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SOCIOLOGY | RESEARCH ARTICLE

Reducing service barriers to people with dual diagnosis in Norway

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Abstract: In the following, we examine how and why service provision changes. We argue that the role of service providers as a result of the Norwegian Action Plan for **Mental Health** has evolved to be characterized more by advocacy than by maintaining barriers. Furthermore, dominant public policy instruments shape the choices they make. The analysis is conducted within a theoretical framework of characteristics of service provision and governance policy instruments. **It is** based on interviews with providers of home-based services to people with severe substance abuse and mental health problems and other employees involved from local authorities and specialist services. The analysis shows that the use of legislation has established a new role of coordination for the service provider, which is strongly based on **clients'** right to services. The use of organizational tools like the purchaser-provider model has given the service provider the opportunity to promote additional services for **clients**. Furthermore, processes of **decentralization** of services for people with substance abuse and mental health problems have changed the role and function of the service providers.

Subjects: Policy Analysis; Public Policy; Social Policy; Health Policy; Sociology & Social Policy

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PUBLIC INTEREST STATEMENT

This article highlights **changes in** service provision for people with substance abuse and mental health problems. We explore how policy instruments shape the role of the service providers and the choices they make. The instruments are legislation, information, organization and economic means respectively. The **data** show that legislation is strongly based on patient rights and **clients'** rights to services. Service providers have a new role as **coordinators** of services. New ways of organizing local services **enable** service providers to promote additional community services. Earmarked funds have been used for suitable housing. Better housing and home-based services have **made service** providers more aware **of clients'** needs. Accordingly, we argue that the role of service providers can be characterized by advocacy rather than gatekeeping. Furthermore, the analysis **illustrates** how dominant policy instruments shape the choices service providers make and the role they take.

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Keywords: service provision; substance abuse and mental health problems; health and social services; policy instruments

1. Introduction

When the Norwegian government presented its Action Plan **for strengthening mental health services in a parliamentary white paper** in the late 1990s, one of the reasons was that people with mental health problems were meeting too many barriers in seeking help (White Paper No. 25, 1996–1997). Here, we discuss how this picture has **changed, partly** due to new conditions for **service** providers, and **how** these altered conditions are largely a result of planned political strategies.

Norway's system of health and social care is organized into two tiers: the state and local authorities. The more than 400 local authorities vary in size from fewer than 500 inhabitants to more than 600,000. Hospitals and specialized polyclinics are the state's responsibility, while local authorities are responsible for the provision of local primary health and social services. The comprehensive municipal health and social services include housing, financial support, medical treatment, substance abuse counselling and activity-based services. The focus of this article is local services to clients with dual diagnosis (concurrent substance abuse and mental health problems), which are mainly provided by nurses and social workers. Local authorities have gradually upgraded their services for this target group over the past 20 years and have increased the number of employees. By 2017, about 55% of those employed in the sector were college graduates in health and social studies. In addition, more than half of these had further education in mental health or substance abuse work (Ose & Kaspersen, 2017). In Norway, addiction treatment was defined as social services until 2004, but since then they have formed part of the health services and are included in the health legislation. In the current national education guideline, services to the target group are still described as a central part of social work (Rammeplan for 3-årig sosionomutdanning 2005).

The group of clients with dual diagnosis has long been considered one of the most challenging (Evjen, Kielland, & Øiern, 2012). This is partly because the group demonstrates a wide variety of problems, different and complex needs and differing objectives. Furthermore, the knowledge base regarding causes and effective treatments for such conditions is considered to be uncertain and controversial. This is often described as a wicked problem (Einstein, 2007; Hannigan & Coffey, 2011).

The classic description of professional service providers is that they represent professional competence that qualifies them to determine the "right" solution to the problems presented by clients (Freidson, 1988). The choice of the "right" solution is, of course, dependent on the professionals' background and the panorama of actions they represent (Abbott, 1988). In addition, employees in public administration typically have a passive role in relation to clients, and expect clients to take the initiative if they want or need a service (Lipsky, 1980).

This means that many clients with dual diagnosis experience various barriers to services (Neale, Tompkins, & Sheard, 2008). These include prejudice and stigmatization (Gallagher, Arber, Chaplin, & Quirk 2010) and paternalism and poor collaboration and integration of services (Gale, Baldwin, Staples, Montague, & Waldram, 2012). They also have difficulty in finding their way in the variety of services on offer (Sweeny et al. 2012).

Freidson's (1988) description of professions as representatives of the "right" solutions has been challenged in recent years by an ever-increasing expectation that clients should be included and participate in the design of services. Approaches such as empowerment (Braye & Preston-Shoot, 1995) and recovery (Davidson et al., 2008) emphasize the change in the role of service providers from expert to advisor. In this context, it has also become increasingly common to underline that professionality also implies acting as the clients' advocate (Schwarts 2002; Tahan, 2005).

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Nevertheless, the review by Oliveira and Tariman (2017) shows that there are still a number of barriers before service providers are able to act as advocates for clients.

The following section describes the situation of service provision before the Action Plan. The next section gives an overview of the theoretical framework for the analysis, i.e. characteristics of governance policy instruments. We then give a brief **outline** of the methodology and data basis of the article. The findings and developmental features of services to clients are presented along with a discussion of how the picture described by the government has changed and how the changes can be understood as a result of the actions carried out by the government.

2. Characteristics of service provision

In this section, we present approaches to service providers and tensions associated with the role and different sets of values. Against this background, we will give a brief account of service provision before the Action Plan.

Public services are scarce benefits and their access must therefore be regulated (Sabates-Wheeler & MacAuslan, 2007). This regulation can be described as a "counter model" with three steps: gate, line and counter (Schaffer & Wen-Hsien, 1975). This means that access to the services is regulated through the **client** having to go through three kinds of "filtering" before accessing services. Firstly, **clients** must document that they are qualified to be considered for services, for example, through a **formal** referral or a particular diagnosis (the gate). Secondly, they often meet a sort of queue arrangement, where it takes time before they can access the assessment of what services they will receive (the line). Finally, they arrive at the service office, where they must negotiate and argue for services (the counter) (MacAuslan & Sabates-Wheeler, 2011). The success of such a process depends largely on the resources **of the clients** (Schaffer & Wen-Hsien, 1975). This is a challenge for **clients** with dual diagnosis, and many of them **found it difficult to access services in the 1980s and 1990s** (Rønning & Solheim, 1998; Solheim, 1996).

Those in charge of the services saw the same challenges. When the leaders of local health and social services were asked which groups of people had most difficulty in getting help, nearly 90% answered that this applied to people with mental health problems White Paper No. 25 (1996–1997, p. 39). In 1996–97, the **Norwegian** Ministry of Health and Social Affairs presented a parliamentary white paper on mental health problems and services. The Ministry assumed that an important reason why people with mental disorders have such major problems are the accessibility challenges caused by the "counter model". The Ministry concluded in its assessment that:

The "counter model" becomes particularly problematic in cases where the **client**

- needs long-term services,
- needs services from several different agencies simultaneously, and
- is not fully able to ask for necessary services (p. 94).

The challenges are greatest for people with mental disorders who also have problems with substance abuse, finances, housing, etc. Based on the **review in** the white paper, the Ministry felt the need for a comprehensive **enhancement of** the service level for this target group. Actions should be implemented in a number of areas, such as financing, organization and **training**. An increased **client** focus with more **client** involvement and **the** organization of integrated services around the **client** with individual plans were key elements of the strategy **outlined by the Ministry** White Paper No. 25 (1996–1997).

The aim of this paper is to explore whether the policy changes have **resulted in** the desired development.

3. State management

We employ a state management perspective in order to ascertain the development of roles and functions in service provision in the context of overall governance and management signals relating to the health and social sector.

An approach where overarching governance and management changes are key drivers for understanding changes in the way service providers function makes theories about the implementation of policy instruments a relevant analytical framework, involving not only which instruments are used but also the different ways in which they are used. In the following, we assume that the instruments have different effects on behaviour (Schneider & Ingram, 1997, 1990). We will draw on Vedung (1998) and Hood (1983)/Hood and Margetts (2007), who have similar types of taxonomies of policy instruments. The latter taxonomy uses four categories of instruments, namely nodality, authority, treasure and organization, while Vedung (1998) labels the same first three instruments regulation, economic means and information. Vedung (1998) argues for omitting **organization** as a separate category on the grounds that **organization** is regarded as a precondition for adopting the other instruments, but is not an independent policy instrument, which is a point of view we do not share in this context. We would rather, with Hood and Margetts, argue that there are examples where "government operates directly through organizations rather than dealing through contractors or intermediaries" (2007, p. 103). In the following, we apply the terms regulation, information/knowledge, economic means and organization.

Regulation refers here to the use of laws, regulations and directives to ensure that the persons concerned act in accordance with the applicable order. It involves the exercise of state coercive power through permissions, prohibitions, requirements, recommendations and guidelines, to which the service providers have to adapt (Hood and Margetts 2007). Examples of Norwegian laws relevant to the health and social care sector in general and mental health and substance abuse patients in particular are the Patients' Rights Act, the Health and Care Services Act Ministry of Health and Care Services Prop. 91 L, (2010–2011) and the Act on Social Services in the Labour and Welfare Administration.

Information/knowledge as a tool consists of the communication of facts and normative messages. The purpose is to influence the recipient through the transfer of knowledge, persuasion, information campaigns, education and training packages, reasoned arguments and propaganda. Information is thus not only the transfer of knowledge or objective facts, but also more value-laden judgements about how the recipient should act and what objectives and measures are good or bad (Vedung, 1998). Hood (1983) argues that the spread of information and the use of policy signals may be one way for the government to control public agencies, but often without putting its authority at risk. Expertise, knowledge of client participation and the recovery approach are examples of factors involved in the application of this type of instrument; we will discuss these below.

Organization refers to the use of physical facilities and other resources and the use of structures to change behaviour. Organization may also be a channel to access information and knowledge (Chr & Margetts, 2007). This refers to how the authorities use the organization of services as an instrument and how responsibility for various tasks is allocated between levels of government. Organizational instruments also include the centralization and decentralization of decision-making authority (Bjørkquist, 2011). Management through organization refers to a perception of the importance of connecting participants, problems and solutions while also being a question of distribution of power (Olsen, 1988). The Norwegian welfare model involves a division of authority and responsibility where the central government makes various overarching decisions while local government administers and implements national policies. At the same time, local authorities have a large measure of freedom in the way they choose to organize their health and social care

services (Norwegian Agency for Public Management and eGovernment/DIFI, 2010). Examples of relevant organizational instruments in care services in general and for dual diagnosis clients in particular are the purchaser-provider model **and decentralization.**

Economic instruments are to be understood as all material goods or money that can be allocated or involved. The recipient is not obliged to adopt such instruments, but has some latitude in choice of action and can consider whether it will be cheaper in terms of money, time and effort to reach specific goals (Vedung, 1998, p. 32). The application may vary from earmarked funds to block allocations, perhaps using pay-for-performance financing, although the latter has been little used in Norway to date (Norwegian Directorate of Health, 2012). The use of a block allocation gives central government control of the overall framework that the local authorities may use (Bjørkquist, 2011), but little control of how the money is spent. This contrasts with earmarked funds, which are only released with the provision that they are used for a specific purpose, thus helping to manage priorities and resource use in local authorities.

4. Method and data collection

Our empirical basis is a project where we studied the work of providers of home-based services to clients with concurrent severe substance abuse and mental health problems. Some of these clients lived in ordinary flats and received outpatient services there, while others lived in sheltered housing for this client group, where staffing was usually on a 24-hour basis. We studied eight schemes in six local authorities, and our database is 30 semi-structured interviews with 117 people (some interviews were group interviews). We also carried out ten observations of the staff in their everyday work. Most of the service providers we interviewed had bachelor's degrees, and many had additional further education. The staff informants were not selected based on particular characteristics or how typical they were of their group. However, against our background of almost 20 years of research in the field, we perceived these people to be typical service providers.

The interview guides were open; **we wanted the employees to tell us** as much as possible about how they worked and what **they focused on** in their work. For **service** users, the key questions were related to how they experienced the service they received in terms of positive and negative points.

In this article, the data we collected has been re-analysed based on **ideas from so-called** "contribution analysis". Mayne describes contribution analysis as "a theory-based approach to evaluation aimed at making credible causal claims about interventions and their results" (Mayne 2012, p. 270). This means that we have looked for statements showing whether the theories presented earlier may explain if and how **client** barriers were reduced through the strategies of the Action Plan and the subsequent public policy changes. We have **categorized statements according to the theoretical framework of regulation, information/knowledge, organization and economic means in order to discuss how these tools have affected employees' work.**

5. Changing governance tools and implications for service provision

Our ambition is primarily to present examples of service providers who **take on** the role of advocacy towards their clients and thus contribute to reducing the barriers. This is partly the result of a deliberate, politically controlled development and partly the result of developments in society that have created new opportunities and scope for service providers. The findings are discussed successively under headings corresponding with the policy instruments of regulation, information/knowledge, organization and economic **means.**

5.1. Regulation

There seems to be a deliberate strategy by the Norwegian authorities to influence health and social care service provision through legislation. A key element of this trend was new legislation in the form of four new health acts that came into force in the early 2000s. Of particular importance in this context was a separate patient rights act. This implied a clear legal obligation for service providers to safeguard clients' rights. One important aspect was the individual plan (IP); this was to

be both a right for clients and an obligation for service providers and is thus a regulatory tool to ensure a certain behaviour (Chr & Margetts, 2007). This right is now provided for in the Patients' Rights Act (1999) as follows:

> Patients who require long-term, coordinated health care services have the right to an individual plan drawn up in accordance with the provisions of the Health and Care Services Act, the Specialist Health Services Act and the Mental Health Services Act (§ 2-5. Right to an individual plan).

Originally, the requirement of IPs was related to general care legislation, but later there turned out to be a need to include the obligation to develop IPs in other legislation also, such as the Municipal Health Care Act.

There is a particular regulation on the creation of IPs (Ministry of Health and Care Services, 2011). It states that the purpose of the individual plan is to make services visible that are:

- individually tailored and based on user participation
- unified and coordinated

In our context, it is particularly relevant that there is to be a person responsible for coordinating the IP and the various actions involved. This coordinator will thus have the responsibility for drawing up an IP based on client needs, resources and goals.

How this responsibility is to be maintained is elaborated further in a guide from the Norwegian Directorate of Health, which emphasizes how important it is that the coordinator is someone who actively volunteers to help the client to get the services he/she needs. Several studies have shown that these legal guidelines are in fact being complied with (see for example Hansen, 2007; Riiser, 2011; Thommesen, Normann, & Sandvin, 2003). Accordingly, this also implies control and the exercise of power through regulation (Chr & Margetts, 2007; Vedung, 1998).

The staff we interviewed also clearly stated that developments in the services have led to distinct changes in the services offered to clients. One of the staff **described** the consequences of this as follows:

> I think that if we work systematically with individual plans—and work systematically at cooperation with other services, I think we'll find there are lots of needs users have that haven't been actively addressed before.

This statement points out that in relating to the fact that clients have a legal right to an individual plan, the various services will jointly discover that clients have greater needs than would otherwise be obvious. Accordingly, the use of regulation and state authority **changes** service providers' behaviour (Chr & Margetts, 2007). In one local authority using the purchaser-provider model, a purchaser explained what this resulted in:

> Yes, that's the way it is, we find out in the meeting what the clients need. I'm supposed to have a holistic approach; I have to make sure they get all the services they're entitled to.

This shows how the requirement for cooperation on individual plans indicates that the purchaser should to relate to the fact that this cooperation reveals additional client needs.

The focus on client participation in recent years has **led** to staff having a different view of clients:

> Many staff used to have reservations about suggestions made by clients … they kind of brushed them aside. Now we say that basically it's the residents themselves who should

define their care needs in the home and elsewhere. So we focus strongly on giving the residents support to allow them to live as good a life as possible.

This statement **may** illustrate how an emphasis on client participation has led to a situation where the role of the staff has changed from telling clients what to do to facilitating what clients want to do themselves.

The legislation and guidelines have thus established a new role in which it is important to put in place a unified and coordinated programme for the client. This implies not only placing demands on one's own professional practice, but also on other service providers and institutions to ensure that they too provide the services the coordinator thinks the client needs. The coordinator will then be the one presenting the clients' needs and the one arguing at the different counters, rather than the clients themselves.

Service providers have to maintain a balance between regulations, resources and client needs. Previously, regulations laid down clear requirements for service providers. The current trend involves increasing rights for clients. We get what is called "management at a distance", where the requirements are not as clearly directed at service providers as before, being replaced by more rights for clients (Hansen, 2007; Sahlin-Andersson 2003). Legislation has thus created the role of coordinator as a key figure in service provision to focus strongly on promoting **clients'** rights to services and take responsibility for facilitating these services rather than watching the gate.

5.2. Information/knowledge

Our next point is the change in **competencies, and thus in knowledge, to be seen in the services**. Firstly, we see an increased level of expertise in local services (Helgesen, Feiring, Hansen, & Ramsdal, 2005). Specialist care is no longer alone in having expertise in the field. Local care providers thus make independent assessments of how services should be provided. In this context, discretion is a key element in the professional practice of service providers, but discretion is not exercised independently of their education.

User participation, empowerment and similar concepts have become important elements of courses in the field of health and social care (Helgesen & Hansen, 2010). As early as the mid-1990s, when the national framework plans of the Ministry of Education and Research for the relevant bachelor's degree courses were revised, client participation was a central aspect and students were required to safeguard clients' interests. This has been followed up with textbooks that both emphasize the importance of client participation and outline ways in which it can be achieved. It can be argued that this illustrates the use of knowledge and normative messages as instruments through education (Vedung, 1998). Client participation has thus become an ideal in the field of health and social care. It is debatable to what extent such participation actually takes place. This may be expected given that information and knowledge are not strong steering instruments for changing behaviour.

However, although many clients only to a limited extent participate in decision-making, many care decisions are based on what service providers believe clients want (Hansen & Ramsdal, 2015). Client participation often appears to be an institutional value (March & Olsen, 2006) which forms the basis when staff exercise their discretion. Since these wicked problems have no clear scientific principles on which to base discretion, we may assume client participation to be a manageable basis. We also see a trend where client participation becomes part of health and social care strategies and where the government attaches great importance to communicating knowledge that client participation, empowerment and related concepts lead to more professional and effective services. Service providers are clearly well aware that clients vary and cannot all be put in the same basket. This leads to different approaches. The staff we interviewed reported that it was important to carry out an extensive survey of the functioning and needs of a client before any decision on treatment; this could take place in the

form of close monitoring and study of the client for as long as 12 weeks. Others had an initial focus on flexibility, where a firm framework was not established until staff had become quite familiar with the client and his/her needs. This meant that even clients who were neighbours in the same housing complex could receive completely different services. This employee at an office of the Norwegian Labour and Welfare Administration (NAV) explains how service providers view such a comprehensive mapping of clients:

> The people who assess the clients are building up a relationship built on trust. This enables clients to be more willing to open up and talk about difficult things in their background. That's not always easy for us here at NAV.

There was general agreement that functional level, needs and individual wishes were not static. The staff based this on a common understanding that this client group fluctuated considerably during their disease course and that services needed to be adjusted accordingly. One of the employees put it this way:

> It's social therapy, I mean individually adapted. What do you want us to do for you? And then start with that. People must choose for themselves what they need. I think it's mostly about focusing on what actually works. There are in fact some things that work.

The staff based their work on an awareness of the difficulty in relating to the clients as a group. Although the group as a whole could be viewed as having certain needs in common, it was evident that this was not the same as having wishes in common. One of the newly built housing complexes with eight units started up with the idea that it might be appropriate to have joint activities. However, they soon found out that this was not a sensible solution. The following statement may illustrate the experience of staff there and elsewhere:

> At first, we organized things for the whole group—hired a minibus to go on a trip. But it didn't work—nobody showed up. Now we realize that we have to give the initiative to the individual client—go on a trip if that's what one of them wants, go with them to the shop if someone wants that, or help someone else with cooking and housework if that's what they need.

Centres of expertise have been established whose main purpose is to provide information about clients and client participation. One example is the "Norwegian Knowledge Centre for Mental Health Care" (NAPHA) which, according to its mandate from the Directorate of Health, "... should emphasize the relationship between mental health care and substance abuse rehabilitation, and base its work on the client perspective". NAPHA appears to be strongly focused on the client perspective, and has been greatly involved in communicating ideologies and principles which emphasize client participation. The recovery approach has been in particular focus (Borg, Karlsson, & Stenhammer, 2013).

There is today quite extensive literature on the integration of the recovery approach into service provision. Although the use of the term varies somewhat according to context, there are some basic principles in common, primarily the idea that recovery involves supporting the client's own efforts to get better (Topor et al. 2011; Davidson & White, 2007). This implies that an important task for health and social care staff is to guide and support clients' efforts to overcome the obstacles they meet (Borg and Karlson 2011). Topor, Borg, Di Girolamo, and Davidson (2011) go so far as to say that the role of support person should in many cases be **expanded** to go beyond what is normally described as a professional relationship. To make knowledge of recovery more accessible, NAPHA has prepared an overview that highlights and documents recovery practices in Norway and abroad (Borg et al., 2013). This can be understood as a way of opening rather than closing the gates for the patients and it illustrates the implications of the use of information and knowledge as steering instruments (Vedung, 1998).

5.3. Organization

We have thus far described how regulations and information/competencies have encouraged health and social care staff to actively promote client interests. But that is still insufficient to exert a strong influence on these employees.

Services for dual diagnosis clients in Norway have now largely been decentralized, which implies the use of the organization tool (Bjørkquist, 2011). Several reforms involving services for these clients (e.g. the Action Plan for Mental Health and the Coordination Reform) implied that patients should only be in hospital to receive treatment that could not be given outside the hospital setting. All other treatments and services should be given in outpatient clinics by specialist and community care providers. In practice, this meant that most clients needed more than one type of service at the same time. In addition, specialist and local authority services clearly represented two distinct treatment traditions, often described as cure and care (Gloubermann and Mintzberg 2001). This led to considerable challenges in coordinating the services (Ramsdal, 2010, 2013).

The consequence of this deinstitutionalization and decentralization is that services are now generally provided in the client's home. This takes place in two main ways, either in sheltered housing, usually staffed round the clock, or through outpatient services in clients' homes (Hansen, 2013). Services are provided on the basis of administrative decisions. Service providers who regularly visit a client at home will develop close contact with the client and therefore get a different picture of his/her needs than a person who just visits once to make a quick assessment (Almvik et al. 2011; Hansen & Landsnes, 2013). Therefore, they see it as their task to communicate to the specialist services the client needs they discover. The service provider becomes more of an advocate than a gatekeeper.

Decentralization also reveals that clients have a great need for more services than merely treatment, related to e.g. housing, finances and social participation. The specialist services also realize that they cannot easily provide their form of assistance without other types of intervention (Hansen & Ramsdal, 2006). Many services are therefore now increasingly focused on the fact that it is impossible to provide adequate help unless comprehensive measures are in place. This is particularly evident when coordinators have been appointed in connection with individual plans. Service providers are thus given a new role where they are not only responsible for their own service provision, but also have a clear responsibility to identify needs and help clients obtain a broader range of services. They will thus be focused on facilitating more comprehensive services than they themselves could provide (Hansen, 2007).

One of the challenges for service providers has been that they have been responsible for balancing client needs against resources, which in effect means the time they have available to work with the client (Vabø, 2014). Staff have had aspirations to make greater efforts for clients, but there has been no scope for such efforts. It may be said that the new organizational principles for local authorities have helped to redefine service provision. This new situation has led to opportunities to change service provision, and the introduction of the purchaser-provider model has been particularly important in creating these opportunities.

Today, staff are keen for clients to receive the services they are entitled to. This is particularly evident in local authorities with the purchaser-provider model. One of their employees clearly presented the challenges they faced:

> Psychiatric patients aren't good purchasers; we often have to be the client's spokesman, to a large extent we're the ones who order services for the clients.

Service providers take on the role of agents in such cases, acting on behalf of the client to help the client get services. Another employee described this in a more general context:

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> We work with the clients to find solutions—often in relation to other actors involved. We each sit on our own little island—we all have expertise—but when we make contact, we meet a lot of goodwill in the system. Clients say that too: "When we make contact, we're given the cold shoulder, but when you people do it, it's so much easier".

According to theory, the purchaser-provider model should have a clear distinction between purchaser and provider (Busch & Vanebo, 2001). In Norway, we see an extensive use of the soft version of the purchaser-provider model, which is less faithful to theory; here, there is regular contact between purchaser and provider (Hansen, 2007; Hansen & Ramsdal, 2005). However, in our study, it was clearly the purchaser unit that was responsible for putting in place the various services. This made it easier for a service provider who saw that a client needed additional services to discuss this with the purchaser, rather than trying to convince colleagues in other provider units to take on more work. The organization of local services, which separate the provider and purchaser roles, may may be contributing to the changed framework for service providers. This illustrates how the use of organization as a governance tool may change the responsibility for tasks (Chr & Margetts, 2007).

The pressure to limit the use of resources is today primarily directed towards the purchaser units (Hansen & Ramsdal, 2005). Service providers can therefore ally with clients to persuade purchaser units to increase the services available to clients, without being themselves responsible for prioritizing resources. In this way, a purchaser-provider model also makes it easier for a service provider to assume a role of promoting client needs.

5.4. Economic means

It is also important to note that additional funding has been channelled to this client group through various actions in recent years. The first important measure was the Escalation Plan for Mental Health from 1999 to 2008 (White Paper No. 63, 1997-98). This channelled considerable funds to local mental health services, most of which were earmarked (Ose, Kaspersen, & Pettersen, 2012). These earmarked funds resulted in a significant strengthening of local services for people with mental health problems (Kalseth & Eikemo, 2008). The use of earmarked funds gives government greater control **than in the case of** block allocations (Vedung, 1998). Some of the earmarked funds were used for suitable housing, mostly aimed at the most demanding clients (Holm, 2012). In addition, the city project of the Norwegian State Housing Bank has included funding for housing for double diagnosis clients (Hansen & Landsnes, 2013).

As we have mentioned, investments in suitable housing and services for clients in their homes give service providers a different and often broader view of client needs (Almvik et al. 2011; Hansen, 2013). Better housing and home-based services have therefore meant that service providers have become more aware of the needs of clients and have acted upon this by helping clients with formal applications for additional services, or by informally influencing the purchaser unit to decide on new and expanded services. These changes would imply less focus on both gatekeeping and on maintaining the counter.

6. Closing discussion

Based on our data and the discussion above, we argue that there is a trend where service providers **are focusing** more on advocacy than on maintaining service barriers like those of the gate, line and counter. This is partly because the law requires service providers both to take client participation into account and to conduct more extensive surveys of client needs. The emphasis on client participation has also led to a changed relationship between service provider and client, where service providers are now less paternalistic. The organizational framework of service providers has also changed in that the responsibility to determine the services to be provided has now been transferred to individual units. While service providers **still** to some extent keep up barriers, they would be better termed **as advocates**. In many respects, they act as representatives for "their" clients and work towards expanding the services on offer rather than limiting them. Furthermore, local services have received earmarked allocations to support local priorities.

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We have shown examples where government policy design can explain changes in the professional role of various providers of services to dual diagnosis clients. The fact that the reforms do not affect all service providers demonstrates that it takes time before public administration changes in line with new policy signals (Pierson, 2004). Further, the role of service providers and how it can be performed is not only influenced by changes propelled by the external environment.

Intraorganizational forces can draw politically initiated change in a different direction from the intention. Such forces can also result in service providers scarcely changing their behaviour or in a delay in the change (Pierson, 2004; Thelen, 2003). This can be understood as institutional reproduction where processes involving conflicts, power and negotiation can lead to incremental change or alter the direction of developments motivated by national reforms. Individual behaviour in organizations is understood as governed by institutional norms that may persist even if the formal guidelines have changed (March & Olsen, 2006; Pierson, 2004). Institutional norms governing collective practices will thus also play their part in preventing change (Pierson, 2004). In this way, institutional norms may counteract the impact of measures and changes introduced by the government.

We also see other factors that may influence the shaping of service providers' role. Other studies have indicated a number of barriers that restrict service providers' ability to act as advocates for clients (Oliveira & Tariman, 2017). For example, there may be disagreement about the organization's goals and strategies, short staffing, limited finances, employees' personal assertiveness and relationships between employees and between employees and clients.

How various policy measures have led to greater advocacy has been discussed in detail above. Although there are examples of service providers who have not changed their roles, this does not detract from our general conclusion that changes in government policy have changed the roles of professionals. We have used services for dual diagnosis clients as the empirical basis for our discussion. Our main findings illustrate how the Norwegian government through legislation and knowledge dissemination has highlighted the goal of client participation, where service providers have a responsibility to provide comprehensive and coordinated services based partly on client goals and needs. Several policy instruments have been made to complement each other and in different ways prevent clients from standing alone at the counter (Schaffer & Wen-Hsien, 1975). Further, service providers no longer merely adopt a passive role in anticipation of clients requesting services (Lipsky, 1980), but are proactive in advocating the client's rights at the counter.

By adopting the purchaser-provider model, local authorities have, for their part, created a distinction between those providing services and those who establish a framework for the services. This has given providers an opportunity to focus more strongly on client participation and to promote client needs for more services than they probably would have had if the providers had been themselves responsible for balancing client needs and their own resources. In this way, the service providers' loyalty has gradually been transferred from the system to the clients. The developments in service provision that we have presented in this article may thus be understood as a combination of deliberate strategies by the government and opportunities that have arisen as a result of organizational changes.

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