Reflections on How Research and Local Practice Can Evolve Together

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Introduction

A shortcoming often pointed out with regard to social work (along with other disciplines), both internationally and in Sweden, is the gap between research and practice. The fact that a sizable gap may exist between research findings and its use in local practice, such as in the treatment of alcohol and substance abusers, has been established in a number of settings (Bergmark & Lundström 1998; Carroll & Rounsaville 2003; Dellgran & Höjer 2000; Rawson & Branch 2002; Robson 1998; SBU 2001). Even though available research findings support certain types of treatment methods for certain client groups, such as family therapy, cognitive-behavioral therapy, and pharmaceutically assisted treatment, it has not meant that these methods have been implemented or applied to any greater extent within the treatment of substance abusers in Sweden (SBU 2001). The widespread response in favor of *Evidence-Based Practice*, an outlook originating in the sphere of medicine and one which has also gained acknowledgment within other disciplines and fields such as social work, can be interpreted as a desire and a willingness to bridge this gap (Trinder 2000; Gambrill 2003).

Several investigations and reports in Sweden have indicated certain discrepancies with regard to the awareness of the results and values provided by various social programs and care options. These investigations and reports have to this end recommended the enrichment of the knowledge base and a direction of efforts towards a more evidence-based practice within social work. A comprehensive national project has been launched in order to create a framework for the integration of practice, education and research with the objective of stimulating intervention studies and implementing scientifically documented methods (Socialstyrelsen 2001; SOU 2000).

A major focal point for these efforts has been the care of substance abusers, and the instating of a special method institute by the Swedish authorities along with the introduction of systematic documentation systems such as the ASI (Addiction

Severity Index). The production of research overviews on an evidence-based foundation may be regarded as a response to these discrepancies.

In the extensive report by SBU, *Behandling av alkohol- och narkotikaproblem ("Treatment of Alcohol and Substance Abuse")* published in 2001, scientific findings with regard to various care options for alcohol and substance abusers are presented and summed up. Inefficient methods presently in use are to be replaced by methods regarded as efficient, and the authors of this report suggest that resources be allocated to this end. The results have been the subject of debate, and it has been questioned whether these findings can be applied in practice (Bergmark 2001; Hesse 2002; Mäkelä 2001; Socialstyrelsen 2002b).

Thus, new findings do not guarantee a change in treatment methods. In Sweden, conscious attempts have been made to encourage and promote coordinated efforts between clinicians and practitioners in the care sector for substance abusers, such as the SWEDATE (Swedish Drug Addict Treatment Evaluation) project. However, we still lack long-term and ongoing projects in which research and local practice interact in the pursuit of knowledge. We do, however, believe that the prospects for a mutually beneficial partnership are good at this point in time.

The aim of this article is to discuss – with a departure from given examples – a framework within the care sector for substance abusers, in which research ventures and monitoring are characterized by a systematic view and continuity. We will also discuss how extensive empiric material from the DOK system (a Swedish acronym for documentation system) can be applied to a theoretical frame (Rossi et al. 2003) for describing and analyzing clients, interventions and outcomes. In addition, this article will touch on the various aspects that have an impact on practitioners and researchers in order to generate collaborative efforts.

The initial survey of publications on this subject is based on a selection of texts that specifically deal with the collaboration between practice and research within the care sector for substance abuse. Another distinction has been literature that focuses on projects based on a computer network comprising several treatment centers that are connected to the DOK system. Literature searches have been performed using Medline and PubMed. Key words used in the search were *Substance/Drug Abuse Treatment, Collaboration, Practice,* and *Research.* A bibliography by Sorensen et al. (2004) was also employed. This means that the number of references is limited, and should be regarded as a backdrop for the review of the DOK and other comparable projects. This summary does not claim to provide a fully comprehensive picture of the subject area.

The second part describes the DOK system itself, and how extensive empirical material obtained from the treatment of substance abusers can be applied to a theoretical frame. In our opinion, there is much to be learned from this type of project. A fruitful collaboration can evolve between practice and research. We hope that this paper will contribute to discussions on the knowledge-based care of substance abusers[1].

Collaboration Between Practice and Research Within the Substance Abuse Care Sector

A wide knowledge base, available on the international arena, deals with how to bridge the previously mentioned gap between local practices and research, and how a framework can be constructed to, on the one hand, conduct research on effective methods and, on the other hand, implement these findings within the care sector for substance abusers (Carise et al. 2002; Carroll & Rounsaville 2003; Marinelli et al. 2002; Rawson & Branch 2002). Several active researchers within this field have taken an interest in the reason why such a gap occurs, and how to address the problem. Some of the reasons for the lack of an alliance between practitioners and researchers are thought to be rooted in fundamental historical differences in their respective working culture, levels of education, and their assignments. Other explanations mentioned are the differences in how much store is set by research findings compared to experience (ibid).

Thus, this orientation indicates how the gap can be bridged, and what is needed to establish a fruitful partnership. *Technology transfer* is a concept often heard in connection with this issue, and is defined as a systematic process where various successful and promising approaches, techniques or models based on research findings are transferred and applied in practice (Backer 1995). However, the significance of the concept also emphasizes the mutual exchange of knowledge inherent in the process: ”The diffusion of information between research and practice, not only *from* research *to* practice” (Sorensen et al. 2004, 2).

Marinelli et al. (2002) deal with comprehensive activities such as arranging conferences and other forums, which enable a dialogue involving shared issues,

[1] In part, this paper is the result of research activities generated within the national research school conducted in 2003-2004 under the direction of Oscarsson and Dellgran, at the Department of Social Work at Örebro and Göteborg University, which focused on the development of the knowledge base and was directed towards evaluation research and intervention studies. This route brought us to our present station, an interest in issues concerning the knowledge-based care of substance abusers and the collaboration between practice and research (www.sos.se).

publications on the subject of joint ventures, and the initiation of specific projects aimed at bridging differences. However, even more fundamental principles, conditions and incentives are necessary in order to create sustainable, efficient and rewarding alliances between treatment programs and research. Important criteria for collaboration based on a number of large-scale joint ventures in the US, such as DENS (Drug Evaluation Network System) and CTN (Clinical Trials Network) have been presented. The following conclusions are drawn from these projects (Carise et al. 2002; Rawson & Branch 2002):[2]

- Practitioners are involved in designing research projects
- Participating treatment units are to receive compensation and added value for their part in a research effort
- Instruments for data collection are to be user-friendly
- Any data collected must be reliable and is to comply with scientific requirements
- Practitioners are to be offered support in the form of training and support
- Findings are to be reported to the units involved on a regular basis

As previously mentioned, several large-scale projects have been conducted in the US aimed at creating an ongoing dialogue between treatment units and researchers within the care sector for substance abusers, such as DENS (Carise et al. 2002; Rawson & Branch 2002). This project has employed ASI as a foundation for identifying change and trends in the addict population, and has created a framework for future studies and comparisons between various client groups. Through the DENS project, a number of concrete and positive results have been generated: Several studies have been built on good and reliable data, change has been effective in working methods and new features have been introduced into treatment programs, which are factors that have most probably led to improved care. This is illustrated by the fact that several of the programs involved have significantly improved their results with regard to drop-out levels (Carise et al. 2002).

Corresponding projects within the Swedish care sector for substance abuse are fairly few in number, and the SWEDATE project is possibly the only one of its

[2] We return to these conclusions in the final discussion.

kind (Berglund et al. 1991). In SWEDATE, the largest and most extensive investigation of substance abusers in Sweden, interviews were conducted with drug addicts who were admitted to various treatment centers during the years 1982-83. A comprehensive question was posed: "W*hat type of treatment is the most effective for which type of client?"*. Assisted by various types of questionnaires/interview instruments, some 1,656 clients were studied as to their backgrounds, 31 treatment centers were reviewed as to their treatment and care organizations, and 438 individuals from the original client population were followed up a year after their treatment had been concluded.

Another objective of the SWEDATE project (ibid), in addition to the purely scientific aspects, was to develop, in conjunction with the units participating in the project, a self-evaluation instrument that could be used on an ongoing basis for status reports and in the development of methods. Based on the experiences gained during this project, Bergmark & Oscarsson (1996) launched their concept of introducing a basic documentation system as a first step in systemizing locally gained knowledge about clients and interventions, which in turn could be applied to discussions between colleagues as well as in the development of methods and research.

The conclusions from SWEDATE paved the way for the DOK project (Documentation within the care sector for substance abusers). Segraeus, a member of the SWEDATE project, used her experience of the project and created together with Jenner, in their capacity as chief officers of SiS, Statens institutionsstyrelse (The National Board of Institutional Care), a documentation system for both the compulsory and the voluntary care of substance abusers (Jenner & Segraeus 1997).

Description of the DOK System

In 1994, a project was initiated within the care sector for substance abusers in Sweden – the DOK system. The objective was to initiate the development of quality control and methods within the care sector for substance abusers based on a scientific foundation. The DOK system can be defined as a network of treatment units which, by using questionnaires and a shared data base, collects and processes information which in turn becomes a possible foundation for status reports, self-evaluation processes and the development of quality control. For clients, this documentation can be the basis for treatment and follow-up plans. On a general/national level, this documentation can also contribute to a development of the knowledge base in general, and may provide basic epidemiological

information for research and development purposes. Jenner and Segraeus (1997) formulated the following objectives for the DOK system:

- *To create a foundation for self-assessment in the form of descriptions of clients and treatment efforts, and to initiate a pattern of continuous assessment.*

- *To expand the platform for self-assessment by facilitating comparisons between units.*

- *To spread knowledge on how self-assessment can be used for quality development.*

- *To collect basic epidemiological information for use on the national and international level.*

- *To evaluate treatment efforts.*

Since 1997, DOK is a regularly implemented system that consists of SiS-DOK and IKM-DOK. The SiS-DOK unit is operated by SiS, Statens institutionsstyrelse (The National Board of Institutional Care. All (12) compulsory care units for drug addicts in Sweden apply the DOK system. The IKM-DOK is managed by Växjö University, IKM (The Institute for The Development of Knowledge and Methods in the Treatment of Drug Abuse), and the city of Gothenburg. Upon the conclusion of the project, the IKM-DOK has been financed by way of subscription (roughly 70 participating units), and regional coordinators provide their members with questionnaires, computer programs, training and supervision (www.ikmdok.com).

To Create a Foundation for Self-Assessment in the Form of Descriptions of Clients and Treatment Efforts, and to Initiate a Pattern of Continuous Assessment

The DOK system was created to satisfy a long acknowledged need for assistance as regards the documentation and development of methods within the care sector for substance abusers in Sweden. This process was initiated in 1991 and was inspired by other documentation systems found in Sweden, the rest of Europe, and the US. The system was based on a "from-the-bottom-up" perspective, which means that practitioners were involved in designing the system, and that its usefulness was the main focus. Once preliminary questionnaires were drawn up, implementation could begin in 1994, with the assistance of regional coordinators who were assigned to contact a number of units throughout Sweden and have them join in and help fashion this new documentation system.

The contents of the questionnaire are based on the need to map out various areas of life, where clients are interviewed when *admitted* for treatment, when they have major *check-ups,* when they are *released* from treatment, and when they have *follow-ups* upon concluding treatment (Jenner & Segraeus 1997; www.ikmdok.com).

To Expand the Platform for Self-Assessment by Facilitating Comparisons Between Units

A systematic documentation system involving ongoing reports from the participating units is the foundation for the DOK system today. Seminars, courses, computer workshops and an annual conference are arranged, which provide individual treatment units with the opportunity to compare themselves with other units, to use these forums to partake of discussions and to reflect on the experiences they and others have had.

Each unit has a DOK manager who receives support from a regional coordinator from the main DOK system. These coordinators are instructors and supervisors. Their job is to provide motivation and know-how. Their position involves visiting the various workplaces, conducting local seminars, and being available as "sounding boards" for questions ranging from concrete computer problems to ethical issues in client interviews (IKM 1999; www.ikmdok.com). However, no large-scale comparative studies of different units have been conducted so far.

To Spread Knowledge on how Self-Assessment Can be Used for Quality Development

The DOK system places an emphasis on the development of methods and quality control, primarily with regard to local tasks such as analysis and discussion; the mission and objectives of the unit; descriptions of clients; efforts and results in relation to the objectives; target groups and actions taken. It is the responsibility of the regional coordinator to spread information and present the DOK system from a quality control perspective. An annual report (IKM 1999) summarized these efforts as follows:

> ”Identifying the necessary prerequisites that enable quality control has not been a self-evident process within the care sector for substance abusers – despite the fact that treatment measures are basically ’client-oriented’, in the respect that the individual needs of each client determine the treatment plan chosen. Quality control and assessment have generally been merely empty words.”(p. 43).

To Collect Basic Epidemiological Information for Use on the National and International Level

Within the EU, at the central unit MCDDA (European Monitoring Centre for Drugs and Drug Addiction) in Lisbon, an information network has been established (Reitox) to provide reliable information on the European narcotics situation. In Sweden, institutions such as Folkhälsoinstitutet and Socialstyrelsen (The Institute for Public Health and the National Board of Health and Welfare) are responsible for this type of coverage. Since the IKM-DOK contains all the information found in the national and the European reports, no work efforts are duplicated, and all the participating units are able to submit the pertinent data by way of the IKM-DOK (Dahlberg 2004).

To Evaluate Treatment Efforts

The information in the DOK system, collected in a central database, could be the foundation for assessment and follow-ups on both a local and a national level. Each year, a report is compiled mainly to describe data pertaining to newly admitted clients. Comparisons have also been conducted between clients who are undergoing treatment on a voluntary basis and those who have been committed to care (Jenner & Segraeus 2005). In addition, there are several instances of local use of the DOK data, e.g. in the form of mapping out client groups and follow-ups of certain treatment outcomes. However, no scientific studies using the empirical material have been carried out (IKM 1999; www.ikmdok.com).

The following information, which is limited in scope, was obtained from the upcoming annual report, IKM-DOK, 2004:

During 2003, a documented total of 2,271 individuals were admitted for treatment, 29% were women and 71% were men. The age distribution was as follows: 32% were under the age of 30, 36% were 30 to 44 years old, and 33% were 45 or older. In most cases (60 %), the clients themselves initiated the contact with the treatment unit. Approximately half (51%) of the clients had their own households, while 8% were homeless. 37% had children under the age of 18.

In terms of income, 33% were on welfare, 25% were employed or receiving unemployment benefits, while 15% received a disability pension or temporary disability benefits. The primary abused substance was listed as being alcohol in 50% of the cases, 17% stated drugs stimulating the central nervous system, 14% listed opiates, and 11% indicated hashish or marihuana (www.ikmdok.com).

A Design for Research and Evaluation

It is possible to apply the DOK system within a wide range of research areas. Jenner & Segraeus (2005) suggest some of these areas in an article, where one such area pertains to treatment outcome. This subject will be approached by discussing a basic structure for the evaluation of programs and social interventions along the lines recommended by Rossi et al. (2003). This subject matter will be broken down into two parts; a discussion of the usefulness of the model, and a description of a research project in which we plan to study different spheres of Sweden's care sector for substance abuse by way of a quantitative

study of the DOK material. The figure below illustrates the aforementioned basic structure:

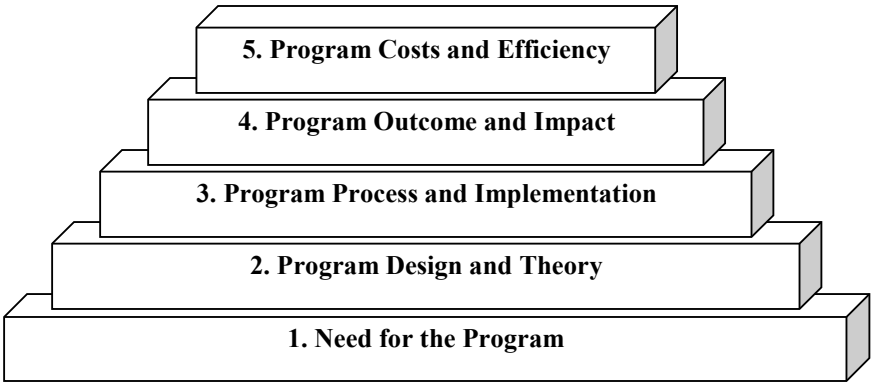

Fig. 1.Basic structure for assessment according to Rossi et al. (2003)

The most unique feature of Rossi's model is that it can be employed to tailor solutions for intervention studies. The model was developed by researchers with extensive experience in this field. Another special feature is the model's emphasis on the importance of studying the interventions in detail, both with regard to the premises of the treatment program and the actual activities pursued. This emphasis is based on the belief that it is vital to take these factors into account in order to be able to make any connections between the outcome and the impact of a certain program when regarding different interventions. This can be seen as an attempt to slightly open the lid of "the black box".

1. Need for the Program

The first stage involves identifying and mapping out the issues and needs that the program intends to address, in our case, substance abuse. The problem is to be defined in detail and described as to its scope on a general level. Previous research, previous surveys and assessments are used to support this definition. In addition, the specific target group that is undergoing intervention shall also be described in detail as regards treatment needs (Rossi et al. 2003). The figure below summarizes the projected activities for the first stage:

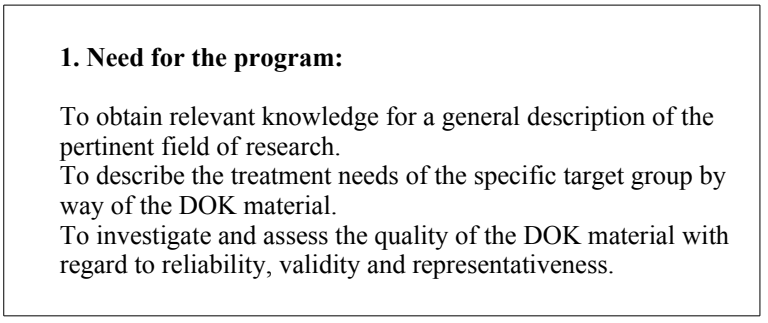

Fig. 2. Planned activities during the first stage

During this stage, we will need to thoroughly explore the quality of the DOK material; in other words we need to see if the client interviews conducted using the DOK questionnaire yield information that can be regarded as reliable, valid and representative. The admittance form should contain what could be referred to as background information about the individuals initiating treatment for substance abuse. Obviously, this information should maintain a high level of quality/integrity in order for the study, conducted in accordance with the model presented, to be relevant. The admittance data obtained from the DOK material provides a general picture of the substance abuse aspects of the target group in question, the social situation of the various members of the group, their criminal history, etc.

Since reliability, validity and representativeness are of utmost importance for our projected study, we elect to initially put a high priority on these issues. To assess

reliability, we intend to proceed in the same manner as SWEDATE, by comparing double interviews. Validity can be assessed by cross-checking various indexes. Checking just how representative the DOK material is will be an extensive undertaking. However, comparing the DOK material with the findings in the annual national surveys by Socialstyrelsen (the National Board of Health and Welfare) (SoS 2004) appears to be a good route, since this institute receives data pertaining to gender distribution, type of substance abuse, previous instances of care for substance abuse, the interventions and methods used, etc. As we intend to describe in the next segment, the DOK material includes similar information from the various participating units.

2. Program Design and Theory

The next stage is a report on the interventions employed, which also includes a description of its program theory, i.e. the underlying concept of what should be done in order to obtain a certain outcome. This makes it possible to understand how a program is designed. Different approaches exist depending on how extensive the evaluation is intended to be: studies of documents, focus group interviews with care providers, observations, etc. To begin with, the intervention itself is to be articulated with a logical explanatory model detailing how this treatment process works in practice, with items such as how and why an individual changes his/her abuse patterns when he/she receives a certain type of therapeutic support.

The description also contains a definition of the objectives in relation to the needs of the target group as well as other relevant research findings. Should it prove difficult to clearly describe a particular treatment and its objectives, or if there are any reservations about whether the program theory is realistic, it is justifiable to question whether it is at all possible to evaluate the model at hand (Rossi et al. 2003). An alternative strategy to describe a more implicit program theory could be to deconstruct it and break it down into smaller parts, and then look for changes in a few select components (cp Petrosino 2002). Figure 3. shows the activities we have planned for this stage:

2. Program theory and design:

To describe interventions and efforts based on the DOK questionnaire.
To account for the methods used with reference to the DOK questionnaire.
To try to describe the underlying theory by way of interviews with units involved in the program.

Fig. 3. Planned activities during the second stage

Within the field of substance abuse treatment, program theory design is dependant on the basic underlying tenets of the program/intervention. For our purposes, this stage entails a number of heterogenic models and treatment programs for institutional and non-institutional care units are described using the DOK questionnaire, which includes the following areas (www.ikmdok.com):

- Organization (i.e. principal authority and No. of clients/year)
- Staff (i.e. No. of positions, professions, and gender distribution)
- Primary target group (i.e. gender, age range, specific substance addiction)
- The unit's basic tenet/theoretical departure point/treatment focus
- Actions taken by the unit

To begin with, by compiling and systemizing the questionnaire for the participating units we are provided with a general picture of the actions taken by the units, and by actions we mean investigations, physiological and psychological surveys. Secondly, we obtain a description of the methods employed, both models/mindsets and specific treatment techniques. Thirdly, through interviews with a selection of representatives from the units, we are able to obtain material that will enable us to describe any underlying program theories that govern the choice of methods and actions.

3. Program Process and Implementation

The purpose of this stage is to illustrate whether a theoretical program is actually implemented, in which case how well, and how it is carried out in practice – an example of which is if projected group therapy sessions actually take place. Thus, an evaluation focusing on these processes will be based on activities that have been planned and will require ongoing checks or surveys. Other possible criteria could be based on professional or ethical standard requirements for the treatment of substance abusers. The figure below shows the activities we have planned for the third stage:

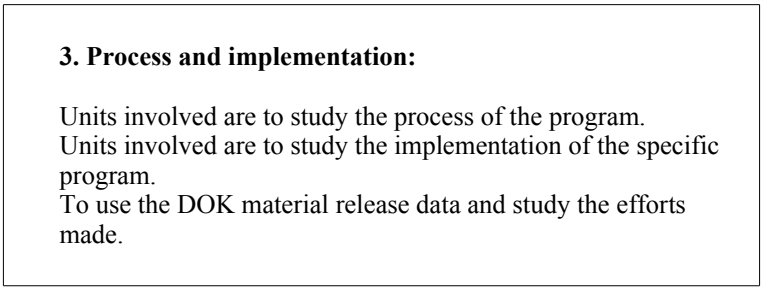

Fig. 4. Planned activities during the third stage

On our part, this stage involves conducting interviews at, and making observations of, units corresponding to the ones used in stage two in order to study the processes and implementation of the various treatment programs. By carefully describing the contents of each program and detailing how they put their ideology into practice, we will obtain clues as to how different interventions can be tried to certain outcomes, and thus make it possible to draw more general conclusions as to any differences that may exist (Petrosino 2002; Rossi et al. 2003). This data will also be supplemented with information from release interviews that detail which treatment actions were documented as being performed by the units. In this way, we will obtain three pictures of the operations and programs: from interviews, observations, and from the action descriptions in the DOK material.

Hopefully, stages two and three also create the possibility of categorization by program theory and its implementation. This means that these categorizations could be a central starting point for our studies during the next stage.

4. Program Outcome and Impact

The purpose of the fourth stage is to investigate the outcome and the impact of the various interventions. When we discuss outcome it is important to point out that tying a certain outcome to a certain intervention is complicated. Figure 5 shows the activities we have planned for the fourth stage:

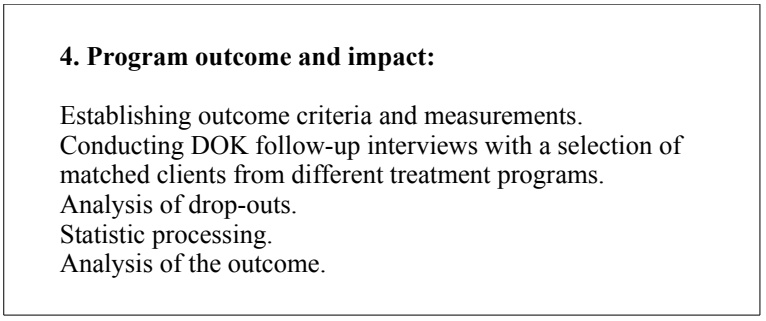

Fig. 5. Planned activities during the fourth stage

Structured interviews in accordance with the DOK system constitute a basis for the description of the groups undergoing treatment, which also ensures a means of controlling the comparability of the clients. These interviews are conducted in connection with the initiation of treatment, the conclusion of treatment, and a follow-up a year after treatment has been concluded. A selected number of clients will be followed up, and an analysis of the drop-out rate will be conducted by making a comparative survey involving the clients who completed the intervention with regard to background, abuse patterns, etc. During this follow-up, supplementary questions are asked as to how the individuals perceive any changes that have occurred and what impact the treatment had on their lives.

The first step we will take in the fourth stage is a general study of the outcome. By this we mean general factors such as gender, age, the choice of the substance

abused, the duration of the treatment, etc. The next step is to investigate whether we are able to relate any changes that have taken place with the need for treatment, in other words, check the clients' backgrounds and their current situation. The third stage of our study involves studying the outcome in connection with the program theory and implementation. Do the specific programs display different outcomes according to the follow-ups conducted one year after the treatment program has been concluded? Are there any similarities or differences that are significant beyond the framework of the specific programs applied, and is it possible to relate them to the outcome of the treatment?

The analysis of the outcome is performed in several different ways. Firstly, the outcome of the follow-ups is compared to the situation present at the beginning of the intervention, and is assessed with regard to the established outcome criterion. The second step is to relate the outcome to other relevant studies, such as SWEDATE. The third step is to employ theoretical points of reference as a guide for interpretation. The final step is to perform statistic processing and analysis of the material, which could pave the way for some other conclusion or hypothesis.

5. Program Cost and Efficiency

Stage five entails a cost-benefit analysis, or a cost-efficiency analysis, that is based on the results of the previous assessments. The first analysis explores the direct connection between the outcome and the costs incurred by the program, while the second analysis compares the impact of the program in relation to the costs to society. The latter analysis in particular requires sophisticated measurement methods, and frequently calls for special knowledge and the support of consultants (Rossi et al. 2003). This type of evaluation is highly uncommon in Sweden as regards social programs, and the Krami-study is an exception (Nyström et al. 2002).

Discussion

This final discussion consists of three parts. The first part concerns reflections on an upcoming research project and on the "staircase model" presented in this paper (Rossi et al. 2001). The following part deals with aspects described by Rawson and Branch (2002) as being important for projects where there should be a collaboration between practice and research in relation to the DOK-system.

Finally, we will present a few thoughts regarding systems for basic documentation within the care sector for substance abusers.

Reflections On the Projected Research Project

The DOK system has its strengths and weaknesses as an instrument. One limitation is, of course, the fact that the documentation conveys a relatively static and incomplete on-the-spot account of the client's situation. However, this instrument also provides the opportunity to base studies on documentation created jointly by care providers and clients. By involving practice it is possible to create a feedback process, thereby stimulating a basis for a continued exchange of knowledge. If the desired outcome is to promote the use of research findings within the care sector for substance abusers – which is the entire point of evidence-based treatment – we believe that it is necessary to conduct research and evaluation that touch on the treatment work itself, which focuses on the manner in which actions taken can lead to better results (cp Morén & Blom 2003).

The evaluation model has been described as a "staircase model", where each step builds on the previous step/stage creating a hierarchy. We have explained and discussed the activities we intend to pursue in our study with regard to each "step". Following set models can involve risks – they may act as straight-jackets, restricting an undertaking – but the Rossi et al model has the advantage of being flexible, making it possible to modify your approach and methods. In addition, it accommodates vital scientific aspects and it can be used as a checklist when planning studies of social interventions and as a guide for extensive empirical material.

Promoting Collaboration Between Practice and Research

As was previously mentioned, Rawson & Branch (2002) and Carise et al. (2002) presented a number of important aspects for projects where collaboration between practice and research is expected in order to reach a mutually beneficial end. We intend to employ these aspects in order to discuss our projected study that will include the DOK material as an empirical base.

Practitioners are involved in designing research projects

If we look at the first aspect, the DOK-system has been developed by an expressed "from-the-bottom-up" strategy as a guiding principle. The participating treatment units had taken part in the construction of questionnaires and computer programs. Questions were tailored to suit the requirements of both practice and research. Consequently, developments were initiated mainly from a standpoint of the wishes and needs of practitioners.

Rawson and Branch emphasize this aspect in their paper, but they also point out the difficulties inherent in transforming the issues of practice into viable research issues. In regard to the DOK system, the objective of creating an operational and useful system for documentation was at the forefront. To this end, practice has been involved in the process through the input of the participating units as to the design of questionnaires and computer programs. Questions have been tailored to suit the requirements of both practice and research (Jenner & Segraeus 1997).

Compared to the projects mentioned earlier (Carise et al. 2002; Rawson & Branch 2002), it seems that the DOK system was not expressly directed towards a research project. Instead, the emphasis has been on the documentation for the treatment units' own purposes, and self-evaluation. This particular aspect, however, may have contributed to the fact that the involvement of practice and the usefulness of the system have been tested for roughly ten years now, allowing the system to evolve. This means that research has the responsibility to maintain the existing tradition of collaboration, and to keep up the dialogue that has evolved within the DOK project now that the system will be a foundation for empirical studies as well. In this view, practitioners are seen as being partners and their involvement also guarantees the continuity of a research project – not only as a supplier of information.

Participating treatment units are to receive compensation and added value for their part in a research effort

The second criterion focuses mainly on economic compensation, etc. In contrast to projects in the US, the treatment units within the DOK system pay a yearly fee for participating in the project and for the requested technology, education and support. The participation itself supplies several advantages and this opposite position is probably a consequence of cultural differences.

We would also like to point out two aspects which, in our opinion, involve added value. Firstly, participating in a research effort will affect operations at a treatment unit in a positive way (cp Carise et al. 2002). Secondly, several units within the DOK system have continuously expressed a desire for evaluation, and many units have a great need for such a process, but this often fails to take place due to a lack of time, resources or know-how.

In this context, we believe that many units within the care sector for substance abusers could be enlisted, and that care providers believe that researchers can find the answers to important issues. This ”expectation” can possibly be regarded as an expression of the fact that, so far, research has not been able to present models for the evaluation of local practice that are sufficiently concrete and useful, thereby enabling evaluation to become a natural part of daily operations.

Instruments for data collection are to be user-friendly

Instruments should be user-friendly, in other words, they should be simple to use during interviews, easy to fill out, and be tailored to clinical application (Rawson & Branch 2002). However, in addition to this, the output from the monitoring activities is viewed as a useful tool that can be the basis for treatment and follow-up plans. As previously mentioned, this aspect has been in focus during the development of the DOK system. The interests of treatment facilities have been safeguarded through seminars and contacts with system coordinators. Questionnaires, manuals and computer programs have been revised and developed in an ongoing dialogue between the researchers in charge and the participating treatment units. Today, the DOK system consists of a basic module (containing the Reitox questions) and a number of segments that can be enriched by more extensive client interviews. The needs of the treatment units have to a great extent governed this development process (Jenner & Segreaus 2005).

Any data collected must be reliable and must comply with scientific requirements

It is important that the instruments are user-friendly, but it is equally important that the collected data is credible and useful for research purposes and this aspect includes issues pertaining to reliability and validity (Rawson & Branch 2002). In stage one (Need for the Program) we described how we intend to deal with these issues.

Some assessments as to the scientific quality of the documentation from the DOK system have been made, but we are obligated to call attention to the fact that this is a weak point when it comes to tying in the DOK system with research. There are some functions built into the system to deal with errors, i.e. special checkpoints when transferring the forms into the computer program, but there remains a lack of scientific tests of validity and reliability and this is an urgent matter for research to attend to.

In our opinion, the reliability of the collected data can be related to the following aspects; *practitioners are to be offered support in the form of training and support,* along with *findings are to be reported to the units involved on a regular basis.*

Practitioners are to be offered support in the form of training and support

The DOK system is organized as a network, in accordance with similar projects in the US, with the addition that it employs regional coordinators. These coordinators are responsible for education and ongoing support efforts. They are consultants that act on specific issues concerning the different treatment units, such as documentation and activities. Their tasks also include making regular visits and organizing seminars and conferences at a local, regional and national level. These meetings are occasions where it is possible for the staff from different units to meet each other and discuss pressing matters, or to meet researchers and partake of their results and findings. The mission of the regional coordinators is multifold and appears to be a strong and basic function of the DOK system. But at the same time, this is a very vulnerable aspect when it comes to the maintenance of the project.

Findings are to be reported to the units involved on a regular basis

Today it is up to the participating units within the DOK system, with support from the regional coordinators, to put the collected data together and use it for self-evaluation. On a local level, a number of evaluations have been carried out, and some of them have also been published. But still, there are several units that have not realized this intention.

The following features are of vital importance for maintaining a project like the DOK system: activities to keep up the motivation for collecting data as well as those that encourage the participation in research work. The latter activity is a new aspect for the DOK system, and one that is of growing importance. The experiences obtained in the ongoing project can hopefully also be of use when keeping up motivation during research participation. New activities such as sharing and discussing research findings on a regular basis can be viewed as a payoff to the treatment units and this process makes it possible to compare specific results with other units. Another option is to arrange seminars which are joint ventures between researchers and treatment professionals; seminars that raise issues such as how research findings can be implemented into treatment routines in a concrete manner.

The collaboration itself, based as it is on an ongoing dialogue between researchers and treatment professionals, might turn out to have a greater impact on the development of methods than the actual research findings. Instead of condemning entire treatment models and programs, thereby risking "throwing the baby out with the bath water", it would be possible to pinpoint which features are effective, or do not work. They could then be evaluated, and either implemented or removed. It is highly probable that this approach will appeal to treatment professionals, and thereby gain a greater impact and practical importance. Since the method in itself has a limited effect on the final outcome, it is more important to focus on and explore "the active mechanisms" rather than the treatment program as such (Armelius & Armelius 1999; Pawson & Tilley 1997; Segraeus 1994).

In Conclusion

In conclusion, we believe that basic documentation conducted on an ongoing basis, concerning the clients and the interventions involved in the treatment of substance abusers, is imperative in order to create a self-reflecting knowledge-based practice and research that attempts to identify effective treatment methods and convey their findings. In this respect, we share the opinion of Bergmark & Oscarsson regarding the benefits of basic documentation:

> ”In the long run, this appears to be the only route that will lead to the development of professional attitudes within the care sector for substance abusers, which is based in social services. The systematical documentation of certain data about clients and their treatment aspects is the first step towards such a development” (1996, 47).

Naturally, we are unable to guarantee that our upcoming project will be able to satisfy all the various demands and aspects that are important in obtaining an ongoing and fruitful collaboration between practice and research. We do, however, claim that a sturdy platform already exists, one which fulfills several of the criteria that play an important part in the initiation of a successful partnership – and one that could be a good starting point – as DOK enters a new phase and approaches the research sector.

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