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Ethnographic reflections on access to care services

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Ethnographic reflections on access to care services

Abstract

By taking our empirical point of departure in a multisited ethnographic field study of the management of citizens with complex problems in Danish welfare systems, the purpose of this article is twofold. It explores how gatekeepers' ways of regulating the researchers' access to knowledge in/about care services reflect the systemic and interpersonal values that inform the systems' daily workings at street level. It also explores how our methodological experiences resemble the value-informed regulatory strategies that professionals and users themselves experience in their daily encounters in the same local practices that we have studied. By means of Michael Lipsky's outline of access regulation, we will analyze the following regulatory strategies that we identified during the fieldwork: 'Gatekeepers' sympathy and creaming', 'Queuing and delay', and 'Withdrawal of consent and 'no resources'. The article suggests that trust, shared goals and sympathy seemed to be key to our, as well as professionals' and users', process of getting access to information and help from these welfare systems. Despite principles of neutrality, equal rights and access to services in welfare systems, our experiences thus tend to support other research within bureaucratic and care organizations, which has found that interpersonal relations, sympathy, dislikes, norms and values etc. can heavily influence timely access to services, tailored information and support.

Introduction

Gaining access to information and knowledge is important for researchers as well as for citizens in need of help and employees in care organizations, to inform their care provision and to “make things work” on a daily basis. In this article, we explore how our methodological experiences of gaining access to knowledge in three types of care services reflect some of the systemic and interpersonal values that inform the systems’ daily workings. By identifying three pairs of bureaucratic, regulatory strategies (Lipsky, 2010), we wish to shed light on the quantity of thresholds that need to be accessed and on the gatekeepers that ensure access to the right kind of help or information in the everyday practices of care organizations.

The article’s empirical point of departure is a largescale, multisited ethnographic field study of the management of citizens with complex problems in Danish welfare systems. In this study, a citizen with complex problems is defined as a person who is simultaneously in contact with the drug treatment system, employment services and the psychiatric system. Given that the municipal employment and drug treatment services and the regional psychiatric services are currently geographically, organizationally and politically separated in Denmark, the study focuses on how the regulation or provision of citizens’ access to these types of welfare systems is conditioned by different political requirements, traditional organizational characteristics and professional views of the citizen. For example, a range of common uncertainties and tensions associated with inter-system regulation of sharing information about a case arose during a joint, interdisciplinary meeting about the management of the case of a 37-year-old male with complex problems:

Social worker, drug treatment: *Is verbal consent sufficient, or do we need a signed consent form to have this joint meeting?*

Psychiatric Nurse: *No, not the written one. You only need the one that is scanned into your [electronic documentation] system. [...]. You need to fill one out once a year.*

Social worker, employment: *Yes, ours accounts for the entire time he is enrolled [but] a consent form is not a blank check that allows you to do anything, even though collaboration with other actors is ticked off. Things can change, as they say. [...]. So, I agree that it is best if the citizens are involved every time something new comes up.*

Psychiatric Nurse: *and because our patients are so disturbed. [Impersonating an example of a patient] “I do not remember that I allowed you to talk to her six months ago”. They are often extremely paranoid [...], so, if they feel that we talk behind their backs, they really will have reason to be paranoid.*

Social worker, drug treatment: *That makes good sense.*

The excerpt shows how professionals from the three systems negotiate their divergent views of the importance of the citizen's consent. The example reveals how the professionals agree that external access to information and inter-system exchange of knowledge about citizens must be formally regulated either by verbal or written consent. It also highlights that information exchange and involvement of the citizen, and others, relies on the professionals' judgments about the citizen's condition and their discretion about whether or not to include other relevant sources of information. Paradoxically, this took place without the presence of the citizen at the meeting – despite the fact that his psychiatric, drug and employment problems and subsequent needs for support had been assessed. This exemplifies how professionals' views of some citizens' complex cases can frame how they emphasize or downplay the formal requirement of the citizen's consent to share information and involve

others. In this sense, the workings of these separate, yet interconnected, welfare systems are not only framed by different legislation and an array of national and local policies, these systems often rely on professionals' judgments and diverging notions of the citizen. The study of citizens with complex problems thus raises the question of how the organizational and professional architecture of the systems may, in fact, position the citizens in a juxtaposed situation to get help.

Yet, gatekeeping and regulation of access to services and information is important, not only for citizens in need of help but also for employees and researchers in care organizations who either try to provide services to or study the bureaucratic management of citizens with complex problems, respectively. This issue is a traditional topic in ethnographic research on field workers' relations to informants and gatekeeping (Bondy, 2012, Reeves, 2010).

Similarly, it is a centre stage discussion in research on public organizations and bureaucracies (Lipsky, 2010, Herzfeld, 1993) that often points to the overall observation made by Michael Lipsky (2010), that, on the one hand, gatekeeping and access to welfare services are regulated by government policy at the systemic level. These policies promote regulation of resources, time, manpower and public opinion influencing the playing out of access to care. On the other hand, Lipsky's (2010) work emphasizes how service provision and citizens' access to care also relies on the discretionary actions of professionals. At street level, professionals' personal views and professional attitudes towards citizens also determine citizens' access to benefits and frame whether collaboration with and involvement of others is relevant for the management of the case. The dynamics between the values/ideologies of different policies at the systemic level and professionals' ideals and value-laden attitudes at the interpersonal level are inherently bound up in the daily management of citizens at street level (Jensen, 2015, Frank and Bjerger, 2011, Brodtkin, 1997, Herzfeld, 1993). In the discretionary process, different systemic and interpersonal values can thus be emphasized or downplayed by

professionals in the management of a particular case, as well as from case to case, and different regulatory strategies can either facilitate or obstruct access to care services or knowledge about care practices (ibid.). Informed by Lipsky's work (Lipsky, 2010), the purpose of this article is to explore how gatekeepers' ways of regulating the researchers' access to knowledge, in/about these particular types of care services, reflect the systemic and interpersonal values that inform the systems' daily workings at street level. Moreover, we also aim to explore how our methodological experiences resemble the value-informed regulatory strategies that professionals and users themselves experience in their daily encounters in the same local practices that we have studied. By means of Lipsky's (2010) outline of the different regulatory strategies, we will answer both issues, not by addressing them in two separate sections, but by analyzing our own and the informants' experiences. The regulatory strategies are: 'Gatekeepers' sympathy and creaming', 'Queuing and delay' as well as 'Withdrawal of consent and "No resources" '. These will guide the presentation of the analysis below.

Background

The issue of gatekeeping and regulation of information and services in care organizations is a key topic in studies of bureaucracy and public organizations (Jensen, 2015, Møller and Harrits, 2013, Frank and Bjerger, 2011, Gubrium and Holstein, 2001, Van Maanen, 1978, Brodtkin, 1997). This issue is important for interrelated reasons. First, it speaks to the very nature of welfare services by shedding light on values underpinning the question of who is entitled to receive which kinds of services. Second, the workings of such service systems can make it difficult for professionals to provide services to citizens with complex problems and lead to negative consequences for citizens who do not get access to timely and tailored help (Ness et al., 2014, Hansen and Bjerger, 2017).

According to Lipsky (2010), gatekeepers' regulation strategies encompass the time spent on accessing services (queuing arrangements, timing of service coordination and service delay), regulation of information (withdrawal of information, service availability or tight application processes), and population differentiation. The latter can imply the institutionalization of stereotypical tendencies, which are often receptive to prejudicial attitudes among professionals, constitutive of the division of populations based on assessment of needs (triage), favoring of citizens with greater chances of benefitting from services (creaming) and professionals' sympathy (worker bias) (ibid). Yet, the values of both the systemic and the interpersonal level condition the gatekeepers' regulation of access of researchers, professionals and citizens with complex problems who require knowledge and assistance from service providers to perform their job or recover, respectively.

The *systemic* level is informed by historical, political and institutional frameworks, enveloping prevailing values in the organization of the welfare state, social and health care policies and laws, resources, public agendas, etc. (ibid). In relation to the above-mentioned three welfare systems, previous Danish research shows that different ideological views underpin these systems (Oute et al., 2015, Bjerger et al., 2016, Bjerger et al., In preperation). First, drug treatment is framed by health policies and social service policies which, respectively, frame regulatory prescription medicine and psychosocial interventions (Bjerger et al., 2016). In the latter, the user is presented as a potentially resourceful person with the ability to become responsible and self-managing (Bjerger and Nielsen, 2014, Socialministeriet, 1998), while on the other hand, for example, the guidelines for Opioid Substitution Treatment depict drug users as citizens who are not fit to make rational decisions. Thus, this policy frames the understanding that control measures are needed (Bjerger and Nielsen, 2014). Second, employment policies drawn up by the Ministry of Employment direct specific funds to employment projects. In employment policies, the

citizen is portrayed as someone who should contribute actively to society by, for instance, documenting that she or he is actively seeking employment (Holm Vohnsen, 2017, Arbejdsmarkedsstyrelsen, 2016). Third, the Ministry of Health and the Danish Health Authority and/or the Ministry of Social Services and The National Board of Social Services are responsible for overseeing the regulation of prescription medicine, psychiatric treatment, and psychosocial interventions. In Danish health care policy, a psychiatric patient is commonly seen as a weak or vulnerable person, who lacks the proper understanding and responsibility to identify with the diagnosis and comply with treatment or care (Sundhedsstyrelsen, 2007, Oute et al., 2015). In spite of political emphasis on autonomy and patients' rights to informed consent, psychiatric patients are often regarded as someone in need of professional protection, surveillance and medical control (Oute et al., 2015).

At the *interpersonal* level, certain ideals and value-laden views also inform the practices of professionals that users and researchers engage with in order to gain access. In our research project, professionals are mainly social workers, teachers (and other types of educational staff), nurses, psychiatrists, managers and administrators. Their ways of managing their jobs are not only framed by laws and ideologies of the system in which they are employed but they are also related to phenomena such as professional training, prior experiences, and personal values, all of which influence the strategies they deploy in interaction with other professionals, users or researchers. For instance, psychiatric policy and professional values do intersect, as professionals often identify as parental subjects whose role is to safeguard the patients who are, often, considered weak and incapable of making valid consents about their mental health without the permission of professionals (Oute, 2017). Moreover, it is well known that dually diagnosed persons with co-occurring mental illness and substance and alcohol use are often denied access to psychiatric services (Oute et al., 2018). This exclusion process originates in a professional view that these drug- and alcohol using patients are “bad”

patients while mental health professionals often sympathize with and favor good patients who are perceived to be more likely to submit themselves to professionals' categorizations and gain from professional treatment, due to the incentive of creaming patients with positive effects of treatment. However, access regulation can also be conditioned by a paternalistic professional identity in psychiatry as it often works as a framework within which professionals consider themselves obliged to control the patient's right to determine the relevancy of the patient's perspective on his/her health issues and consent to involve others in these issues (Oute and Bjerger, 2017, Bredahl Jacobsen, 2006). On the contrary, in psychosocial drug treatment services, professionals often establish a relationship with the citizen based on equality and trust (Frank and Bjerger, 2011, Lilly, 2000), understanding, for example, drug use as a social phenomenon to be handled through social reform and educational tools (O'Malley, 1999, Houborg, 2010). Therefore, there is often a notion of how "going an extra mile", e.g. in terms of willingness to help citizens navigate other care organizations outside the drug treatment system, is essential to the work these professionals do (Bjerger and Bjerregaard, 2017, Bjerger et al., Forthcoming). In employment services, the main task is to get unemployed citizens to obtain employment or participate in courses to make citizens become available for employment, and the field is highly regulated in terms of who receives what at what time based on which criteria etcetera. Despite many individual professional's ideals, incentives in the form of economic sanctions - and thereby control of citizens activities - are the measures most commonly used (or at least feared by citizens), and the professional's individual space of discretion is often rather limited (Bjerger et al., Forthcoming, Bjerger et al., in preparation). Taken together, these forms of systemic frameworks and interpersonal attitudes rely on different values that inform the regulation of access to care, collaboration and knowledge across the geographically and organizationally separated systems (Lipsky, 2010, Brodtkin, 1997). However, few ethnographic studies have

scrutinized the dialectics between the systemic and interpersonal values/ideologies that condition gatekeepers' regulation of access to care and knowledge in the above-mentioned service systems.

Methods and materials

Our empirical data stems from a large, qualitative study, examining the management of citizens with complex problems (Bjerger et al., In preparation, Christensen, 2017). An adequate, official definition of what counts as a “complex problem” does not exist. However, in recent Danish policies the term is being used repeatedly, and is often broadly defined in the following way:

a complex problem consists of multiple problems present at the same time [...] In many cases [e.g.] the misuse of drugs will not be reduced if the user's mental illness is not taken care of. At the same time, misuse of drugs can obstruct the kind of treatment that is provided to patients who only have one problem (Socialministeriet & Indenrigsministeriet, 2016: 13)

Thus, complex problems can entail numerous elements such as drug use, mental illness, homelessness, a criminal record, unemployment, severe health problems etc., all related to different types of welfare organizations such as drug treatment centres, psychiatric wards, shelters, the prison system, employment services, hospitals etc.. As noted above, our project focuses on citizens who are enrolled in drug treatment, psychiatry, and employment services and investigates how these different problems necessitate different types of services with different administrative tools, different professional approaches and different types of national and local policies. Taken together, this composition of care organizations, professional approaches and policies constitutes a complex web of overlapping, and

potentially conflicting, ways of managing and helping citizens. The analysis reflects on our experiences of gaining access to care systems during fieldwork conducted between the autumn of 2015 and the summer of 2017.

Due to the complex nature of the study, we draw on a multisited ethnographic approach (Marcus, 1998, Shore et al., 2011). Rather than relying on the classic notion of the field as a single site, the field is perceived as fluid. This means that the field can span from everyday activities, “*through local institutions, to national and international agencies and governing bodies*” (Shore et al, 2011: 27-28). Thus, the field of study transgresses time and space and relies on empirical materials drawn from multiple sites. In this line of thought, the study investigates how care services targeting citizens with complex problems are articulated and enacted at multiple sites and how these services are interpreted and put to work in conjunction with an array of local, social and institutional processes. The circulation of policies and professional objectives that constitute how the political construction of the citizen with complex problems, and the ways in which he or she should be managed at street level are contested by, for instance, professional identities or value-laden attitudes towards the citizen, in practice and transformed across time and space. Hence, the empirical materials and our reflections on access regulation from the fieldwork can be seen as an assemblage of the political-practical configuration of the management of access in the contexts of care for citizens with complex problems.

Sites: The management of citizens with complex problems was investigated in all of the aforementioned types of welfare institutions at three geographical sites: a municipality in the capital area (A) and two municipalities located in the area of two large provincial cities (B, C). These sites were selected because they differ significantly in size, but also have a considerable number of citizens with complex problems and offer the three forms of welfare services. Such a selection of settings enabled us to identify a broad and varied selection of

citizens, professionals and institutional sites that were conducive to the attempt to access services while also requiring that we worked closely with gatekeepers and negotiated access across nine sites.

Materials: To gain as differentiated and detailed knowledge as possible about how access to the field sites mirrors the often contradictory frameworks of, and understandings within, welfare service systems, the overall study relies on several types of data (Holstein and Gubrium, 2008, Agar, 1987). By means of following intertextual references, we collected approximately 8000 pages of national and local policy documents framing practices in the above welfare systems (Nygaard-Christensen et al., Accepted). Moreover, the first author negotiated access to collect citizens' records from each of the systems in all of the geographical sites; i.e. 45 (3x3x5) records. Eventually, a total of 30 records consisting of approximately 3500 pages was collected as the research team failed to gain access to records from the psychiatric system in site B and employment services in site A and B (Oute et al., in preparation). Using an interview guide covering three themes (Policies in practice, Daily management of citizens and navigating requirements, Reflections on future possibilities for action and change) derived from the overall research issue, the members of the research team produced a total of 69 and 11 formal, semi-structured interviews with professionals and citizens, respectively. Even though the interviewees were asked specific questions referring to the main themes from the interview guide, the semi-structured approach also allowed the interviews to follow unexpected routes and cover new and more wide-ranging themes. Data from records and interviews was collected during the 14 months of fieldwork in two employment-oriented workshops for citizens with complex problems (A, B) and a temporary, employment-oriented housing facility for dually diagnosed individuals (C). In these settings, the researchers observed daily (and nightly) interactions among professionals and citizens with complex problems, participated in staff meetings, shift hand-overs, joint collaborative

meetings between case workers, social workers, nurses and occupational therapists (O.T.'s) from the different municipal subsystems and the regional psychiatry (Nygaard-Christensen et al., Accepted, Bjerger et al., Forthcoming). Finally, text messages from, and email correspondences with, gatekeepers about our access to the field sites were included in the data set. Taken together, the participatory observations and the, at times, unexpected trajectories of the semi-structured interviews provided the researchers with a deeper understanding of the complications of the everyday management of citizens with complex problems. For instance, they revealed a strong resemblance between the researchers' and professionals' frustrations related to obtaining consent and sharing information across the gaps between systems, inspiring this article's analytical focus on the strategies that were used to facilitate or obstruct access to knowledge and help in/across the systems.

Gatekeepers' regulatory strategies

The data from the fieldwork showed that the gatekeepers' value-laden articulations concerning accessibility did not only signal the individual's personal values, but rather they reflected a range of strategies, resembling the common forms of regulation as pointed to by Lipsky (2010). In particular, gatekeepers used three sets of strategies that either facilitated or obstructed our own and the informants' access to knowledge and care services. Access was facilitated by gatekeepers who sympathized with and favored (creaming) our endeavor, whereas our failed attempts to gain access to information or care were hampered by professionals' somewhat uniform ways of regulating our access by way of using queuing and delay arrangements and strategies such as withdrawal of consent and no resources. These strategies are outlined below.

Gatekeepers' sympathy and creaming

Paraphrasing Lipsky's idea that street level bureaucrats tend to favor citizens with greater chances of benefitting from services as well as those citizens with whom they sympathize, we experienced how, in particular, the latter was key for gaining access. Given the complex organization of the welfare systems, our access to information in them was negotiated with multiple gatekeepers at several geographical locations. As also experienced by our informants, the systemic level and interpersonal precision of the entry points were characteristic of our efforts to access each of the systems. In order to identify a gatekeeper who understood and favored our wish to gain access, a common lack of clarity about how and where to do so required that the research group reflected on how and from whom to get access to do the fieldwork in the systems. Due to our lack of experience with accessing multiple field sites at the same time, we spent a lot of time reflecting on what level of the municipal management to approach to pitch our project and who to ask for permission to access the systems. This is described in a field note written up at an early stage of the fieldwork:

Our project spans several units of support, as the citizens' problems can involve employment services, social services, and drug/alcohol rehabilitation services. The larger municipalities have several managerial levels and the frontline staff that work with the citizen's problems are often at 'the bottom' of several managerial layers. Should we only ask permission from the frontline staff's immediate managers or also the managers of the entire centres? Or should we ask the directors of the entire administrations? We ended up using different strategies and starting off at different levels. (field note, October 2015)

The research team continually considered where and to whom, in the organizational structure, our requests for access should be directed. Based on who we knew from previous work and the present field study, we used different strategies to locate a gatekeeper, whose position was

constituted by what we thought of as the “right” interpersonal and systemic properties: a person who would not only trust the researchers but also find the study significant enough to collaborate about it and, at the same time, had the formal authority and position in the systems to grant us access to make enquiries in their field of practice. Throughout the entire fieldwork, we informally talked to, interviewed or corresponded with a range of different professionals from each system in order to identify such gatekeeper(s).

These experiences also resemble the experiences and considerations pointed out by several citizens with complex problems, who participated in the study. For example, it came clear in the way a young woman addressed this issue:

Like I said, I think that the system has a hell of a lot of cracks in it, because you have to get the right case worker to get the right output (woman, 20 years old)

This young woman has been in contact with all three types of welfare systems over the course of more than a decade. She explains that the workings of the systems are somewhat incoherent. By expressing frustration, she articulates a potential risk of spending a lot of time being stuck in the cracks of the system if one does not “get the right case worker”. By the right case worker, she refers to a professional who would be sympathetic to her situation, willing to act upon it and at the same time be knowledgeable about where to gain access to information and services.

Similarly, our process of trying to gain access to the fields was in most cases delayed and time consuming. In some cases, the amount of time spent on gaining access was, however, significantly reduced, depending on the gatekeeper’s position and approval of our work. For instance, our initial access to conduct field work in municipality ‘C’ was negotiated with a high-ranking gatekeeper in a substance use treatment center, who was in a position to approve the conduct of the study in the municipality.

This site was chosen as the researchers knew the area from previous research whereas the particular access point was chosen because a member of the research team had previously worked with this person who was considered likely to sympathize with the researchers and our endeavor. First, we established contact with the gatekeeper, and oral and written information about the study was subsequently given. Then, the gatekeeper organized a joint meeting among ten key social workers and educational staff, all of whom were employed in the drug treatment and employment systems. These professionals were selected by the gatekeeper, because they were considered especially knowledgeable about the study population. The gatekeeper's way of managing our wish to access the municipal systems coincided with their official collaborative approach to working with citizens in the municipality – called “relational coordination” – which, time and again, was highlighted by local gatekeepers and employees across the field sites. One social worker from the employment system articulated it as follows:

Here [in our municipality], it has been decided that we must collaborate using relational coordination. This is a small town, so it works really well because we all know each other (field note, May 2016)

Thus, the fact that several professionals were able to attend the meeting at the same time can signal the political articulation of this way of managing the complexity of the different professional actors' views within the different municipal (and at times regional) systems. The negotiation between different perspectives and the joint construction of adequate responses to the citizens' complex cases often required that the professionals either tinkered with fitting the services to fit the individual case or tinkered with the interpretation of the individual to fit the available services (Nygaard-Christensen et al., Accepted). This process, making the constantly changing case and the available services fit, emerged during a joint meeting involving several employees from across the relevant sectors who were involved in managing

the particular case of a citizen called Marianne. The meeting was led by a high-ranking manager who, in line with the rest of the involved social workers, arguably sympathized with Marianne and articulated a strong belief that their efforts would lead to a positive transformation of Marianne's situation. In this sense, sympathy and creaming might have framed a view that the joint meeting offered an opportunity for the professionals to scope and agree on which resources were available for them to craft an adequate response to her complex situation (Nygaard-Christensen et al., Accepted). In an interview conducted after the joint meeting, a social worker, Lise, commented, *'Sometimes we need to confirm that we're all going in the same direction, because if we professionals can't figure it out... I mean, it's hard enough for citizens to understand the system'*. As with collaboration between the actors involved with managing Marianne's case, the collaborative approach also enabled the professionals' joint approval of our access to their system, given that we, as researchers, were allowed to ask permission to and discuss the possibilities of conducting the study in their fields of practice. Yet, the professionals' joint consent to this and their way of coordinating our request to do research not only paved the way for our access to municipal and regional institutions, this framework also corresponded with the overall focus of the research project. Hence, our wish to study the dynamics between policies and practical concerns in these specific systems can be seen as creaming as the researchers' interest in inter-systemic collaboration about citizens with complex problems reflects an implicit recognition of their joint efforts to help citizens with complex problems. However, this could also have been facilitated by the gatekeeper, who may already have trusted and had sympathy for the researchers, based on previous experience. Despite the fact that these interpersonal circumstances may have influenced the gatekeeper's willingness to invite us to talk to the employees about the project, the rather rapid process of gaining access might also signal concurrence between the aims of the study and a key policy for the professional management

of citizens in that particular municipality in which the gatekeeper was obliged to abide. This suggests that the gatekeeper might have sympathized with the researchers but perhaps more importantly the concurrence points to a case of creaming. That is that the gatekeeper and the practitioners that we encountered during the initial meeting favored collaboration with the researchers due to a perceived greater chance of reciprocally benefitting from the research conducted into their systems that potentially would reflect positively on the professionals' practices. As we shall see below, our efforts to access other parts of the system highlight how professionals also regulated access to these systems in cases where the project seemingly did not match their political-practical ideals of good practice. In those cases, our access was impeded using several forms of queuing strategies that encompassed prolonged (if any) responses to phone calls or emails, time regulation (delay), meetings being postponed and contact information being withheld (information withdrawal).

Queuing and delay

As with gatekeeper sympathy and creaming, queuing and delay strategies are not only reflections of the gatekeeper's personal preferences and ideals but also signal a broader set of political requirements and organizational characteristics. These strategies often emerged in situations in which we sought information about how to get in contact with particularly knowledgeable professionals working with citizens with complex problems. For example, to make contact with a manager, we had to go through another, employment manager. This frustrating and time-consuming situation is written up in the following field note:

"In the municipality ['B'], I sought access via a gatekeeper [at the drug treatment center], who knew a new manager in the Employment service system who could help me into one of the services offered to citizens with complex problems. Over the telephone, another manager from the employment system tells me about a service that offers support for citizens with complex problems that employment caseworkers do

not know how else to support. However, I do not get the direct contact information for the manager of this service as the employment manager will not provide me with the direct information and says that the contact has to go through her. Despite repeated phone calls to her over several months, I am not given this information. It ends up taking about 3 months from the first contact on the 3rd of December 2015 until the manager sends me an email the 24th of February 2016 inviting me to come and present the project to him. At this point, it still remains uncertain whether he or his employees will allow me to do fieldwork there. Luckily we are granted access, and the fieldworker can, after a meeting for all employees in the service, finally start conducting the field work in April 2016.” (Field note)

The fact that the first manager held back information can be seen as a form of queuing arrangement or service delay functioning as a form of regulation of the pathway, not only between the drug treatment and employment service systems, but as a barrier within the employment service system itself which hindered our access to knowledge about the appropriate service. The example does, however, raise new questions about the framework for and understanding of the organization of daily practice, in the managers’ initial way of delaying our entry. What does the fact that the manager from the employment system held back information about other professional actors and the accessibility to other systems reflect? Several options seem possible. Does the example reflect a municipal or national drug policy framing the understanding that control measures are needed to protect vulnerable citizens? Or could judgmental attitudes about citizens with complex problems frame an understanding of a privileged administrative practice for professionals, in which they maintain a position to regulate access to information about citizens with complex problems which has been described in previous studies (Ness et al., 2014, Hansen and Bjerger, 2017)? Or does the above mirror a way of trying to be a helpful and effective gatekeeper who does

not pass anybody on to the next person before being absolutely certain about who the right person might be? Time and again, these options seemed possible in a large range of other examples, where the researchers' emails and phone calls were ignored or when we were asked to wait. Yet, examples like these suggest that barriers were put in place at the entry points of the systems, as well as in the interpersonal relations within the welfare institutions. Thus, such experiences are exemplary for the above mentioned issues of not getting the right caseworker to be able to proceed and/or of delayed access to the information needed.

This was accentuated during an informal conversation with a citizen from municipality 'A'. With constructive facilitation and help from a local middle manager, who, arguably, sympathized with the researcher and the aim of the study, the researcher had formally asked the citizen for his consent to participate and let the researchers use his record as documentation in the study. The citizen, a 27-year-old man with a several year-long treatment career for his mental health and substance use problems, stated that:

I would be glad to help you, man! The systems do not talk together at all. That is a huge problem. So, of course you can see my record. I cannot do anything and it really ruins your life when you cannot get help (field note, August, 2017)

During the conversation about his consent, the man pointed out that he felt trapped and powerless when he was either told to wait for his turn, put on hold or had his case referred on to a new manager, who often wanted the same or additional information about why he asked for help. He described how this form of queuing or prolonged service delay made him feel ridiculed, frustrated and could even worsen his condition when his access to help was put on hold, further delayed or even rejected. This suggests that citizens with complex problems, professionals and/or researchers are dependent on gatekeepers in the right position to navigate the fragmented systems, because it is likely that one is ignorant about, and possibly bewildered and made powerless and passive by the complex pathways into and between the

systems – whether one tries to pilot them to get help or access to professional collaboration or data.

Our efforts to access the psychiatric system at the geographical site of ‘B’ were particularly exemplary of these ways of regulating access by using queuing arrangements. Here, our interactions with the professionals highlighted how access was regulated using the political requirement of informed consent, but they also suggested how value-laden views at the interpersonal level could also frame the delay:

Today I was going to see ‘Kirsten’, a nurse at a project, bridging psychiatric and drug treatment. As we already knew each other and shared interests, I asked her to do an interview. We also planned to have an informal talk about how we could gain access to patient records and to interview more of her colleagues. A few hours before the meeting, I received a cancellation by email: “I just talked to my boss about our appointment today. He wants to run it through the ward management [who already knew me from my time as a nurse practitioner and my previous studies of involvement of patients and relatives in psychiatry] in relation to [our right to be] sharing information from patients’ records (field note, October 2016)

The manager’s suggestion that the interview with the nurse might lead to a violation of Danish Health Law (2016) signals a delay strategy, despite the fact that the nurse had willingly consented to talk to the researcher. It begs the question as to why the manager rejected our request to talk to the nurse about their work and about who one could approach to gain access to patients’ records. On the one hand, the manager might be unsure if the project aim would lead to a breach of confidentiality and data protection, according to Danish Health Law (Sundhedsministeriet, 2016). In this case, the example highlights the use of a strategy of regulating access in the form of queuing and withholding information, in accordance with the individual patient’s rights. On the other hand, it also begs the question as

to whether the researcher, who had previously conducted and published studies on social issues in psychiatry and worked as a practitioner in the same institution, was in bad standing with the management (Lipsky, 2010)? Does the manager's cancellation signal that their political and professional framework for good practice was at odds with the management's expectation of the researchers' focus? If so, does it imply that the management was not interested in letting social scientists investigate practices within psychiatry, where medical professionals historically have worked hard to uphold professional authority (Miller and Rose, 1986, Rowe et al., 2011)? In this case, the regulation could also reflect a strategy of delay due to lack of sympathy for citizens (or patients) with complex problems, such as unemployment and co-occurring mental illness and drug – or alcohol use. As pointed out in previous welfare research and ethnographic research in psychiatry, the professionals' temporary rejection of our access to study citizens with complex problems resembles the exclusion of researchers and dually diagnosed people, who are often believed not to identify with health care professional authority and accentuate the positive effects of the system representatives' practices (Lipsky, 2010, Oute, 2017, Oute and Bjerger, 2017). Little information was given, however, regarding the manager's personal motivations and reasons for delaying the appointment and overruling the nurse's openness and judgment. Resembling findings from recent research on patient participation and caregiver involvement in psychiatric treatment (Glasdam & Oute, 2018, Priestley and McPherson, 2016), the manager's judgment and the cancellation of the appointment thus highlights that Danish Health Law (2016) is often actively used as a means to delay or entirely block researchers', relatives' and professionals' access to help and/or information within psychiatric treatment organizations.

In response to the initial denial of the appointment with the nurse, the researcher suggested that he could come by the ward as planned and give oral and written information

about the study to the manager in order to ensure adherence to Danish Health Law. Shortly after, the researcher received the following email, stating that:

he [her boss] is not available today and he wants to have a green light from the ward management before doing anything. As an alternative, we could talk after working hours. He is wondering why I booked an interview with you during work hours, as it is not related to our work here, and therefore he wants the go-ahead from the management before it can be arranged. But I am thinking that it couldn't be a problem if it is after working hours (field note, October 2016)

The email suggests that the nurse is placed in a Catch-22 situation. On the one hand, her boss requires “a *green light from the ward management*” and views the project as being unrelated to the work. On the other hand, her suggestion to “*talk after working hours*” articulates a clear interest in cooperating about the project and helping us to get access to information. The fact that our request positioned her in a situation in which she could be subjected to criticism (i.e. harm) by her manager if she provided the research team with information, meant that the situation signaled the possibility of unethical conduct on behalf of the researcher if he engaged further with the nurse. As divergent views have to be managed within the psychiatric system, the example thus puts on display how external access to information is delayed and put on hold by emphasizing a political requirement. As we shall see below, this coincides with a well-known protective strategy for professionals to safeguard knowledge about weak and vulnerable patients and information about their condition (Priestley and McPherson, 2016, Oute, 2017).

Withdrawal of consent and “no resources”

As with the researchers and the participating citizens with complex problems, the professionals often felt frustrated and disempowered by the inter-systemic values and barriers

and the subsequent time-consuming processes of gaining access to knowledge in order to provide adequate and coherent services. This came became clear during an interview with a nurse from city of 'B' who was employed at a project aiming to bridge psychiatric and drug treatment for patients in need of help from both systems:

Yes, it takes a hell of a lot of time [to gain access to and share information across the systems]. The problem is that we cannot see that each of us might have received consent [from the patient]. We often sit there, and you do not know if the person from the other system has the information you need. There is really no connection between the systems (Psychiatric nurse)

As suggested above, the nurse also articulates that collaboration and access to information between the three types of welfare systems can be disrupted by the protective use of the requirement of consent. In this sense, she points to a risk of disconnecting the systems, because one does not easily get the “*information that you need*” if the citizen has not given his or her consent to share information, as consent to share information is pivotal to regulating professionals’ or researchers’ access to information and collaboration with the systems’ representatives (Oute, 2017).

Given that our requests to retrieve formal information through the above-mentioned nurse could position her at risk of harm, a formal request to collaborate was directed to the management in order to understand their reasons for their above mentioned refusal. The formal request included the project protocol and specified procedures complying with legal requirements for patients’ consent, research ethical standards in the health field and information about data protection. In the request, we asked for access to collaborate with the psychiatric professionals as follows: 1) For psychiatric professionals to identify 8-10 patients fitting the inclusion criteria and ask them for their informed consent to access their records on

site, and 2) to interview professionals during working hours about their management of citizens.

Subsequently, we received a formal email from a local high-level manager, rejecting the possibility of collaborating and getting access to patient records in the system:

I have discussed the case with our lawyer. We cannot allow researchers to have access to the patients' electronic records. If you have received informed consent from the patient or a vicarious consent from the Danish Health Authority [which previously had the formal authority to grant legal access to retrieve information from records to be used in research projects] and a permit from the Danish Data Protection Agency, we can provide information from the patient's record. This requires that we know very specifically what information is needed. We can only provide information about the things to which the patient has specifically consented. (email correspondence, Psychiatric Manager)

This correspondence mirrors a common way of obstructing access that, on several occasions, was identified among psychiatric professionals at all of the three geographical sites. First, the fact that the manager “*discussed the case with [the] lawyer*” articulates a strategy of withdrawing information by referring to requirements set out in Danish Health Law (2016).

This protective strategy involves the manager proposing that the researchers must spend several months meeting a range of legal requirements about patients' consent and data protection in order to apply to the Danish Patient Safety Authority for vicarious consent (ibid.). Given that these requirements had already been addressed and met in the initial, formal request and in the protocol, the manager's claim is exacerbated by stating that “*we can only provide information about the things to which the patient has specifically consented*” and, thereby, rhetorically ignoring the request to provide help with identifying patients for the study. In doing so, the manager paradoxically limits the opportunity to gain access by

reasoning that they can neither allow researchers to have access to the patients' consent nor to their records, because the researchers have failed to apply for provision of "*information about the things to which the patient specifically has consented*". This raises the question as to why the manager withdrew the opportunity to get informed consent and thereby blocked our access to information. Several options seemed possible.

Do the manager's actions reflect a common psychiatric policy framing the outlook that control measures are needed in order to protect weak and vulnerable patients from the researcher, as pointed out in previous qualitative, psychiatric research (Juritzen et al., 2011)? Or, could the common perception of patients as being weak and vulnerable frame a value-laden understanding of a privileged administrative practice for professionals in which they uphold their legitimate position to regulate access to information on behalf of the patient (Hansen and Bjerger, 2017, Ness et al., 2014, Oute, 2017)? Or, do the manager's discretionary actions mirror an idealized way of being an alert and law-abiding civil servant who wants to emphasize patients' legal right to confidentiality and consent and, if so, why were the researchers not given the opportunity to ask patients for their consent? These questions were elucidated by a psychiatric professional who articulated some connections between the withdrawal of the citizens' consent and professionals' reasons for involving others:

Interviewer: *who decides the timing* [of involving others in psychiatric treatment]? *Is it you, your colleagues or the patient?*

Psychologist: *If it is possible, it is discussed with the patient. Based on what they describe, we evaluate it at our interdisciplinary conference in which psychiatrists, psychologists and nurses take part. Then, we decide what would be relevant right now. And then we make contact with their therapist if they are already in contact with*

the drug treatment centre. [...]. But of course, the citizen has to consent to us making contact, but when we have his/her consent, we try to figure out how their treatment is going and what they think.

Here, the psychologist talks about how the citizen's consent is seen as a requirement when the psychiatric professionals have decided that "it is relevant" to invite the drug treatment therapist to support the psychiatric treatment. The professionals relied on a protective interpretation of the requirement of the patients' consent that implied that the patient is required to accept or comply with the treatment plan as proposed by the professionals (cf. Oute, 2017). As indicated above, this protective approach suggests that the consent can be used as a regulatory strategy to ensure that professionals can withdraw information or not share it with others until the professionals consider information exchange and collaboration to be favorable and timely in relation to the psychiatric treatment plan. This example suggests that the aforementioned manager's response to our request to ask a small number of patients for their consent could have been framed by an equivalent custodial logic, where professionals see themselves as the experts who, without the involvement of the patient, are to decide if, when and how information exchange and collaboration is relevant. Thus, the combination of the legal requirement of the patient's consent and the professionals' protective values, arguably framed the professionals' subsequent requirement for the researchers to apply for a vicarious consent from the Danish Patient Safety Authority (and not the Danish Health Authority as stated in the above email from the manager). By contrast to the gatekeepers who sympathized with and favored inter-systemic and intra-systemic collaboration, the manager's proposal can be seen as a value-laden, yet meaningful strategy, not only to delay our access to information, but to entirely withhold information about the patients' mental health condition and professionals' practices. This, however, suggests that

the denial of access could have been framed by the fact that the researchers' interest in inter-systemic collaboration did not fit well with the custodial logic that was often identified at the entrance point to the psychiatric systems. Time and again, this access regulation strategy was used when professionals argued that they could not participate in collaboration with the researchers or with other systems' representatives because they lacked resources (e.g., lacked time or staff). In fact, this strategy was also emphasized in the final paragraph of the above mentioned email, where the manager from the psychiatric system blocked our access to ask patients for their informed consent. The manager did so by adding that getting informed consent from patients *"requires that we have the necessary resources to locate that information – and currently, that is somewhat difficult"*. As encountered in several other cases throughout the project, this manager's discourse implicitly neglects the possibility of collaborating about obtaining informed consent from patients to access their records, by making it clear that all of the above requires *"the necessary resources"*, which are currently unavailable.

In response to the manager's proposal, the researchers applied to the Danish Patient Safety Authority (a newly formed division of the former Danish Health Authority that now has the formal authority to grant legal access to retrieve information from records to be used in research projects) for a vicarious consent to access 15 patients' records for the purposes of the study on May 2nd 2017. After providing the Danish Patient Safety Authority with supplementary information about the target group and particular information sought for on August 8th 2017, the researchers received the following formal, email rejection of the application on December 12th 2017:

"Based on the present [application], the Danish Patient Safety Authority has decided that there is patient contact during the semi-structured interviews with the users. Therefore, there is a direct possibility to inform the patient about the project and to

let the patient consider if the patient is willing to consent to recorded information being provided for the purposes of the research project. The Danish Patient Safety Authority makes the assertion that oral information about the study should be supplied with short, written information [for layman] about the project, and that the involvement of the patients cannot be seen as a hindrance for the completion of the study.”

The rejection of the formal application to access information from patients’ records thus reflects a paradox. Whereas the Danish Patient Safety Authority seems to emphasize the ideal that patients themselves are given the opportunity to consent to participating and allowing the researchers to access their recorded information, the psychiatric professionals tend to emphasize the ideal of regulating access to the patients and their information using a protective strategy. This, paradoxically, not only suggests the requirement of informed consent is politically idealized but is also suggests that intra-systemic, professional values frame how professionals often limit researchers’ and others’ possibilities of attaining patients’ consent to access their information.

However, this strategy emerged in a variety of both formal as well as informal ways across several geographical and institutional sites during the fieldwork. For example, one psychiatrist from site ‘B’ explained that *“I figure that my time is best used treating patients’ illnesses rather than talking to teachers and case workers in the municipality”* (Psychiatrist, field note, March 2017). Similarly, when we discussed the early stages of our negotiation about access to citizens’ records in site ‘A’, the fieldworkers were told that *“There was too much going on and we did not have the time”* (Case worker, field note, August, 2016). During the fieldwork, our informants from the regional psychiatry service at site ‘A’ and ‘B’ also provided some evidence that they encountered similar articulations. For instance, a middle manager from a drug treatment setting kept telling the researcher that *“it is impossible to*

dance [i.e. a metaphor for collaboration] *with people from psychiatry – everybody knows that they are busy doing their own thing*” (field note, April 2016). Similar articulations also emerged throughout a range of meetings and interviews in the same settings. By using equivalent descriptors, such as “*rigidity*”, the informants referred to a widespread belief that their social tango was characterized by a lack of reciprocity which previously has been described as a lack of conceptual common ground in dual diagnosis research (Davidson and White, 2007). By doing so, the informants suggested that psychiatric professionals use the argument of ‘no resources’ as a means to withdraw information and disrupt collaboration between drug treatment and psychiatry. Similarly, a frustrated portrayal of delay arrangements and arguments of no resources were also presented by a social worker from the regional psychiatry department, who stated that “*it is really difficult to work with [some] drug treatment-oriented housing facilities, as we are told to wait if they say that they have no available places right now. Then, we have to keep patients here for a long time, because we cannot just put them out on the street after a long treatment period.*” (field note, August, 2016). This suggests that these strategies are used, not only in psychiatric institutions but across several of the welfare systems that we entered during the study. Repeatedly, the strategy of referring to there being “no necessary resources available” was experienced after we had gained formal access to a given centre: the most time consuming experiences were in city of ‘B’. The research team had quickly gained access to a centre, because two of the researchers had previously worked with the manager and co-manager. The managers expressed their sympathy towards the research project. As part of the project, the employees at the centre had promised to help identify users for interviews and ask them for their consent to read these users’ individual records. But, despite the fact that immediate formal access was provided, it took us more than a year of frequently visiting and contacting the centre to follow up on the process. Although users were regularly absent from their appointments with

professionals, the employees argued that there was “*scarce time*” to identify the citizens and that meant that the researchers were only put in contact with five users. This suggests that “going an extra mile” for someone and adding to their workload by helping researchers was not a priority within the professional framework of a busy working day. On the one hand, this suggests that the professionals were working hard to provide timely services to citizens and that the professionals experienced that they had limited resources available for them to participate and collaborate with the researchers and others. On the other hand, this also brings to the fore that the very notion of limited resources is often used as regulatory strategy. The professionals’ use of this strategy suggests that it reduces the interference of others in their work and diminishes use of collaborative measures that are not immediately favorable for the professionals despite collaboration being considered a virtue in order to close systemic gaps, share knowledge and provide more coherent and tailored services to citizens with complex problems.

Discussion and concluding remarks

This article shows how gatekeepers’ ways of regulating the researchers’ access to knowledge in/about particular types of care services reflect regulatory strategies that professionals and citizens themselves experience in the daily workings of the systems. As pointed to, this is hardly breaking news as field workers’ relations to informants and gatekeeping are common topics in ethnographic research (Bondy, 2012, Reeves, 2010). However, this article’s contribution is twofold. First, it adds to the literature by analyzing how our first hand experiences of trying to gain access to information and data provided us with important insights in relation to understanding the nature of our object of study: professionals’ and users’ experiences of the bureaucratic management of citizens with complex problems. Second, it also contributes to ethnographic work on gatekeeping and field relations by casting

light on how certain political and professional values underpin access to care services. But in spite of the similarities between the political and professional frameworks, constitutive of our access to the same services, it is important to bear in mind that there is, at least, one important difference between our experiences and those of our informants. That is, of course, that we were allowed access to the field based on their sympathy, good will and interest in the project, whereas citizens with complex problems and professionals have legal rights to support and information. Another difference is that consequences of being subjected to regulatory strategies such as queuing, time regulation and information withdrawal included more work, frustrations, revising our time line etc., and the possibility that we would have had to give up our project, had we not been met with sympathy and interest from most of our informants. As suggested above, the consequences of being subjected to regulatory strategies as a citizen with complex problems can potentially be much more dramatic and devastating, resulting from the incapacity of the systems to provide timely access to tailored help, professionals' lack of awareness about available resources for support, and/or willingness to provide help and support due to stereotypes or protective attitudes towards the citizen (Møller and Harrits, 2013, Jensen, 2015, Brodtkin, 1997, Lipsky, 2010, Van Maanen, 1978, Gubrium and Holstein, 2001).

Although the use of regulatory strategies seems to be a generic trait of welfare organizations, our study contributed to this literature by elucidating a common distinction about the conditionality of accessibility and regulation in the care organizations involved. This distinction refers to how access to knowledge and service provision is conditioned not only by the divergent political ideologies across the welfare systems but also by the, at times, conflicting values and understandings of the citizens which, in part, are shaped by our or the professionals' social background and professional socialization (*habitus*) (cf. Bourdieu, 1986). For example, employees in the medically dominated psychiatric field could be

reluctant to invite social scientists, because psychiatric professionals' lack of conceptual common ground between medical and ethnographic research could underpin misunderstandings of the possible purpose and use of the research project (Davidson and White, 2007). Moreover, the ideals for ethically sound research in medical fields (particularly psychiatry) also rely heavily on the long-standing paternalistic view of patients as weak and inept in conjunction with the legal-ethical requirement that participants must be considered in a proper state of mind to be able to make a valid consent to partake in a medical trial (Oute, 2017). This differs from the more processual and reflexive nature of ethnographic research ethics, including the ideals of listening to marginalized individuals' voices (Hoeyer et al., 2005). In this respect, our research practice and attempts to gain access could be interpreted as unethical from a medical point of view. In line with previous research, this suggests why medical ethics were used to justify regulation of access to information in the psychiatric field (Hoeyer, 2007). Yet, it also seems feasible that the managers' knowledge about previous social studies in psychiatry and previous researchers' unethical conduct simply could have caused mistrust and suspicion about the research agenda. This could have led to the decision to block our access in order to avoid the risk of having their already socially contested professional practices being the subject of critique. By contrast, some of our failed attempts to get access were experienced while trying to access the employment and drug treatment services. Especially, we experienced a higher degree of success in our efforts to enter the municipal drug treatment systems. Historically, the drug field has been open to social researchers. Our process of gaining access perhaps also signals an alignment between the professionals' relational approach and good interpersonal relations between the researchers and the gatekeepers. In relation to the employment system, we experienced a similar interest in our project and much openness towards helping us to gain access amongst the professionals. However, a rather bureaucratic and strict legal set up of this system (due to

economic sanctions) at the systemic level, made access to some types of information difficult. Altogether, trust, shared goals and sympathy seemed to be key to our process of getting access. However, the “good will” of many of our informants was sometimes hindered by the systemic setup of the different systems. Despite principles of neutrality, equal rights and access to services in welfare systems (Weber et al., 2013), our experiences thus tend to support research within bureaucratic and care organizations, which points to interpersonal relations, sympathy, dislikes, norms and values etc. heavily influencing timely access to services, tailored information and support. Yet, this seemingly trivial insight calls into question whether, how or to what extent the informal values and personal preferences that often inform street-level bureaucrats’ discretionary actions might outweigh political requirements and users’ legal rights in care organizations? If so, how do professionals’ discretionary actions align with practices that support recovery in citizens with complex problems? This article thus suggests that there is a need to develop a deeper understanding of how professionals and citizens with complex problems work creatively to balance personal or professional values with the need to meet diverging requirements at the thresholds of the systems. This implies that more research is needed to get a clearer picture of the kind of work in which citizens and professionals actively engage in order to gain access to or provide timely and tailored help to other kinds of citizens such as individuals with co-occurring mental health and substance use problems or socially marginalized minorities.

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