicians, psychologists, nurses and social educators are part of the “basic staffing” in alcohol and drug treatment services in all urban municipalities. In recent years, awareness of health and lifestyle issues has meant that the authorities employ people with expertise in areas such as nutrition and physical activity. The interdisciplinary approach also appears in issues related to service development. The various professional groups contribute to the development of services and allow services to be developed in new directions. The services allow that employees can and should be seconded to other authorities. This is a deliberate strategy of accessing new ideas that can further be used to develop services. Employees and managers organise and participate in workshops locally, nationally and internationally. Such venues are actively used for service development purposes. In this way skills and inspiration are transferred between organisations who work with alcohol and drug issues. Such professional collaboration processes mean that service development stakeholders must respond to changing values in the environment and to socially created norms about how, at any time, services should be designed and developed as a result of uniform direction (Christensen et al., 2009). Equality blends well with the welfare state principles that citizens should receive services of equal quality regardless of residence and socio-economic status. The fact that services are equally challenging market abstractions is a fundamental principle of freedom of choice. Uniformity can cause diversity in alcohol and drug treatment services in all urban municipalities to disappear, which many point out is an
important principle when treating and following up people suffering from alcohol and drug related illnesses (Nesvåg, 2012).

Our study shows that the stakeholders are constantly seeking good-quality solutions. The service development stakeholders probably concern themselves unnecessarily when they associate uncertainty with both the alcohol and drug treatment profession’s legitimacy and the services’ ability to implement new knowledge. The alcohol and drug treatment profession has historically undergone major changes in its scope, understanding and action. Even if the profession is lacking school medicine’s secure knowledge about the relationship between diagnosis and treatment, systematic efforts are being made in both practice and research.

We find that service development stakeholders have a very wide leeway in terms of local professional service development, and that, partly through processes described here, they are developing services along fairly similar lines. Local freedom of action should actually lead to greater variation in the development of services between countries. When this is not the case, we believe that it must be attributed to this type of interaction processes leading to local, national and Scandinavian agreement on the main lines for alcohol and drug treatment. The services work with a group of people who have a need for cross-sectorial treatment, and receive economic gains for performing well within their own sector. Our empirical evidence shows that services in all the cities are working on a sectorial basis. An important reason for service development is the need to get around challenges that the NPM model’s level-specific approach creates. NPM is basically unsuitable for grasping the multi-sectorial challenges. The sector thinking that follows in the wake of NPM creates challenges for the required horizontal co-operation. The extent of horizontal co-operation suggests that co-ordination is grounded in professionalism and organisational meetings. Our results suggest that horizontal professional co-operation is an underlying norm in health and welfare services for alcohol and drugs. Employees in such organisations perceive that professionalism includes co-operation. Both between agencies and professions. We find clear characteristics that horizontal co-operation can both be explained through bureaucratic rules as formulated from the top but also by employees’ normative expectations regarding their own professionalism. The driving forces for horizontal contraction between sectors come in the latter case from the practice field.

Organisational models in an NPM context are intended to create a clearer division of tasks and responsibilities and better management internally between the elected officials, administration and professions. When an organisation has been re-designed in isolation from the individual authority level, this has been at the expense of co-ordination between the sectors (Opedal, 2013). The services work with a group of people who have a need for cross-sectorial treatment, and...
a key driver for service development is the recognition that at times unnecessary breaks in the treatment occur. This recognition is shared by the local service development agencies and central authorities. Continuity of treatment is an important organisational principle for follow-up and treatment of drug-related problems (Nesvåg, 2012). Such service development is rooted in what the stakeholders have in common.

In Norway and Sweden especially there has been a hybridisation between the levels. Responsibility for treatment and follow-up is split between two levels of government. In Denmark, the bulk of the services are assigned to the municipality, while the regional level only becomes involved for the very sickest patients. In Stavanger several businesses have grown up which have the network model’s characteristics in that they share responsibility for clients, staff and budgets. Such organisations see the light because stakeholders recognise that they share some challenges and believe that the challenges are better addressed if the joint responsibility is also reflected in the organisation. This is also seen in Umeå. The common denominator for these kinds of initiatives is that they have grown locally. Challenges associated with such organisations are provisions regarding confidentiality. It follows that client records must be entered twice in two separate record systems. There is also some lack of clarity as to who actually has responsibility if something should happen to the service users as a result of treatment/follow-up. Having a joint organisation allows multiple tasks to be performed by a single agency, which in turn ensures a greater continuity of treatment.

The need for seamless transitions between the services results in a wide variety of locally-initiated co-operation agreements and hybrid organisational models. In some areas co-operation agreements are imposed through reforms, as is the case with the Norwegian Co-operation Reform. In both instances the justifications are drawn from a common desire for seamless services. Network models and binding co-operation agreements between levels testify to professions moving away from purely level-specific services, as requested by the NPM reforms initially, and toward different types of post-NPM solutions that emphasise vertical and horizontal co-ordination and integration (Opedal, 2013). Our study shows that service development stakeholders use various forms of networking solutions for task management. What is common in many of these measures is that they develop locally after initiatives from the stakeholders themselves.

Conclusion
We find that local service development is taking place in all three urban municipalities. All service development stakeholders are continually exploring alternative approaches with a view to improving existing services. Freedom of action for change, both perceived and in real terms, is elastic.

We find that the urban municipalities have developed a model for service development which combines NPM and different variations of network models. NPM has inherent overarching performance management, but does not micro-manage the professional environments. The network models promote horizontal professional co-operation between different disciplines and research. On the minus side,
there is reason to question whether these types of collaboration models may confuse and blur responsibility for the treatment provided.

We have shown that signals from public health and welfare political management restrict the practice field’s room for manoeuvre in relation to the objectives. Our results show that service development stakeholders’ room for manoeuvre is limited both in terms of objectives and methods if the context in which they are deployed is characterised by hierarchy. NPM and network solutions allow service development stakeholders to have relatively large freedom to develop qualitatively good treatment models. The overriding goal of the models is to deliver the best possible services at the lowest possible cost. The model is less concerned with how the goals are achieved. In these contexts we find that stakeholders have considerable leeway to exercise local service development while maintaining national health policy.

There is little debate about the goals of the practice field, which could mean that the health and welfare policy and practice field have largely congruent goals.

The pursuit of higher academic quality drives service development toward various forms of networking solutions. The need to improve co-ordination of complex tasks, involving more than one administrative level, seems to be the main driving force for the establishment of sectorial network models. We find that the motive for this type of activity is to overcome the limitations of the level-specific methods of an NPM-inspired market model. We find that organisations mimic each other, both with regard to organisation and choice of method.

In the shadow of controls imposed by economic incentive schemes, the choice of treatment methods and philosophy is largely a matter left to the stakeholders themselves. Stakeholders learn from their own and others’ experiences and draw inspiration from contact with research environments.

Further research should examine what implications wide local leeway has for national authorities’ need for standardised solutions regarding the welfare state’s obligation to provide equal treatment regardless of, among other things, socio-economic status and place of residence. Future research should also look more closely at the implications network models have for responsibilities and obligations for users of the alcohol and drug treatment services.

**Declaration of interest** None.

**Ole Næss**, Researcher  
The Norwegian Centre for Addiction Research (SERAf)  
Center for Alcohol & Drug Research (KORFOR)  
E-mail: ole.naes@sus.no

**Ståle Opedal**, Public health coordinator  
Stavanger municipality  
E-mail: staale.harald.opedal@stavanger.kommune.no

**Sverre M. Nesvåg**, PhD  
The Norwegian Centre for Addiction Research (SERAf)  
Center for Alcohol & Drug Research (KORFOR)  
E-mail: ness@sus.no
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