Frontline Workers at the Intersection of Welfare, Labour and Health: Re-Integrating users with Severe Health Problems in the Labour Market

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Sammendrag

Et av hovedmålene i norsk aktiveringspolitikk er å integrere brukere med helseproblemer i arbeidsmarkedet. Veilederne ved Arbeid- og velferdsaetatens (NAV) lokale kontorer er viktige aktører for å oppnå målene. Avhandlingen undersøker hvordan disse frontlinjearbeiderne reflekterer over sitt arbeid med å reintegrere brukere med alvorlige helseproblemer i arbeidsmarkedet. Det er mange faktorer som kan tenkes å påvirke hvordan frontlinjearbeidere jobber med sine brukere, f.eks. deres fagbakgrunn, personlighet og tilgang på ressurser. Denne avhandlingen ser på hvordan mer overordnede institusjonelle logikker setter seg igjennom frontlinjearbeidernes måte å forstå og begrunne arbeidet sitt.

Avhandlingen bygger på data fra åtte fokusgruppeintervjuer utført ved forskjellige lokale NAV-kontorer. I intervjuene ble frontlinjearbeiderne presentert en vignett som skildret en bruker med traumatisk hodeskade. Vignetten gav blant annet informasjon om medisinske vurdering og evaluering av brukerens fysiske tilstand, samt informasjon om sosiale aspekter knyttet til brukerens ambisjoner, motivasjon og familieliv. Avhandlingens analyser trekker på institusjonell teori, herunder teorier om aktørers «institusjonell arbeid», og teorier om utøvelse av skjønn. Disse perspektivene blir brukt for å undersøke de institusjonelle rammene som påvirker fronlinjearbeidernes refleksjon om deres arbeid.

Avhandlingen består av tre artikler. Den første artikkelen identifiserer en dominerende logikk i NAV som vektlegger arbeidsmuligheter framfor hindringer for å delta i arbeidslivet, og forstår arbelidslivsdeltakelse som grunnleggende positivt for helsen. Analysen av frontlinjearbeidernes overveielser viser at det de utfører, er det et institusjonelt arbeid hvis formål er å «eksternalisere» denne logikken til fastlegene, dvs. få dem til å overta denne forståelsesrammen. Den andre artikkelen utforsker hvordan frontlinjearbeiderne beskriver og reflekterer over arbeidet med å motivere umotiverte brukere, og dermed få dem inn i en prosess i retningen tilbake mot arbeidsmarkedet. Det identifiseres tre dialogorienterte strategier – «mulighetsprat», «arbeidsprat» og «identitetsprat», med mål om å styrke brukeres motivasjon. Den tredje artikkelen ser på frontlinjearbeidernes skjønnsmessige begrunnelser for sine tilnærminger til brukere med alvorlige helseproblemer. Analysen fokuserer på argumentasjonen som frontlinjearbeiderne bruker for å støtte sine resonnementer om hvilke tiltak som best sikrer en brukers retur til arbeidsmarkedet. Artikkelen viser at argumentasjonen som brukes av frontlinjearbeiderne i de forskjellige fokusgruppene, er ganske lik og at denne likheten kan være grunnet i at frontlinjearbeiderne trekker på den

samme institusjonelle logikken, karakterisert ved en mulighets- og arbeidsorientert tilnærming.

Avhandlingen bygger videre på tidligere forskning på frontlinjearbeideres tilnærming til brukere på tre måter. For det første, mye tidligere forskning gjelder andre brukergrupper, som f.eks. personer med langtidsfravær fra arbeidslivet og sosialklienter. Avhandlingen fokuserer på brukere med store helseproblemer forårsaket av traume, for å utforske fronlinjearbeidernes forståelser av sitt arbeid med slike brukere. For det andre bruker avhandlingen institusjonell teori som et verktøy til å utforske hvordan frontlinjearbeiderne reflekterer over sitt arbeid. Bruken av institusjonell teori gir en tilgang til å identifisere sentrale premisser som frontlinjearbeidernes refleksjoner baserer seg på, som f.eks. at arbeid er helfremmende selv for de med alvorlige helseproblemer. For det tredje utforskes hvordan institusjonelle logikker kan sies å virke inn på frontlinjearbeidernes resonnementer. Dette gjøres gjennom å analysere argumentene som støtter resonnementene deres rundt en brukers prosess i retningen tilbake mot arbeidsmarkedet.

Summary

Norwegian activation policy towards users with health problems aims at re-integrating users into the labour market. The local offices of the Norwegian Labour and Welfare Administration (NAV) are the main agencies tasked with implementing activation policy. The thesis' investigates how the frontline workers reflect on their work of re-integrating users with severe health problems in the labour market. There are several factors which could influence how the frontline workers go about their work, such as profession, personality and access to resources. This thesis attempts to explore the institutional logics' influence on the frontline workers' reflection about their work.

The thesis draws on data from focus group interviews performed at eight local NAV offices where the frontline workers are presented with a vignette depicting a fictitious case. The vignette depicts a user who has suffered a traumatic brain injury, providing information regarding health-care workers' assessments and evaluations of his condition, as well as information on social aspects such as family ties, aspirations and motivation. The analyses draws on institutional theory, in particular the perspective of institutional logics, combined with a theoretical approach to discretion, to explore the institutional influences of the frontline workers' reflections on their work.

The body of the dissertation consists of three articles. The first article identifies a dominant logic in NAV that emphasizes work opportunities, rather than hindrances to participation, and work regarded as conducive to health promotion and well-being, termed an 'asset model' of activation. The analysis of the frontline workers reflections show that they are performing institutional work aimed at externalizing the logic to the general practitioners (GPs). The second article explores how the frontline workers describe their work with motivating unmotivated users to embark on a return to work process. The article identifies three strategies termed 'opportunity talk', 'work talk' and 'identity talk' due to their reliance on dialogue with the users. The third article explores the discretionary reasoning which the frontline workers exhibit when they reason about measures that can enable return to work, analysing the argumentation which supports the reasoning. The article finds that the reasoning exhibited in the focus group discussions are similar across the offices represented in the study, and argues that the supporting argumentation draws on an institutional logic characterized by an opportunity oriented and employability enhancing approach.

The thesis expands on previous research on frontline workers' approach in three ways. First, as much of the earlier research tends to focus on hard-to-employ users and social clients, this thesis addresses users with severe health problems, caused by trauma. The focus on users with severe health problems allows for exploration of the frontline workers understanding of their work aimed at such users. Second, this thesis draws on institutional theory and concepts as a means to explore how the frontline workers reflect on their work. This use of institutional theory allows for the identification of central principles supporting the frontline workers argumentation, such as an understanding of work as beneficial to health despite hindrances. Third, the influence of an institutional logic on the frontline workers reflections is explored. The influence is explored through analysing the arguments which supports their reasoning on a user's return to work process.

Contents

Article 1

Håvold, OKS., Harsløf, I., Alm Andreassen, T. (2017). Externalizing an ‘Asset model’ of Activation: Creative Institutional Work by Frontline Workers in the Norwegian Labour and Welfare Service. *Social Policy & Administration, 52: 178-196*. Doi:10.1111/spol.12305

Article 2

Håvold, OKS. (2018). Opportunity talk, work talk and identity talk: motivating strategies used by the Norwegian labour and welfare offices, *Nordic Social Work Research*, 8:2, 158-170

Article 3

Håvold, OKS (revising). All Roads lead to Rome: Discretionary Reasoning on Medically Objective Injuries at the Norwegian Labour and Welfare Offices. *Professions and Professionalism*. Submitted 27.09.2017 (revised and resubmitted 08.06.2018)

Introduction

An active approach to people with health problems has been a part of the Norwegian Active Labour Market Policies (ALMP) since the early 1960s. The ALMP introduced comprehensive vocational rehabilitation measures and a parallel launch of relatively generous permanent disability benefits (Terum and Jessen 2015, Terum and Hatland 2013, Dropping, Hvinden, and Van Oorschot 2000). The 1990s re-affirmed the active approach towards people with health problems in the white paper on occupational rehabilitation (White paper 39 1991-1992) which coined the term 'work approach' (arbeidslinja). The aim of this approach was to counter the rising number of people who were outside the labour market as the result of what was conceived of as 'medicalization' of social problems (White paper 39 1991-1992, 8-9).

The work approach is an overarching approach to social policy that focuses on having as large a proportion of the working age population employed. This approach includes integration, retention and re-integration into the labour market, as well as incentives to keep people working longer. The activation policy in Norway focuses on the co-responsibility of benefit claimants to gain employment and qualify for labour-market participation, and as such is a part of the work approach. As part of the activation policy in Norway, temporary benefits are provided on the condition that recipients partake in treatment or measures aimed at gaining employment. These measures are aimed at identifying residual work capability and helping people to use it (Bay, Hagelund, and Hatland 2015, 31-33). The frontline workers at the Norwegian Labour and Welfare Administration (NAV) are the agents tasked with making (or commissioning) work capability assessments of users with severe health problems. When making such assessments, the frontline workers are operating at the intersection between the health care sector and the labour and welfare sector.

Despite a continuing tightening of the work approach throughout the 1990s and 2000s, there was an increase in the proportion of people receiving health related benefits relative to the proportion of people receiving other benefits. Hence, while the employment rate in Norway in the 2000s has remained relatively stable, the number of people on health related benefits has risen (Bay, Hagelund, and Hatland 2015, Kalstø and Galaasen 2015). This development has been a cause of concern for policy-makers, as eventually people on health related benefits are more prone to become permanently excluded from the labour market (Terum and Hatland 2013, 14-15). Consecutive governments have attempted to counter this development through a number of initiatives.

Among these initiatives was the establishment of NAV in 2006, replacing two independently working state bodies (employment and national insurance) and parts of the municipal social services. The new agency launched a change in the manner in which issues of poor health are approached. From focusing on people's limitations, the explicit intention of NAV is to focus on their opportunities (Christensen 2008, 50, Parlament Proposal 46 2004-2005, 74). The main goal of the reform was to get more people active and off passive benefits, while creating a system that was easier to navigate and more user-oriented and efficient welfare system (Alm Andreassen and Aars 2015).

At the local level, the reform involved the creation of new local NAV offices in line with a 'one-stop-shop' thinking, designed to deal with a large variety of claimants (Askim et al. 2011). The frontline workers at NAV are the face of the intensified activation policy. However, the authority that makes decisions about who is to be granted health related benefits is placed at the Regional Insurance Administration Units.

Ágota and Balázs (2013) find that Norwegian policy has followed the OECD general recommendations of reducing the generosity of cash benefits and increasing incentives for labour market participation. They argue that the implementation of these policies at the local level is poor.

In order for a user to be granted health related benefits a work capability assessment has to conclude that there is a reduction in work capability in excess of 50% due to sickness, injury or congenital defects (NAV 2015). The completion of a work capability assessment requires several pieces of information, such as medical information, documentation of work experience and skills, an assessment of the user's social and economic situation and the user's motivations and aspirations (NAV 2015). A completed work capability assessment is necessary for both access to benefits, as well as the creation of an activity plan, containing measures aimed at re-integrating the user into the labour market. If the frontline workers assess that the user has residual work capability they are to draw on their knowledge of the labour market to locate opportunities for future employment, and use relevant measures to re-integrate the user into the labour market. Thus, the frontline workers are to take into consideration information from three sources. First, each user's situation, problems and opportunities. Second, information and treatment from the health care sector. Third, opportunities available in the labour market. This entails that the frontline workers need to relate to health services and thus operate at the intersection of welfare, labour and health.

Motivation of the study

This PhD-project is a part of the larger overarching project 'Transitions in Rehabilitations: Biographical Reconstruction, Experiential Knowledge and Professional Expertise'[1]. The 'Transitions' project uses the cases of patients with traumatic brain injury (TBI) and multi-trauma to examine transitions in the lives of the injured individuals, transitions in their rehabilitation processes between different parts of the health care, labour and welfare services. The three PhD projects in the 'Transitions' project pertain to the role of expertise and experiences in the reconstruction of life with an impaired body, experiential and professional knowledge in interdisciplinary rehabilitation and this current thesis based on the conceptualizations of 'work' and 'health' in the health sector and labour and welfare sector and their implications for inter-sectorial transitions.

The 'Transitions' project focuses on those with severe health problems caused by trauma exemplified by TBI and multitrauma. Such trauma is indicated by a sudden incident with the need for a long and complex rehabilitation process (Andelic et al. 2009). Rehabilitation involves various health and welfare services and professions, crossing organizational and disciplinary borders, requiring interorganisational and interprofessional coordination and collaboration (Wade and de Jong 2000). Charmaz (1983) finds that individuals who experience chronic illness lose motivation and hope. The users, which the frontline workers are to re-integrate into work, may need additional support to motivate them to embark upon the process of returning to work in the wake of a traumatic injury. About 250 users received work assessment allowance for traumatic injuries in 2017 (NAV 2017). The motivation for the study is thus to explore the frontline workers work of supporting users with severe health problems to embark on the process of returning to work.

Research question

The purpose of this thesis is to explore the understandings of the frontline workers at NAV's approach to re-integrating users with severe health problems into the labour market. The thesis examines the frontline workers' reflections on how to approach the cases involving users with severe health problems, and the health care sector, in particular the general

[1] The Transitions project is funded by the Norwegian Research Council, project number 229082.

practitioners (GPs). The frontline workers' position at the intersection of welfare, labour and health informs the research question. The research question is therefore formulated as:

> *How do the frontline workers at NAV reflect on their work involving users with severe health problems at the intersection of the labour and welfare sector and health care sector?*

Further, there are three aspects, which this thesis aims to illuminates in order to explore the overall research question. These three aspects of the frontline workers work are explored in the articles which constitute the main body of this thesis. First, the frontline workers depend on medical information in assessing the users work capability; this is particularly important when working with users with severe health problems. Second, surviving severe injuries, in particular TBI, may result in a lack of motivation for embarking on a lengthy process aimed at returning to work. Third, the frontline workers exercise discretion in their handling of the cases; here discretion is understood as the way in which the frontline workers argue for their suggested courses of action. These three aspects relating to the frontline workers' reflections and work with re-integrating users with severe health problems lead to these three sub-questions:

> *1. How do the frontline workers relate to the adjacent medical field in order to support users with sever health problems back into the labour market?*
>
> *2. How do frontline workers motivate users with severe health problems to embark on a return to work process?*
>
> *3. How do the frontline workers reason when they argue in support of their suggested course of action to re-integrate users with severe health problems into the labour market?*

This thesis draws on the theory of institutional logic (Thornton, Ocasio, and Lounsbury 2012, Thornton and Ocasio 2008). This theory is summarized in the following quote:

> Perhaps the core assumption of the institutional logics approach is that the interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics. Decisions and outcomes are a result of the interplay between individual agency and institutional structure. While individual and organizational actors may seek power, status, and economic advantage, the means and

> ends of their interests and agency are both enabled and constrained by prevailing institutional logics. (Thornton and Ocasio 2008, 103)

A dominant institutional logic legitimizes actions within a field as proper, or correct (Scott 2014, Thornton, Ocasio, and Lounsbury 2012). Hence, in the local labour and welfare office, an institutional logic offers the frontline workers legitimate solutions to problems through institutionalized knowledge. Institutionalized knowledge refers to knowledge that the frontline workers draw on in order to perceive the world. Institutionalized knowledge is generalizable knowledge perceived as an objective fact. In other words, it is knowledge that is taken for granted which creates a lens through which a social actor perceives the world.

The main body of the thesis: The three articles

The main body of the thesis consists of three articles that combined address the overall research question, by each answering one of the sub-questions. The articles are termed Article 1, Article 2 and Article 3 corresponding to the numbers here presented.

1. Externalizing an 'Asset model' of Activation: Creative Institutional Work by Frontline Workers in the Norwegian Labour and Welfare Service.

2. Opportunity talk, work talk and identity talk: motivating strategies used by the Norwegian labour and welfare offices.

3. All Roads Lead to Rome: Discretionary Reasoning on Medically Objective Injuries at the Norwegian Labour and Welfare Offices.

The articles draw on the same set of data, focusing on different thematic aspects of it. The thesis research design combines focus group and the vignette approach to investigate the institutional logic that underpins the frontline workers' work. The data came from eight focus group interviews held at the local NAV offices. The focus groups had from 2-5 participants, with a total of 27 participants. Each focus group was presented with a vignette depicting a TBI patient, a 34-year-old carpenter, and contained information on health problems, work experience and motivation and social aspects relating to family and network. The constructed vignette had two aims, first to start discussions on how to approach and deal with the character from the vignette, second to allow for justification and specification of the

institutional logic supporting the frontline workers' understanding of activation policy in the Norwegian context.

Article 1 explores how the frontline workers approach and work with GPs, in order to facilitate a better flow of medical information on their users. This article draws on the institutional work perspective which understands institutional work as the 'purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions' (Lawrence and Suddaby 2006, 215). In the article we argue that although the new activation policy is not theirs to develop, in order to bring about changes in practice, 'creating' institutional work by the frontline workers is required. Four forms of 'creating' institutional work is identified that is undertaken by the frontline workers: 'defining' – enacting legislation and regulation in relation to GPs; 'constructing normative networks' – creating a more collaborative relationship with the GPs; 'educating' – teaching the GPs about the rules and regulations, and the opportunities and assistive measures they can offer to the injured; and thereby also 'changing normative associations' of GPs towards the activation policy.

Article 2 explores what the frontline workers say about how they attempt to motivate unmotivated users to embark on a return to work process. The second article draws on the perspective of 'schema' (the learned way of solving specific problems (Thornton, Ocasio, and Lounsbury 2012, 85-91)) to analyse the strategies for motivating users to embark on a return to work process. The article identifies three strategies aimed at motivating unmotivated users, arguing that these strategies are part of a schema. The article indicates that these strategies draw on learned ways for the frontline workers to understand their role. Further, the article argues that these strategies relate to an understanding of work as beneficial to health and well-being.

Article 3 explores the reasoning process that the frontline workers engage in when considering the options best suited for the vignette character's re-integration into the labour market, considering his health problems. The third article relies on a combination of institutional logics perspective, and a theoretical perspective on the epistemic dimension of discretion (Molander 2016). The reasoning exhibited by the frontline workers is analysed with a particular focus on the arguments which support the suggested courses of action. The findings indicate that the frontline workers identify and understand the problems in a similar way, and for the most part utilize similar arguments when suggesting courses of action.

The structure of the thesis

The structure of the thesis is as follows. The following section, section two, focuses on the background of the thesis, both the activation policy and previous research relating to the frontline workers. Section three introduces the theories that this thesis applies, as well as further exploring important concepts on which the thesis is based. Section four presents the methods used in the thesis, and how these were applied as well as their limitations and generalizability and ethical considerations. The fifth section summarises the three articles, while the sixth section discusses the findings of the articles in light of the background and theoretical framework. The seventh section is the conclusion where the research question is answered. The appendices comprise of the vignette (Appendix A), the interview guide (Appendix B), the acknowledgement of received notice on the empirical data collection and storage by NSD (Appendix C), as well as the letters and information sent to NAV (Appendix D).

Background

The purpose of this background section is to describe the social political context in which the NAV fronline workers operate. First, there is a brief introduction to Active Labour Market Policies (ALMP) in the Nordic countries, which draws on previous research relating to the frontline workers at NAV. I conclude with a summary.

Active Labour Market Policies and Activation Policies in the Nordic Countries

The modern Nordic welfare states began developing in the aftermath of the Second World War, introducing active labour market policies (ALMP) with the aim of securing full employment (Bonoli 2010). By comparative standards, these welfare states are characterized by universal social security coverage, generous benefits and wide-ranging services offered by the state or local government (Bonoli 2010, Dahl, Drøpping, and Lødemel 2001). According to Giddens (2006), the similarities between the Nordic countries stem from a historical egalitarianism that seems to have made Nordic populations more ready to accept high taxation for the funding of comprehensive welfare states.

ALMP may concern vocational training, incentives for workers or stimulating job creation, workplace accommodation or incentives for employers (Stjernø, Jessen, and Johannessen 2014, Bonoli 2010, Swenson 2002). Sweden was the first Nordic state to enact such policies in the early 1950s followed by Norway in the 1960s (Swenson 2002, Dahl, Drøpping, and Lødemel 2001). Bonoli (2010) argues that Denmark did not embrace ALMP fully in the aftermath of the Second World War, which accordingly led to Denmark adopting activation policies earlier than the other Nordic countries.

There were an increasing number of people on disability benefit in Norway in the 1980s. As a response, Norwegian policy makers have tried to curb this trend by tightening the eligibility criteria. Throughout the 1990s, medical criteria were tightened and people applying for disability benefit who were able to work were required to be geographically and occupationally mobile in searching for jobs. The revival of the 'work approach' in Norway in the 1990s strengthened the focus on work as part of welfare benefits and services (Dahl, Drøpping, and Lødemel 2001). This 'turn' to activation as it has become known, was arguably only a correction in the course taken rather than a ground-breaking innovation (Halvorsen and

Jensen 2004). According to Hatland, Kuhnle, and Romøren (1996) the 'work approach' was a reaffirmation of the ideas embedded in the social insurance act of 1967, where disability benefit was only an option if occupational rehabilitation had been tried. While ALMP was mostly geared towards the unemployed, activation policy targets more groups such as those on health related benefits (Bay, Hagelund, and Hatland 2015, 31-33). The introduction of activation policies in the Nordic countries was part of an international trend (Daguerre 2007).

Central to activation reforms is that cash benefits are made contingent upon the service user's activity. Eichhorst, Kaufmann, and Konle-Seidl (2008) divide activation policy approaches into two categories: restrictive and supportive. A restrictive approach aims to tighten eligibility criteria in order to reduce the number of people that receive benefits, while a supportive approach aims to increase the number of people returning to work by strengthening their skills and qualifications. The activation policy of Norway mirrors policies in the other Nordic countries as it involves mandatory activation programs in return for financial support (Bengtsson 2014, Thorén 2008, Johansson and Hvinden 2007). Norway arguably uses an approach that supports users; the frontline workers' focus is on removing hindrances (Gjersøe 2016a). However, throughout the 1990s and early 2000s, Norway has seen an increase in conditionality (Harsløf 2008).

The tightening of the eligibility criteria for receiving health benefits in Norway over the past two decades has impacted the context in which the frontline workers operate. In 2004, a temporary 1-4 year disability pension scheme was introduced. With the introduction of the Work Clarification benefit in 2010, this scheme was abolished. The introduction of a temporary disability scheme was particularly motivated by the intention to counter the rising number of people entering the ranks of recipients on permanent disability based on what was conceived of as 'diffuse illnesses' diagnoses (Harsløf 2008).

In 2004, the 'sickness certificate' was replaced with a 'sick note'. GPs no longer had the authority to certify incapability to work, but only to describe health problems (Damberg 2009, 140). In addition, GPs were obliged to report specifically on their patients 'work capability' when they issued a sick note (Damberg 2009, Hammer and Øverbye 2006). The replacement of the 'sickness certificate' with a 'sick note' implies a change in both the power of the frontline workers, as well as in the purpose and rationale guiding their work. This change means that in an assessment of a user's capability to work, the frontline workers make the final decision, rather than the GPs.

The 2005 NAV reform resembles the post-new public management reforms in the other Nordic countries in that it aims to create one-stop shops which deal with a variety of labour and welfare related issues (Jantz, Christensen, and Lægreid 2015, Christensen, Fimreite, and Lægreid 2014). The local NAV offices are the one-stop shops tasked with implementing activation policy. The frontline workers main task is to implement the policy in such a way that they promote the re-integration of users into the labour market. According to Alm Andreassen and Aars (2015) the creation of NAV was in part motivated by the issue of users becoming stuck in the system. The National Insurance Agency may have perceived the users as too healthy to receive benefits, while the National Employment Service viewed them as too sick to work. The intention was that the new organization was to be more user oriented, approaching the users holistically, and consequently reducing the number of users stuck in the system. However, with the establishment of the Regional Insurance Agencies, the separation between employment and National insurance was re-established. The re-establishment of services reduced the frontline workers' influence over decisions relating to benefit claims by users.

The year 2010 brought two significant changes in the approach towards health benefits. First, an expert group re-conceptualized labour market participation as beneficial to health and wellbeing (Ekspertgruppen 2010). The idea behind the re-conceptualization was that full health, in most cases was neither sufficient, nor a necessary requirement for the capability to work (Tengland 2011, Nordenfelt 2008). Second, the temporary disability pension scheme, along with the rehabilitation allowance and the occupational rehabilitation allowance was replaced with the work assessment allowance. The work assessment allowance involved activity plans and required active participation on the part of the recipient. Replacing all three benefits with the work assessment allowance meant that all the benefits were subjected to an equal demand for active participation on the part of the user. The main criterion for granting the work assessment allowance can be found in the National Insurance Act § 11-5 , stating that there must be an injury, illness or defect. In other words, to be granted the work assessment allowance, a user requires a diagnosis.

Research on the frontline workers at NAV

Earlier research on frontline workers at NAV has looked at different groups of employees regarding their educational/professional background, position in the organization, as well as

the types of users they work with or the kinds of programmes and tools they administer. The research that was oriented towards the organization indicates that there was a shift in logic taking place at NAV from one that emphasises income-securing and bureaucratic regulations to one characterized by employment, professionalism and labour market opportunities (Alm Andreassen and Fossestøl 2014, Helgøy, Kildal, and Nilssen 2011, Hvinden 2008).

Helgøy, Kildal, and Nilssen (2013) analysed whether frontline workers at NAV are moving towards a common basis for the occupational role at the local NAV offices. The original idea of a generalist role has been difficult to successfully implement, which has led to (re)specialization of work at the local offices. Despite the inability to create a common generalist role for the frontline workers at the local offices, there is a common understanding of the goals of the reform that established NAV. However, Helgøy, Kildal, and Nilssen (2013) find that the implementation of tools used in all the local offices, such as work capability assessment and activity plans, have been instrumental in creating a stronger focus on the work approach and activation of users. Thus, the frontline workers have developed a common understanding of the goal, and a role focused on work

Røysum (2013) investigated social workers' understanding of their role towards the recipients of social assistance in the initial phase of the establishment of NAV. The data was collected in 2008 at different local offices and a conference for social workers. She describes how the social workers expressed concern about the increasing pressure to do administrative casework and reach standardised goals. This pressure lead the social workers towards 'one way of thinking', with increased standardization and less professional autonomy leading to less time for comprehensive follow-up of users. Further, she argues that this standardization may be a threat to the professional basis of social work. Alm Andreassen and Aars (2015) show that there were two important aspects in the establishment of NAV which led to the re-specialization in local offices. First, the Regional Insurance Administration Units that administered benefits were established without sufficient supporting infrastructure. Second, the establishment coincided with the financial crisis of 2008-2009. These two aspects led to focusing resources on handling cases related to benefits in order to reduce an increasing backlog, putting the development processes at the local offices on hold.

Fossestøl, Breit, and Borg (2016) found that the leaders at the local offices are developing a common role for the social workers in some offices. However, the role is not necessarily the same among all the offices, as some focus on social work competencies, while others ignore these.

According to Fossestøl et al. (2015) there are conflicting demands at the local NAV offices. They argue that these conflicts stem from two logics. First a NPM logic which focuses on a single purpose organization characterized by an emphasis on labour market participation and standardization of services. Second, a post-NPM logic which is multipurpose characterized by a focus on income security and labour market participation as well as individualization of services with coordinated and comprehensive assistance.

Malmberg-Heimonen et al. (2015) found that among frontline workers in the Qualification Program (QP), a centrally initiated training program increased the frontline workers' subjective competence and mastery in performing their work. Among the factors which Malmberg-Heimonen (2015) found as a possible explanation for this perception of increased competence among those in the QP were extended follow-up in the period after the training combined with being allowed to adapt what they had learned to local needs. Such centrally initiated measures also increased QP users' participation in the labour market. While the measures had little to no effect on full-time employment, they found that it had significant effect on the part time employment of the users involved. These findings indicate that such centrally initiated actions have a measurable effect on the delivery of services by the frontline workers providing they are allowed to adapt the information to the realities of their work in a local office.

Solvang (2017) explored how the social workers at NAV are tailoring measures to users receiving social benefits in the QP. Solvang identified two different discretionary approaches to tailoring measures for long-term recipients: the employability enhancing approach and the needs oriented approach. The employability enhancing approach attempts to personalise suitable activation measures in terms of feasible employment strategies, while the needs oriented approach focuses on personal needs and challenges as the basis for setting goals and appropriate activation measures. She argues that the frontline workers' focus on the employability enhancing approach may obscure challenges, while a one sided focus on the needs oriented approach overlooks potential capability to work. She argues that the objectives which are in activation policies are set as premises forcing the users into pre-existing institutional frameworks which are far beyond the control of the social workers. Solvang's findings imply that there is room for discretion among the social workers in the QP. Although Solvang (2017) studies the QP and the social workers' approach, the findings of pre-existing institutional frameworks which guides discretion is of importance for this thesis, as these frameworks exist across the organization, and not only within the QP.

Alm Andreassen and Fossestøl (2014) explore how the development of policy relating to work and work inclusion has led to a new logic. The new logic challenges the established logic at NAV, the labour market and in the health care sector. The analysis is based on data from a case study from 2007 to 2010 in which they find that those working in the field appear to be unaware that activity is beneficial for those that are ill. While the policy in the field requires parallel intervention towards users, all the fields involved are challenged by the new logic introduced through the policy, resulting in sequential interventions towards users. Alm Andreassen and Fossestøl (2014) demonstrate that the understanding that is dominant in the field is being challenged by new policies, such as the focus on assessing the capability to work rather than the illness or disability.

In a comparative study by Gjersøe (2016b) looking at the work capability assessment of Norway and the UK, she finds a shift in the decision making models in these countries. While traditionally a bureaucratic model has dominated the administration of national insurance, this is now being challenged in Norway by the professional model. The shift towards professionalism in Norway emphasises the central role of the frontline workers as professionals applying knowledge and discretion when considering a broad set of individual and external factors. This shift thus indicates that the frontline workers' reliance on rules and regulations inherent in a bureaucratic model is diminishing, increasing the use of discretion in such cases.

Research on medical information in cases handled by NAV

The frontline workers require medical information from the GPs in order to assess their users' capability to work. Since medical information is the cornerstone of the assessment, the frontline workers require the information to be accurate in terms of what the users are able (or not) to do, in order to be able to identify opportunities in the labour market (or the lack thereof). According to Gjersøe (2016c), the frontline workers perceive the medical information from the GPs as certain, while their own knowledge about the labour market is uncertain, implying that the medical information is more valuable than the knowledge they possess. The frontline workers may therefore opt to work administratively according to the regulations, rather than challenge a GP's medical knowledge as a way of coping with this perceived difference in the value of their respective knowledge. Gjersøe here points out that the frontline workers themselves make clear in the interview that it is they that make the final

decision; however, if they perceive their own knowledge as less certain, this implies that the frontline workers perceive medical information as more valuable since it is *certain*.

A study by Aarseth et al. (2016) finds that the medical certificate of disability tends to over-emphasise low functionality and symptoms at the cost of potential and ability. They argue that the medical certificate limits the GPs' ability to inform the frontline workers in complex assessments due to limitations in the form that they are required to fill out on the work capability of the user. The analysis shows that the medical certificate lacks a space for the user's perspective, and thus there is no obvious way to distinguish between what the GP is saying, and what the patient says. The design of the form leads GPs into making statements without clarifying from where the information comes; this may elevate the user's own experiences to the level of medically objective findings (Aarseth et al. 2016, Aarseth et al. 2014, Solli 2007).

Another study by Aarseth et al. (2017) on the medical certificate for incapability to work focuses on how GPs select and mediate information about users. This study shows that the certificate lacks coherence between facts and evaluations, while struggling to provide verifiable factual information and consistent evaluations. The study finds that medical certificates display little understanding and insight into working life, regardless of diagnosis. Aarseth et al. (2017) finds that GPs frequently fail to provide clear, relevant and factual information and evaluations to justify a user's claim for a disability pension. In other words, the medical certificate may not be a reliable source of information regarding a user's capability to work.

Research on the role of the frontline workers: Professional activation work?

Terum, Tufte, and Jessen (2012) found that employees with higher education comprise almost two-thirds of staff at the local NAV offices. Once the numbers are broken down, about one-third of the employees have a social work education, while another third has a social science education. Other educational disciplines represented by the employees include economy and administration and law as well as combinations of different subjects. Frontline work is not a profession as it lacks a common scientific knowledge base and education; however, van Berkel, van der Aa, and van Gestel (2010) argue that depending on the definition used, it could be understood as a profession.

Fossestøl, Breit, and Borg (2014) found that frontline workers at NAV lack sufficient competence and knowledge regarding the labour market, and call for more training in this respect. Increased competence and knowledge about the labour market is a pre-requisite for making good assessments of a user's capability to work and the opportunities for re-integration into the labour market.

According to Hagelund (2016), frontline workers attempts to fill the void left by there being no accepted common knowledge of activation work. The study found that the void is being filled with knowledge on 'how to work with people' (Hagelund 2016, 736); knowledge which aims at motivating, and making the user self-reliant, in effect empowering them. Hagelund (2016) argues that the activation policies emphasise individual action plans and individual tailoring of measures, which places the question, 'how-to-activate?' with the user. As the question is located with the user, the frontline workers' role becomes one of coaching a self-governing user. The frontline workers at NAV therefore focus on motivating techniques and advising the users, attempting to make the user self-governing, as part of the return to work process.

Focusing on long-term sick and disabled users, Gjersøe (2016a) investigates how frontline workers respond to the activation policy measures to get users out of the temporary benefits scheme. Gjersøe (2016a) points to how the current mode of operation at local NAV offices is challenging the frontline workers to make the users self-reliant as well as ensuring that the users' needs and rights to a secure income are met. In the study, she finds that there are three strategies employed by the frontline workers in relation to the formal work capability assessment: 'rubber-stamping decisions', avoiding the work capability assessment and working backwards. She argues that the challenges experienced by the frontline workers are due to a lack of control of the exit options, the labour market (employers) and disability benefits (Regional Insurance Administration). The lack of control leads the frontline workers to keep their users on work clarification benefits, in effect locking the users as temporary benefit recipients. In response to the challenge, frontline workers appear to focus on securing an income for users, a smooth workflow and benefits-transactions; in effect, locking users with complex health problems into temporary benefits. The focus on a secure income implies that the frontline workers in this study hesitate to use measures which may endanger a user's income.

Summary

The last twenty years has brought about significant changes in the organization of welfare services, moving towards a more joined-up and collaborative approach. The changes in the organization and its governance have challenged the dominant logic guiding frontline workers' actions. Earlier research on NAV indicates that the frontline workers are to a lesser extent focusing on rules and regulations in their approach to users. Rather the frontline workers are considering a broad set of individual and external factors when they approach users.

The past two decades have also brought significant change in power relation between frontline workers and GPs. The move to 'sick notes' and the removal of GPs' authority to certify whether an individual was capable of work has transformed the work of frontline workers at NAV, who have been given the responsibility to assess work capability. This transformation indicates that frontline workers need additional knowledge beyond that of laws and regulations. Frontline workers are required to assess medical information in order to determine users' capability to work. Both the change in understanding and the practical implication of the change in responsibility may have influenced how frontline workers use discretion when approaching users with severe health problems.

This shift in power relations needs to be seen in light of the reconceptualization of work as beneficial to health. In order to understand the influence these changes have had, it is important to bear in mind that frontline workers depend on medical information from GPs and on information from the user about how they experience their disability. This information is used to assess the user's work capability, identify appropriate work-oriented measures, follow-up the user's return-to-work process, and eventually conclude whether permanent disability benefit is the only viable option. Frontline workers now have to activate the user by testing capability to work and implementing measures to improve it as early as possible. The main tasks of the frontline workers has thus moved from evaluating whether medical information on the user fulfils the requirements of the law, towards assessing whether the user's capability to work matches opportunities in the labour market. However, the medical information is often ambiguous and reduced to general assessments without adequate thorough assessments of functionality.

The frontline workers have traditionally focused on the users' right and need for a secure income as a passive benefit. In the context of activation policy, the right is now dependent on

active evaluative and vocational measures aimed at increasing employability. The frontline workers use these measures to identify users' available labour market opportunities. Thus, new ways of working have raised a demand for the knowledge that frontline workers have; in addition to knowing laws and regulations, they require clearer information pertaining to prognosis and ability to function and understanding of the labour market. The increased knowledge demands indicate that the job of a frontline worker is now more complex than before.

Concepts and Theoretical Framework

This thesis draws on institutional theory in order to explore the frontline workers' understanding of their work with re-integrating users with severe health problems into the labour market. Institutional theory is a theory which has developed in several fields, such as economy, sociology and political theory (Scott 2014). Across these different areas, an institution has been understood both narrowly, as equalizing a concrete organization to more broad and general formations such as the state or the family. In this thesis, in line with the definitions of Scott, institutions are regarded as abstract structures which create stability and meaning in social life (Scott 2014).

In this section, I will first outline the institutional logics perspective and elaborate on the above definition of institutions in the context of this thesis. The notions of institutional work, schema and practices of discretion are then presented. Afterwards, a brief account on the street level bureaucracy perspective that has been used extensively in research focusing on frontline workers is provided. Finally, the implications of the concepts and theoretical framework are summarized.

Institutional logics

An institutional logic is a set of presumptions and perceptions that guides the action of the social actors in a field (Thornton, Ocasio, and Lounsbury 2012, 114). If institutions are 'the rules of the game' then institutional logics are the 'underlying principles of the game' (Leca and Naccache 2006, 632). An institutional logic is taken-for-granted as it establishes the core principles for organizing activities, and focusing interests (Thornton, Ocasio, and Lounsbury 2012, 77). In order to define the area in which a logic is present I rely on the term organizational field. In defining an organizational field I follow the definition used by DiMaggio and Powell (1983).

> By organizational field, we mean those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products. (DiMaggio and Powell 1983, 148).

Thus, an organizational field consists of a group of diverse and interdependent organizations that share a common meaning system.

Institutional logics operate through providing knowledge to those social actors. Institutional logic focuses attention through providing roles, identities or schemas which offer knowledge and solutions for social actors (Thornton and Ocasio 2008, 85). In offering knowledge and solutions to the social actors, an institutional logic guides the decision-making processes and judgements that they make. Social actors are 'institutionally constructed actors whose values, interests and practices are partially determined by the institutional logics that structure the organizational fields in which they operate' (Garrow and Grusky 2013, 104). In other words, an institutional logic operates as an abstract knowledge structure creating inferences on how social actors perceive their reality (creating a shared meaning system). The social actors' perception of their reality directly links with what they see as the best way to solve a problem.

Within each field there may be several logics which are competing for dominance in order to provide a frame of reference for what is perceived as rational and logical (Thornton, Ocasio, and Lounsbury 2012, 2,77). Institutional logics may be conflicting or complementary. The diversity of institutional logics creates a cognitive world in which social actors draw on these underlying principles to create new or challenge existing institutional logics (Friedland and Alford 1991). 'Each [Institutional] logic is associated with a distinctive mode of rationalization – defining the appropriate relation between subjects, practice and objects' (Scott 2014, 90).

In this thesis two terms related to embeddedness are used. First, embedded in institutional logic is used in accordance with Thornton and Ocasio (2008, 103) 'the interests, identities, values and assumptions of individuals and organizations are embedded in prevailing institutional logics'. The understanding of embeddedness is echoed in Pache and Santos (2013, 8). The notion of being embedded in institutional logics is common among scholars that apply the institutional logics perspective (see for example Dunn and Jones (2010) Thornton and Ocasio (2008), Thornton (2002)). Second, using the term institutional frameworks is possible as well as the institutional logic as this constitutes an institutional framework as institutions are embedded in higer-order societal logics i.e. institutional logics according to Thornton's (2002) interpretation of Friedland and Alford (1991).

Institutions

According to Scott (2014, 57) institutions are structures that exhibit stabilizing and meaning-making properties because of the processes set in motion by regulative, normative and cultural-cognitive elements. These structures are supraorganizational structures rooted in material practices and symbolic systems (Friedland and Alford 1991). Therefore, while institutional logics provide the principles on which an institution is based, an institution is the application of an institutional logic or logics set in a particular context. 'Institutions are the result of the ways in which actors transpose these institutional logics through precise scripts, rules and norms in specific contexts' (Leca and Naccache 2006, 632).

Institutional structures provide elasticity that guide behaviour and resist changes (Scott 2014, 57). Institutions both impose constrictions on behaviour while simultaneously supporting and empowering activities and actors through distinguishing between what is acceptable and unacceptable behaviour (Scott 2014, 58). The social actors re-produce and change the institutions through activities and interaction (Scott 2014, 57). While, institutions both control and constrain behaviour, institutions themselves may undergo changes, both revolutionary and incremental (Scott 2014, 58). Institutions create legitimacy by establishing rule-systems through setting standards for behaviour and action, which reduces a social actors' environmental uncertainty (Zietsma and McKnight 2009, 5). Institutions reduce the environmental uncertainty through making certain aspects taken for granted, and affecting how the social actor perceives a situation (Berger and Luckmann 1991[1967], 71-73).

Legitimacy rationalizes the institutional order, by giving objectified meanings cognitive validity which is critical for the stability of institutions (Berger and Luckmann 1991[1967], 110-111). Legitimacy here refers to an assumption or belief that the action of a social actor is desirable, proper or appropriate within a socially constructed reality (Suchman 1995, 574). According to Scott (2014), there are three pillars which support institutions by providing legitimacy through what he terms the regulative, normative and cultural-cognitive pillar. The regulative pillar is instrumental as individuals that craft laws and rules do so wishing to advance their interests, while individuals comply with the laws and rules wishing to gain rewards or avoid sanctions (Scott 2014, 62). The normative pillar supports through social beliefs and codes by which individuals with exemplary behaviour may feel respect or honour, while trespassing may invoke a sense of shame or disgrace (Scott 2014, 66). The cultural-cognitive pillar relies on a common framework of meaning, which affects the correctness and

soundness of a perceived idea or action (Scott 2014, 68-71). However, empirically it is rare to observe institutions relying on one of the pillars; rather varying combinations of pillars would support an institution (Scott 2014, 70).

Following Scott's (2014) strong institutional view, legitimacy is perceived as a '… condition reflecting perceived consonance with relevant rules and laws or normative values, or alignment with cultural cognitive frameworks' (Scott 2014, 72). Legitimacy is, to paraphrase Scott (2014), the oxygen of institutions, which is only missed once it has been lost (Scott 2014, 72). Thus, legitimacy is a prerequisite, not a resource, for institutions that prescribe behaviour and actions for the social actors embedded in it. In other words, the behaviour and actions which are prescribed by the frontline workers at NAV in the focus groups are legitimate institutionalized actions which rely on one or more of the pillars described by Scott (2014).

Institutional Work

Institutional work is described as 'the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions' (Lawrence and Suddaby 2006, 215). At the core of institutional work lies the notion of 'embedded agency' – the way in which social actors 'whose thought and actions are constrained by institutions are nevertheless able to work to affect those institutions' (Zietsma and Lawrence 2010, 189). Institutional theory assumes that social actors are 'rational in the sense that they are able to work with institutionally-defined logics of effect and appropriateness' (Lawrence and Suddaby 2006, 219). Institutional work is thus actions undertaken by the actors of a field with the purpose of defining what is logical and appropriate therein. In following the metaphor of institutions as 'the rules of the game' (Leca and Naccache 2006), institutional work is 'maintaining or modifying the rules of the game' through practices of creating, maintaining or disrupting established institutions.

Since institutional logics do not provide 'ready-made' institutions, the establishing of new institutions require social actors to frame it drawing on the principles available in an institution (Leca and Naccache 2006, 633, Benford and Snow 2000). According to Battilana, Leca, and Boxenbaum social actors are reflexive, goal oriented and capable. Thus, the focus shifts towards the action of actors as the centre of the institutional dynamic, which suspends

the dichotomy of structure and agency and focuses the attention towards the interrelationship between these dimensions (Battilana, Leca, and Boxenbaum 2009, 74-75).

In this thesis, I have focused on the creation of new institutions. Creative work can take place through nine strategies. These strategies focus on the pillars that are needed to support an institution, according to Scott (2014). The regulative work aims at creating rule systems by using advocacy, defining and vesting work. The normative work aims at altering or creating new norms and belief systems through constructing identities, changing normative associations and constructing normative networks, while the cognitive work alters abstract categories, creating systems for problem solving that cut across the boundaries of meaning systems through mimicry, theorizing and educating work (Lawrence and Suddaby 2006, 228-229). Thus, social actors have the possibility to exert influence on the institutions in an organizational field through performing strategic actions that aims at creating fertile conditions for new practices.

Schemas

Schemas is a central concept in institutional logics (Thornton, Ocasio, and Lounsbury 2012). Schemas are learned ways of solving specific problems as they offer strategies that the frontline workers rely on when dealing with a problem. In continuation of the metaphor of institutions as 'the rules of the game', schemas are 'the strategies by which to win the game'. While an institutional logic operates at both the macro (society/organization) and the micro level (frontline workers), there are limitations to the availability of knowledge contained in an institutional logic at the micro level. In such a situated event (e.g. approaching a user), social actors tend to focus their attention on particular attributes of a user, case or problem which offer them access to desirable solutions and decisions (Thornton, Ocasio, and Lounsbury 2012, 85-91). Schemas are learned top-down knowledge structures which shape attention in order to solve specific problems, and as such resemble automatic scripts (Thornton, Ocasio, and Lounsbury 2012, 88-89). This thesis uses the concept of schemas as advocated by Thornton, Ocasio, and Lounsbury (2012), which draws on the pragmatic reasoning schema identified by Cheng and Holyoak (1985). Contrary to automated scripts, pragmatic reasoning schemas serve to facilitate the reasoning and interpretation of information based on what is perceived as a desirable decision (Cheng and Holyoak 1985). Pragmatic reasoning schemas are abstract knowledge structures, which are applied to specific domains of action or classes

of goals (Cheng and Holyoak 1985, 395). Thus, schemas are both automated and dependent on what is taken-for-granted, while still requiring reflection due to the application of an abstract knowledge structure invoked in order for the frontline worker to determine the desirable outcome.

Discretion

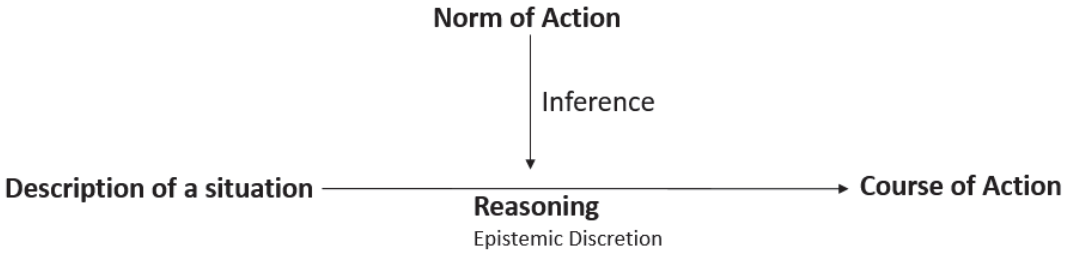
Discretion is an integral part of the frontline worker's decision-making. Discretion is according to Freidson (2001) an under-analysed but central aspect of professionalism and professional work. That the frontline workers are making discretionary judgements about their users, defines, according to Lipsky (1980) frontline work. The central and defining aspect, which ties discretion and professional work together, indicates that the frontline workers cannot avoid using discretionary judgements. The frontline workers are embedded in an institutional logic that infers and guides the discretionary reasoning. In following the metaphor of institutions as the rules of the game, discretion is the tactics of the game.

There are two dimensions of discretion, the structural and the epistemic dimension. While the structural dimension focuses on the space in which social actors may use discretion, the epistemic dimension pays attention to the process of reasoning which the social actors perform. Dworkin (1978) used the metaphor of a doughnut, in which the dough represents a belt of restrictions, while the hole at the centre is the space in which discretion may be used. The hole in the doughnut is the space left open by a delegating authority for a social actor to make judgements in accordance with the standards set by the delegating authority. The epistemic dimension explores the reasoning process that a social actor undertakes in order to prescribe an action that solves a problem. Thus, the epistemic dimension is concerned with what the frontline workers think 'ought to be done' (Molander 2016, 25).

The epistemic dimension of discretion or discretionary reasoning is the construction of arguments based on a set of premises (Molander 2016, 25). These premises are formal rules, which influence what constitutes a logical argument (Molander 2016, 25-26). The theoretical approach used to explore the epistemic dimension of discretion is based on the general model of argumentation by Toulmin (1958). Molander has further developed Toulmin's model in cooperation with amongst others, Grimen and Wallander (Molander 2016, Wallander and

Molander 2014, Molander and Grimen 2010). The model has three parts, a description of a situation that requires discretion, a course of action, and the norm of action. In this thesis, the description of a situation refers to the vignette, a course of action is the prescribed actions, which the frontline workers suggest in relations to the vignette, and the norm of action refers to what the frontline workers 'ought to do' inferring on their reasoning. The norm of action thus resembles an institutional logics influence on the decision-making of the frontline workers. This process is termed as the discretionary reasoning process and is illustrated in Figure 1. Social actors tend to rely on the norm of action in helping to guide discretionary reasoning.

Figure 1. Model of epistemic dimension of discretion



Based on Wallander and Molander (2014, 3)

Setting discretionary reasoning as the construction of logical arguments to support one's claim as a premise focuses the analysis on how the frontline workers construct these arguments, the knowledge that they rely on, and what makes sense to them, thus allowing for identification of the institutionalized knowledge on which they rely and more important, how they use it.

The Street Level Bureaucracy Perspective

In the seminal work of Michael Lipsky (1980), attention is drawn to two aspects of the frontline workers' work[2]. First, the frontline workers' considerable discretionary power in implementing policy. As Lipsky (1980) points out, the frontline workers hold significant discretionary powers confined by regulation and the availability of resources and the complexity in the nature of their work. The discretionary power makes the frontline workers

[2] The street level bureaucracy perspective encompasses a large and broad stock of literature, which in the scope of this thesis has not been possible to explore in depth. The focus has thus been on how the perspective views organizational influences on the work of the frontline workers.

ad-hoc policy makers through operationalizing policy (Caswell et al. 2017). Discretion allows for sound flexibility when solving complex cases, although it may also be perceived as problematic since it may lead to unequal treatment (Rothstein 1998, Goodin 1986). Second, the frontline workers are under pressure from both the organization and the user to come up with satisfactory solutions through their work. According to Lipsky (1980) the frontline workers deal with this pressure through the development of coping strategies that aim at creating a more manageable work load. These coping strategies relate to how the frontline workers adapt their ideal understanding of the job to the pragmatic realities through categorizing clients as deserving, easy etc.

The street level bureaucracy approach has been a productive approach in exploring how the frontline workers operationalize policy as exemplified by (van Berkel et al. 2017, Gjersøe 2016a, Brodkin 2015, Thorén 2008). However, there has been criticism of the street level bureaucracy approach for seeking explanations for variations on the same level such as 'individual characteristics and personal views of the actors involved'(Hupe and Buffat 2014, 549). Echoing this critique, Garrow and Grusky (2013) state that 'Embedded agency […] calls into question the assumption of individualistic interests that underlies much of the research on street-level discretion'. According to Hupe and Buffat (2014, 555) there is a lack of studies which consider the institutional setting as important. In other words, through largely ignoring the institutional setting, the explanations for variation in policy implementation is found at the individual level pertaining to personal characteristics of the frontline worker. The criticism by Hupe and Buffat thus relates to the aspects of the level of explanatory factors. Brodkin (2011a, 2011b) has introduced the concept of street level organizations which 'challenges the researcher to consider street-level organizations as embedded in the broader political economy and society […] when they do policy work'. However, Brodkin (2015) does not include the institutional context, but rather the organizational framework. Arguably, the institutional perspective used in this thesis is a good supplement when considering the frontline workers' understanding of their work conforms to external pressures, namely the institutional logic in which they are embedded.

Implications of Concepts and Theoretical Framework

This section has introduced several concepts and accounted for a theory and although they may be perceived as overlapping, each term has a specific purpose as it relates to different

aspects of overarching terms. For example ‘institutional logic’ is both a ‘general abstract knowledge structure’ which offers solutions to problems and contains ‘underlying premises’ which tends to influence what is perceived as a desirable outcome. One could argue that one could use only institutional logic to describe both; however, it would render the analysis less nuanced if one did so.

The institutional logic perspective turns our attention towards the process by which institutions govern action albeit in a non-deterministic way, understanding the frontline workers as *guided by* institutional logics, *not bound*. While an institutional logic constrains the frontline workers, they are still able to perform strategic actions which may affect the logic. Through providing ‘underlying principles’ and ‘general abstract knowledge’ to the frontline workers, an institutional logic provides access to schemas with legitimate solution to problems. As these solutions are legitimate and as such taken for granted, the frontline workers may not feel the need to legitimise them further. The frontline workers performance of discretionary reasoning is linked to the institutional logics inference on the ‘norm of action’, providing the logic for constructing arguments to support their suggested action. Thus, the key task for the researchers is to make the frontline workers reason on their suggested action so as to provide access to the presumptions and perceptions which indicate traces of an institutional logic on which discretionary reasoning and rationale are built.

Method and Methodology

This section presents the method applied in the thesis and relates it to overall methodological discussions concerning credibility, transparency, and ethics. Terminology has important implications, and increasingly discussion revolve around what terms to use. For example discussions concern whether to talk about a 'disabled person' or a 'person with disabilities'. The first term, so it is argued, indicates that it is society which, through lack of facilitation for peoples' mental and physical prerequisites, disables the person. The second term, proponents of this term holds, emphasises that the human being is more important than whatever physical ailment is present (McPherson, Gibson, and Leplège 2015, 46). In rehabilitation research, some scholars are critical of the use of the term patient, as it implies, they hold, passivity in a field in which the outcome of the individuals' rehabilitation relies on full participation of said individual (McPherson, Gibson, and Leplège 2015, vii). In activation research, the term 'client' is prevalent, in particular among scholars using the street-level bureaucracy perspective (van Berkel 2014, Brodkin 2011, Pollack 2008, Thorén 2008). Similar to the term 'patient', 'client' implies passivity and lack of influence. In this thesis, I have chosen to use the term 'user' in most situations to describe individuals that receive assistance from NAV; in some cases, I use 'patient' when describing those in the health care sector. I consider 'user' as a better term in describing the individuals that require assistance from NAV for two reasons. First, as NAV requires the individuals to return to work to participate and corroborate with them, the term 'user' implies agency and potential influence. Second, the Norwegian term used by NAV to describe these individuals literally translates as 'user' (*bruker*). Thus, the term 'user' adequately describes the agency and influence that these individuals have.

In this section, the first subsection relates to the choice of method for answering the research question. The second describes the process of selecting which NAV offices to participate in the study, while the following subsections go into further detail on the chosen methods (focus group interviews and the vignette method), and analysis of data. The final subsection discusses the advantages and limitations of the methodological choices in terms of credibility, transparency, and ethical considerations.

As previously mentioned, this thesis is a sub-project within the overarching project, 'Transitions in rehabilitation: Biographical reconstruction, experiential knowledge and professional expertise'. The project considers patients with traumatic brain injury (TBI) and

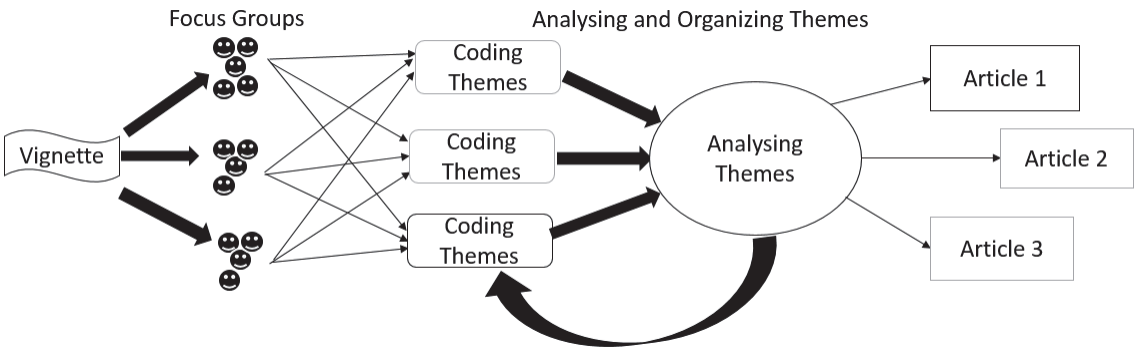
multitrauma as a case to understand patient trajectories across institutional boundaries, inter-professional and inter-agency interaction, and the general organization of the field.

The overall project description sets certain premises for the present thesis. This also concerns data sources. In this regard, the project description set the stage for 'focus group interviews with professionals in the services involved in the later phases of the rehabilitation process' (p.4). Further, 'a case vignette method, which is shown to be a valid and comprehensive method to focus on professional practice' which in combination with 'focus groups of teams is beneficial for accentuating team' characteristics (p.4). The overarching design of the project has thus had implications for the choices available for the methodological approaches in this thesis. This section expands on the rationale behind the methodological choices.

Holstein and Gubrium (2004, 143) argue that interviewing is not a one-way pipeline for transporting knowledge, but rather a meaning-making conversation implying that an interview is unavoidably interactional and constructive. In this thesis, I consequently use the term, 'co-construction' (collaborative construction) in regards to the data collection in acknowledgement of the influence the researchers have on the data which is produced (Holstein and Gubrium 2004, Gubrium and Holstein 2000).

The data comes from eight focus group interviews conducted between 2014-2015 at the frontline offices of the Labour and Welfare Service. The groups were presented with a vignette as a point of departure for the discussion. The first interview served initially as a pilot, but the data was deemed to have value and was included in the data set, for reasons to be further discussed later in this section. There were altogether 27 participants in the different focus groups. Figure 1. depicts the process of co-constructing data for the present study.

Figure 1. Co-constructing and analysing data



Selection of Offices and Participants

We wanted to conduct interviews at offices that had recently had contact with a case involving multitrauma and / or Traumatic Brain Injury (TBI). It was important that the offices had recent experience with such a patient, since this increased the likelihood that the frontline workers would draw on experience from this type of case. In order to do this, we acquired information on municipalities that recently had had patients from two rehabilitation hospitals. Cross-referencing the information from the rehabilitation hospitals created a list with municipalities that had experience with patients that fitted the project's patient-level inclusion criteria. However, it was not stipulated that the concrete focus group participants had to have experience with such cases, as such cases are rare.

The project established contact with the relevant local labour and welfare offices in a three-step process. The first step consisted of sending a letter with information about the project to the Directorate of Labour and Welfare (see Appendix D). Secondly, after approval from the Directorate, the regional branches of the Labour and Welfare Administration received a similar letter, and thirdly the local offices were asked if they wanted to be part of the study and set up the interviews. The local offices were only contacted after permission from the central offices had been acquired.

Twenty-four offices were invited to participate in the study, yet only eight agreed to do so, i.e. 33% of those asked. The ten offices, which responded negatively, stated that they had no time to participate at this time, while six offices did not respond at all, despite several reminders. Of the eight that participated in the study, only one agreed without one or more reminders.

The start of the process of gaining participants was slow due to formal requirements for approval by the national and subsequently regional administrative offices. As Table 2 shows, the process of accessing participants was not as straight forward at the local level either. Only one office responded to the initial e-mail request for participation in the study, while most of those that participated only agreed to do so after the second reminder; in some cases, a follow-up phone call to the local manager was necessary to secure the arrangement. Most of the refusals to participate were not received until a phone call had been made to remind the office of the request.

The offices that did refuse to participate said that they were too busy. A few said that they had no experience with cases involving multitrauma and/or TBI, despite our information from the

rehabilitation hospitals. These reasons for not wanting to participate may indicate three things. First that the offices we interviewed are those which are 'best' at dealing with such cases. The 'best' offices would imply that the participants we have interviewed tend to follow NAV's procedures and thus the data would depict NAV as it wishes to be perceived. Second, it may be, as their response indicated, that they did not have the possibility of participating due to lack of resources. Third, it may imply that the users with multitrauma and/or TBI are somewhat 'invisible' at the local labour and welfare offices, which suggests two possibilities. First, that the supervisor which received the request for participation was not aware that they had such users. Second, that the information we received from the rehabilitation hospitals was inaccurate. As the study progressed and it became apparent that fewer than the originally intended 10 local offices wished to participate, I decided to include the pilot interview as part of the data.

Among the individual focus group participants from the eight offices, there was a range of different professions, including four health professionals, seven in social work, three with law degrees, one economist, seven with a background in social science and one teacher.
In addition, four participants did not have university/university college degrees. Table 3 compares the education of the participants in this study to the national average.

Table 1. The participants' educational background compared to the national average among frontline workers in the NAV local offices

	Health and social education	Law degree	Pedagogic education	Social Science education	Economic * education	Other education
Participants	40.7% (11)	11.1% (3)	3.7% (1)	25.9% (7)	3.7% (1)	14.8% (4)
National average	25%	6%	11%	22%	16%	19%

* While Economy is a social science education, the National Average separated economy from social science
National average in 2014 as stated by Ekspertgruppen (2015)

Looking at table 3, we see that the proportion of participants who had health and social education as well as those with a law degree was considerably higher than the national average. There are fewer with pedagogic and economic education than the national average, and close to the national average educated in social sciences. There are two apparent reasons for these differences. First, the national average includes all personnel working for NAV including the cleaners and administrative personnel. Second, the participants invited to partake in this study work with users with severe health problems. Thus, there is in particular a high proportion of participants with health and social education. Table 4 shows information

about the participating local offices and the educational background of the research participants.

Table 2. Local offices and Participant background information

Local Office ID	*Type of municipality*	*Number of employees at Office*	*Number of Research Participants*	*Educational background of Research Participants*
N1	City District, 48,000 inhabitants	53	3	1xS 1xPS 1xW
N2	Suburban municipality, 60,000 inhabitants	40	5	1xL 1xS 1xU 1xB 1xW
N3	Rural municipality. 10,000 inhabitants	10	4	1xE 1xU 1xW 1xSW
N4	City, 80,000 inhabitants	180	5	1xH 1xT 2xSW 1xS
N5	Rural municipality, 13,000 inhabitants	28	2	2xL
N6	City in Rural district, 30,000 inhabitants	65	3	1xN 1xU 1xC
N7	City, 50,000 inhabitants	80	3	1xSW 1xS 1xH
N8	City District, 45,000	70	2	1xH 1xU

Legend for Table 4: S=Sociology, PS= Political Science, W= Welfare Studies, L= Law, H= Health Sciences, SW= Social Work, B= Business, T= Teacher, C = Criminology, U= Upper Secondary + Internal

The Vignette Method

Even though vignettes have traditionally mostly been used in quantitative research, the use of this method in qualitative research has grown during the last 20 years (Eskelinen and Caswell 2006, Wilks 2004, Barter and Renold 1999). A vignette case is a fictional case constructed by the researcher. Usually, it is meant to be as similar to a real case as possible, while allowing the researcher to strategically construct it in a way that prompts a discussion addressing specific research questions (Ejrnæs and Monrad 2012, Patton 2005, Wilks 2004, Rossi and Alves 1980). Ejrnæs and Monrad (2012) describe the vignette method as a "realistic description of a phenomenon that in most cases would be fictive or hypothetical because one constructs them" [Translation provided] (Ejrnæs and Monrad 2012, 13), and that it can be a story or describe either a person or a situation (Ejrnæs and Monrad 2012, 13). The ability to control the start of a discussion is of importance when interviewing a group. The vignette method is instrumental in this respect (Ejrnæs and Monrad 2012, Wilkinson 2004).

The vignette method is, according to Ejrnæs and Monrad (2012, 24-25, 33-34), especially suited to uncovering attitudes that guide assumptions leading to decisions and actions. One can describe the vignette method as a tool for investigating understandings as, if properly constructed, the fictional case requires the person to justify the actions they propose through explicit reasoning. This offers the researcher the opportunity to explore both the knowledge that the participants exhibit when discussing a vignette as well as identifying traces of an institutional logic on which it relies.

Exploring the institutional logic in question in an organization requires deep discussions, making the frontline workers argue for their actions and decisions. The intention of the vignette is therefore to provide realistic information of the kind the frontline workers would receive in a case. The rationale behind this application of the vignette is based on which information is necessary for the process of assessing the work capability of a user. This assessment lists the relevant information as work experience and wishes, education, competence and skills, health and functional ability, age, interests and activities, personal opportunities and hindrances, social and material conditions.

Important in this thesis is gaining access to the institutional logics and the knowledge that guide the participants' interpretations and actions. The constructed vignette is the starting point of the discussion; on the other hand, it is more than just a start, since a carefully constructed vignette enables the researcher to dig deeper into revealed themes and sub-themes by changing key characteristics in the vignette (Ejrnæs and Monrad 2012, Holstein and Gubrium 1995). The vignette portrayed a case with an uncertain prognosis to the participants, offering opportunities to explore revealed themes. The uncertain prognosis was based on a head injury, outcomes for which are difficult to predict, even one year after an accident. This uncertain prognosis was indicated by limited improvements in the health and capabilities of the vignette case. The intended goal was to ensure that the participants had the possibility of drawing on their experiences with users who had similar health problems to the one depicted in the vignette.

In the early phase of the study preparation we considered whether we should use more than one vignette. Initially two vignettes where constructed. The rationale for having the second vignette was that it may have allowed for further exploration of the conceptualization of age in the focus group interviews. However, the pilot interview clearly showed that there would

be insufficient time to discuss a second vignette for any length of time. Therefore, the study proceeded with the use of one vignette (Appendix A).

Creating the Vignette

The vignette was constructed with the purpose of prompting discussions about work and health, in order to provide rich data on shared understandings within the organizations in question. This includes issues such as the economic situation of the family with the wife reducing work to a 50% position in order to do more at home, depression and the lack of motivation to return to work for the user. The vignette concerns a 34-year-old carpenter, with a wife and two young children, who had an accident that resulted in a traumatic brain injury caused by cerebral haemorrhage. The symptoms consisted of paralysis in the left extremities, which was the main reason for the rehabilitation. In addition, the 34-year-old had severely limited balance, as well as minor symptoms regarding headaches, light depression and a lack of energy, and thus was not motivated to return to work. His GP had declared him 100 per cent disabled *pro tem*. In addition, the vignette described the recommendation of health personnel that further rehabilitation would be advantageous. The time of the accident was set at 12 months prior to the focus group session, the point at which frontline workers are required to stop sick-leave benefits and approach the crossroads of either disability benefit or the work assessment allowance. The work assessment allowance is a benefit given to users whose work capability is being tested and evaluated in order to determine whether they are capable of work or require a permanent disability pension. Although the case in question was fictional, several of the frontline workers indicated that the vignette amply mimicked information they usually received about a case. The vignette is therefore subjective from the perspective of the character in the vignette regarding family, wishes, feelings etc. and objective regarding the medical information on injuries and diagnosis but provides little information about prognosis.

The vignette case underwent several screenings by professionals working at relevant institutions, an early pilot, as well as the user panel of the 'Transitions' project twice. The medical aspects of the vignette were constructed with the help of a medical doctor, as well as other medical professionals with experience in rehabilitation services. The user panel of 'Transitions' project all had experience with the injuries sustained by the character in the

vignette, either as a patient or as close family to such a patient. This led to certain revisions in the original text such as limiting the use of adjectives to describe the character in the vignette, further specification of the injuries and a change in the motivation of the user. The interview guide (Appendix B) also went through the same screening as the vignette by both medical professionals and the user panel of the 'Transitions' project. The purpose of the screenings was to construct a vignette which was credible and realistic, so that the frontline workers would not get caught up in irregularities.

Much of the criticism against the vignette method relates to the degree of realism of the vignette and thus the degree to which the vignette allows the researchers to gain knowledge on the research topic at hand (Parkinson and Manstead 1993, Faia 1980, Neff 1979). Applying one of NAV's casefiles would probably alleviate some of these shortcomings regarding the degree of realism. However, the underlying problem with using a 'real' case is the same as with a vignette, the frontline workers' suggested actions may not be what is performed by them in practice as a researcher would be present (Wilks 2004). For example, in the sub-projects concerning what is going on in the specialized hospitals, the case can be studied through observations and interviews regarding *actual* patient cases. However, when it comes to the municipal general health services and the labour and welfare services, considered in this thesis, using observations/interviews regarding actual cases is less obvious, as TBI cases are not as frequent here. Using one of NAV's casefiles would further complicate the research process through two problems. First, there are ethical considerations that could be challenging concerning the anonymity and the well-being of the person or persons owning the chosen case or cases. I will discuss ethical aspect further in the ethics subsection. Second, the number of participants would be severely reduced, as it would require us to interview the frontline workers who dealt with the particular case. In addition, the choice of using a vignette rather than a real case stems from a compromise between the time and resources available, the realism of a real case, and the control of the discussion as a vignette offers. The coming subsection elaborates on the construction of the vignette in order to increase the realism of the vignette prior to the use in the focus groups.

Defining a Focus Group

Several scholars (Carey and Asbury 2016, Krueger and Casey 2014, Stewart and Shamdasani 2014) use sizes ranging from three to 14 participants to define of what can be called a focus

group. The literature seems to favour sizes from five to 12 participants, but does not seem to take into account certain aspects such as the homogeneity of the group, the level of involvement with the topic amongst the participants, and how deep into the information one needs to delve (Morgan 1996, 42-43). As seen in table 4, the number of research participants in each group is from two to five. However Morgan and Spanish (1984) note when discussing size that 'nothing is sacred (or necessarily correct)' of how to do focus group interviews, as there are strengths and weaknesses with both small and large focus groups.

A focus group is determined by the interaction in the group rather than the size (Morgan 1996, 6-7, 42-43). As the method aims at gaining access to the shared understandings of the frontline workers, the size of the groups was determined to be less important than the role and familiarity with cases such as that described in the vignette. The interactions in the discussions among the frontline workers required little moderation, even though the size of the group was smaller than we initially hoped. That said, the two groups with only two participants (due to last-minute cancellations) were too small to constitute 'focus groups', but arguably still of high importance to the study, as they provided insight into the shared understandings of users with severe health problems in these municipalities. The smaller group sizes are further discussed in subsection, 'Credibility, Transparency and Limitations'.

Focus Groups as Qualitative Research

Morgan (2012, 161-162) states that he bases his approach to focus group interviews in part on the work of G.H. Mead from the symbolic interactionist tradition, which suggests that social interaction and the participants' identities can be interpreted. This perspective further holds the pragmatic view that the researcher as a co-constructer of meaning through his or her interaction with a focus group can access the participants' deep-lying conceptions and meaning making. According to Calder (1977, 355), there are three types of focus group interaction in qualitative research; exploratory – to generate scientific constructs and validate them against everyday experiences; clinical, using clinical judgments in order to create scientific constructs, and phenomenological to explore the conceptualizations which create everyday experiences (Calder 1977). The phenomenological approach is by far the most fitting in that it explores the conceptualizations that shape participants' reality and how they interpret their experienced reality.

The design of the interview guide focuses discussion so that relevant data for the study is generated. The process consists of two overlapping stages of 'sharing and comparing' and 'organizing and conceptualizing' (Morgan 2012, 164,170). 'Sharing and comparing' provides the subject matter for the 'organizing and conceptualizing'. During the first phase, the interest of the participants focuses the conversation in one direction, while the second phase enables the participants to conceptualize based on these interests. When studying an organization, it makes sense to conduct interviews within the workplace you wish to study (Geertz 1973[2000]). Using the workplace as the location for the focus group interviews gives access to social aspects, since it is still within the 'work sphere'. The composition of focus groups is based on colleagues who share an 'organizational language' and 'react appropriately to what others say' (Morgan 2012, 169), thus increasing the likelihood of advancing towards the 'organizing and conceptualizing' stage of the discussion (Morgan 2012, 169-171).

In the following example, interviewer 2 re-introduces a metaphor that the participants used earlier in the interview - the loss of a service user's earlier life in a question relating to re-integration into the labour market. This re-introduction of a term exemplifies the co-construction that the interviewers and participants are going through in a focus group interview.

> Interviewer 2: I think you have talked about this, the loss of the life that he had before and other aspects relating to figuring out an alternative career. Finding a 'new life' compared to how it was before… do you react to this type of life reflection?
>
> Participant 3: We try, but to be honest… most of my users have an understanding that it has been a long time since they were well, and functioned working. They have had health problems, and it has been going down ever since. Therefore, it is not that often that we get users who have functioned well in their job one day, and the next everything is different, but we do have such cases, just not so often, and perhaps not as clear as this case
>
> Interviewer1: Do you often get users that have had accidents such as this?
>
> Participant3: No, I have only had one…
>
> Participant1: No, not so many..

> Participant 3: So… total, not that many…
>
> Participant 2: but, this type of injury we do not have that many, but we experience that many users feel a serious loss of health. Especially this guy, who is so young, but no matter if you are 34 or 54 a loss of health does so much to you[…]. The first thing that struck me when I read the vignette was that he needed to get out of his box, he has been at home for one year now, He needs to try some activities. We have some rules that apply to us, and some to the users, so we will try to get this guy active, but it's not easy. (Office 1)

In addition to the 'co-construction' that I have pointed out, this quotation also exemplifies three other important aspects. First, the participants required low levels of moderation, as the moderators did not need many questions in order to move the discussion forward (Morgan 1996, 51-54). Second, the use of information on the part of the participants that was not part of the vignette but from their own experiences. In this example, the information is general concerning users who work well one day and not another (Participant 2). Third, it shows how the participants move through the two overlapping stages of 'sharing and comparing' and 'organizing and conceptualizing', as participant 2 conceptualizes the box that the character inhabits.

The research questions determine how to design and analyse the focus group interviews (Morgan 2010, 718-720). In exploring the shared understandings in which the frontline workers are embedded, the focus is on how the frontline workers talk about their work, and how they reason (Morgan 2010). Morgan holds that "Saying that the interaction in a focus group produces data, is not saying that interaction is data" (Morgan 2010, 718), or in other words interaction in itself is not necessarily data, but rather a means of generating data.

When focusing on interaction, Morgan underlines the importance of contextualizing quotes, what he describes as 'lead-ins' and 'follow-outs' which describe the act of setting up a scene before as well as the aftermath of a quotation (Morgan 2010, 720). The composition of the focus group is also important; a minimum level of homogeneity will help facilitate the discussion from a 'sharing and comparing' discussion to an 'organizing and conceptualizing' discussion (Morgan 2012, 164-168). In other words, following Morgan's pragmatic approach to focus groups, four aspects are considered. First, the design of the focus group interviews

must focus on the research questions; secondly, the focus group participants should be comfortable talking about the topic; thirdly, the analysis of the transcriptions should consider aspects of the context; and fourthly, researchers should be aware of their influence on the interview situation.

The study applies the vignette case method as a point of departure for all focus groups, which creates analytical possibilities beyond the organizational hierarchy of the services (Ejrnæs and Monrad 2012). The rationale behind this method is to try to find differences in the values imprinted in certain key terms (Wilkinson 2004, Peabody et al. 2000). The design supports a semi-structured interview following the two phases described by Morgan (2012), which gives the frontline workers an opportunity to show their reasoning and shared understanding of the activation policy.

There are several factors which could affect the data produced in such an interview situation; primarily, the researchers involvement themselves and the information available in the vignette (Ejrnæs and Monrad 2012, Yin 1989). An example of too active an involvement is to create interesting data by creating tension in the group or 'pitting' them against one another. Morgan (2012) describes how the researcher themselves affect the situation through their presence. This is difficult to address, however, following Morgan's (2012, 162) pragmatic approach, the researcher should anticipate how the interaction among the participants might change in their presence. On the other hand, a similar cognitive process can be used to prevent a researcher being overly active, echoing Holstein and Gubrium's (2004) assumption that all interviews are active and thus the researcher will influence the data. Consequently, the focus group is encouraged to discuss among themselves in order to 'share and compare' in the first part of the interview following Morgan (2012, 162-163), while the researchers ask probing questions focusing on the later "categorizing and organizing" discussion.

The focus group discussion according to Morgan will give access to the interaction and conceptualization aspects of the group; the interactional perspective would be lost in individual interviews (Morgan 2010). When discussions about conceptualization related to their understanding of activation policy, the interviewer digs deeper asking elaborating questions in order to create more discussion in the focus group allowing the participants to build their arguments. This follows the principle of the 'reverse funnel' where one moves

from a more structured interview in the early stage towards less structured at the later stage (Morgan 2012, 172).

Conducting the Focus Group Interviews

Before the interview took place, the participants were given a paper with the vignette and a consent form, in case they had not already received the consent form from their manager. The interviews lasted between 60 minutes and 90 minutes. All the interviews were sound recorded. In addition, interviewers wrote notes particularly focusing on subjects of interest for questions to be asked at a later point in the interview. In each of the focus groups, two interviewers were present and they rotated in the roles of observer and interviewer. Specifically, this means that the one asking the questions focuses on the conversation while the other focuses on how the group responds to what the participants are saying, while taking notes on the interaction.

One primary interviewer guides the study participants through the case, narrowing or broadening the discussion based on both the feedback and the interview guide. Morgan and Spanish (1984) indicate that focus groups do not necessarily need moderation or input from the researchers. Often they operate as their own moderators, requiring little to no input to move a discussion forward (this was particularly true for the groups of three to four participants). The focus groups that participated in this study experienced similar dynamics. In some of the focus group interviews, one of the participants took it upon themselves to be the leader and guide the discussion.

The initial part of the interview focuses on the background variables of the office and the focus group participants such as office organization, professional experience, education and role in the organization. This was deemed important on the basis of previous research on health and welfare organizations, such as Eskelinen and Caswell (2006) who investigated the role played by the age of caseworkers in considering appropriate treatment for welfare claimants in Denmark. Other interesting variables include education, work-experience and time in their current jobs (Håvold 2009, Eskelinen and Caswell 2006, Lindqvist and Grape 1999). In moderating the focus groups, the background variables were of particular

importance in regards to; a) interaction between the frontline workers; b) the actions suggested by the frontline workers as connected to their professional role.

The focus group participants often drew on experiential knowledge of cases that they themselves had handled or had heard about, which brought another level to the data. Most of the focus group interviews were characterized by the few questions asked by the researchers, as the groups that were larger than two individuals, tended to discuss among themselves. The group interviews involving only two participants were characterized by somewhat more moderation by the researchers; however, this allowed for deeper probing into issues, as the pace of these focus groups more resembled a conversation than for the groups with more participants.

The vignette allowed for a common discussion point and it was easy for the participants to take part in the discussion because they were able to refer to the vignette which they had in front of them. According to Morgan (1996) the main question to ask before choosing focus group interviews as a method is 'how actively and easily are the participants able to discuss the topic of interest?' As the topic of interest related to the work that they did on a daily basis, our expectation was that the participants would actively and easily discuss the vignette. These expectations were well founded, as the focus groups tended to be active regardless of their size.

The interview guide (Appendix B) contains the main questions, probes and follow-ups, but the interviews were largely unstructured, except at the start where participants were asked for background data such as role, position, education, work experience and about the organizational structure of their NAV office. Following these questions, in all office but one a researcher read the vignette aloud. The main questions followed, focusing on how they approached the user and the rationale behind this approach. Additional probing questions related to how they viewed the prognosis for the character in the vignette. In conducting the focus groups, we aimed for discussions among the participants with a low level of intervention. We reasoned that this would allow for a thicker description of the rationale, and at the same time prompt other participants to voice their views (Geertz 1973[2000]).

Methods for Co-Constructing Data

The selection process of which methods to use hinges on the match between the research questions and the time available to collect the data. Three methods for collecting data are discussed in this subsection; individual interviews, participant observation and focus group interviews. The goal of this thesis is to explore the phenomenon of frontline workers' approach to cases of users with severe health problems. Exploring such a phenomenon requires a method that is capable of accessing information that relates to how the frontline workers at NAV as a group share understandings. In essence, the research question requires a method that creates a setting that makes the research participants aware that they are representatives of an organization and answer accordingly.

Individual interviews have a clear advantage over both focus group interviews and participant observation as individual interviews allow for better control over the interview situation, as there would necessarily be a close relationship between interviewer and interviewee. In addition, the individual interview allows each participant more time to share information. The individual interview is often considered the best way achieve depth in the data, depending on the sensitivity of the subject (Legard, Keegan, and Ward 2003). Such deep data would necessarily be rich with personal attitudes and opinions (Morgan 1996). However, focus groups have an advantage over individual interviews when the research question requires access to group understandings through allowing access to the meanings and knowledge which a group shares (Krueger and Casey 2014, Gill et al. 2008, Morgan 1996, Kitzinger 1994). In addition, there is no evidence that the researcher has any more impact on the data produced in a focus group than in participant observation or individual interviews (Morgan 1996).

Focus groups and individual interviews could possibly enrich each other, through validating findings across methods. However, the research question does not focus on individual attitudes or personal characteristics of the frontline workers. In the end, the choice of method revolves around two questions. A) Confidentiality – who do the frontline workers have the most confidentiality with, the researcher or the other frontline workers? B) The research question - are we attempting to explore individual variations, or shared understandings? Answering these questions leads us towards the use of the focus group method, as it is likely that the frontline workers have more confidentiality in their colleagues, and the research question revolves around the common understanding that the frontline workers share.

Participant observation would entail the researcher observing the frontline workers' various actions relating to a case, including their interaction with the user and other actors. The strengths of participant observation is linked to the naturalism of the interaction and discussions observed (Kawulich 2005). However, the weaknesses is connected in particular to the difficulty of locating and gaining access to a substantial set of observation on the topic at hand, and the difficulty of observing decision-making and attitudes

In addition, one may employ casefile analysis. Casefile analysis entails the collection of documents from real cases. The strength of analysing such casefiles is gaining access to the decision which the frontline workers *made*, as a file would contain information on the different measures adopted. Importantly, however, the weakness of such a method is the limited information on the rationale that the frontline workers used in determining which measures to adopt. There are differences between how decisions are justified *ad hoc* in a casefile and the rationale, which the frontline worker express before reaching a decision such as the work capability assessment being written after the actual deliberation (see Gjersøe 2016a). Casefile analysis in combination with, for example, interviews could be interesting as one would have the possibility to ask the frontline workers about the choices made in each case. Unfortunately, there are some problems gaining access to both cases and the frontline workers that worked on these cases as the work process at NAV on cases such as the vignette case likely span years with several frontline workers involved at different times due to re-organization, sickness and or career changes.

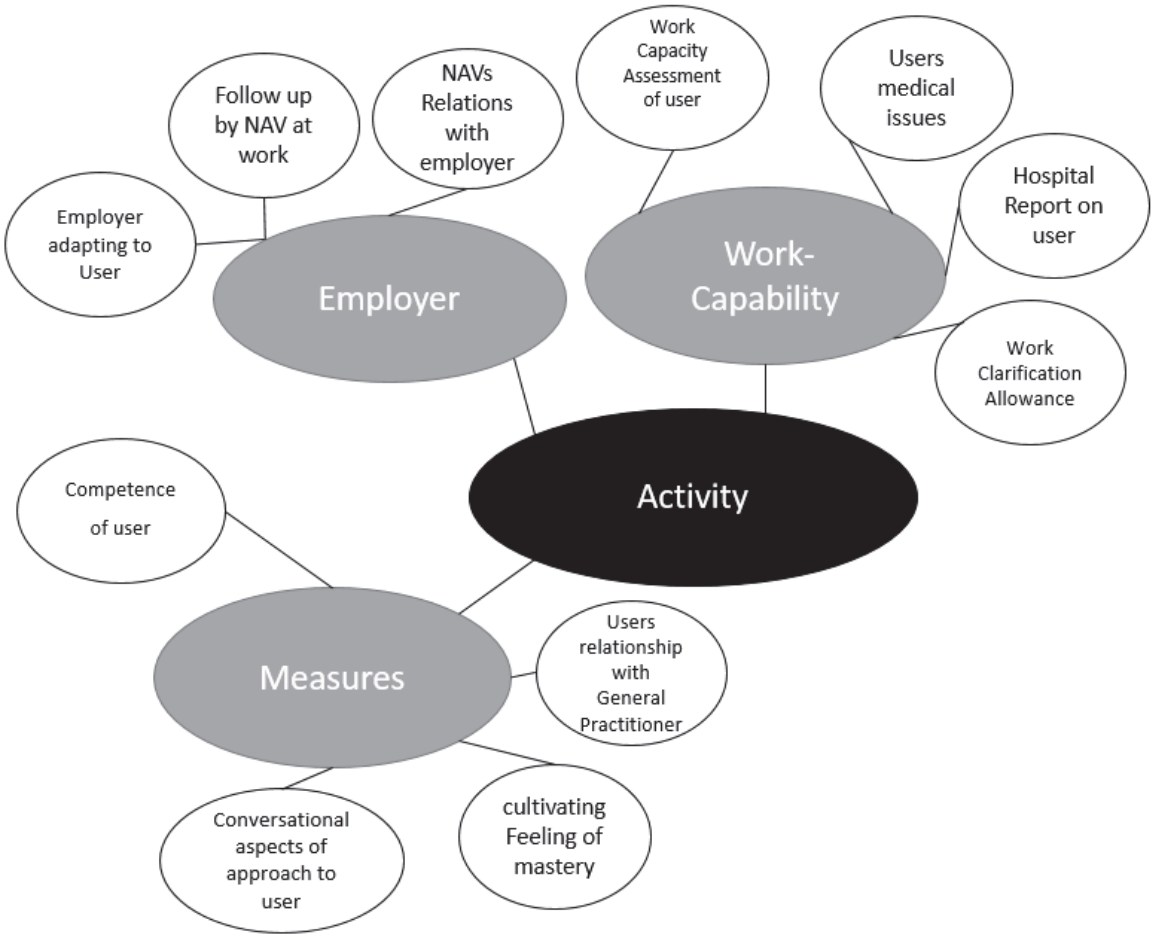
Coding Thematically

The data collected were transcribed verbatim and thematically coded using NVivo 11. The data were initially coded according to recurring themes in the discussions. These codes had sub-groups relating to key terms. The sub-group codes were added at the initial reading and coding of the interviews. In order to make sure that codes were consistent throughout the material a second reading and coding were completed. As the data was thematically coded, an additional layer of codes was used in the analysis of the themes that emerged. The data were then coded on the frontline workers' accounts of how they interacted with their users in

order to motivate them to reintegrate into the labour market, how they reasoned when doing that, as well as how they interacted with other social actors in their field.

In coding the data, I used a thematic network approach (Attride-Stirling 2001). It is argued that the root of the thematic network approach can be found in '*The Uses of Argument'* written by Toulmin (1958). Argumentation theory provides a structured approach aimed at analysing a negotiation process. The theory creates a framework for exploring the connections between the explicit statements, and implicit meanings in a person's (or group's) discourse. The thematic network approach aims to uncover how someone understands a problem, rather than create a unified understanding of the problem (Attride-Stirling 2001). In other words, the thematic network approach is a tool that breaks up the text and helps explore the institutional logics in which the frontline workers are embedded through the ways that the participants rationalize and argue for actions or decisions. For example, a participant at an office explicitly stated that the GP 'wants people sick'. This statement expresses an understanding of GPs as adversaries to the frontline workers, underlining a conflict between the frontline workers and the GPs. This statement is of course dependent on context, and does not indicate that there is conflict between all frontline workers and GPs. Figure 2 shows the structure of a thematic network as used in this thesis.

Figure 2. Structure of a thematic network



Based on Attride-Stirling (2001, 388)

There are three levels in the coding process according to Attride-Stirling (2001). First, basic themes (themes which back up central statements about a belief, but do not make sense on their own as they need to be seen in light of other basic themes). Second, organizing themes (a cluster of basic themes grouped together, exploring the underlying assumption underpinning the group of basic themes). Third, global themes (a cluster of organized themes that encompass all of the data, detailing the experienced reality of the research participants). The global themes summarize and make sense of the lower order themes in the context of the data. In this thesis, the global themes are activity, health, user, regulation, organization and frontline worker. Table 5 shows the structure of the global and organizing themes in accordance with the global themes.

Table 3. Organization of Coding Themes[3]

Global Theme	Activity	Health	User	Regulation	Organization	Frontline Worker
Organizing themes	Work-capability, Employer, Labour-market, Predictability, Re-educate, Realism-of-user-wishes-for-work, NAVs-Medical-advisor, Measure, Opinion-of-Users- Profession	Treatment, Support, Diagnosis-Prognosis, GP, Functioning, Quality-of-life, Psychology, Social-worker, Health-related, Specialists, Sick leave	Activity-plan-of user, Age, Responsibility, Support-group, Family, Past, Future, Expectations, Individual-plan-of-vignette/user, Interests, Motivation, Re-orientation, Loss-of-health, Education, Vignette-validity, Wishes,	Demands, Rights, Benefits, Income, Resources,	External-Cooperation, Internal-Cooperation, Competency, Authority, Follow-up, Process, Service-Gap	Dilemmas

While Attride-Stirling (2001) advocates an approach where one starts with basic themes and works one's way up, my approach differed as I initially had a reasonably clear idea of the global themes from both the construction of the vignette, and my participation as researcher in all the focus group interviews. These initial global themes did however change as I read and reread the transcribed interviews, growing from four to six global themes.

As mentioned, the coding was clustered where a passage of the text was coded using several codes. For example, a sentence might be about both activation and health, and both codes were therefore applied. In order to specify, one or more subcodes were added to the same piece of text. The reasoning for this coding falls in line with Morgan (2010) who states that an important aspect of analysing focus groups relates to the contextualization of the quotes. In particular, this was done so that we could use the Nvivo software to find the codes easily while having the context available without having to jump back to the transcribed interviews too often.

Analysis of the Themes

The analysis focused on the organizational and global themes of the codes, drawing on the three levels (basic, organizational, global) of the thematic network approach (Attride-Stirling

[3] The basic themes are not inserted as they are too numerous as many organizing codes consist of as few as six sentences (or as many as 120). I did not find it necessary to include those in this table.

2001). This means that the analyses of the focus group interviews were initially done thematically. After the initial thematic analysis, the theoretical perspective described in the previous chapter were used. However, the analysis was conducted based on the global themes which were identified in the interviews, as well as the initial reading of the transcripts. This approach to the analysis was the inverse of the one advocated by Attride-Stirling (2001).

The analysis focused initially on the three levels of basic, organizational and global themes. In doing this the three levelled coding encompassed the entirety of the data material, with several sentences connecting to different organizational themes. The organizational themes could be used to analyse particular ideas or concepts such as the GP category. The organizational theme GP contained statements from the frontline workers on GPs in general, and included the context of the discussion topic in which these statements arose. The analysis for article 1 applied the theoretical perspective of institutional work to identify the ways in which the frontline workers attempted to change their relationship with the GPs and the rationale behind this. In addition, the global theme of health was included as it helped to shed light on the rationale for the organizational themes, connected to such aspects as prognosis or diagnosis. As the different forms of institutional work were identified, the focus was on the arguments which the frontline workers used as a rationale for their actions (Lawrence and Suddaby 2006). Exploring the arguments helped to identify the underlying institutional logic on which they relied when rationalising an action (Thornton, Ocasio, and Lounsbury 2012).

In the second article, following a similar approach to that described earlier, I used the organizational code on motivation as the starting point by which to identify the strategies which the frontline workers used when attempting to motivate unmotivated users. After the initial analysis of the coded data on motivation, the global theme 'user' was explored as a contextualization of these motivational theories. The analysis focused initially on identifying a schema, or an operationalized institutional logic. Identifying the schema was done as an iterative process jumping back and forth between the raw data, and the organizational and global themes relating to motivation. Three strategies were identified based on the stated aims and principles of the frontline workers. The strategies were further analysed using the rationale for the arguments, which the frontline workers described. To explore these strategies further I utilized institutional logics and in particular the integrated perspective of schema (Thornton, Ocasio, and Lounsbury 2012).

The third article had a five-stage analytical process. First, I used the organizational theme connected to the vignette, in which the frontline workers were talking about the character in

the vignette, not drawing on other cases as a starting point. Second, I looked at what they suggested as a course of action for the character. Initially I wrote one model for the frontline workers' suggestions per office, relating the suggestions to one of three global themes (Health, Activity and User). Third, I re-read the raw data to make sure my models were accurate, and identified a process for three courses of action; the health care service, the evaluative, and the return-to-work measures. Fourth, I followed the process focusing on how they argued for each of their actions relating to the vignette character, focusing on the reasoning process using Molander's (2016) model of the epistemic dimension of discretion. Fifth, I analysed the rationale of the arguments using institutional logics (Thornton, Ocasio, and Lounsbury 2012).

The user panel of the 'Transitions project' were presented with tentative anonymous findings in order for the panel to be able to duscuss these findings, all had experience with the injuries sustained by the character in the vignette, either as a patient or as close family to such a patient. This allowed me the opportunity to draw on their experiences in identifying interesting patterns, while being exposed to other interpretations of the data. The user panel of the 'Transitions project' exposed me to other interpretations allowing me to view the data in other ways, informing my research and writing process.

Credibility, Transparency and Limitations

According to Kvale (1997), qualitative research has been engulfed by quantitative validity criteria such as the quests for reliability, generalizability and objectivity. Qualitative research has accordingly been held to standards that it cannot meet, and perhaps should not meet (Møller 2015). Others have pointed out that qualitative researchers should rather focus on credibility and transparency contrary to quantitative generalizability and objectivity (Gubrium and Holstein 2000). Qualitative research is often interpretative and critical, thus objectivity is neither plausible, nor desirable in such research. Others again have advocated for less focus on rigorous systematic methods, and more focus on the implications of the research. This latter position further implies that one should not be afraid to use several theories to explore the implications of the data (Møller 2015).

According to Higgs et al. (2012), qualitative research exists because it allows researchers to open up new intellectual spaces and be creative. However, creativity is not a *carte blanch* to

do whatever you wish, the research should still be rigorous and close to the data, but allow for creativity to open up understandings of human activity. Møller (2015) argues for a critical method which prioritizes and values interpretation (through or from theory), anchoring this in the data. Interpretation does not imply that there is no empirical evidence, but follows a constructivist notion which allows for the existence of multiple interpretations of a given event, granting central importance to the role of context and subjectivity (Kvale and Brinkmann 2009). The constructivist notion implies that empirical evidence is constructed as part of a context, as an experienced reality. Using theories to support the interpretation in the analysis allows for more depth in the research while still anchoring it in empirical data.

As previously mentioned, a researcher is required to reflect on their own position, allowing for other researchers to have sufficient information for assessing the quality of the research (Chabal and Daloz 2006, Morgan 2012). A researcher's need to reflect stems from the inability of human beings to completely detach themselves from their context, in other words, a researcher will always bring along some baggage. In light of the baggage I bring, it is important that I describe my own process of reflection on the data and analysis. My academic background is in social anthropology and public administration, while my work experience is largely from the public sector as an administrator within the health sector. My previous work experience has not included any experiences with NAV; however, at the start of the 2000s I interacted with a predecessor of NAV (Aetat) due to an accident. This is now more than 15 years ago, and I have not had any other contact with NAV beyond that which almost every Norwegian has at one time or another.

The research design required two researchers at each of the focus group interviews. I was the only researcher present at all the focus group interviews at NAV. There was, however, always a senior researcher with me, usually one of two supervisors. However, at one interview a third senior researcher was present in lieu of a supervisor. The rotational basis of the moderator role in the interviews meant that each of the researchers had limited influence on the co-construction of data. In addition to the interviews at NAV, I was one of the two interviewers at the municipal coordination units. The original project description called for interviews with the coordination unit to explore how they worked and communicated with NAV, and explore if different understandings were causing difficulties in the rehabilitation process of patients/users. The data collected from the coordination units is used in a collaborative article with Ivan Harsløf and Mirela Slomic, as well as in Slomic's (2018) thesis: Knowledge in

action: Experiential and professional knowledge in interprofessional rehabilitation. However, in the course of interviewing both NAV and the municipal coordination units it became apparent that the contact between these organizations was limited to equipment to support at-home patients - a service in NAV not directly connected with the local offices in question. However, the experience in interviewing the coordination units helped to familiarize me with the focus group method and allowed me to see more clearly what was typical in NAV compared to the coordination units.

In order to ensure the transparency of the study and credibility of the data I have explained in detail how the vignette was constructed and how the participants were chosen as well as the rationale behind the focus groups. I have also explained how the focus groups were conducted. In addition, the coding and analytical processes have been described both in this section, as well as in the theoretical framework. Theories help to abstract the implicit meaning of understandings and practices, which the frontline workers relied on when approaching the vignette case.

It may be argued that eight focus groups, with a total of 27 participants are slim data on which to base a study. There are two main reasons why I consider 27 participants to be sufficient data on which to base this study. First, while the original research proposal called for ten focus group interviews, eight where deemed sufficient due to the recurring discussions in the focus groups indicating that data saturation had been reached according to Fusch and Ness's (2015) definition of data saturation. Fusch and Ness's (2015) definition revolves around 'rich' and 'thick' data. 'Rich' data implies the quality of the data, how detailed and multi-layered it is, while 'thick' data refers to the quantity. In order to reach data saturation, the same questions were asked in the different focus groups. These questions tended to lead to the same discussions, data saturation was achieved when no new understandings emerged. The data co-constructed by the combination of a vignette and focus group method created 'rich' data on the research topic as it pertained to a specific topic of interest, which may be defined as 'thick' given the density of relevant and revealing statements in the data. Second, NAV is an organization that has been significantly researched and evaluated since its conception in 2004. There is a significant amount of previous research on which to base the study as presented in the background chapter (Ekspertgruppen 2015, Terum and Jessen 2015, Aars and Christensen 2011, Alm Andreassen and Fossestøl 2011). Third, the frontline workers have access to the same tools and work under the influence of the same national laws and regulations, which

implies that the the frontline workers at NAV working on users with severe health problems use the same tools, under the influence of the same laws (National Insurance Act and including government circulars).

Focus group interviews allow access to shared understandings through the interactional aspect of the focus group. Determining the knowledge used in the frontline workers' reflection upon their work can be done through encouraging the frontline workers to argue for their point of view concerning what action should be taken in the case outlined in the vignette. For example, one may ask why a certain action is preferable compared to another, if the frontline workers do not initially give reasons for the choice of action.

What one can learn from interviews and focus group interviews is most notably linked to the questions which guide the discussion in the groups (Morgan 1996, Holstein and Gubrium 2004). The main questions used were designed to be broad and open, allowing the participants to explain the process in their own words. However, probing questions were specific, and thus may be perceived as leading due to their nature. Probing questions were hardly used, despite some groups only having two participants; they required little input to sustain a discussion. The follow-ups that were used were worded as 'What do you think of...' or 'How would you…' attempting to let the participants structure the response in the way in which they felt the most comfortable.

According to Morgan (2012, 1996), the dynamics of a focus group affect the data, and as three of the focus groups had only three participants and two had two participants, two aspects must be discussed. First, the size of focus groups is related to the involvement of the participants. This is a multifaceted question, revolving around the participant's interest in and recognition of the topic at hand, as well as the size and composition of the focus group. The lower the involvement of the participants, the more participants are required to keep a fruitful discussion flowing; however, too many participants with high involvement will make a focus group hard to control (Morgan 1996). There were only two participants in one of the most active interviews in the data (Table 2, N5). This group consisted of two supervisors *(avdelingsledere)* who had frontline responsibilities at a smaller local NAV office. The discussion between these two participants revealed interesting perspectives, with a low-level of activity from the moderator. In this interview, one would have expected a different discussion about how to approach the vignette case, which in some respects it was as the language was more formal, and tended towards a discussion of rights and duties. However,

the general notions from this interview were found within the other focus groups. The focus group with the two supervisors revealed interesting perspectives, which I used as a framework when analysing the other focus groups' transcripts. In the other interview with two participants (Table 2, N8), one of them described herself as having worked there for 'many years' while the other participant had barely worked there for six months. The combination of participants made this interview interesting as the more experienced participant used the focus group interview to discuss and 'teach' the less experienced participant how 'things worked'. These two interviews are a good reminder of the importance of the background variables of a focus group.

The second aspect is the moderator influence on the focus group. Both the group itself, as well as the moderator, may influence how the frontline workers answer. The group itself may have a moderating effect on what is said conforming and withholding information that they may have revealed in private. The moderating effect may also stimulate discussion if a participant makes a harsh statement, this may entail the other participants either supporting or counter arguing such a statement (Morgan 1996, 11-13, Kitzinger 1994). In several interviews participants made what they themselves called a 'brutal' or similar statement, only to be supported by other participants in the general notion of the statement, who then nuanced it drawing on their own experiences. Thus, the presence of a group clearly affects 'how they say it', and 'what they say' (Morgan 1996). The researcher, in the role as moderator directs and guides the focus group according to the research interests, Each time the moderator, interacts with the group potentially influences how the participants respond to the question or clarify what they say. However, this is a problem in all but the most unobtrusive social science methods. Acknowledging the influence of the researchers does not solve the issue of bias in the data. However, the research design aims to explore shared understandings among the frontline workers, which the combination of vignette and focus group does through focusing the discussion around a carefully designed vignette, and being influenced by the focus group's conforming effects. The participants in the focus groups worked as frontline workers, but as table 2 shows, their educational backgrounds were diverse. In the smaller focus groups where one educational background dominated, one could expect a different discussion than in one where there was a more diverse background. However, these characteristics tended to change 'how the frontline workers say it', but not 'what they say' (Morgan 1996). When comparing the two person focus groups with the rest of the data, the general notion, language and decisions are not significantly different from the ones with three or five participants. This

indicates that despite being small, the participants in these focus groups are aware that they represent NAV, and thus they limit information pertaining to personal attitudes and opinions.

Ethical Considerations

The PhD project notified the Data Protection Officer (Personvernombudet) at the Norwegian Centre for Research Data (NSD) and received its necessary approvals (see Appendix C). The study did not collect any sensitive personal information. The participants in the study were anonymised through assigning a number based on the first time the participant spoke in the recording while transcribing (e.g. 1, 2, 3, etc.). The local offices were also anonymised using either a number or letter as the identifying characteristics. The transcripts contain only general names of medical institutions that support a region.

All the participants gave written consent to participate in the study. The signing of the consent form was done at the initial phase of the focus group interview, where the participants also had the opportunity to ask for more information about the purpose of the interview. The vignette, which was the point of departure for the focus group interviews, was fictional in nature, and thus did not require any form of anonymization.

Considering the type of case required to answer the research question, I considered that using a vignette case was preferable to using a casefile from NAV. A case similar to that depicted in the vignette case might include a user that had cognitive limitations, which means one may need to consider their ability to consent. These considerations are particularly relevant for this project, as one could actively discuss a person that is not present with a third party, the frontline workers.

Summary of the Three Articles

In this chapter, the three articles that comprise the thesis will be presented. Since the preceding chapters have explored previous research, method and theoretical framework, this chapter will focus on the results and conclusion of each paper.

Article 1. 'Externalizing an 'Asset Model' of Activation: Creating Institutional Work by Frontline Workers in the Norwegian Labour and Welfare Service'

This article aims to investigate the forms of institutional work with which frontline workers engage in order to externalize their asset model of activation in the adjacent medical field and thus towards the GPs. Norwegian activation policy over the past two decades has undergone a shift in logics from a 'deficit model' to an 'asset model' that has affected frontline workers' approach to users with severe health problems. The idea behind the asset model can be found in the 2010 expert groups' re-conceptualization of work as beneficial to health and well-being, despite hindrances. The idea behind this re-conceptualization is that full health, in most cases, is not a pre-requisite for an individual's ability to work. The deficit model tends to focus on hindrances, while an asset model focuses on opportunities, despite hindrances. In this article, we use a concept borrowed from health promotion and term this new approach an 'asset model' of activation. This shift implies that part of the GPs' work has moved from the health sector to the labour and welfare sector, effectively 'enrolling' them in NAV. Frontline workers are disposed to externalize their logic towards the GPs in order to facilitate a better flow and relevance of medical information.

The article draws upon data gathered in focus group interviews at eight local NAV offices. The focus group participants were presented with a vignette depicting a victim of an accident, and contained medical and social information. The article leans heavily on institutional theories, namely institutional work (Lawrence and Suddaby 2006) and institutional logics (Thornton, Ocasio, and Lounsbury 2012). The institutional work perspective is employed in order to identify how the frontline workers externalize an 'asset model', while institutional logics is used to describe the idea of an 'asset model' at the policy level.

According to the analysis, frontline workers employ several forms of institutional work to externalize an 'asset model' of activation towards the GPs. These forms of institutional work rely on the creative work of 'defining' – conferring status and creating hierarchy;

‘constructing normative networks’ – and establishing spaces for discussions and dialogue; ‘educating’ – teaching GPs the policy and regulation of activation; and ‘changing normative associations’ – changing the GPs’ views of activation policy and measures.

The article identifies four different forms of institutional work that have different characteristics. ‘Defining’ relies on coercion and authority to signal that the GPs are not the ultimate authority on the issue of employability and work incapability, defining part of the GPs work within NAV. On the other hand, ‘constructing normative networks’, ‘educating’ and ‘changing normative associations’ rely heavily on co-operation and dialogue to cultivate a setting in which it is natural that frontline workers and GPs have the same goal. These three forms of institutional work are in line with the general direction of national insurance policy and activation policy in Norway as it focuses co-operation and dialogue. Such dialogue-oriented action can be tied in with the ingrained optimism and positive opportunity approach to activation of the asset model. In addition, frontline workers experience three types of tension relating to GPs; in particular, how GPs tend to work towards keeping the authority traditionally bestowed upon their profession, by creating alliances with the users. Frontline workers counter the GPs’ authority by employing their own doctors to work as medical advisors. However, frontline workers aim to stimulate equal and cooperative relationships with GPs, at times resorting to regulative and professional authority to make GPs comply with the requirements of the activation policy.

The article argues that frontline workers are gaining ground in the inter-sectorial field of health and welfare, thanks to important incremental institutional transformations. Frontline workers employ several forms of institutional work to promote an ‘asset model’ of activation among GPs. We conclude that frontline workers’ institutional work is crucial to understanding how a politically motivated reform leads to changes in practice. Thus, successful implementation of the reform requires the frontline workers to engage in institutional work.

Article 2. ‘Opportunity Talk, Work Talk and Identity Talk: Motivating Strategies Used by the Norwegian Labour and Welfare Offices’

The article explores the forms of talk that frontline workers use to motivate unmotivated users to return to work, focusing on the knowledge the frontline workers access when they are using these forms of talk. The frontline workers indicate that an important aspect of their work is to motivate their users to embark on a return to work process.

This article relies on the same data as the first article: from eight different local NAV offices. However, the data were coded differently, focusing largely on what frontline workers said they would do to motivate an unmotivated user. This means that discussions about the vignette in particular were also used; however, all the examples used concerned some sort of health related issue.

The article employs the perspective of schemas, in order to identify how the frontline workers attempt to motivate their users. The theoretical framework relies on an understanding of schemas as abstract knowledge structures, drawing knowledge from an institutional logic at the macro level, offering frontline workers solutions for problems at a micro level. Thornton, Ocasio, and Lounsbury (2012) describe how an institutional logic operates at the micro level as a schema. Institutional logic is thus understood as general abstract knowledge, while a schema is understood as applied knowledge.

In the analysis, the different forms of talk are categorized based on two aspects: first, whichever of Scott's (2014) pillars legitimizes the form of talk at the macro level; second, whichever relationship with the user's environment it targets. This leads the analysis to identify three different strategies. First, 'opportunity talk' aims at convincing the user that frontline workers have access to the best means of getting them back to work. Second, 'work talk' that cultivates the user's already positive feelings towards work, strengthening the relationship between the user and work. Third, 'identity talk' aims at using the user's relationship with their family to encourage self-reflection on who they are, and who they will become if they do not return to work. These strategies are termed 'talk' because of the dialogue-oriented nature of these strategies.

The analysis shows that all the focus groups use two of these forms of talk. 'Opportunity talk' is present in all of the eight focus groups; while 'work talk' is present in six, 'identity talk is only present in two. The three strategies appear to be oriented towards enhancing employability. The discussion revolves around how 'opportunity talk' appears to be the initial approach used by frontline workers, while 'work talk' and 'identity talk' tend to work as supporting strategies when frontline workers motivate users to return to work. The analysis indicates that both 'work talk' and 'identity talk' draws on the idea of work as beneficial despite hindrances. On the other hand, 'opportunity talk' focuses on removing hindrances for returning to work. These three forms of talk are perceived as the application of a schema which is activated when the frontline workers approach users that are unmotivated. The

different application of ‘work talk’ and ‘identity talk’ may imply that the abstract knowledge of the institutional logic is applied differently by the focus groups depending on context.

I conclude that the strategies that frontline workers employ to motivate unmotivated users draw to a large degree on the 2010 expert group’s re-conceptualization of work as beneficial to health to legitimize their approach towards such users. Further, the successful implementation of policy requires the understanding of how frontline workers use abstract general knowledge such as work is beneficial for health, when attempting to motivate users.

Article 3. ‘All Roads Lead to Rome: Discretionary Reasoning on Medically Objective Injuries at the Norwegian Labour and Welfare Offices’

The third article explores the frontline workers’ discretionary reasoning since an extensive element of discretion in public administration’s frontline services may challenge the formal principle of justice as it may involve unequal treatment of the same type of case. The article explores discretionary reasoning exhibited by the frontline workers towards the vignette case. The frontline worker are presented with a vignette concerning the case of a user with medically objective findings, a severe head injury.

The analysis relies on two theoretical perspectives, the primary analysis draws on a understanding of epistemic discretion advocated by Molander (2016). In utilizing Molander’s understanding, the article analyses the reasoning exhibited by the frontline workers as a construction of arguments that supports the frontline workers’ suggested action. An important aspect of the analysis is the ‘norm of action’ that expresses what the frontline workers ‘ought to do’. The ‘norm of action’ is understood as a guiding influence on the frontline workers’ reasoning and conceptualized as the shared understanding, i.e. an institutional logic inferring on the reasoning. The supporting arguments are analysed following the institutional logics perspective paying particular attention to the principles on which the arguments rest. The combination of theoretical perspectives allows for an exploration of the arguments, as well as the suggested course of action, and if they are in accordance with the principle of justice.

The analysis focuses on the way in which the frontline workers reason before reaching a suggestion on how to proceed with the case. The analysis shows how frontline workers in the different NAV offices draw on similar knowledge when reasoning about the vignette. The suggestions they give are very similar, with only slight differences that depend on the

resources available at the offices. The reasoning process is divided into measures, where the discussion revolves around the goal of the measures, dividing the analytical phases into health care service measures, evaluative and return-to-work measures (RTW). The frontline workers accept medical recommendations from health professionals; however, the character in the vignette has a 100% p.t. reduction in work capability and frontline workers seem to put little stock in this, rather focusing on their own evaluation of the character's capability to work. The evaluative measures focus on gaining more information about what the character in the vignette is still able to do, as frontline workers complain about the kind of information concerning prognosis that the medical personnel give them. The evaluative measures have two purposes, gaining more information about what the user is able to do, as well as activating the user. Activation of the user is imperative according to front line workers in order to prevent a user from slipping away from the labour market. The RTW measure tends to focus more on employers than users, since labour market inclusion according to the frontline workers relies on the employer's willingness to take on a person with reduced work ability. Frontline workers focus their attention on the current employer of the character in the vignette; several of them state that the current employer is *always* the best option for users. The frontline workers base their reasoning on the background in the vignette; they tend to think about what opportunities the employer might have for the user, or whether the user should attempt a change in career. The frontline workers do not tend to focus on laws and regulations in their argumentation, rather building the arguments on knowledge of measures and shared understandings of the medical information. The findings point towards different avenues of reasoning in the focus groups to reach the same conclusion as to the treatment of the vignette case. The article argues that the institutional logic that guides the frontline workers' actions infers the reasoning process through an instrumental "norm of action" which states how it ought to be done.

The frontline workers' reasoning tends to focus on knowledge regarding the medical issues and prognosis of the character in the vignette, as well as what plausible measures could be put in place to increase the character's employability. The article discusses the three measures and the 'norm of action', essentially focusing on the principles on which the frontline workers base their reasoning. In the discussion, the similarities in the empirical findings are connected to a norm of action offering legitimate arguments derived from an institutional logic. The legitimate arguments offered by a norm of action would imply that the institutional logic guides the reasoning process of the frontline workers. The analysis in light of the implications

of a ‘norm of action’ as understood here imply that the frontline workers reasoning on cases with medically objective findings follow the principle of justice. However, the reasoning does exhibit slight variations.

The similarities in reasoning imply that the frontline workers are moving towards a professional form of discretion, in line with the findings of Gjersøe (2016b).

Discussion.

How do the frontline workers at NAV reflect on their work involving users with severe health problems at the intersection of the labour and welfare sector and health care sector? The local NAV offices are the agencies tasked with implementing the activation policy. Thus, the frontline workers in these agencies are the agents who are putting the activation policy into practice.

Hupe and Buffat (2014) argue that there is a need to incorporate institutional, organizational and individual factors to explain frontline worker discretion. Street level bureaucracy researchers have increasingly included the street level organization as a factor in their analysis (Brodkin and Marston 2013, Brodkin 2013). However, in order to explore the institutional influences on the frontline workers, this thesis draws on the institutional logics perspective. Using this perspective allows us to identify the understandings which the frontline workers have of activation policies in re-integrating users with severe health problems in the labour market.

An 'Asset Model' of Activation – The Guiding Logic

The 2000s brought about significant changes in frontline workers' work processes regarding users with health problems as 2004 saw a reduction in GPs' formal capacity to decide upon permanent work disability through the 'sick note', and the reconceptualization of work as beneficial to health in 2010 (Damberg 2009, Hammer and Øverbye 2006). The change in the power relationship between NAV and GPs, and the reconceptualization of work as beneficial to health despite hindrances, heralded a shift in the way frontline workers went about their work. Frontline workers were now to identify labour market opportunities for their users, rather than focusing on their limitations. The change in power relations between GPs and NAV offered frontline workers the possibility of challenging the medical information provided by GPs.

Article 1 identifies a new logic which the frontline workers have adopted that affects their work with users with health problems. The preceding logic based the assessment of work capability on GPs' medical judgements; in addition, the unfolding asset logic draws on the frontline workers' knowledge of the labour market and relevant workplaces. An 'asset

model' of activation is identified as the logic which guides frontline workers' approach to GPs in order to create a common understanding of what the users need in order to be re-integrated into the labour market. Article 1 argues that the frontline workers have shifted from a 'deficit model' emphasising the limitations of a user's capability to work, to an 'asset model' focusing on a user's opportunities despite hindrances. The shift to an 'asset model' is directly linked to the re-conceptualization of work and the shift of authority from GPs to frontline workers in making the final judgement of incapability to work. As article 1 describes the externalizing of an 'asset model' of activation, this externalizing implies that this logic is already established and internalized among frontline workers. The institutional work carried out by frontline workers supports an 'asset model' of activation by attempting to 'enrol' the GPs in the fields of labour and welfare through cultivating a common understanding of work as beneficial to health despite health problems. In other words, the institutional work of the frontline aims to influence the underlying principles in the adjacent medical field, attempting to alter the institutional logic in which GPs operate. I perceive an 'asset model' of activation as an institutionalized understanding supported by the regulation and tools of NAV.

Helgøy, Kildal, and Nilssen (2011, 2013) point towards a transformation in the frontline workers' understanding of their role as part of the merger of the three welfare agencies that became NAV in 2006. As shown in article 1, there are three factors which have been influential in the new understanding of their role: the creation of NAV, the reconceptualization of work as beneficial to health and the reduction of the GPs' authority to certify incapability to work. After working to institutionalize the logic internally, frontline workers have shifted the focus towards other actors in an adjacent field, namely GPs, in order to externalize an 'asset model' of activation. As part of the operationalizing policy, frontline workers are the linchpin in the successful implementation of policy. An 'asset model' of activation is the logic on which frontline workers rely when they work on re-integrating users with severe health problems.

Article 2 argues that the frontline workers use of forms of talk for motivating unmotivated users are the application of a schema derived from this 'asset model' of activation. A schema allows frontline workers to deduce and use forms of talk which draw on the general abstract knowledge contained in an 'asset model' of activation. These strategies comprise the 'asset model' used in practice by the frontline workers, basing the forms of talk on the principles of opportunity orientation aimed at removing hindrances to returning to work (opportunity talk), or that work is beneficial, even for those with health problems (work talk and identity talk).

The knowledge applied in these forms of talk are in turn legitimized by cognitive and normative pillars that support an institution as described by Scott (2014). 'Opportunity talk' is legitimized by the cognitive pillar as frontline workers argue that they can offer the user the best chances of returning to work. 'Work talk' and in particular 'identity talk' is legitimized by the normative pillar as the frontline workers attempt to motivate the user by drawing on social factors such as work is good for you or how others view them, in order to motivate them to return to work. That these strategies are legitimate (among the frontline workers) is indicated by their use in different offices.

The large shifts in the organization of the fields of labour and welfare during the last twenty years in Norway have influenced frontline workers' tasks and behaviour moving it towards a more joined up and collaborative approach, aimed at cooperation with other actors in the field (Alm Andreassen and Fossestøl 2014, Hagelund 2014). According to Fossestøl et al. (2015) the fields of labour and welfare are exposed to competing logics derived from the NAV-reform. The NPM logic is a single focus logic on labour market participation while the post-NPM logic is multipurpose focusing on a holistic approach including income security, individualization of services and comprehensive assistance. Some local offices have developed hybrid responses to reconcile the different logics, achieve their goals, and perform their tasks. (Fossestøl et al. 2015). An 'asset model' of activation relates strongly to the post-NPM logic, as it tends to focus on the holistic and comprehensive assistance as indicated by frontline workers' strategies in article 2. The forms of talk identified in article 2 indicate that they are based largely on a post-NPM logic as described by Fossestøl et al. (2015), relating to the individualization of services and in particular comprehensive assistance apparent in the focus on the numerous measures available when using 'opportunity talk'.

The success of the introduction of a policy hinges on frontline workers' support for the new institutions initiated by politicians (Breit, Alm Andreassen, and Salomon 2016). Articles 2 and 3 show how frontline workers draw an 'asset model' of activation in order to facilitate users' re-integration into the labour market. These principles socially construct the reality of frontline workers and offer solutions to problems. The two supporting forms of talk identified in article 2, 'work talk' and 'identity talk' are not used by the same offices in the data. However, it is not necessarily clear as to why they do not apply both forms of talk. Both 'work talk' and 'identity talk' relate to the idea of work as beneficial to health, but have different targets. The differentiation between 'work talk' and 'identity talk' comes from the qualitative difference inherent in these strategies (McNeil 2009, 20-25). While 'work talk' is a

non-judgemental approach aimed at focusing on dignity and self-esteem aspects of work, 'identity talk' is judgemental and tends to locate the problem in the user (McNeil 2009, 23-24). Thus, 'work talk' turns the focus towards work, accentuating already held positive feelings about earlier work experiences to motivate the user. On the other hand, 'identity talk' shifts the focus and targets the user, focusing on the users perception of self. The two forms of talk may therefore be mutually excluding, as 'work talk' targets the user's external relationship to work, while 'identity talk' targets the self of the user.

NAV and the GPs – A Somewhat Ambivalent Relationship?

From 2000 until 2010 there were, as mentioned, two significant changes in the relationship between frontline workers and GPs. The shift in power relations and the reconceptualization of work influenced how frontline workers understand their work. An important aspect covered in all three articles which comprise this thesis is how frontline workers view the medical information which they receive from GPs. Markussen, Røed, and Røgeberg (2013) find that Norwegian GPs have quite varying practices in the issuing of 'sick notes', corroborating what frontline workers discuss in article 1. Frontline workers describe a large variation among GPs in keeping users on health related benefits, or actively supporting their return to work. The institutional work by frontline workers attempts to encourage GPs to adopt an 'asset model' of activation with its positive opportunity-oriented perspective and understanding of work as beneficial to health. In addition, to attempt to gain more relevant information, the institutional work which frontline workers are doing aims to enrol GPs in the fields of labour and welfare. Although most frontline workers perceive GPs as cooperative in their efforts to re-integrate users into the labour markets, frontline workers perceive some GPs and their patients in some instances, as creating an alliance against NAV. Although this is not a common occurrence, article 1 shows that frontline workers may withhold benefits from a user if the 'sick note' does not contain sufficient information to support the GP's argument that this user should not be exposed to activation measures. According to the frontline workers interviewed, the younger generation of GPs tend to have adopted the idea of work as being beneficial to health; even for those with health problems, and thus these GPs tend to support frontline workers' opportunity oriented approach (see article 1).

Article 1 finds that frontline workers in some cases perceive the information they receive from GPs as not being medically objective. In several instances, frontline workers describe it

as a re-packaging or re-branding of the patient's subjective story. Aarseth et al. (2017) finds that in some cases the presentation of information, which the frontline workers receive in medical declarations, conflate the GP's and the patient's voice, which may in some cases just be a repackaging of the patient's story. Frontline workers say that the information received often lacks proper prognosis and a focus on opportunities. This lack of diagnosis is found in research on the medical information pertaining to permanent disability, which indicates that it focuses on medically objective findings that support a bio-medical evaluation of the user, limiting the often-complex assessments to simple un-nuanced statements (Aarseth et al. 2016, Aarseth et al. 2014, Solli 2007). This presentation of information makes it difficult to distinguish between what the GP and the patient is saying. (Aarseth et al. 2017, Aarseth et al. 2016, 1391-1392).

The frontline workers' call for more nuanced medical information is further explored in article 3. This article finds that frontline workers think that they often do not receive sufficient information on which to make good assessments of their users' capability to work. The article further underlines the ambivalence at times associated with the medical information received from GPs. Frontline workers perceive it both as important documentation for assessing the capability to work, while simultaneously viewing it as somewhat dubious as they think it focuses too much on the user's limitations. The ambivalence towards the medical information indicates that frontline workers perceive GPs in some ways as hindrances to a return to work process. However, frontline workers do not perceive this as a malicious intention on the part of GPs, but rather as the GPs lacking knowledge of the measures and incremental approach which frontline workers have the possibility of employing during a return to work process. The ambivalent relationship with the GPs and more importantly with the medical information provided makes it a logical strategic action to attempt to influence the GPs to give clearer and more relevant information, as pointed out in article 1. Aarseth et al. (2017) finds that the medical information pertaining to permanent disability often fails to provide the information required to support a user's claim. The failure to provide sufficiently nuanced information on complex cases often results in creating an unnecessarily resource demanding process for frontline workers. Despite the apparent shortcomings often found in medical information provided by GPs, Gjersøe (2016c) finds that for frontline workers it is the foundation of their assessment of the work capability of their users, describing it as certain information due to GPs' medical knowledge. Contrary to the findings of Gjersøe (2016c) that GPs' medical information is perceived as 'certain', article 3 points out that some frontline workers have a

strained relationship with the information that GPs provide, not putting much stock in the GPs' evaluation of work incapability until they themselves have assessed the case. This may imply that some of the GPs' claims are not legitimate in the frontline workers' context of an asset model of activation.

Approaching the Users

Enhancing Opportunities

The slogan of NAV 'We give people opportunities' epitomises the optimistic and opportunity-oriented approach of frontline workers. Article 2 shows how frontline workers are drawing on this optimistic and opportunity-oriented approach inherent in an 'asset model' of activation in their work to motivate users to embark on a return to work process. There are two overlapping tasks at which the forms of talk are aimed. First, to motivate the user to embark on the process of returning to work. Second, to show the user that frontline workers have access to measures which may realise this process. 'Opportunity talk' focuses explicitly on showing the user all the opportunities which frontline workers have in their arsenal to enhance their employability and help them return to work. 'Opportunity talk' is used by all the focus groups indicating that this is a common form of talk for motivating users. The two others, 'work talk' and 'identity talk', tend to be supportive or auxiliary approaches indicated by the less frequent references to these forms of talk in the focus groups. Article 2 suggests that frontline workers draw on general knowledge available in an 'asset model' of activation as a means of devising strategies to motivate unmotivated users by activating a schema that offers solutions and identifies problems.

Further, article 2 shows how frontline workers use these three strategies for motivating users to embark on the process of re-integration into the labour market. The knowledge invoked through the application of the three strategies in article 2 indicate that frontline workers are moving towards having a common knowledge base. The reference to 'common knowledge' indicates here what the important aspects are pertaining to how to motivate users to return to work according to frontline workers. These pieces of knowledge are things such as 'work being beneficial to health, despite health problems' and the opportunity orientation inherent in 'opportunity talk'. Frontline workers indicate that there is usually an opportunity to re-integrate a user into the labour market. Opportunity talk thus operates at two levels:

opportunities which frontline workers have to help, and opportunities which the user has in the labour market. Frontline workers do however have a somewhat different application of the different strategies, despite the reliance on a common stock of general knowledge. The common knowledge with different applications may indicate that frontline workers are in the midst of a professionalization project to define activation work. Professionalization project here means defining a common knowledge base on which to base their role pertaining to activation work rather than certifying education, occupational closure, etc (Hagelund 2016, Muzio et al. 2011).

Research by van Berkel, van der Aa, and van Gestel (2010) describes activation workers as professionals without a profession. This description indicates that there is no clear criteria for 'what activation intervention works best for whom under what circumstances?' (van Berkel, van der Aa, and van Gestel 2010, 455). Activation workers lack common available knowledge on how to assess and decide which intervention works for each user. In Norway, Hagelund (2016) explores how frontline workers attempt to fill the void of accepted knowledge. Hagelund finds that the individual action plans and tailoring of measures locate the question within the user, making frontline workers' role one of 'how to work with people' (Hagelund 2016, 736). She finds that the role of the frontline workers is one of coaching with the aim of developing self-reliant users. The strategies portrayed in article 2 corroborate Hagelund's (2016) findings as the three strategies all aim to create a self-reliant user who takes the initiative in the process for their own return to work. Frontline workers exhibit coaching behaviour aimed at motivating their users to embark on a return to work process. According to the frontline workers, they *know* that the best way to motivate a user is by making them focus on opportunities, despite hindrances.

Reasoning About the User

The manner in which discretion is exercised is a core interest in research on frontline workers and their practices, as it is concerned with the translation of policy to practice (Caswell et al. 2017, Lipsky 1980). This translation gives room for discretion increases the probability of arbitrary decisions, such as the individual tailoring of measures (Heum 2014, 21-23).

Discretion is an integral part of the practice of frontline workers as it allows for sound flexibility in the performance of their tasks (Lipsky 1980). According to Hupe (2013, 426),

street level bureaucracy research focuses on discretion, in one way or another. Researchers who have employed the street level bureaucracy perspective have particularly focused on frontline workers as *ad hoc* policy makers (Caswell et al. 2017). Hupe and Buffat (2014) have commented on the street level bureaucracy approach when attempting to find explanations for frontline workers' behaviour in individual characteristics and personal views, rather than drawing on organizational and institutional perspectives. Hence, the context of the frontline worker becomes opaque, and thus less nuanced. Using an institutional approach in conjunction with the street level bureaucracy approach may create a clearer view of the context in which the frontline workers operate. Earlier research showing that frontline workers at NAV apply different approaches to the users indicate that they have considerable room for discretion (Solvang 2017, Hansen and Natland 2016).

Of key importance in article 3 is the 'norm of action', which tells the frontline workers 'what they ought to do'. Article 3 argues that the 'norm of action' is a derivative of an 'asset model' of activation that dominates the frontline workers' field, and as such, the institutional context influences the reasoning process that frontline workers engage in by setting the premises for the reasoning. In other words, what this understanding of discretion brings is the ability to explore both the reasoning process in which frontline workers engage, while at the same time offering access to the argumentation and thus the shared understandings on which frontline workers base their reasoning. Thus, article 3 expands on the knowledge of how frontline workers use discretionary reasoning in one way in particular. In using the same vignette in several offices the method of combining vignette with focus group interviews allows for a detailed analysis of the arguments which the frontline workers use to defend their suggested actions. Such a detailed analysis allows for identifying the logic on which the frontline workers' reasoning rests as shared understandings.

As article 3 focuses on the argumentation for suggested courses of action using the same vignette, it allows for comparison among offices. The frontline workers often suggest the same courses of action, with small variations in their arguments. An 'asset model' of activation seems to be the foundation on which frontline workers base their arguments. The key elements of frontline workers' arguments are opportunity orientation, identifying plausible ways for the user to be re-integrated into the labour market, and that work is beneficial for health and well-being, despite health problems. The similarity in the reasoning indicates that they have a shared understanding, which is not related to personal characteristics. Frontline workers have similar reasoning despite having different educational

and work-related backgrounds and despite focusing on different aspects of the vignette. Contrary to what the social workers fear (Røysum 2013), article 3 finds that frontline workers seem to practice the ideal of equal treatment and thus the formal principle of justice.

The reasoning process exhibited by frontline workers seems to be instrumental, as it expresses means-end connections. That the reasoning is instrumental is a characteristic of the discretion of professionals, something which corroborates the findings of Hagelund (2016) and Gjersøe (2016c). Hagelund (2016) finds that the knowledge, which constitutes activation work among frontline workers, is how to work with people. One of the signs of professionalization can be found in the work of Gjersøe (2016c) where she clearly shows how frontline workers, despite being in a bureaucratic context of administering demands and rights, moves towards the professionalization of discretion.

Conclusion

The past 20 years has brought about significant changes in the institutional context for the frontline workers, most importantly the creation of NAV. The time periode placed the frontline workers, through re-conceptualization of work, change in power relations towards the GPs and re-organization, at the intersection of welfare, labour and health. The intersectional position of the frontline workers indicates the key position that they have in the re-integrating of users with severe health problems in the labour market. In addition, the intersectional position indicates that their work, in particular pertaining to users with severe health problems, has become more complex. The focus group data suggests that the frontline workers' reflections on their work involving users with severe health problems depend in particular on a highly opportunity oriented approach, in combination with an understanding of work as beneficial to health, despite health problems. These two aspects are termed an 'asset model' of activation.

The intersection between welfare, labour and health indicates a complex institutional context in which the frontline workers have to take into account different social actors with understandings different from their own. The frontline workers need to reconcile different understandings from the health care sector and the labour market, with their own opportunity oriented understanding. In an attempt at alleviating problems steming from different understandings The frontline workers are doing institutional work. The institutional work is indicated by the internalization of an 'asset model' of activation and currently, it seems that the frontline workers are attempting to convey this logic towards the GPs in the adjacent health care field.

In addition, an 'asset model' provides the frontline workers with motivational strategies aimed at motivating users with severe health problems to begin the process of returning to the labour market. The discretionary reasoning among the frontline workers seem similar, and the arguments constructed tend to depend on an 'asset model' for legitimacy. Exploring the frontline workers' argumentation and reasoning on suggested courses of action gives an insight into the principles which support their reasoning process. The analysis indicates that the frontline workers have a significant amount of shared understandings of how they should work to re-integrate users in the labour market. The frontline workers' dependence on an 'asset model' of activation in their work may imply a process of professionalization among

the frontline workers as they are developing a common understanding of how to perform their work.

The thesis has explored the understandings which support the frontline workers reflections on how to approach users with severe health problems. While the reflections and understandings are similar, the findings do not indicate the actual practice by the frontline workers. When asked if their statements are what they do, they tend to take proviso along the line of 'this is what we *should* do', however 'this is not always what we do'. In short, the frontline workers may not 'practice what they preach'. Consequently, I argue for more research on the frontline workers actual practice towards users with severe health problems, in light of the understanding of 'how things *should* be done'.

The use of institutional logic has in particular been helpful as it has allowed for the identification of some underlying premises and knowledge on which the frontline workers base their understanding. In combining institutional logics with other theories, this thesis may be of help in identification of some key principles which guide and support the frontline workers' approache to users with severe health problems.

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Appendix A. The Vignette

Vignett

Rehabiliteringssykehus

Innlagt: xxx Utskrevet: xxx (3-ukers rehabiliteringsoppholdet)

Pasientansvarlig lege: xxx xxx

Dg: H82 Svimmelhetssyndromer ved sykdommer klassifisert annet sted

F07.2 Posttraumatisk hjernesyndrom

F33 Tilbakevendende depressiv lidelse

Pasient: Mann, 34 år, gift, 2 barn (2 og 4 år). Tømrer med fagbrev, 12års erfaring, p.t. sykemeldt. Kone i 50% permisjon uten lønn og fungerer som støtte og omsorgsperson i hjemmet.

Innlagt pga. behandling av tidligere diagnostiserte balanseproblemer som følge av en ulykke for 12 mnd. siden med traumatisk hjerneskade og lammelse i venstre ekstremiteter. En brist i hoftekam og flere ribbeinsbrudd godt leget. Lett/moderat depresjon diagnostisert etter skaden.

Fått tilbake funksjon i venstre ekstremitet, noe nedsatt styrke og problemer med dagligdagse funksjoner grunnet manglende finmotorikk i hendene. Behandling på intensiv avdeling, primær rehabilitering gjennomført ved Universitetssykehus. Anbefalt videre rehabilitering for svimmelhet og finmotorikk i spesialiserte rehabiliteringssykehus. Han er satt på venteliste. Fikk tilbud om plass etter 5 uker. Samtaleterapi grunnet depresjon som gjennomføres hos psykolog.

Gjennom oppholdet tydelig balanseproblematikk, samt problemer med finmotorikk. Han klager over dårlig hukommelse og sterke hodepine i tillegg til manglende energi til å hjelpe hjemme og med barna. Han utrykker et sterkt ønsker å ha energi til å leke med barna. CT av hode – uendret. Nevropsykologisk testing viser til en avgrenset kognitiv svikt med begrenset minnespenn. Konen blir beskrevet av ham som en god støtte.

V/utskrivelse: Både balanse og finmotorikk forbedret etter trening. Fysioterapeut og ergoterapeut anbefaler videre oppfølging og opptrening. Nevropsykolog anbefaler videre kognitiv terapi for hukommelsesproblemer. Medikamentell behandling for hodepine etter behov. Han er lite motivert for videre arbeid. Fastlege mener han p.t. er 100% arbeidsufør.

Appendix B. The Interview Guide

Intervjuguide

Fremgang i intervju situasjonen:

Velkommen! Vi er takknemlig for at dere ønsker å delta i forskningsprosjektet, og ønsker å vise dere en tekst om en person som har vært igjennom første del av rehabiliteringen sin etter en ulykke hvor man har pådratt seg bl.a. en mild hjerneskade. Det vi ønsker er at vi leser denne teksten sammen, og stiller dere noen spørsmål om hvordan dere vil gå frem i denne saken.

Vi ønsker at dere presenterer dere selv med

-Fornavn
-Stilling
-Rolle
-Utdannelse
-Arbeidserfaring
-Hvordan er dere organisert internt?

Vignetten leses i Plenum. Hver deltager skal også ha en skriftlig versjon. Vignetten er utgangspunktet for diskusjonen, men diskusjonen er ikke begrenset av vignetten.

1. Når dere får inn en bruker i hans situasjon, hva vil dere gjøre i en slik sak?

Hvilke spørsmål ønsker dere å stille ham (personen i vignetten)?

-Hvorfor ønsker dere å stille ham de spørsmålene?

2. Hvorfor går dere frem slik?

3. Hva er deres begrensinger i å hjelpe ham? (tid, penger, personell?)

4. Hva ser dere som hans største problem?

5. Han er i slutten av sykepengeperioden, vil ha få arbeidsavklaringspenger i etterkant? Kan dere forklare hvordan dere tenker rundt dette?

Hvis det svares overfladisk, lite utdypende spør mer for å avklare hva som menes.

Hvis det er stor enighet, ikke skap uenighet som ikke eksisterer (polarisering i fokusgruppen).

Mulige spørsmål ved manglende diskusjon:

Hva er hans hovedproblemer slik dere ser det?

-Hvorfor synes dere det?

-Hva kan han selv gjøre?

-Hva kan dere gjøre for ham?

Tror dere han vil komme tilbake i arbeid/utdanning?

-begrunnelse?

-Har han andre muligheter?

Hva mener dere er det viktigste å ta tak i nå?

-Hvorfor det?

Hva er problematisk slik dere ser det for ham fremover?

-Hvordan kan dere hjelpe ham med det? Hvilke muligheter har dere til å støtte ham videre?

Det er viktig for ham å komme tilbake i arbeid/utdanning, hva mener dere om dette?

-Hva må i så tilfelle gjøres?

Hva kan dere gjøre for å hjelpe ham tilbake til arbeid?

-Hvorfor?

Hva med hans ønsker?

Dere forteller om mange muligheter, er det noen hindringer som gjør at disse ikke alltid vil bli utløst i praksis?

Forandringer i vignetten (komplisere saken):

«Hvis legen mente han hadde X% (rest) arbeidsevne, hva hadde vært fremgangen da?»

«Hvis arbeidsgiver hadde vært negativ (ev positiv) til å få ham tilbake, hva ville det betydd?»

«Hvis han var en ung mann som var under utdanning og ikke var kommet ut i arbeidslivet, hvordan ville dere jobbet da?»

«Hvis dette var en person på 59 år, hadde det forandret deres fremgangsmåte?»

Hvordan går dere frem for å motivere/realitetsorientere brukere?

Ville dere samarbeidet med andre rundt en slik bruker? Innad i NAV-kontoret eller utenfor?

Hvem ville det i så fall være? Og hva ville samarbeidet bestå i?

(koordinerende enhet, fastlege, andre i helsetjenesten f.eks)

I slike saker, hvor er det dere oftest møter utfordringer?

-Hva tror dere er grunnen til (disse) utfordringen(e)?

Så flytte samtalen litt videre fra den konkrete vignettpersonen og over på NAVs arbeid mer generelt:

Har dere mange slike saker som dette? Er dette en typisk sak? Hvis ikke, hvordan er den annerledes?

Hvordan fungerer samarbeidet mellom NAV og helsetjenesten?

(f.eks med koordinerende enhet, fastlegene, andre?)

Til slutt: Er det noe vi ikke har tenkt på å spørre om, som dere mener det er viktig at vi vet?

Appendix C. NSD feedback on research project

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr: 985 321 884

Ole Kristian Sandnes Håvold
Institutt for sosialfag Høgskolen i Oslo og Akershus
Postboks 4 St. Olavs plass
0130 OSLO

Vår dato: 15.09.2014 Vår ref: 39475 / 3 / IB Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 18.08.2014. Meldingen gjelder prosjektet:

39475	*Conceptualization of 'work' and 'health' in the health sector and the labor and welfare sector, and their implications for inter-sectorial transitions*
Behandlingsansvarlig	*Høgskolen i Oslo og Akershus, ved institusjonens øverste leder*
Daglig ansvarlig	*Ole Kristian Sandnes Håvold*

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Katrine Utaaker Segadal

Inga Brautaset

Kontaktperson: Inga Brautaset tlf: 55 58 26 35
Vedlegg: Prosjektvurdering

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 39475

Vi kan ikke se at det skal behandles personopplysninger med elektroniske hjelpemidler, eller opprettes manuelt personregister som inneholder sensitive personopplysninger. Prosjektet vil dermed ikke omfattes av meldeplikten etter personopplysningsloven.

Det ligger til grunn for vår vurdering at alle opplysninger som behandles elektronisk i forbindelse med prosjektet (lydfiler og transkripsjoner) er anonyme.

Med anonyme opplysninger forstås opplysninger som ikke på noe vis kan identifisere enkeltpersoner i et datamateriale, verken:
- direkte via personentydige kjennetegn (som navn, personnummer, epostadresse el.)
- indirekte via kombinasjon av bakgrunnsvariabler (som bosted/arbeidssted, kjønn, alder osv.)
- via kode og koblingsnøkkel som viser til personopplysninger (f.eks. en navneliste)
- eller via gjenkjennelige ansikter e.l. på bilde eller videoopptak.

Personvernombudet legger videre til grunn at navn/samtykkeerklæringer ikke knyttes til sensitive opplysninger.

Appendix D. Letters and Information to NAV

Til: Arbeids- og Velferds- direktoratet v/XXXX

Fra: Ole Kristian Håvold
Høgskolen i Oslo og Akershus

Forskningsprosjekt hos NAV

Jeg skriver til dere angående et doktorgradsprosjekt mitt "Conceptualization of "work" and "health" in the health sector and the labor and welfare sector, and their implications for inter-sectorial transitions" fordi jeg ønsker å gjøre intervjuer I lokale NAV-kontor. Prosjektet dreier seg om overgangene mellom helsetjenesten og NAV-systemet for personer med mild traumatisk hjerneskade og/eller multi-traume. I prosjektet vil jeg undersøke hvordan man tilnærmer seg problemstillinger rundt arbeid og helse i NAV-kontorene og i de kommunale koordinerende enhetene. Antakelsen er at helsetjenesten og NAV har ulike tilnærminger og at dette kan prege samhandlingen mellom tjenestene. Mitt doktorgradsprosjekt er del av et større forskningsprosjekt finansiert av Norges Forskningsråd. (Se vedlagte informasjon.)

I følge stortingsmelding 47 [Samhandlingsreformen] fra 2009 er det store samfunnsøkonomiske innsparinger å hente ved å minske utfordringene for pasienter som går igjennom et rehabiliteringsløp. Gjennom dette prosjektet håper jeg å framskaffe kunnskap som kan gi bedre muligheter for å gi hjelp til de som er så uheldige at de blir utsatt for omfattende skader.

Dermed kan prosjektet forhåpentligvis forbedre kommunikasjonen mellom Helsetjenestene og NAV på en måte som gagner NAV, helsetjenestene, pasienter og samfunnet generelt.

Jeg håper at NAV vil være positiv til å bidra til dette prosjektet. NAVs bidrag vil være å gi anledning til å gjennomføre fokusgruppeintervjuer på et utvalg lokale NAV-kontor i Sør- og Østlandet. Utvalget av kontor/kommuner vil besluttes av prosjektet. Det vil være en spredning etter størrelse og geografi, men alle kommunene vil ha innbyggere som har blitt rammet av omfattende skader eller hjerneskader. Jeg vil kontakte aktuelle NAV kontorer selv med informasjon om prosjektet for å høre om de er interessert i å være en del av denne forskningen. NAV kontorene ligger i Oslo, Akershus, Østfold, Oppland, Buskerud, Hedmark og Vestfold.

I fokusgruppeintervjuene vil jeg fremstille en vignett dvs. en fiktiv, men realistisk, sak for deltagerne og stille spørsmål om veien videre og tanker rundt framtidsutsikten for pasienten beskrevet i vignetten. Slike fokusgruppeintervjuer vil jeg også gjennomføre ved de kommunale koordinerende enhetene.

Dersom det er bestemte prosedyrer jeg må følge i min kontakt med NAV, ber jeg om nærmere informasjon om dette.

Jeg håper på en positiv innstilling og godt samarbeid med NAV.

Med Vennlig Hilsen,

Ole Kristian Sandnes Håvold
Stipendiat hos Høgskolen i Oslo og Akershus.
Vedlegg

Informasjonsskriv om overordnet prosjekt og doktorgradsprosjektet

Til: NAV XXXX v/fylkesdirektør

Informasjon om forskningsprosjekt hos NAV

Jeg skriver til dere angående doktorgradsprosjekt mitt "Conceptualization of "work" and "health" in the health sector and the labor and welfare sector, and their implications for inter-sectorial transitions" fordi i forbindelse med prosjektet ønsker å gjennomføre gruppeintervjuer ved lokale NAV-kontor i deres fylke. Prosjektet dreier seg om overgangene mellom helsetjenesten og NAV-systemet for personer med mild traumatisk hjerneskade og/eller multi-traume. I prosjektet vil jeg undersøke hvordan man tilnærmer seg problemstillingene rundt arbeid og helse ved NAV-kontorene og hos de kommunale koordinerende enhetene. Antakelsen er at helsetjenesten og NAV har ulike tilnærminger og at dette kan prege samhandlingen mellom tjenestene. Mitt doktorgradsprosjekt er del av et større forskningsprosjekt finansiert av Norges Forskningsråd. (Se vedlagte informasjon.)

I gruppeintervjuene som gjennomføres der vil jeg fremstille en vignett dvs. en fiktiv, men realistisk sak for deltagerne og stille spørsmål om veien videre og tanker rundt framtidsutsikten for pasienten beskrevet i vignetten. Slike gruppeintervjuer vil jeg også gjennomføre ved de kommunale koordinerende enhetene for habilitering og rehabilitering.

I følge stortingsmelding 47 [Samhandlingsreformen] fra 2009 er det store samfunnsøkonomiske innsparinger å hente ved å minske utfordringene for pasienter som går igjennom et rehabiliteringsløp. Gjennom dette prosjektet håper jeg å framskaffe kunnskap som kan gi bedre muligheter for å gi hjelp til de som er så uheldige at de blir utsatt for omfattende skader.

Arbeids- og velferdsdirektoratet ved Tjenestedirektør Bjørn Gudbjørgsrud er blitt informert om prosjektet og har bedt meg om å informere fylkesadministrasjonen i de respektive fylkene. I en e-post fra seniorrådgiver Guro T. Sundklakk ble jeg informert om at NAV sentralt ikke hadde noen innsigelser mot prosjektet. Dette er bakgrunnen til at jeg henvender meg til dere nå.

Vi i prosjektet foretatt en utvelgelse av relevante NAV kontorer for å sikre en spredning etter størrelse og geografi, og for å sikre at at vi får med kommunene med innbyggere som har blitt rammet av omfattende skader eller hjerneskader.
Jeg vil selv kontakte de aktuelle NAV kontorene med informasjon om prosjektet for å høre om de har mulighet til å være med i dette prosjektet. Vi vil strekke oss langt for å skape minst mulig forstyrrelser i en travel hverdag på NAV-kontorene.

Jeg håper på et godt samarbeid med NAV.

Med vennlig hilsen,

Ole Kristian Sandnes Håvold
Stipendiat hos Høgskolen i Oslo og Akershus.
Vedlegg

Informasjonsskriv om overordnet prosjekt og doktorgradsprosjektet

Informasjonsskriv angående innsamling av data i NAV i forbindelse med forskningsprosjekt «Transitions in rehabilitation: Biographical reconstruction, experimental knowledge and professional expertise»

Forskningsprosjektet "Transitions in rehabilitation: Biographical reconstruction, experiential knowledge and professional expertise" (TIR) er finansiert av Norges forskningsråd for perioden 2013-2016 (prosjektnummer 229082). TIR skal studere rehabiliteringsprosessen til personer som har opplevd omfattende skader (multitraumer eller hodeskader). Vi skal studere rehabiliteringsprosessen slik den oppleves fra de skaddes perspektiv, og belyse hvorvidt og hvordan de profesjonelles innsats og den tverrfaglige/inter-organisatoriske samhandling støtter opp under den enkeltes prosess. Prosjektet skal anvende kvalitative metoder og intervjue pasienter og fagfolk samt observere tverrfaglige team på sykehusene.

Prosjektet ledes fra Høgskolen i Oslo og Akershus, og samarbeidspartnere er Oslo Universitets-sykehus og Sunnaas sykehus. Prosjektet har danske samarbeidspartnere fra Aalborg universitet, Regionhospitalet, Hammel Neurocenter og Hvidovre Hospital.

Ph.d.-prosjektet "Conceptualizations of 'work' and 'health' in the health sector and the labor and welfare sector and their implications for inter-sectorial transitions" inngår i TIR. Her studeres overgangen mellom helsetjenesten og NAV. Prosjektet fokuserer på hvordan rehabiliteringstjenestene tenker rundt arbeid og helse samt hvordan dette spiller inn i samhandlingen mellom disse tjenestene. Det utforsker hvordan de organisatoriske, faglige og strukturelle forhold helse- og velferdstjenestenes påvirker tjenesteyting og støtte til brukerne.

Gruppeintervjuene vil finne sted i ti utvalgte kommuner i nedslagsfeltet til Oslo Universitets-sykehus og Sunnaas sykehus, både i helsetjenesten og i NAV, noe som vil si ca. 10 hos NAV og ca. 10 hos de koordinerende enhetene. De som deltar i fokusgruppeintervjuene vil få presentert en såkalt vignett, dvs. en skriftlig historie om en fiktiv pasient som har vært gjennom rehabilitering. Fokusgruppen skal diskutere denne historien ut ifra spørsmål om hvilke muligheter NAV og den koordinerende enheten har til å støtte pasientens videre vei tilbake til en aktiv og selvstendig tilværelse. Det er minimum 3 deltagere i hvert gruppeintervju, og det er ønskelig med flere enn minimum antall deltagere.

Datainnsamlingen vil pågå i perioden september-desember 2014 og hvert enkelt av de utvalgte NAV kontorene vil bli forespurt direkte og informert om målet med prosjektet. Ansatte hos kontorene som ønsker å delta vil få informasjon skriftlig og bli bedt om å skrive under på en samtykkeerklæring.

Prosjektet er meldt hos Norsk samfunnsvitenskapelig datatjeneste (referansenr. 39475).

Med vennlig hilsen

Ole Kristian Håvold
Ph.d.-stipendiat

Tone Alm Andreassen
Professor, prosjektleder

Article 1

Article 1

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Externalizing an 'Asset Model' of Activation: Creative Institutional Work by Frontline Workers in the Norwegian Labour and Welfare Service

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Abstract

The past two decades have brought significant shifts in Norwegian activation policy towards a joined-up and employability-enhancing approach to labour market inclusion in order to promote return-to-work despite health problems or disabilities. Utilizing a concept from health promotion, we term this approach an 'asset model' of activation. The Norwegian Labour and Welfare Service (NAV) and its local offices are the main agents implementing the new policy. This article aims to investigate the strategies that the frontline workers of NAV engage in, in order to externalize an 'asset model' in the adjacent medical field and to the general practitioners (GPs) in particular. We analyze these strategies as forms of creative institutional work – the purposive actions undertaken to change existing presumptions and opinions among relevant actors. We argue that although the new activation policy is not theirs to develop, in order to bring about changes in practice, 'creating' institutional work by the frontline workers is required. Our findings show that the frontline workers develop strategies in order to externalize an asset model to the GPs, as part of operationalizing an 'activation' reform into practice. We identify four forms of 'creating' institutional work undertaken by the frontline workers: 'defining' – enacting legislation and regulation in relation to GPs; 'constructing normative networks' – creating a more collaborative relationship with the GPs; 'educating' – teaching the GPs about the rules and regulations, and the opportunities and assistive measures they can offer to the injured; and thereby also 'changing normative associations' of GPs towards the activation policy.

Keywords

Activation policy; Return-to-work; Frontline workers; 'Creating' institutional work; Asset model; Vocational rehabilitation

Introduction

The past two decades have brought significant shifts in Norwegian activation policy towards a more joined-up, collaborative and employability-enhancing

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approach to labour market inclusion (Andreassen and Fossestøl 2014; Hagelund 2014; Minas 2014). In countries such as the UK, a narrow behaviourist policy response is seen, in which an increase in sickness absence and disability benefit claims is perceived as a problem of attitude and behaviours and met by stronger conditionality in the benefit system and compulsory activation (Lindsay *et al.* 2015). While conditionality is also increasingly seen in Norway, here it is combined with assistive measures and employability-enhancing programmes aimed at promoting return to work despite health problems or disabilities.

Rather than focusing on peoples' health problems and limitations, the explicit intention of the Norwegian Labour and Welfare Service (NAV) is to turn attention to their opportunities and to the removal of workplace barriers to employment. These endeavours are spurred by a new understanding of labour market participation as beneficial to health and well-being, even to individuals with long-term health problems or disabilities. The idea is that full health, in most cases, is neither a sufficient nor a necessary requirement for work ability (Tengland 2011: 278). The policy shift is encapsulated in NAV's mission statement, 'We give people opportunities'.

Applying a concept from health promotion (Morgan and Ziglio 2007), we term this new approach an 'asset model' of activation. Emphasizing individuals' strengths and opportunities, this model stands in contrast to a 'deficit model', which is characterized by a focus on illness, problems and needs.

In health promotion, 'assets' are factors or resources that enhance the ability of individuals to maintain health and well-being. An asset model tends 'to accentuate positive capability to identify problems and activate solutions […] promoting salutogenic resources that promote the self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services' (Morgan and Ziglio 2007: 17). According to Morgan and Ziglio, many of the assets key to health and well-being are located within the social context of peoples' lives. An asset model thus resembles a social model of disability, rather than a medical model locating the problems solely in individual deficits. A social model of disability addresses the need to eliminate workplace barriers and engages employers as partners in delivering opportunities (Lindsay *et al.* 2015).

The collaborative and employability-enhancing approach to labour market inclusion, with its 'asset model' of activation, has challenged predominant institutional logics, i.e. the set of presumptions and opinions governing actions within the labour market and the health care system, as well as within NAV itself (Andreassen and Fossestøl 2014).

NAV and its local offices are the main agents in implementing the new policy. Internalizing an asset model among frontline workers in local offices represented a challenge, as it shifts the focus from income security and bureaucratic regulation to labour market opportunities and the development of an employment-oriented professionalism (Grung 2008: 77; Helgøy *et al.* 2011; Alm Andreassen 2011; Andreassen and Fossestøl 2014). The process not only involved subjecting users to more active follow-up and participation in work integration programmes, but even entailed a kind of 'activation' of the frontline workers themselves as they

were presented with new and challenging tasks (Gjersøe 2016b: 2; Van Berkel 2013).

NAV frontline workers have to *externalize* the new opportunity-oriented perspective to other institutional actors in the inter-sectoral domain of health and welfare. In this article, we analyze how they go about this. Hence, we investigate the strategies that the frontline workers use to promote an asset model to the adjacent medical field. In particular, we discuss strategies towards the users' general practitioners (GPs) with the authority to assess and certify work (in)capability.

In order to understand these strategies, it is important to bear in mind that NAV frontline workers depend on medical knowledge to perform their duties – assessing users' work capability, finding appropriate work-oriented measures, following up the users' return-to-work process, and, where necessary, drawing the conclusion that permanent disability benefit is the only possible option. Arguably, the medical profession holds an elite position in the professional hierarchy. In comparison, frontline workers at NAV typically have a lower position in terms of educational backgrounds. They are facing medical professionals who are likely to mobilize their agency when their role and status are threatened (cf. Currie *et al.* 2012).

We analyze the frontline workers' strategies as forms of 'creating' institutional work (i.e. the work of creating institutions). By this, we mean purposive actions undertaken to amend existing presumptions and opinions among relevant actors. We argue that although the new activation policy is not theirs to develop, in order to transform the policy into practice, the creative institutional work undertaken by the frontline workers is required. The empirical data comes from eight focus groups conducted at different frontline offices in Norway. The fictitious case of a patient with traumatic brain injury at the end of his initial rehabilitation opened the discussion.

Theoretical Framework

An institutional logic is a set of presumptions and perceptions that guides the action of the social actors embedded in a field (Thornton *et al.* 2012: 114). A dominant institutional logic establishes the core principles for organizing activities and focusing interests (Thornton *et al.* 2012: 77). Thereby, it provides a frame of reference for what is perceived as rational and logical within an organization or a field to an extent where it becomes taken for granted (Thornton *et al.* 2012: 2, 77).

The concept of institutional logic turns attention to processes through which institutions govern action. For instance, it is shown how the core institutional logic of the organizational field in which frontline workers are embedded will make them more likely to implement policy mandates in a manner that is congruent with the aims and assumptions of this field (Garrow and Grusky 2013).

Although studies often have emphasized the enduring nature of institutions, there is increasing attention on the ways in which institutions rely on the action of individuals and organizations for their reproduction over time (Lawrence and Suddaby 2006).

Political reforms instigate institutional transformation and thereby challenge established institutional logics (Cloutier *et al.* 2016). Putting into force such transformations requires institutional work, understood as 'the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions' (Lawrence and Suddaby 2006: 215). This concept suggests culturally competent actors with practical skills and sensibility who creatively navigate within their organizational fields.

Implementation of policy reforms hinge on institutional work on the part of a wide range of actors, not only powerful ones endowed with political or administrative authority, but also actors on the ground to implement the policies and with the resources and skills to act as entrepreneurs.

According to Lawrence and Suddaby (2006: 221), there are three different categories of institutional work: '*creating*' (i.e. creative), '*maintaining*' and '*disrupting*' work. Since, in this article, we are exploring the strategies used to promote a gradual transformation of an inter-sectoral field, we focus our attention on the '*creating*' (i.e. creative) work. Creative institutional work again consists of three sub-categories resembling the three pillars needed to support institutions according to Scott (2014).

The first sub-category resembles the *regulative* pillar (in Scott's framework) and reflects work which kind of co-produces policies on the ground by interpreting and elaborating rule systems, using 'advocacy', 'defining' and 'vesting' in order to do so. In this regard, 'advocacy' focuses on 'the mobilization of political and regulatory support' in order to gain access to the social and political capital needed to create new institutions (Lawrence and Suddaby 2006: 222). 'Defining' contributes to the creation of rule systems that grant status or identity, define boundaries of membership or construct status hierarchies within a field in order to define, or redefine, boundaries or a framework within which a new institution can be formed. 'Vesting' is directed towards the creation of rule systems which confer property rights; a process which entails a 'regulative bargain' between the state or some other coercive actor and some other interested actor.

The second sub-category resembles Scott's *normative* pillar. The strategies within this domain attend to the roles, values and norms that underpin institutions. It involves work which alters norms and belief systems by 'constructing identities', 'changing normative associations' and 'constructing normative networks'. In this regard, 'Constructing identities' means providing new identities and thereby (re)shaping the relationship between actors and the field in which they operate, often encompassing the development of new or the transformation of existing professions (Lawrence and Suddaby 2006: 223–4). 'Changing normative associations' involves reinterpreting the moral and cultural foundations of a practice, shaping the understanding of the practice but not the practice itself. 'Constructing normative networks' alters the relationships between the actors within a field through changes in the normative assumptions intertwining them. In other words, it alters how practices become normatively sanctioned through the inter-organizational connections constructing an institution.

The third category resembles what Scott regards as the *cultural-cognitive* pillar underpinning institutions. This type of strategy concerns work which

alters abstract categories, creates systems for problem-solving and spans the boundaries of meaning systems through 'mimicry', 'theorizing' and 'educating' (Lawrence and Suddaby 2006: 225–9). 'Mimicry' legitimizes a new institution through its association with a pre-existing institution, easing the introduction of the new institution and utilizing the juxtaposition of old and new templates to make the new institution accessible and understandable. 'Theorizing' develops and specifies abstract categories elaborating on the chains of cause and effect, creating a new cognitive map of a field, which supports the new institution and its practices. 'Educating' provides actors in a field with a cognitive framework, such as templates for how to act or solve problems through the promotion of the necessary skills and knowledge to support the new institution.

Institutional Logics and Institutional Work in Activation

Below we outline the relevance of the chosen theoretical framework to the understanding of the shift in institutional logic which the frontline workers in NAV are to bring about vis-à-vis the health system.

Actors may be differently positioned to undertake creative institutional work. Regulative forms of institutional work, such as 'defining' and 'vesting', involves governmental authority, and work of governmental agencies in creating regulation and legislation that underpin institutional transformation. 'Vesting' is directed towards the creation of rule systems, which confer property rights; a process which entails a 'regulative bargain' between the state (or another coercive actor) and some other interested actor. 'Defining' relates to the possibilities within the regulation to perform actions towards actors in adjacent fields and is often directed towards 'establishing the parameters of future or potential institutional structures and practices' (Lawrence and Suddaby 2006: 222). In our case, the 'regulative bargain' involves the frontline workers, on the one hand, who represent the labour and welfare authorities, and the GPs, on the other hand, who represent the health system. The 'defining' work of governmental agencies provides resources in frontline workers' work to institutionalize an 'asset model' in the medical field.

In the case of NAV, this institutionalization is achieved through several means. First, it is done by giving the frontline offices the task of assessing work capability with an assessment instrument that concentrates on the need for work-related follow-up services (see Gjersøe 2016a). The outcome of this assessment is an activity plan. Second, institutionalization is achieved by equipping the frontline offices with a range of work-oriented measures to offer to individuals who are in the process of returning to work, ranging from work capability tests, employability-enhancing training programmes, and all sorts of follow-up measures during the process. An individual activity plan can include such measures in addition to medical treatment and rehabilitation. Third, institutionalization is done by extending the regulation to the actions of the GPs. From 2004, the concept of 'sickness certificate' was replaced with a 'sick note', indicating a radical, re-conceptualization of health and work in which the GP no longer holds the authority to certify work incapacity, but only to describe health problems (Damberg 2009: 140). Moreover, GPs

were obliged to report specifically on patients' work ability when issuing such sick notes (Hammer and Øverbye 2006; Damberg 2009). Through this obligation, GPs are effectively 'enrolled' in NAV. Rather than having the authority to certify sickness and disability (and thereby even benefit needs) from a position within the health care system, GPs are given the role of supplier or service provider to NAV. Fourth, NAV has its own medical advisors who can be used to re-examine assessments produced by the health care system.

The institutional work of 'theorizing' – in our case the nurturing of beliefs that support an asset model of activation – has also been undertaken at the governmental level. In 2010, a government-appointed group of experts proposed an activation reform emphasizing work as beneficial to health, and return-to-work processes not presupposing restored health. The theorizing delivered by the expert group outlined a cognitive map of an asset model.

In table 1 we aim to capture the main features of the policy shift from a deficit model to an asset model.

Table 1

Changing logics of activation of people with health-related problems

	The preceding logic based on a deficit model	The unfolding logic based on an asset model
Perception of work	Work only when health is restored	Work during rehabilitation: work as beneficial to health
Assessment of work capability	GPs assess work capability and benefit need, based on medical judgements	NAV frontline workers assess work capability based on medical information and knowledge of the labour market and relevant workplaces
The position of medical experts	GPs are located in the health care system	GPs are to some degree 'enrolled' in the labour and welfare service

Material and Method

Design: focus groups with frontline workers

To examine the institutional work of the frontline workers, we employed focus groups conducted in 2015 at eight different frontline offices ranging in size from ten to 180 employees, in seven different municipalities. There were 27 participants in total, in groups ranging from two to five participants. Table 2 contains the background information on offices involved in this study and the focus group participants.

The time worked in Labour and Welfare Service (or its predecessors) varied from six months to more than 30 years. Educational background varied from upper secondary school to Master's degrees. Eight study participants had

Table 2

Background information on the focus groups

Office	Municipality (type/size)	Number of employees at the office	Number of research participants in interview
A	City district, 48,000 inhabitants	53	3
B	Suburban municipality, 60,000 inhabitants	40	5
C	Rural municipality, 10,000 inhabitants	10	4
D	City, 80,000 inhabitants	180	5
E	Rural municipality, 13,000 inhabitants	28	2
F	City in rural district, 30,000 inhabitants	65	3
G	City, 50,000 inhabitants	80	3
H	City district, 45,000 inhabitants	70	2

higher education in social sciences, seven in social work, four in varying health professions, three in law, and one as a teacher. The others had upper secondary school in combination with internal training from the former national insurance administration.

This varied educational background reflects the traditional low degree of professionalization in the labour and welfare service, compared to for instance health care with the classic profession of medicine and widespread requirements to certification and authorization.

The focus group method

The focus groups were designed to facilitate discussion among the participants, in order to access the different strategies that aligned with the frontline workers' real practice. Two moderators were present at each of the focus groups, and took turns leading the group and observing. However, one primary moderator guided the study participants through the case, narrowing or broadening the discussion as needed, in line with the discussion guide.

As a point of departure for the group discussion and our questions, the participants were presented with a vignette, formulated as a standard report from a rehabilitation hospital. In this vignette, mild traumatic brain injuries (cerebral haemorrhage and temporary paralysis in the left extremities) constituted the need for rehabilitation. In other words, the diagnosis was based on objective medical findings. The vignette is further elaborated later. From the vignette, the moderator directed the discussion to the frontline workers' experiences of relating to medical expertise in general. The discussion guide indicated certain areas of interest in which the discussion should take place, such as perception of medical knowledge, co-operation with actors with medical expertise, as well as more open questions about the vignette person's case.

We followed Morgan's (2012, 2010) approach, in which the focus group discussion is regarded as two overlapping phases of 'sharing and comparing' and 'categorizing and conceptualizing' (Morgan 2012: 70, 169). During the first phase, participants related to each other's experiences and knowledge. The second phase focused on involving the participants in generating more generic knowledge on the subject (Morgan 2010). According to Morgan (2012: 169–71), using homogenous groups such as colleagues who share an 'organizational language' and 'react appropriately to what others say' (Morgan 2012: 169), increases the likelihood of advancing towards the 'organizing and conceptualizing' stage of the discussion.

The focus groups lasted between 60 and 90 minutes. The focus groups were transcribed verbatim, and coded using NVivo 11. Utilizing Glaser's (1978: 72–7) analytical codes, we systematically looked for passages in the material related to strategies, i.e. the frontline workers' ways of promoting an asset model, and whether they indicated changes in their practice over time. Through this exercise, we identified eight specific forms of strategies. In a second review of the material, we mapped the prevalence of these strategies across the offices. The inductive nature of this strategy implies that some strategies may also be applied in offices other than those where we could identify them through the frontline workers' descriptions.

Analysis

Frontline workers' perception of medical professionals

In all focus groups, the frontline workers stated that the variation among GPs was huge when it came to how prone they were to keep a patient on a health-related benefit or alternatively to support a return-to-work trajectory. Indeed, research on Norwegian GPs demonstrates that they have quite different practices of issuing sick notes (Markussen *et al.* 2013). According to the frontline workers, with many GPs, collaboration was easy. Some frontline workers stated that the younger generation of GPs appeared more inclined to collaborate in order to facilitate a fast return to work process. They were more flexible and it was easier to find solutions in line with an asset model, *'They are more into the idea that work is good for your health'* (Office B).

Nonetheless, the group discussion revealed several difficulties in relation to at least some of the GPs, which came to the surface in frontline workers' initial reflections around the vignette case.

The vignette presented a 34-year-old male carpenter. The presentation emphasized aspects of his health and social life, such as treatments, the opinions of health personnel and his own wishes for the future. The timeline in the vignette was set to 12 months after the injury, since this is the point at which a patient would stop receiving sick leave benefits, and hence be approaching the crossroads of either permanent disability benefit or a process of returning to work supported by a benefit called 'work clarification allowance'.

The vignette stated that his GP had declared the man 100 per cent disabled *pro tem*, and that he himself was not motivated to return to work.

Several frontline workers found that the information presented focused too narrowly on health problems:

> *'A lot is written here about this man's limitations. We would try to look at the kind of competencies, work experience etc. that he has, take assistive measures and look for potentials to build upon. The information here is very focused on illness.'* (Office D)

The quote above illustrates the frontline workers' asset approach – they will search for opportunities instead of focusing on limitations and illness. Whether a user is assessed to be 100 per cent or 50 per cent disabled by the GP, the frontline workers will still try out opportunities leading towards employment:

> *'All the time the focus is work, work, work. What does it take to get you to work? That is how we perceive our role – we are to see peoples' potentials.'* (Office C)

> *'It's important to work! It's important to work even if only a little bit, to be in activity! [interjection from another participant] And I think that focus has also been increased.'* (Office B)

Moreover, the frontline workers positioned themselves differently to GPs, referring to the knowledge they have about opportunities in the labour market and in the workplace and about the work-accommodating measures and programmes at their disposal. According to the frontline workers, the GPs lacked information on the possibilities and opportunities available in order to facilitate an accommodating return to the workforce:

> *'The GPs don't know what kind of information we need, and they don't know what kind of measures we can offer.'* (Office H)

> *'They have little information on how many opportunities NAV has. Even if we try to keep them up to date, they are not aware of this.'* (Office B)

> *'In a case like this, I wouldn't have given the view of the patient's GP any concern. They don't have much competency on these matters. They have a tendency to be too negative. They are holding back instead of seeing the opportunities.'* (Office B)

The frontline workers expressed a concern that the health system in general and the GPs in particular focused too much on health deficits, and too little on opportunities:

> *'We often think that the GPs think too little in terms of activity and work, that they are too preoccupied with peoples' diseases. They are confining opportunities rather than enhancing them.'* (Office D)

From such statements, it appears that the GP's evaluation of the vignette person being currently 100 per cent disabled would not significantly impact

the frontline workers' action. Rather, they will look for opportunities with a longer perspective. Yet, they still requested medical expertise in order to understand in which way the patients' functioning was affected by illness or injuries, and what their prognoses were.

The frontline workers requested knowledge about the *implications* of the diagnosis – the functional aspects and prognoses:

> *'Functional descriptions where they [the GPs] say something about the functional ability [of the patient] […] that means a lot to us. Not just a diagnosis, but how he performs with that diagnosis.'* (Office D)

However, according to the frontline workers, this was not always what they received. The information from GPs could be vague, not providing the frontline workers with sufficient information to make judgements about appropriate measures, or about whether they could push the user forward or hold back and wait for further recovery. When relating the fictitious vignette case to real experiences, the frontline workers said that GPs did not always provide objective assessments, but instead passed on the patient's subjective accounts:

> *'Our experience is that GPs are often their patients' "advocates". They write what the patient says and thinks, instead of providing their own objective account.'* (Office E)

> *'I feel that the GP is somewhat controlled by the patient and the patient's wishes. The GP's opinion about what the patient can actually do is not clear. […] The information eventually becomes blurred […]. What is the GP's medical assessment and what is in reality the patient's opinion? And what motivation lies behind the assessment?'* (Office G)

Referring to it as the 'greatest challenge' in her work, one frontline worker described a type of 'round dance' where the frontline worker agreed with the user on a specific work-oriented measure, whereupon the user went to her GP and 'asked' for a sick note stating that she was unable to participate, in effect delaying the assessment process:

> *'… it was my understanding that we had taken a step in the right direction, that we had assessed the documentation and the underlying conditions, and that we have had a common understanding at least to a certain point … and then I get a medical certificate stating something else.'* (Office H)

The frontline workers suspected that some GPs wanted to shelter the patient from activation measures, at the same time safeguarding their alliance with the patient and even their own economic outcome – which is dependent on patient fees and consultation reimbursement from the insurance system. Moreover, at stake for the part of the GPs, according to the NAV frontline workers, were their own professional position in the status hierarchy.

According to some frontline workers, in aiming to protect the patient, some practitioners may overstate the limitations caused by medical conditions, thereby delaying the return-to-work process:

> *'NAV tries to map the resources and potentials that an individual has … an approach that the GPs and the health services might not be familiar with… They therefore become anxious and want to protect their patient from the testing that NAV is carrying out.'* (Office A)

Some frontline workers also pointed to a kind of patient-practitioner alliance nurtured by some practitioners. When the GP referred only to the patients' opinion about their health condition, they avoided confrontations with the patient and left it to NAV to tell the patient that they were not ill enough to qualify for benefits, *'The GPs almost want us to be the big, bad wolf'* (Office D). According to the NAV frontline workers, this kind of alliance can work to the detriment of work reintegration processes:

> *'They make them stand up against us. (…) Then we're not allowed to enter the stage with our offers. We can facilitate a gradual and accommodating return-to-work process if we all play as a team, but when we are all doing our own thing, it becomes difficult.'* (Office F)

Another frontline worker went further, saying that the GP had often reached a conclusion that the future of the user was permanent disability benefit:

> *'(…) it is often when both patient and GP have made up their mind that this [disability benefit] is what the patient should have. Then they have the fight going on – a fight against NAV, because we are saying "no disability benefit".'* (Office G)

> *'I experience that quite a few practitioners are using a common hostility against NAV in order to strengthen their own relationship with the patient – so that they two become a kind of team against NAV.'* (Office F)

The frontline workers indicated that GPs may actively utilize the users' aversion in order to forge a stronger alliance between the patient and themselves.

Some even suggested that some practitioners had a personal interest in retaining their patients in long-term treatment. In addition, some frontline workers suggested that GPs wanted to demonstrate the power that has traditionally been bestowed on their profession:

> *'I think – and this may be like cursing in church – that they have a need to show that they are the GP, they are the ones who decide.'* (Office B)

To sum up, while the frontline workers stated that some GPs had adopted an asset model and co-operated well with NAV, the focus groups also conveyed abundant accounts on difficulties in their relationship to other GPs. These difficulties are what the frontline workers try to ease through strategies that we conceive as creative institutional work.

Institutional work to externalize an asset model of activation

From our focus group material we identified four forms of creative institutional work enacted by the frontline workers: 'defining' – conferring status and creating hierarchy; 'constructing normative networks' – establishing spaces for discussion and dialogue; 'educating' – teaching GPs the policy and regulation of activation; and 'changing normative associations' – changing GPs' view of activation policy and measures. Some forms of institutional work appear to be widely prevalent in the material; some only appear in a few offices. Table 3 provides an overview of the types of strategies we identified in the eight offices.

Table 3

The use of strategies in the different frontline offices

	Office							
	A	B	C	D	E	F	G	H
'Defining'								
Temporarily suspension of benefits in order to instruct GPs to provide better documentation		X			X			
Advisory medical staff evaluation of cases	X	X		X	X	X		X
Constructing normative networks								
Dialogue meetings with GP	X	X	X	X	X	X	X	X
Information exchanges with GP	X	X	X	X	X	X	X	X
Educating								
Co-operative meetings	X	X	X	X	X	X	X	X
Initiate medical assessment/treatment	X		X	X	X		X	
Changing normative associations								
Include GPs in preparation for labour market inclusion		X		X	X	X		X
Emphasizing positive measures	X	X	X		X	X	X	

The strategy of defining. While 'defining' concerns governmental authority as materialized in laws and regulation, the concrete enactment is undertaken by frontline workers. Hence, frontline workers in their daily casework, through their discretion, are practicing processes of defining, hereby conferring status and altering hierarchies.

The sick leave regulation stipulates that if, after eight weeks, return-to-work has not taken place, 'activity', in the form of at least part-time work in combination with sickness benefit should be the norm, and 100 per cent sick leave the exception. Beyond that point, the reasons for 100 per cent sick leave have to be specifically stated by the GPs.

At two offices the frontline workers described that on some occasions they had suspended the user's sickness benefit temporarily on the grounds of lack of information from the GP. This suspension was done when there was a lack

of sufficient information to assess the case, and when repeated attempts to obtain this information from the GP proved unsuccessful:

> *'We want to have more information from the GP, in other words, they need to do more work. They know their patient, and they put them on 100% sick leave. But the GP's assessment does not give enough information to justify that the user cannot take part in any form of activity.'* (Office E)

By applying this strategy, the frontline workers signal to the GPs that they have to provide more information.

A government-assigned resource, to which the frontline workers have access, is the employment of advisory medical staff within NAV. By employing its own medical staff, NAV redefines the hierarchical position between the GPs and NAV. The frontline workers use assessments made by the advisory medical staff to determine how to proceed with the case, either giving disability benefit or trying out assistive measures in order to reintegrate the user into the workforce.

Several frontline workers explained that the advisory medical staff's assessment and evaluation of difficult cases were important since they themselves lacked the necessary medical knowledge. The advisory medical staff evaluate, for instance, whether every relevant form of treatment has been tried out, whether the reasons for the benefit application are sufficiently described or whether the user instead could return to work, at least part time. In doing this, they also evaluate the assessments made by the GPs and other health specialists involved in the patients' case:

> *'Can the functional description explain the reduced work capability? Is it objective … Is it a subjective finding? The advisory medical staff can interpret the statements given by specialists in a different way than we can.'* (Office E)

> *'Lately, during the recent half year, we have declined more cases [of health related benefits] than previously … Maybe because our medical advisory, who goes deeper into the case, makes us more aware on reading the documentation in a different light.'* (Office E)

Constructing normative networks. The frontline workers set up different kinds of meetings with the GPs, some aimed at discussing a single case, while others aimed at presenting the activation policy in general. An example of the latter is meetings set up with practitioners with the authority to issue sick notes (now with the heading 'Evaluation of work capability'), such as GPs and chiropractors. These meetings appear to serve the function of cultivating common norms, and on the part of NAV, to ensure that GPs adopt the norms congruent with an asset model.

There is a consensus among the frontline workers that relationships with GPs would improve greatly if they could discuss actual cases together, as in the so-called 'dialogue meetings' regularly set during a sickness absence process. The GP, the patient and the patient's employer could take part in these

meetings. According to the frontline workers, the meetings helped to generate support from the GP for NAV's suggestions, as expressed in this quote:

> *'If we manage to get a dialogue with the GP and the patient, and have a meeting with them, and present some suggestions of what to try, then I feel that the GPs are backing us up.'* (Office B)

Through such meetings, the frontline workers involve the GPs in the 'difficult conversation' with the patients about their functional ability, and what realistically to expect in terms of benefits from NAV. As described above, in several instances, the frontline workers felt that they were the ones left with the task of motivating the patient for a return to work, or, even worse, that they were assigned the role as the patient's enemy, denying the benefits which they and their GPs thought of as the best solution to their problem.

The frontline workers often referred to the meetings aimed at presenting the activation policy in general as 'information exchanges'. This is because they also used the meetings to gain insight into the patient's health-induced limitations as perceived by the patients themselves and by the GP. The frontline workers considered them helpful in creating normative consensus and fostering collaborative attitudes.

Yet, facilitating meetings with the GPs is not easy since the GPs are spread over large geographical areas. Furthermore, the GPs do not get reimbursement for time spent travelling to and from the meetings.

The strategy of educating. In order to address the problem that GPs do not always act according to the formal requirements of NAV, let alone its asset-oriented mission, the frontline workers 'educate' the GPs. For example, in order to address the problem that sick notes and medical declarations do not provide the kind of information the frontline workers need, one office organized a meeting with the purpose of communicating the appropriate approach to providing objective accounts of level of functioning. In such meetings, the frontline workers make it clear to the GPs that even if the patient's employer is reluctant to cater to certain health needs, the patient may still have a general work ability, even if not with this employer.

As described above, according to the frontline workers, GPs lack information on how the frontline workers test the patients, and how accommodating their return to work can be made by assistive measures through NAV. Co-operative meetings are held in order to 'educate' the GP and the patient about the opportunities these measures represent.

The frontline workers found that some GPs focus too narrowly on acquiring disability benefits for their patients, not knowing the tight eligibility criteria:

> *'You need to give some of these GPs a "reality check" and say, "Yes, but according to the testing so far, this will not lead to a disability benefit; the application will be rejected".'* (Office A)

However, the frontline workers also 'educate' the GPs to follow up their patients more closely and to perform thorough medical assessments:

> *'Sometimes we have to initiate medical assessments and treatment, for instance neuropsychological testing, if permanent disability benefit is to be applied for.'* (Office D)

> *'In some cases, I wonder, "why haven't you been referred to an examination for rheumatism or at least an X-ray of your spine, instead of years with painkillers?" I had a case where I recommended the user to find another GP and suddenly a lot of medical declarations arrived, stating that the patient was very ill.'* (Office A)

Changing normative associations. The frontline workers work continually towards changing the GPs' view of activation policy and measures. Since, as described above, GPs can view work-oriented measures as a strain and pressure on their patients, and try to shelter the patients from them, the frontline workers try to present them instead as representing opportunities.

One strategy for instilling an asset-based focus as the guiding principle in the case is involving the practitioners in the preparation of the patient's labour market reintegration plan. According to the frontline workers, through such involvement, the different parties are more likely to work collaboratively towards the same goal.

The frontline workers use every opportunity to point out to the GPs the possibilities for assistive measures, for example, facilitating personal transportation to enable a user to undertake return-to-work measures. By emphasizing the positive measures, they can make the GPs revise their standpoint on what is an appropriate way to proceed with a patient.

Discussion

In the previous section, we identified four forms of 'creating' (i.e. creative) institutional work undertaken by the frontline workers: 'defining', 'constructing normative networks', 'educating' and 'changing normative associations'.

'Defining' is a form of institutional work that rests on governmental authority, regulation and legislation that underpins institutional transformation. The future is created by defining parameters (Lawrence and Suddaby 2006: 222). The potential inherent in regulation, such as the regulative framework of activation policy, is yet to be realized. The rule systems, hierarchies and boundaries established through governmental authority must be put into practice through the 'creating' (i.e. creative) work of frontline workers. In that sense, even frontline workers undertake 'defining' institutional work.

'Defining' work is coercive and authoritative, as when frontline workers temporarily suspend users' sickness benefits in order to make GPs produce the information required or when they make use of advisory medical personnel to re-assess the information and decision of the GP. By employing this strategy, the frontline workers signal to the medical professionals within the health care system that they are not the ultimate authority on the issue of employability and work incapability. Moreover, the frontline workers signal that they – rather than the GPs – have the power to make an assessment on whether or not sickness absence is sufficiently justified. Through these 'defining' endeavours, the frontline workers locate part of the GPs' job within NAV,

and the hierarchy between the medical professionals and the frontline workers is redrawn. Our data suggested that where these forms of institutional work are undertaken, they seem to be increasingly enforced.

The creative institutional work in the form of 'constructing normative networks', 'educating' and 'changing normative associations' can in practice take place concurrently – for example, in meetings set up to underpin normative networks, GPs are also educated, and in discussions with GPs the frontline workers attempt to alter the image of NAV's work-oriented measures and programmes.

The frontline workers 'construct normative networks' through information exchanges, for example, through involving the GPs in preparing a plan for the user's labour market reintegration. These information exchanges entail collaboration between the GPs and the frontline workers, informing the GPs about which possibilities and opportunities that NAV offers and trying to prevent GPs from prolonging sickness absence and impeding the user's return to work. According to the frontline workers, through this collaboration, the GP and the frontline workers are more likely to work towards the same end.

The information exchanged in such meetings focuses on the extent to which the work and welfare offices are able to tailor their work-accommodating services to the needs of the individual users. Such meetings were intended to reduce confrontations between the frontline workers on the one side and the GPs and their patients on the other side.

'Educating' other actors requires access to adequate resources in order to succeed, such as the resources available to large organizations. One form of 'educating' is providing templates, which serve as outlines for actions, as well as offering adequate knowledge to engage in these new practices. GPs are, according to the frontline workers, ill-informed about the opportunities NAV can offer. Informing the GPs about NAV's substantial portfolio of assistive measures arguably aims at introducing templates for new practices, and also enhancing the GPs' understanding of the requirements for receiving a benefit from the national insurance system.

The frontline workers' efforts in 'changing normative assumptions' focuses on altering the GPs' perspectives, and thus countering the emergence of 'alliances' that impedes the users' participation in return-to-work measures.

These forms of institutional work rely heavily on co-operation and dialogue between the actors involved, and thus conform to the general direction of social insurance policy and activation policy in Norway (Andreassen and Fossestøl 2014; Fossestøl *et al.* 2015; Hagelund 2014). In other words, this type of institutional work is about creating a setting in which it is natural to have the same goal. Thus, such a dialogue-driven action can be tied-in with an asset model's ingrained optimism and positive opportunity approach to activation. It is aimed at reducing the individual participants' strategic action in favour of communicative action in problem-solving tasks, which is seen in various kinds of rehabilitation processes in Scandinavia (cf. Enevoldsen and Nielsen 2001; Harsløf *et al.* 2002).

However, the creative institutional work of the frontline workers also demonstrates several kinds of tension. The frontline workers are trying to create collaborative relationships with the GPs and build normative networks as

partners who share a common normative interpretation of the activation policy. Their effort is, however, characterized by relationships of asymmetry.

First, their actions aim to counter what they seem to perceive as the GPs' efforts of keeping the traditional authority bestowed on their profession. The frontline workers see the actions of some GPs as demonstrating conflicts of interests. They more or less implicitly describe that the GPs' professional (and economic) interests in pleasing and maintaining good relationships with their patients may prevent objective accounts of the patients' health conditions and functional abilities. The activation policy has, to some degree, enrolled the medical profession – the GPs – into the domain of NAV. This rebalancing of the relationship between the GPs, the frontline workers and NAV, may have encouraged the GPs to undertake institutional work in order to maintain existing resources and control, similar to the process described by Currie *et al.* (2012).

Second, the frontline workers sometimes portray the context in which they work as a kind of combat zone in which the users and the GPs form alliances against the enemy, NAV. The expression 'the fight against NAV', that some of the participants used, alludes to the numerous mediated narratives occurring in the wake of the NAV reform, depicting users in desperate situations due to allegedly poor treatment at NAV, and who then engaged in David versus Goliath-like struggles (Breit 2014).

Third, the elite position of the medical profession is being challenged. The GPs are now facing frontline workers with higher education, some with law degrees, who are utilizing the advisory medical expertise of NAV to re-examine the medical diagnoses of the GPs. As a result, the GPs' position is somewhat devalued. While the frontline workers of NAV aim to stimulate equal and collaborative relationships, they sometimes still utilize regulative and professional authority to make the medical professional comply with the requirements of the activation policy.

Conclusion

The past two decades have introduced a new logic in Norwegian activation policy towards people with health limitations, focusing on peoples' opportunities rather than problems. This shift has been spurred by a re-conceptionalization of work, traditionally understood as a burden, but now regarded as conducive to health promotion and well-being. We have termed this new understanding an 'asset model' of activation.

Our focus group interviews suggest that frontline workers apply several forms of strategies in order to promote an asset model among the GPs. As part of putting the activation reform into practice, the frontline workers undertake creative institutional work in accordance with their environment and goals.

We believe the forms of institutional work described here are crucial to understanding how a politically motivated reform can lead to changes in practice. The frontline workers operate at the boundaries of fields, creating new institutional practices designed to amend existing presumptions and opinions among relevant actors. Accordingly, in order to implement the reform successfully, there is a need for frontline workers' creative institutional work. This

study suggests that gradually NAV is gaining ground in the inter-sectoral field of health and welfare, imposing its work-oriented mission, thanks to incremental but critical institutional transformation of the ways the frontline workers are approaching the traditionally strong medical profession.

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Article 2

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Opportunity talk, work talk and identity talk: Motivating strategies used by the Norwegian labour and welfare offices*

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ABSTRACT

The article explores the strategies utilised by frontline workers at the Norwegian Labour and Welfare administration (NAV) to motivate unmotivated users to return to work. NAV is entrusted with both welfare services and returning unemployed citizens to work. The data analysed consists of eight focus groups conducted at local NAV offices. The analysis identifies three different strategies employed by the frontline workers. These three strategies are termed 'opportunity talk', 'work talk' and 'identity talk', reflecting the reliance on dialogue. The article argues that these three strategies are part of a schema that is operationalizing 'an asset model of activation', and rely on a shift in the understanding of work, traditionally seen as a burden, to an understanding of work as beneficial to health and wellbeing. The results imply that the frontline workers are key to the successful implementation and operationalization of activation policy.

KEYWORDS

Schema; return to work; activation policy; frontline workers; institutional logic

Introduction

In the aftermath of the Second World War, most of the Nordic countries embraced active labour-market policies (ALMP), focusing on removing hindrances to reintegration into the labour market (Swenson 2002; Bonoli 2010; Stjernø, Jessen, and Johannessen 2014). ALMP has been part of policy in Norway since the 1960s, when comprehensive vocational rehabilitation measures were launched (Dropping, Hvinden, and van Oorschot 2000). Activation reforms saw a revival in Norwegian policy documents in the 1990s (Bonoli 2010; Terum and Hatland 2014; Terum and Jessen 2015). The activation reforms beginning in the 1990s culminated in the establishment of the Labour and Welfare Administration (NAV) in 2006, merging the Pension and Insurance Agency, the National Employment Service and Social Services at the municipal level into one organisation. Following this merger, a new role for the frontline workers seems to emerge (Helgøy, Kildal, and Nilssen 2011). This new role came about due to a new approach to unemployed users with health disabilities, based on the idea that full health is not a necessary requirement for work ability (Nordenfelt 2008; Tengland 2011)

'Activation' policy has traditionally been divided into two types of approaches – restrictive and supportive. A 'restrictive' approach focuses on tightening eligibility criteria in order to reduce the number entitled to receive benefits, while a 'supportive' approach aims to increase the number of individuals

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returning to work (Eichhorst, Kaufmann, and Konle-Seidl 2008; Gjersøe 2016b). Arguably, compared with approaches in other countries, the Norwegian policy leans towards the supportive approach (Lødemel and Moreira 2014). Characterising this approach is a focus on improving skills, arranging health treatments and providing education, with the aim of increasing users' chances in the labour market (Gjersøe 2016b, 144, 153). In the past decade, this approach has been intensified in Norway, with an even stronger focus on issues such as motivation and other individual attributes, to the extent that a paradigmatic shift in NAV's conceptualisation of health and work can be seen.

Håvold, Harsløf, and Andreassen (2017) describe the new logic as an 'asset model' of activation, borrowing the term from health promotion (Morgan and Ziglio 2007). The key aspect of an 'asset' model of activation is that it seeks to promote the user's self-esteem and self-worth and puts the focus on opportunities rather than deficits. The user's own resources are 'mapped' (Morgan and Ziglio 2007) and then utilised to reduce the impact of the user's disabilities, with a view to removing barriers to employment and eventually making the user less dependent on public services and support (Håvold, Harsløf, and Andreassen 2017).

An asset model of activation is in many respects comparable to a social model of disability, in that it attempts to remove barriers to employment and seeks to include employers as partners in delivering opportunities for reintegration into the labour market (Lindsay et al. 2015). The frontline workers seem to be in the process of institutionalising an asset model of activation towards labour-market inclusion which is collaborative and employability-enhancing (Andreassen and Fossestøl 2014). Many studies exist on the frontline workers and their agency in operationalizing policies (Van Berkel and Van der Aa 2012; Brodkin 2015; Breit, Andreassen, and Salomon 2016; Nothdurfter 2016), but so far there has been little research into how frontline workers operationalize an asset model of activation when working with people with health disabilities.

Shifts in approaches and problem-solving within organisations can be linked to changes in the institutions governing the field in which the organisation operates (Thornton, Ocasio, and Lounsbury 2012; Scott 2014). Institutional logics offer schemas to actors at the micro level to guide problem-solving. A schema operates by organising cognitive structures that help to guide an actor's problem-solving by focusing their attention and offering solutions (Thornton, Ocasio, and Lounsbury 2012, 88, 89). The frontline workers at NAV apply an asset schema, indicating a shift in the dominant logic from one emphasising income-securing and bureaucratic regulation to one characterised by employment-oriented professionalism and labour-market opportunities (Hvinden 2008; Helgøy, Kildal, and Nilssen 2011; Andreassen and Fossestøl 2014). The shift in dominant logic pushes the users to accept that they are subject to more active follow-up, but also challenges the frontline workers themselves to adapt to new and challenging tasks (Gjersøe 2016a).

This article aims to explore how frontline workers operationalize the new institutional schema in their approach to users with health disabilities. What strategies do the frontline workers use to motivate their users for embarking on a track towards reintegration into the labour market? The following section begins by locating the study within the wider context of activation policy in Norway and the Nordic countries. The theoretical framework on institutional logic and schemas is then articulated, and the focus groups and vignette described. In the empirical analysis that follows the description of the method, it is argued that the frontline workers' approaches to users with health problems can be categorised as types of 'talk', and three dialogue-oriented strategies identified. The final two sections present the analysis and conclude that the strategies identified are part of a schema initiated by the frontline workers.

The Norwegian welfare state and activation policy

In the 1980s, Norway's welfare system was regarded as too fragmented, with several actors at both the state and municipal level working on various aspects of the same cases. The reform passed in 2005, which led to the creation of NAV, resembles the post-new public management reforms in the Anglo-Saxon world, as well as in Germany, the Netherlands and in other Nordic countries. A common feature

of these reforms is that they aimed to create one-stop shops which deal with a variety of labour- and welfare-related issues (Christensen, Fimreite, and Lægreid 2014; Jantz, Christensen, and Lægreid 2015).

The central aim of welfare policy in Norway has, since the 1960s, been to maximise the population's participation in paid employment. Thus, the change which came with the 'turn' to activation in the 1990s was more of a course correction, rather than a path-breaking innovation (Halvorsen and Jensen 2004, 463). Since the early 1990s, activation policy in Norway has focused on the co-responsibility of claimants to gain employment and qualify for labour-market participation. Therefore, attempts have been made to design a welfare system which stimulates retention in or a return to the labour market (Halvorsen and Jensen 2004, 474, 475). Although the policy has a supportive activation approach, sanctioning measures (such as withholding benefits) are available if a user does not comply with agreements between them and NAV.

NAV's optimistic and opportunity-driven approach to activation is reflected in its slogan – 'We give people opportunities'. The frontline workers at NAV utilise a dialogue-driven approach in motivating users to participate in measures or return to work (Hansen and Natland 2016). The importance of dialogue in rehabilitation processes thus seems to be an integral part of problem-solving for the frontline workers. One can further observe how the new approach aims at bypassing agonistic positions. For example, efforts are made to bring different parties (such as the user, the GP and the previous/current employer) into a communicative setting that encourages them to play down their own interests and instead focus on common solutions conducive to the goal of work integration.

Activation policy in Norway mirrors in many ways the policies in the other Nordic countries which involve mandatory activation programmes in return for financial support (Johansson and Hvinden 2007; Thorén 2008; Bengtsson 2014). At present, Norwegian financial support is more generous than that of its Scandinavian counterparts (Lorentzen et al. 2014). Furthermore, the development of activation policies in Scandinavia has arguably followed a supportive approach, aiming at diminishing the impact of an individual's hindrances to returning to the labour market rather than limiting the number of people eligible to receive benefits and measures (Bonoli 2010).

The development of ALMP has been quite similar across the Scandinavian countries (Bonoli 2010). Esping-Andersen (2013) attributes the similarity among the Nordic countries to a strong political left that dedicated significant resources to ALMP prior to the 1990s (with the exception of Denmark). Sweden, for example, developed ALMP as early as the 1950s (Swenson 2002). The development of ALMP arguably consisted of a cross-class compromise between the state, employers and labour unions, which allowed for both the pursuit of political goals and the profitability of capital (Katzenstein 1985). It was not until the mid-90s that there was a steep increase internationally in the appearance of the term 'activation', signalling a reorientation in the policies. Bonoli (2010) argues that countries with a long history of ALMP were slow to embrace the new activation paradigm. Denmark, which had done relatively little in terms of ALMP before the 1990s, was among the first to embrace the paradigm with a series of reforms to implement activation policies in the early 90s. Sweden, on the other hand, did not start implementing activation policies until the late 90s, and with the unemployment insurance reform of 2001, strengthened the orientation of the activation policy towards premarket employment.

Theoretical framework: institutional logics and schemas

Studies have often emphasised the enduring nature of institutions. Yet, attention is increasingly being paid to the ways in which institutions rely on the actions of individuals and organisations for their reproduction over time (Lawrence and Suddaby 2006; Lawrence, Suddaby, and Leca 2009; Thornton, Ocasio, and Lounsbury 2012). An institutional logic is a set of presumptions and perceptions which guide the action of the social actors embedded in a field (Thornton, Ocasio, and Lounsbury 2012; 114). According to Scott (2014), an institution rests on three pillars – the regulative, the normative and the cognitive, which support the institution's core assumptions and knowledge. Thus, a problem-solving strategy relies on one or more of these pillars for its legitimization. A dominant logic establishes the core principles for organising activities and focusing attention (Thornton, Ocasio, and Lounsbury

2012, 77). In other words, frontline workers embedded in a field with strong institutional logics are more likely to implement policy in a way that fits the core aims and assumptions in a field or organisation (Garrow and Grusky 2013). Each organisation and organisational field can support several logics which compete to establish a dominant position in order to provide the actors in that field with a frame of reference for what is rational and logical (Thornton, Ocasio, and Lounsbury 2012, 2, 77). Such competition is especially relevant when an organisation is going through a transformation.

An institutional logic operates at both the macro and micro level, but is not available in its entirety for an actor at the micro level. Instead, an actor embedded in an institutional logic will use part of the presumptions and perceptions of that institutional logic in a specified situation. In such a situated event (e.g. approaching a user), the frontline workers would, through focus of attention, activate certain aspects of the institutional logic (i.e. a schema) in order to solve a problem or make a decision (Thornton, Ocasio, and Lounsbury 2012, 85–91). One way in which institutional logics operate at the micro level (e.g. the frontline workers) is through schemas which are top-down knowledge structures guiding decisions and approaches (Thornton, Ocasio, and Lounsbury 2012, 88, 89). That schemas are top-down knowledge structures implies that these are learned ways of shaping attention and solving problems (Thornton, Ocasio, and Lounsbury 2012, 88). This implies that frontline workers never apply an institutional logic in its entirety, but only partly, i.e. they activate a schema.

Cheng and Holyoak (1985) described one of the schemas they identified as a pragmatic reasoning schema. A pragmatic reasoning schema is not an automatic script which apply in any situation, but rather an abstract knowledge structure which is applied to specific domains of action or classes of goals (Cheng and Holyoak 1985, 395). A pragmatic reasoning schema serve to facilitate the interpretation of information based on desirable actions guided by an institutional logic (Cheng and Holyoak 1985; Thornton, Ocasio, and Lounsbury 2012). Schemas is an integral part of the decision-making of frontline workers and operate at the intersection between regulation, cognition and norms. One schema may offer several strategies to achieve a desirable outcome. Thus, the activation of a schema is to some extent automatically based on what is taken for granted, but still requires a certain degree of reflection due to the abstract knowledge structure invoked in order for the embedded actor to determine the desirable outcome in each instance.

Elaboration on the macro-to-micro level aspect of institutional logic and the application of schemas is required in order to analyse the strategies applied by the frontline workers. Political reforms instigate institutional transformation and thereby challenge established institutional logics (Cloutier et al. 2016). Several studies applying institutional logics theory have shown that in the aftermath of the merger which resulted in NAV, several logics competed for dominance (Andreassen and Fossestøl 2014). Helgøy, Kildal, and Nilssen (2011) find that the frontline workers' perception of their role developed. The frontline workers' new perception of their role implies that a new logic is in the process of asserting its dominance over the core values in the field.

According to Thornton, Ocasio, and Lounsbury (2012), 16, 17, 83, 84), there are connections between the different levels on which institutional logics operate (see Figure 1). The focus of attention guides limited cognitive resources towards what is perceived as relevant, which in turn activates a schema. A schema draws on an institutional logic or multiple logics through focus of attention, in effect deconstructing the abstract knowledge at the macro level to solve a specific problem at the micro level. However, the availability of solutions depends on the embeddedness of an actor in an institutional logic. Thus, an institutional logic offers the frontline workers solutions to problems (i.e. schemas) depending on three aspects - the availability of knowledge, the focus of attention and the organisational practices deemed relevant to achieve the purpose or goal according to the organisation's logic(s) (Cheng and Holyoak 1985; Thornton, Ocasio, and Lounsbury 2012, 83–86). In short, an asset schema as described in this article is an operationalized asset model of activation helping the frontline workers achieve their objective(s) given cognitive limitations by offering different strategies.

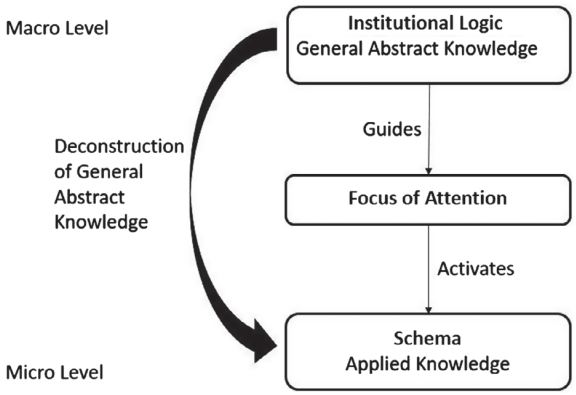

Figure 1. A cross-level model of institutional logics. Based on Thornton, Ocasio, and Lounsbury 2012, 83.

Material and method

The data used in this article derives from a project exploring the transitions of traumatic brain injury (TBI) patients between different organisations during the rehabilitation process. The aim is to reintegrate the patient in the labour market. In order to explore the frontline workers' strategies to motivate users for a return-to-work process, eight focus groups were conducted at local NAV offices. The point of departure for group discussions was a vignette presented in the form of a fictitious standard report from a rehabilitation hospital. The focus groups were held in 2015 at eight local NAV offices that ranged in size from 10 to 180 employees. Each focus group comprised 2–5[1] frontline workers with 27 participants in total. The education of the group of participants comprised four health professionals, four social workers, three participants with a background in welfare studies, three with law degrees, eight with a social science education, one teacher and four with upper secondary education. The recruitment of study participants was a three-stage process. Firstly, permission to contact regional offices was acquired from the central directorate; secondly, the regional offices were contacted for permission to contact their local offices; thirdly, the local offices were contacted to organise the focus groups. The supervisors at each office picked out participants who had experience with users with health problems. The participants were given information on the study and a consent form by their supervisors, which was signed before or during the focus group. The study is registered at the Norwegian Centre for Research Data.

TBI caused by cerebral haemorrhage giving symptoms of paralysis in the left extremities was chosen as the main cause for rehabilitation in the vignette. The local NAV offices were chosen based on data received from two rehabilitation hospitals. The data received contained information on which local offices had recently been referred patients with similar conditions to those presented in the vignette. However, it was not stipulated that the participants in the focus groups had direct experience of such cases, as they are quite rare. TBI was chosen as the injury reasoning that such medical findings are perceived as medically objective. The vignette case would therefore serve as a 'critical case' (Flyvbjerg 2006, 233, 234), reasoning that if the frontline workers suggested a 'restrictive line', they would probably do so in cases with less medically-objective findings.

The vignette was constructed around a 34-year-old carpenter. It detailed aspects of health status, treatments, the opinions of health personnel and the patient's own wishes and current social life. His GP had declared him 100 per cent disabled *pro tem*, and the patient was depressed and not motivated for returning to work. The frontline workers are presented the vignette at 12 months after the accident, the point at which they are required to stop sick-leave benefits, and hence approach the crossroads of either disability benefit or the Work Capacity Allowance (WCA).

The focus groups were set up with the aim of promoting discussion among the frontline workers in order to access the strategies that align with their real practice. Morgan's (2010, 2012) approach was followed, in which the focus group is regarded as two overlapping phases of 'sharing and comparing' and 'categorising and conceptualising' (Morgan 2012, 70, 169). The first phase allows the focus-group participants to relate to each other's experiences and knowledge, while the second phase involves the participants generating abstract knowledge on the subject discussed (Morgan 2010). The focus groups were composed of colleagues that share an 'organisational language' (Morgan 2012, 169) which increases the likelihood of advancing towards the 'categorising and conceptualisation' phase of the discussion (Morgan 2012, 169–171). The 'sharing and comparing' phase prompted the focus-group participants to draw on experience from a large variety of similar cases, intended to further the discussion in the group.

The data collected was transcribed verbatim and thematically coded using NVivo 11. When coding, a pattern emerged showing the frontline workers' attention to the motivational issue of the vignette. The data were then coded on the frontline workers' accounts of how they interacted with their users in order to motivate them for reintegration into the labour market. Following the frontline workers' descriptions of their logic when approaching their users, three different dialogue-oriented strategies for motivating users were identified. The strategies were later analysed focusing on what the frontline workers said they would do and the rationale for their actions.

Empirical analysis

As described in the background section, earlier research on NAV has shown the importance of dialogue in countering agonistic positions in order to work towards a common goal. This section first presents assumptions from the data giving examples of what Håvold, Harsløf, and Andreassen (2017) termed 'an asset model of activation'.

When presented the vignette, the frontline workers in all focus groups described the information it contained as representative of the information they usually receive about a case. Among the frontline workers, there was consensus that both actual cases and the vignette, while focusing on health problems, contain little information on the prognosis for recovery. Motivation was perceived as fundamental for labour-market reintegration, and thus the frontline workers focused their attention on the patient's motivation. The vignette intentionally had little medical information on the potential for recovery, yet the frontline workers agreed that there was potential for restoring work ability. The data show that the different focus groups did not agree on the potential for recovery for the person portrayed in the vignette; however, they did agree that there was potential for recovery. A comment from one of the participants underlines the complexity and vagueness related to head injuries: 'he has such an unclear injury, all we know is that it takes a lot of time to heal, the head injury' (Office 2).

'An asset model of activation'

An asset model of activation is the overarching logic that guides the frontline workers. In the frontline workers' description of how they motivate users, they tend to focus on certain aspects and take these for granted. Initially, the frontline workers attempt to map the user's resources and hindrances, as stated in the following quote:

> We have to figure out what they [the users] are good at. [So we] figure out what measures we can use to help further. (Office 6)

In finding 'what works' and 'what does not work', the frontline workers attempt to identify the best way to initiate a return-to-work process. In initiating a return-to-work process, the frontline workers need to determine what resources are available to the user, and what weaknesses they need to address to increase the chance that the user returns to work.

The frontline workers describe one main underlying assumption that their logic is repeatedly based on in all of the focus groups that 'work is beneficial to health' (Office 2). This understanding of work serves to legitimise the return-to-work process that the frontline workers aim to initiate with their users. Further, the understanding of work as beneficial to health underlines the positive outlook and opportunity-oriented aspect that the frontline workers tend to have when approaching their users.

> It is important that we spend time trying to find the opportunities that the [user's] future offers. (Office 7)

'An asset model of activation' tends to focus on the underlying value of work as beneficial to health, promoting self-confidence through activity and mastery of skills and an orientation towards opportunities despite hindrances.

Opportunity talk

Opportunity talk is characterised by a focus on opportunities despite hindrances. In one focus group, one frontline worker outlined an important aspect of this strategy – making the user talk about his/her own experiences of limitation. The frontline worker attempted at the same time to make the user think positively about the future:

> Try to make him [the patient depicted in the vignette] talk about these limitations and how they affect him in his daily life. In normal circumstances, with family, friends, and such. In the case, it is written that there has been some improvement, so you can hope for even more improvement and try to be optimistic. (Office 1)

Through meetings with the user, the frontline workers wish to talk about the opportunities they can offer for return to work, making the user think more positively about their chances.

> Often we have had to turn things upside down in a way – and say that here we see a lot of hope. […] Here, there are good chances that you will become fit and better, etc., etc. You have to start there. (Office 5)

One of the key aspects of this strategy is the opportunity focus inherent in an asset model of activation. As depicted in the above statement, the frontline workers are painting a picture of a positive future with opportunities in order to motivate the user. However, if a user has spent significant time in the healthcare system, they tend to focus on their limitations:

> It is important that he get himself to a place where […] he can use his competences or get new ones, not only being inside the 'health-bubble' where you focus on your limitations. (Office 5)

The use of the 'health-bubble' trope indicates that those focusing on their limitations due to their reduced health are regarded as hard to motivate. According to the frontline workers, a user's one-sided focus on their health limitations is detrimental to his or her motivation. The strategy guides the frontline workers to counter the user's focus on health limitations, and orient them towards work and the future. The frontline workers tend to cultivate motivation through dialogue:

> Creating motivation for work is challenging. That is what we are trying to achieve, and we experience [after some time discussing with us] that people talk less about their illness and more about getting back to work. That is our goal. (Office 7)

Opportunity talk focuses on encouraging the users to focus on their resources and opportunities. In all of the offices, the general approach to the vignette was optimistic. The frontline workers came up with a range of measures that they could offer the user, while downplaying the limitations that the user experiences and promoting an optimistic outlook.

> I think that seeing the opportunities is very important. Something I am very passionate about is seeing the opportunities to master a skill, which again motivates the user. […] This is not just our case, it belongs to the 34-year-old man, it is he who is in the driver's seat. (Office 7)

Among the most widely used form of opportunity talk in the data is aimed at identifying even the small tasks that the user can master. The reasoning is that if the user can master a seemingly insignificant or small skill in an early phase, this will increase their self-confidence. Restoring self-confidence is, according to several participants, the first step in both activating and motivating the user for a return to the labour market.

Opportunity talk emphasises the possibilities that the frontline worker through NAV has at their disposal for helping the user reintegrate into the labour market. In using opportunity talk, the frontline workers engage in a dialogue with the user framed around a positive outlook towards the future. The frontline workers emphasise their opportunities to support measures and the resources available to the user, while downplaying the hindrances. Thus, the frontline workers actively talk the users into believing that the measures that NAV and the frontline workers have available are their best option.

Work talk

Work talk is a dialogue in which the frontline workers articulate the value of work. The following excerpt exemplifies the work talk strategy:

> Talk to him about jobs, pure and simple […] Ask him about his thoughts about previous jobs, what has it meant for him? You know, there is lots of value in having a job. Start to pin it down, getting him to think about it, himself. And then point to the possibilities. (Office 4)

The above excerpt shows how a frontline worker aims to motivate the user by articulating the value of work. It also illustrates how work talk and opportunity talk are interwoven. Through such dialogues with users, the aim is to emphasise the value of having a job, in order to make the user start thinking about the future and the value of work. In order to use this strategy, the user must have previous experience of the labour market through which they can identify the positive value of work. According to the frontline worker quoted above, they need to move on to showing the user the opportunities they can offer them in their return-to-work process, similarly to opportunity talk.

According to several of the frontline workers, this strategy aims to accentuate already existing positive feelings about work:

> It might be difficult for users to see their opportunities since they might not be able to do what they did before. We need to motivate the user to see [other] opportunities in order to find a job that is compatible with the user's health problems. (Office 8)

The frontline workers mentioned on several occasions that a user's view of the future may be 'locked' by their previous job. 'Locked' implies that the user limits their own opportunities by thinking that they can only do a certain job at a certain company. In which case, the frontline workers need to 're-orientate' or 're-educate' the user, as several focus groups described it. The frontline workers then attempt to convince the user to resign in order to make him or her see their opportunities. Thus, the frontline workers attempt to change the user's understanding of the opportunities they have, by making them think beyond their current profession or workplace.

In some cases, depending on the user's attitude, the frontline workers might take a less direct approach:

> The wording is important. Especially when you are dealing with a person with cognitive impairment, then 'work' can be a provocation, while 'activity' can be everything from taking the dog for a walk to having a good time. And when you […] get to mapping his field of interests, then you can use it to turn the negative [feelings] towards work to something positive towards activity, which in turn can spur positive thoughts of work. (Office 7)

In this less direct approach, the frontline workers focus on 'activity' instead of work. This approach was uncommon, since most focus groups understood 'activity' as NAV's measures for improving work ability, rather than by its general meaning.

Work talk accentuates positive feelings the user already holds about work through both the cognitive and the normative aspect, while at the same time involving the user in contemplation of what work he/she wants in the future.

Identity talk

Identity talk is a contrasting strategy to opportunity talk; it emphasises the lack of opportunities in the future if one does not return to work. In two offices, the manner in which the frontline workers

approached the vignette case indicated that they applied this strategy. In both offices, rhetorical questions were a feature of the identity talk:

> [W]here do you think you will be in three years? What sort of role model will you be, is that all right? You have two small children, should they think of dad as a carpenter or should they not, you know? (Office 5)

This office attaches a strong normative aspect to identity talk. The frontline worker quoted above invites the user to see himself as a 'role model' for his children and seems to attempt to change his behaviour by encouraging self-reflection. The other frontline worker from the same focus group described a similar approach applied in a meeting with several users with health problems. In this meeting, the frontline worker showed the users two photos of a Paralympic athlete, the first showing the athlete in a boat with medals, and the second showing the athlete in a wheelchair. When showing each photo, the frontline worker asked the users, 'what do you see here?'. According to the frontline worker, the purpose was to switch the focus to 'what can work? What can you do in the future?' (Office 5). A second office, described a similar discursive strategy, but took a slightly different approach, where the questions were more open:

> How will it be for you if you do not work? How would that situation become for you? You [the frontline worker] focus on the negative by continuing that train of thought, to make him [the user] try to see and focus on a more positive goal. (Office 1)

Identity talk is, according to the frontline workers, an attempt at making the user think of where and who they want to be in the future. Contrary to work talk, which changes the relationship between the user and work, this strategy aims at changing the relationship between the user and the social environment that he inhabits.

Discussion

In the past decade, Norwegian activation policy has aimed at increasing users' chances in the labour market. The three strategies described in the previous section are examples of operationalization of a schema aimed at motivating the user to embark on a return-to-work process. The strategies derive from a schema and are categorised as different kinds of 'talk', reflecting reliance on one-on-one dialogue with users. In the first, 'opportunity talk', the emphasis is on opportunities that the frontline workers can offer for labour-market reintegration. The aim is to boost the users' self-confidence while giving concrete examples of how the frontline workers can assist them. The second, 'work talk', articulates positive aspects of earlier work experiences and activity to motivate the user. The frontline workers utilise dialogue with the user in order to underline the value of having a job. In effect, changing the relationship between the user and work. The third, 'identity talk', covers talk aimed at motivating the user by encouraging them to reflect on how they are perceived by others, affecting the user's relationship with their social environment. These three forms of talk follow a supportive activation policy line focusing on improving the user's chances in the labour market (Lødemel and Moreira 2014). Each 'talk' is the operationalized form of an asset schema with a different focus of attention. Although 'talks' are inherently normative, the strategies are legitimised among the actors through one or more of the institutional pillars (Scott 2014): the regulative (laws and rule), the normative (emphasising values to make the user act how they are 'supposed' to), and the cognitive (convincing the user that the frontline worker's measures are the best way to improve their lives).

Opportunity talk appears in the data as the predominant strategy for motivating users. This strategy focuses on presenting the resources the frontline worker has access to and can use to help the user return to the labour market. The aim of presenting all the opportunities at their disposal is, according, to the frontline workers, to put emphasis on the multiple opportunities for reintegration into the labour market. In doing so, the frontline worker attempts to shift the user's focus away from health-related problems and encourage a positive and opportunity-oriented perspective of the future. In applying an asset schema to motivate a user, the frontline workers tend to initiate opportunity talk as a primary strategy, focusing on the cognitive aspect of having access to the best measures to help the user. If this

choice of strategy has limited effect, the frontline worker applies the schema once again, now with new information, and initiates a different strategy.

Work talk relies on the user already having positive work experiences, and the frontline workers articulating the value of work. According to the frontline workers, the foundation of this strategy is the inherent value in having a job. This implies that the aim of the strategy is to accentuate a pre-existing positive attitude towards work in order to motivate the user for return to work. The data indicate that work talk and opportunity talk are used in tandem, where work talk is an initial strategy given previous work experience, which then overlaps with opportunity talk. Furthermore, since work talk appears in tandem with opportunity talk, this implies that an asset schema prompts work talk as a possible supportive strategy, motivating users by normatively highlighting the value of work if the user has previous work experience and opportunity talk alone has limited effect.

Identity talk works at challenging the user's perspective by utilising a normative strategy. The strategy relies on rhetorical questions to encourage self-reflection on the part of the user. The frontline worker paints a negative picture of a future without work. In one of the offices, the frontline worker uses the family's perception of the user to normatively push the user to be a 'role model' for their family, implying that in order to be a 'role model', you need to have a job. Thus, by using the family's perception of the user, this strategy normatively targets the user's self-worth and self-esteem. Thus, similarly to work talk, identity talk seems to operate as a supportive strategy in tandem with opportunity talk initiated by an asset schema.

The three strategies described in the previous section point towards the operationalization of an asset schema by the frontline workers. Although the frontline workers may apply somewhat different strategies, institutional logics allows for differences in the application of strategies through the actors' activation of different knowledge within the abstract knowledge structure of a schema. Since these strategies are part of a pragmatic reasoning schema, this underlines that there is conscious reasoning by the frontline workers in choosing strategies to apply. The three forms of 'talk' rely on different knowledge contained in these knowledge structures, as formed by the actor's focus of attention. This indicates that a frontline worker may rely on a competing logic. The three strategies attempt to motivate the user through the 'promise' of a better future, in which work and a steady 'pay check' are part of their lives. The value of work seems to be an underlying norm, which the frontline workers subscribe to when reasoning about the vignette. The reasoning in the data indicate that work as beneficial despite health problems is taken for granted among the frontline workers. According to the focus-group participants, motivation is the key determinant for a successful return to the labour market. The frontline workers reason that without belief in a better future, the user's progress towards labour-market inclusion will come to a halt. According to the frontline workers, motivation is essential for the user's return to work, and as such, these three strategies all aim at motivating the user. Table 1 describes how the different strategies are legitimised by different knowledge in a schema.

Table 2 shows the strategies employed by the frontline workers. All of the focus groups make use of opportunity talk, which indicates that this strategy is the dominant motivational strategy. The table underlines that all the focus groups apply opportunity talk, while there is some variation among the choice of supportive strategy. The different choice of supportive strategy could be due to difference in the frontline workers focus of attention, and therefore in the perception of the knowledge invoked, or which knowledge is activated.

None of the focus groups apply all three strategies in the data, nor do they utilise both work and identity talk. The implication may be that these two strategies are never utilised on the same user, or

Table 1. Properties of the different strategies derived from an asset model of activation.

Strategy	Primary knowledge activated from an asset model of activation	Legitimising institutional pillar
Opportunity talk	Removing hindrances for return to work	Cognitive
Work talk	Work is beneficial, even for those with health problems	Normative
Identity talk	Work is beneficial, even for those with health problems	Normative

Table 2. The distribution of different strategies in the data.

	Office 1	Office 2	Office 3	Office 4	Office 5	Office 6	Office 7	Office 8
Opportunity talk	X	X	X	X	X	X	X	X
Work talk		X	X	X		X	X	X
Identity talk	X				X			

that not all strategies are used at all offices, or it could be an effect of the focus-group dynamics when choosing strategies to apply to the hypothetical situation. Future research could explore if work talk and identity talk operate only as supportive strategies or as main strategies without opportunity talk, as the current data is inconclusive in that respect.

In the focus groups, the participants faced a hypothetical situation; it is important therefore to consider that what they say may not reflect what they would actually do in practice. However, the participants often drew on their own experiences working with other users. This indicates that although the setting of the focus group is hypothetical, the participants seem to apply experiential knowledge in their approach, indicating that the frontline workers treat it as a real situation.

The somewhat blunt statements made by some of the frontline workers may be due to the focus-group situation, in which they might have felt that they needed to underline exactly what they thought and meant. The statements used to exemplify the three strategies may therefore not reflect what they in reality would say to a user.

Conclusion

In 2010, a government-appointed group of experts proposed to reconceptualise work as conductive to health and well-being, which initiated a shift in the frontline workers' understanding of their role. In the understanding of their role, the frontline workers seem to embrace an asset model of activation. The data suggest that the frontline workers at NAV apply three strategies to motivate unmotivated users for returning to work, as part of putting activation policy into practice. The strategies applied by the frontline workers are termed 'opportunity talk', 'work talk' and 'identity talk', emphasising the reliance on dialogue. The implementation of schemas is crucial in understanding how the frontline workers operationalize policy into practice for motivating users. Successful implementation of an activation policy depends greatly on how the frontline workers operationalize the policy.

Note

1. Two of the focus groups had only two participants due to last-minute dropouts; these focus groups were characterised by slightly more questions asked by the moderator.

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Article 3

Article 3

Håvold, OKS (revising). All Roads lead to Rome: Discretionary Reasoning on Medically Objective Injuries at the Norwegian Labour and Welfare Offices. Professions and Professionalism. Submitted 27.09.2017 (revised and resubmitted 08.06.2018)

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Errata for the thesis Frontline Workers at the Intersection of Welfare, Labour and Health: Re-Integrating Users with Severe Health Problems in the Labour Market, submitted for the PhD in Social Work and Social Policy, Faculty of Social Sciences, OsloMet

Page 6, first paragraph, line 1. (after research question)	It reads… 'which this thesis aims to illuminates…' It should read: '…which this thesis aims to illuminate…'
Page 10, first paragraph, line 3.	Part of the sentence after the comma is missing. It should read: 'followed by a section which draws on previous research relating to the frontline workers at NAV.'
Page 23, third paragraph, line 4	The reference to Battilana, Leca and Boxenbaum lacks info year of publication. It should be 'Battilana, Leca and Boxenbaum (2009)'
Page 27 first paragraph, line 12-13	It reads 'Brodkin (2011a, 2011b)…'. It should read 'Brodkin (2011, 2013)…'
Page 37, second paragraph, line 2	G.H. Mead is without reference. It should be G.H. Mead (1934). In the reference list on page 79, after 'McPherson, Gibson and Leplege .2015.' the reference 'Mead, George H. 1934. *Mind, self, and society*. Chicago, IL: University of Chicago Press.' Should be added.
Page 38, first paragraph, line 7-8 reference	It reads '(Geertz 1973 [2000])' it should read '(Geertz 2000 [1973])'
Page 42, third paragraph, line 10 (last line on page).	It reads '(Geertz 1973 [2000])' it should read '(Geertz 2000 [1973])'
Page 44, first paragraph, end of paragraph	The last sentence of the paragraph lacks a period. It should read … 'and the difficulty of observing decision-making and attitudes.'
Literature l (Page 72)	'Andelic, N, N Hammergren, Erik Bautz-Holter, Unni Sveen, C Brunborg, and C Røe. 2009.' should read: 'Andelic, Nada, Nini Hammergren, Erik Bautz-Holter, Unni Sveen, Cathrine Brunborg, and Cecilie Røe. 2009.'
Literature (page 74)	The second Caswell et al. 2017 reference 'Conclusions and Topics for Future Research' should be removed
Literature (Page 75)	Esping-Andersen, Gøsta. 1990. "The three worlds of welfare capitalism" should be removed
Literature (Page 76)	'Geertz, Clifford. 1973[2000]' should read 'Geertz, Clifford. 2000 [1973]'
Literature (Page 78)	Hupe, Peter 2013 "Dimensions of discretion: specifying the object of street level bureaucracy research" should be removed
Literature (Page 79)	In the reference 'Kvale, Steinar and Svend Brinkman. 2009.' The place of publishing contains errors. It currently reads 'LLos A>ngels, CA' it should read ' Los Angeles, CA'
Literature (page 80)	The first reference on the page should read Molander, Anders and Harald Grimen. 2010 not Molander, Anders and Harold Grimen
Literature (page 81)	The reference 'Slomic, Mirela (2018) Knowledge in Action…' should read 'Slomic, Mirela. 2018. *Knowledge in Action: Experiential and Professional Knowledge in Interprofessional Rehabilitation.'*