

Documentation as part of substance use rehabilitation: how workers account for the significance of documentation during interviews

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Abstract

Purpose – The focus of this article is in documentation in substance abuse inpatient rehabilitation. Our article scrutinizes how workers give accounts of the documentation in the inpatient substance abuse rehabilitation unit and what kind of client information the workers record.

Design/methodology/approach – The study focuses on institutional interaction and practices. Our data consist of interviews with substance abuse rehabilitation professionals ($N = 15$). We analyzed the interviews using content analysis and the account concept in keeping with the ethnomethodological research tradition.

Findings – Study shows how workers account for the significance of documentation. Workers deemed documentation significant in four different ways: in gathering basic and rehabilitation information, in storing and transmitting information, as a tool for analysis and assessment and in supporting linguistic transparency in substance abuse rehabilitation. Workers justified the significance of documentation by the legal requirement to record information about clients. Documented information enables clear management of client information and supports substance abuse rehabilitation work in various ways. Documentation contains descriptions of the client's situation and work performed. Additionally, documentation serves as a tool for communication among social care professional.

Originality/value – Thus the research show that documentation plays a significance part in the inpatient substance abuse rehabilitation and are connected to its institutional tasks and practices.

Keywords Interviews, Rehabilitation, Documentation, Accounts, Client information, Inpatient substance rehabilitation

Paper type Research paper

Introduction

Nowadays documentation is a prominent part of inpatient substance abuse rehabilitation. It is also difficult to imagine substance abuse rehabilitation without client documentation, which is a process that entails meeting the client, gathering information and reviewing the documented information. The practices of documentation can be seen as portraying the prevailing social climate reflecting the professional culture in which client information is produced and documented (Prior, 2003). In the documentation process workers write up information on clients and their rehabilitation progress based on their views and

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observations (e.g. Günther and Raitakari, 2008; Ekqvist and Kuusisto, 2020) according to their understanding and interpretation (e.g. Garfinkel, 1967; Smith, 1990). When workers write up information, it is stored for later use in the client information system (Räsänen and Günther, 2018). Client information systems can be considered as boundary objects, which convey information and shared understanding among workers (Star and Griesemer, 1989; McKenzie, 2004). Therefore, they serve as a source of information for workers and a means of sharing knowledge (e.g. Karlsson and Nikolaidou, 2011; Pereira de Souza *et al.*, 2021). According to Isah and Byström (2017), information practices such as needing, creating and sharing information are embedded in the work routines of workers (also Zhong *et al.*, 2023). Thus, documenting is closely linked to institutional tasks and practices (Ames, 1999; White *et al.*, 2009).

In Finland, substance abuse treatment is organized within both social welfare and health care. Their approaches differ from each other: in health care, the focus is more on pharmacological and therapeutic orientation, while in social welfare, the emphasis is on supporting client well-being and sobriety (the Social Welfare Act 2014/1301; Health Care Act 2010/1326). This study focuses on substance abuse rehabilitation within social welfare.

In social welfare inpatient substance abuse rehabilitation those working there are social care professionals with expertise in psychiatry and substance abuse treatment. A prominent part of their work consists of substance abuse rehabilitation, which involves documenting the client's rehabilitation and well-being. Documentation in inpatient substance abuse rehabilitation is prescribed and governed by law, general directions and instructions within the institution. As workers become socialized into their work, they also form a conception of the institution's substance abuse treatment practices, such as documentation (e.g. Sarangi and Roberts, 1999; Günther, 2015).

Documentation in social work practices has been researched from various standpoints, also from the perspective of information documented and included in the client Electronic Health Records (Chen and Garcia-Webb, 2014; Haroon *et al.*, 2018; Wu *et al.*, 2019, 2020; Salovaara and Ylönen, 2022), from the perspective of usability of information systems (De Witte *et al.*, 2016; Shand and Turner, 2019; Gillingham, 2021; Hujanen *et al.*, 2021; Salovaara and Ylönen, 2022; Ylönen, 2024), from the perspective of writing up and producing records (Kagle and Kopels, 2008; O'Rourke, 2010; Günther, 2015; Isah and Byström, 2020; Günther *et al.*, 2015), from the perspective of using records (Borkman, 1998; Clarke *et al.*, 2003; Günther, 2015; Günther and Räsänen, 2022) and also from the perspective of passing on information (Huuskonen and Vakkari, 2013; Ylönen, 2024). However, practices in documentation from the perspective of substance abuse rehabilitation have been little researched. Examining the documentation practices in inpatient substance abuse rehabilitation is important to gain an understanding of its documentation and information practices (e.g. Bronstein and Solomon, 2021). With the research data produced, these practices in inpatient substance abuse rehabilitation can be developed. Secondly, so that workers would understand the power of documented information, through written information, workers can, among other things, form a common understanding of the clients' situation, plan their rehabilitation and monitor their progress (e.g. Günther, 2015; Räsänen and Günther, 2018; see also Borkman, 1998). Thirdly, studying documentation is also important because the written information about clients is influential and often regarded as official truth, containing information about both the client and the workers' actions, and can be used to assess their performance (e.g. Hall *et al.*, 2006; Opel and Hart-Davidson, 2019; Günther, 2015; Räsänen and Günther, 2018). Additionally, studying documentation is relevant because it may lead to improvements in client information systems to meet documentation practices and needs (Kivistö and Hautala, 2020; Salovaara and Ylönen, 2022). It has been observed that information systems do not always communicate with each other or work together, which in part complicates documenting and the exchange of information (Günther and Räsänen, 2022).

Thus, our article is situated within studies on institutional communication and the practices of everyday work and our research question concerns how workers give accounts of the documentation in the inpatient substance abuse rehabilitation unit and what kind of client information they record. Our data consist of interviews with substance abuse workers, two individual interviews and four focus groups ($N = 6$). To find answers to our question we used content analysis and the concept of accounts. In their talk workers give accounts of their own actions in their work (Garfinkel, 1967; Juhila, 2009), thereby describing, justifying and explaining documentation.

The article is organized as follows. First, we discuss the documentation as part of rehabilitation process. Then, we describe the research setting, the data and the methodological framework of our study. In the data analysis section, we illustrate how the workers account for the documentation in inpatient substance abuse rehabilitation. Finally, we discuss the significance of documentation and present concluding remarks about documentation as an everyday communication tool in welfare work.

Documentation as a part of the rehabilitation process and as production of rehabilitation information

Documentation is a part of the everyday institutional routine (e.g. Trace, 2002; Isah and Byström, 2020). Today, documentation is mainly held in various electronic client information systems (Räsänen and Günther, 2018; Salovaara and Ylönen, 2022; Ylönen, 2023), for maintaining documented information and records of clients. According to Kagle and Kopels (2008), documentation is planning, coordination of services, and monitoring (pp. 4–5). It is moreover a tool for compiling, generating, and creating information on clients and sharing as well as storing of data (Günther, 2015; Isah and Byström, 2020; Räsänen, 2022). Thus, documentation can be considered a practice through which workers produce, use, and disseminate information for a specific purpose (Savolainen, 2008).

According to Isah and Byström (2020), documentation helps the worker to focus on the client's issues and to implement services like substance abuse rehabilitation systematically and purposefully. Documentation serves the compiling of information, its writing up in the records and its availability to other workers (e.g. Laihonen, 2012; Buus *et al.*, 2017; Isah and Byström, 2020; Salovaara and Ylönen, 2022). Documentation is also a means to commit clients and workers, a tool in the rehabilitation process and evidence of work accomplished (e.g. Taylor and White, 2000, p. 14; O'Rourke, 2010; Räsänen and Günther, 2018).

Workers write both official and less official information and descriptions of clients which are significant for their work (Buus, 2009; Günther, 2015; Günther and Räsänen, 2022). The workers increasingly written client information in various information systems and standardized forms. These support and assist in the systematic documentation of client information, standardize information entry, and facilitate information transfer (e.g. Räsänen and Günther, 2018; Ylönen, 2023). However, they also entail their own challenges; they may restrict the information to be documented (e.g. Star and Griesemer, 1989; Günther, 2015; De Witte *et al.*, 2016) and they may also involve problems related to usability and functionality, for example (Gillingham, 2013; De Witte *et al.*, 2016; Salovaara and Ylönen, 2022).

When workers write they make choices, for example, as to the language and concepts used to describe the client's situation (Günther, 2015). There is moreover a temporal perspective in these documentations by workers; they describe clients' situations and problems past and present, their coping, progress, or regression and also the services offered to support clients and how (e.g. Taylor and White, 2000). In their descriptions of clients' actions, well-being, and rehabilitation workers frequently use everyday colloquial language. Research has shown that workers have found everyday language better than formal language to describe the clients' situations (Buus, 2009; Günther, 2012).

Information on clients is not only written up for purposes of worker-client work but also serves as a means of communication when liaising with other workers in the clients' interests (Karlsson and Nikolaidou, 2011; Isah and Byström, 2020; Bronstein and Solomon, 2021). As Taylor and White (2000) point out, records are "time-travelers", as they transfer written information from one context and time to another (p. 144; McKenzie, 2004); in social care services, client records have various readers and audiences (e.g. Garfinkel, 1967, p. 200). For example, different readers, such as social workers referring clients to substance abuse rehabilitation, clients' relatives having received permission or the clients themselves can use the written information to construct a picture of their own rehabilitation and situation.

Secondly, documentation creates an image of how the workers have helped and supported their clients, what kinds of services the client has used and how the client has progressed during rehabilitation. The documentation moreover produces information on what kind of work the unit accomplishes and through this the workers' work can be supervised (e.g. O'Rourke, 2010, pp. 20–23, 33; Räsänen and Günther, 2018; Räsänen and Günther, 2018; Isah and Byström, 2020). Räsänen (2012) points out that it is important to take note that when information is written up and read in different contexts there are different interpretations present (e.g. Zimmerman, 1969; Smith, 1990; Günther, 2015). Workers always choose what and how they produce records as well as how they read and interpret them (Zimmerman, 1969). Thus, comprehending the records requires knowledge of the context and culture in which they were created (e.g. Bronstein and Solomon, 2021).

In Finland, workers are required by law to document their work with clients. The most important of these laws are the Act on the Status and Rights of Social Welfare Clients (812/2000), the Act on Processing of Social Welfare and Health Care Client Data (703/2023), the Social Welfare Act 2014/1301 and the Administrative Procedure Act (434/2003). These acts to some extent direct the content and ways of producing records. They also regulate the ways records should be handled and stored, and who has access to what information. Furthermore, they govern the ways client information can be used (confidentiality) and how it should be secured. These acts also regulate the transfer of written information, i.e. what information can be given to whom and in what circumstances. For example, the Act on the Status and Rights of Social Welfare Clients (812/2000) requires each worker working in inpatient substance abuse rehabilitation within social welfare services to record client information and inform the client about why the information is needed, how it will be used, and where it will be stored. The Administrative Procedure Act (434/2003) provides guidance on the principles of documentation and instructs workers to write up client records in accordance with good governance practices, ensuring the confidentiality and security of sensitive information during documentation. Additionally, documentation is regulated by the Act on Processing of Social Welfare and Health Care Client Data (703/2023), which guides workers to write necessary and sufficient information regarding the organization, planning, implementation, monitoring and supervision of social welfare services. The law also regulates the language and information structures used in records, basic information documented in records, right to access information, and the disclosure and storage of data. The Social Welfare Act (2014/1301) as a general law, also regulates the contents of records to be written in social welfare, such as the contents of client plans; what kind of information they must contain. For example, it should include assessments by both client and worker regarding the client's need for assistance and support, as well as the necessary measures and services. In addition to laws, documentation in institutional substance abuse rehabilitation is guided by general documentation guidelines, ethical guidelines as well as internal institutional guidelines and documentation practices, along with criteria set by the service purchaser (Günther, 2015).

Material and methods

Context of study

The context of our study is an inpatient substance abuse rehabilitation unit providing both individuals and families with therapeutic community-based treatment for substance abuse or gambling. Rehabilitation involves communality, no medications and is based on special expertise and knowhow. The unit's operations are governed by values of individuality, communality and are centered on resources. The rehabilitation multiprofessionals are social care professionals: social workers, bachelors of social sciences and nurses and practical nurses with expertise in psychiatry and substance abuse work. In Finland, the well-being counties cover the majority of rehabilitation and treatment costs. Referral to them usually occurs through social welfare.

In the rehabilitation period client information is written up in the records used by the unit (client case documents, rehabilitation plans, assessments and final statements) and stored electronically in the client information system used only by the unit. This enables information to be transferred from one worker to another. The client's own keyworker is generally responsible for updating records, this individual is assigned to the client for the duration of rehabilitation.

Data and ethics

The data in this study comprise six audio-recorded interviews (two individual interviews and four focus group interviews) conducted with workers at an inpatient substance abuse rehabilitation unit ($N = 15$) (total duration 293 min, the interviews lasted on average 49 min and altogether they amount to 293 min). The transcribed data amounted to 103 pages (Times New Roman, font 12 and 1.5 spacing).

Before the interviews, we held an information session for the workers at which we informed them about the study, its purpose and what it entails to participate in it. In that session, workers had the opportunity to ask questions about the research. The structure of each interview was the same: documentation was discussed in terms of themes, namely client records, data systems for documentation, documentation as practical work and text, institutional documentation practices, client participation, changes in documentation and its challenges and potential. The themes were addressed as they were introduced and also guided by the discussion. Each focus group interview involved one researcher and two to three workers. The workers had the opportunity in the interviews to introduce the documentation environment. The focus group interviews also include joint consideration, consultation and shared but also differing conceptions about documentation (e.g. [Pietilä, 2017](#)). Focus group interviews were chosen because they allow as many workers as possible to discuss documentation and present their own perspectives on it. Two individual interviews were included to complement the information provided by the focus group interviews. In the individual interviews, the researcher posed questions that had received less attention in the group interviews. The individual interviews enhanced and supplemented the researcher's understanding of documentation in the context of inpatient substance abuse rehabilitation.

The research data were produced as a part of the (pseudonymized) research project. The organization behind the rehabilitation unit granted research permission in spring 2017. The research project was given a supportive statement from the Ethics Committee of the region (pseudonymized). Participants' consent was requested after they had been informed about the study. They were free to withdraw from the study at any stage. The data examples from the data were pseudonymized by removing names and other identifying information such as the names of places and organizations. The language in the data excerpts was also adjusted so as to avoid the interviewees being identified. The examples are chosen selectively so as to represent a typical expository text regarding both content and style, and they were

translated faithfully from Finnish to English. The research complied with the guidelines of the Finnish codes of research ethics and governance and with the codes of research integrity in Europe (Academy of Finland, 2019).

Data analysis

The study relates to a research genre which focuses on institutional interaction and practices. Interactional situations are structured by workers' institutional tasks and their understanding of how these tasks should be conducted (For example, Drew and Heritage, 1992; Jokinen *et al.*, 1999; Hall *et al.*, 2006; Juhila *et al.*, 2010; Ekqvist and Kuusisto, 2019). The approach enables a more profound understanding of the phenomena under study and also provides a new perspective to study the significance of documentation in the context of inpatient substance abuse treatment and the rehabilitation.

We analyzed the interviews using content analysis and the account concept in keeping with the ethnomethodological research tradition (e.g. Garfinkel, 1967; Baker, 2003). For the first stage of the analysis we used content analysis (Krippendorff, 2013) as a means to order and condense similarities and differences in the data. We then attempted to produce an understanding and a systematic picture of the phenomenon under study without losing the information contained in it (e.g. Krippendorff, 2013).

In the second stage we went into detail by analyzing the accounts. Accounts are general responses to questions demanding an explanation. The concept of account can be used in either a broad or a narrow sense (Buttny, 1993). Broadly defined, accounts consist of descriptions of events and experiences and are seen to be present in all everyday talk, such as describing documentation (e.g. Antaki, 1994). Narrowly defined, accounts refer to explaining and justifying the gap between action and expectation (Scott and Lyman, 1968; Hall *et al.*, 2006; Juhila and Hall, 2017).

In our analysis we relied on the broader definition, perceiving accounts as actions occurring in the routines of rehabilitation work by means of which workers describe, justify and explain their own actions, documentation and its significance for rehabilitation. We took the view that accounts are an integral part of workers' tasks (e.g. Hall *et al.*, 2006; Juhila, 2009; Matarese and Caswell, 2014) and based on the responsibility people bear for their own actions (Garfinkel, 1967). By giving accounts workers make their work more comprehensible. Substance abuse workers are accountable for their actions to clients, other workers and indeed their employers and to the purchaser of substance abuse services (the buyer) and each of these may have expectations regarding the party providing the account.

In particular, the data enabled us to analyze how workers talk into being (Baker, 2003; Morgan, 2012) and attribute the significance of documentation in their work. We perceived the interviews as occasions for collegial accountability, as the participants of the interviews verbalize, explain and justify the significance and role of documentation in rehabilitation work (e.g. Baker, 2003).

In this article, the data were analyzed by two researchers. We analyzed our data individually and collectively to ensure the quality and the reliability of the analysis. Together we discussed our observations, how consistent they were. The analysis of the data falls into three interrelated stages: listening to records and reading transcriptions, analysis of the data using content analysis and its close reading applying the concept of account. At the beginning of the analysis stage, we carefully went through the transcribed interviews mindful of our research question. Applying content analysis, we arranged and classified them using ATLAS.ti 9, utilizing interview excerpts in which the workers produced accounts of client documentation and explained their significance. This round of analysis led us to pay attention to how similarity workers explained documentation. From this it became clear to us that documentation is indeed an important tool for professional workers in inpatient

substance abuse units. The workers presented their documentation and explained their documentation practices to each other as a tool in gathering rehabilitation data on the client, monitoring this and attaching to it justifications for the account. With the help of the account concept, we closely analyzed those parts of the interviews in which light was shed on the significance of documentation. Next, we selected illustrative examples in such a way that they shed light on the importance of documentation, rendered visible the role of documentation and showed how the workers explained and justified their own actions in documentation in rehabilitation work. Together, all three researchers wrote, edited, commented and rewrote the results of the study.

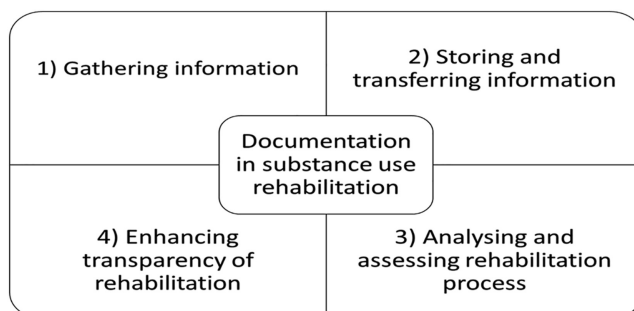
In the data examples W indicates worker. Workers are distinguished in consecutive numbers (W₁, W₂, etc.). The abbreviation for a researcher is R. The sign distinguishing an interview is noted at the end of the quote. Explanatory additions appear after the examples from the data and omissions are noted in square brackets.

Results: workers' accounts of documentation in inpatient substance abuse rehabilitation

We identified four different kinds of accounts in the inpatient substance abuse workers' interviews in which they explained and justified their documenting. Documentation in the accounts was given the meaning of: (1) a tool for gathering basic and rehabilitation information, (2) a tool for storing and transferring information on clients, (3) a tool for the analysis and assessment of the clients' rehabilitation process and (4) a tool to enhance transparent language in substance abuse rehabilitation. The accounts provided differed in how workers justified the significance of documentation in inpatient substance abuse rehabilitation. The accounts have in common the view that documentation is a tool that helps and supports workers' work and brings transparency to inpatient substance abuse rehabilitation. These accounts overlap to some extent and one excerpt might include features of some other type of account. We selected eight illustrative examples from our data to demonstrate them (see [Figure 1](#)).

Documentation as a tool for gathering basic and rehabilitation information on clients

Workers positioned documentation in their accounts as a tool for documenting, compiling and storing basic and rehabilitation information on clients in substance abuse rehabilitation. In gathering client information, workers utilized standardized questions stored in the system and their own professional expertise. The workers explained and justified documentation on clients through the legal requirements and substance abuse rehabilitation work:



Source(s): Figure by Günther, Ekqvist & Kuusisto

Figure 1.
Documentation in
substance abuse
rehabilitation

JD

documentation made it possible to gather rehabilitation information and so to embark on the work of rehabilitation. In the following excerpt, workers describe the use of documentation as a tool for gathering and storing client information:

Excerpt 1.

R: Is this (the client information system) where you collect client histories and final statements that go forward?

W1: When I accept new clients, of course I fill out all these, the basic information (in the client information system) - what there is, and what comes in the interview [-]

R: So this is basic information?

W1: Yep. This is the information on the clients which is collected when they are interviewed on arrival. We go through the substances used, physical health, mental health, readiness for treatment, risk of relapsing, environmental factors and in the case of older individuals parenthood.[-] then after that, when the interview is over, I set about doing the documentation. This information is then the frame when it comes to making the rehabilitation plan. That's where you can take the things the clients have been through or related about their situations, then you start making the rehabilitation plan.

In this excerpt, the worker explains how documentation is used as a tool for gathering and storing client information. At the beginning of inpatient substance abuse rehabilitation, the worker gathers client information through client interviews, guided by standardized questions available in the system and questions based on the worker's own expertise. The worker mentions gathering information from the client about substance abuse, physical and mental health status, readiness for treatment and questionnaires, risk of relapse, environmental factors and information about the client's parenthood. The worker writes and saves the gathered information in the client information system after the client interview, when the client is not present. The worker views client information as the framework for substance abuse rehabilitation work; it forms the basis for individualized substance abuse rehabilitation and rehabilitation planning (e.g. [Taylor and White, 2000](#)). The worker mentions revisiting the documented client information when planning the client's rehabilitation, writing a rehabilitation plan with the client, or updating changes in client information. In excerpt two, the workers describe documentation as a tool for gathering client information related to rehabilitation and explain what kind of information they write:

Excerpt 2.

R: What is your documentation like in general? How do you write it up?

W1: . . . I think that we ((workers)) write client-related matters, the way the client's treatment goes, things happening to the client during a treatment day, if the client takes care of some business, makes phonecalls, these are written up, their content, the decisions on them. Those at least. Then if the client has made any realizations. If maybe there's a conversation with the client about how, kind of, the ((rehabilitation)) process is progressing and what new realizations or understandings have occurred to the client.

W2: And of course changes in ((the client's)) condition if there have been any changes in medications or then you are monitoring something or illnesses. . . some more physical things. Or mental, too. They should be written up in the treatment notes . . .

W1: Yeah.

In the excerpt two workers produce together an account of what kind of information they write up during the client's rehabilitation period. The workers justify the significance of

documentation through the importance of information on the client's rehabilitation. They state that they wrote up the progress of the client's rehabilitation day, such as how the client has taken care of their practical affairs and with whom they have been in contact. The workers moreover wrote up the client's views on their well-being. The information that workers write up pertains to the client's rehabilitation process and its progress, as well as the client's activities during substance abuse rehabilitation. Their shared understanding is that it is essential to write up changes occurring in the client's physical and also mental well-being. These include, for example, changes in medication, illnesses and monitoring their care (e.g. McKenzie, 2004).

Excerpts 1 and 2 show how workers explain and position documentation as a tool for gathering and storing client information. In their accounts, workers justify and substantiate the gathering and documentation of client information from the perspective of the client's substance abuse rehabilitation. In the system, workers write information about the client's various phases of substance abuse rehabilitation. Thus, the documents contain detailed information about the client's physical and mental health status, medication and substance abuse, activities during the course and progress in rehabilitation. The workers create a consistent picture and corroborate each other's accounts. They use a lot of we-talk, by which they illustrate their shared understanding of the documentation practices (Günther, 2014).

Documentation as a tool for storing and transferring information

The workers position documentation as a tool in their accounts, which can be used to store and transfer client information. In inpatient substance abuse rehabilitation, client information is documented in a client information system. Workers utilize the information stored in the client information system when they write a rehabilitation plan and final statement for the client at the conclusion of rehabilitation. The workers explained and justified such storing through the obligation in law and substance abuse rehabilitation work.

For workers, it is particularly important that they can transfer client information from one worker to another and from one institution to another. Workers explain and justify the transfer of client information with legal obligations, substance abuse rehabilitation work and its transparency. In the following excerpt, workers explain the significance of documentation:

Excerpt 3.

W2: ((We, client and worker)) talk together. But we don't exactly do like this ((documenting about the client's actions)) not exactly . . .

W1: No.

W2: That you might write that the client was absent from the group . . . [-]

W1: But, yes, documenting ((in the client information system)) is important just when you're thinking about doing those ((client)) final summaries on that's where ((the client documents)) you can pick out what all the rehabilitation has included, and the rehabilitation plan guides the tasks but there ((in client information system)) you can see, like, how the ((client's rehabilitation process)) has wavered and how that and these twists and turns in well-being, what they're connected to.

R: Yeah, yeah.

The workers described the complexity of documentation in inpatient substance abuse rehabilitation. As part of their work the workers wrote up client information in the client information system, the rehabilitation plan and the final statement among other items. When writing a rehabilitation plan and final statement, they utilized client information that had been stored in the client information system. Through the stored information, the workers could create a picture of the client's rehabilitation history: actions in rehabilitation, how the

client made progress then relapsed, *going back and forth* and of the client's well-being during rehabilitation. The workers described documenting client information as not being written word by word. What the worker meant by this was not divulged.

The workers explained the importance of documentation in their work by claiming that it is always possible to refer back to the information which is stored in the client information system and from there they can read and *pick out* information pertaining to the client's rehabilitation process. In other words, the client information is available for later use. The following excerpt illustrates documentation as a means of transferring client information:

Excerpt 4.

R: How to you see the workers' ((client)) documentation, what's good and what's bad?

W1: What's good in my opinion is what I was talking about at the beginning, that we've started to write more. And certainly, somehow, of course there can be that side, that is it even too much and is it all necessary what gets written about client records. But somehow, I think about the purchaser of substance abuse services, that those client accounts nowadays surely serve to convey what the client is doing here in rehabilitation. Somehow that sort of content.

In the fourth excerpt, documentation becomes significant as a means of transferring information. The worker explains and justifies documentation by stating that it conveys information about the client's actions to other professionals, those who have access to the documented client information. By reading client information, for example, a purchaser of substance abuse rehabilitation, other workers and the client themselves can form a picture of the client's well-being and life situation, as well as what the client has done for their own rehabilitation, which groups the client has participated in, and how the client's well-being has improved and rehabilitation progressed during the inpatient substance abuse rehabilitation period.

Excerpts three and four highlight how workers explain and position documentation as a tool for storing and transferring client information (e.g. McKenzie, 2004). In their accounts, workers justify and validate the storage and transfer of client information from the perspective of substance abuse rehabilitation and its transparency: it is important that the service purchaser, the client and other workers can follow the client's rehabilitation process and well-being.

Documentation as a tool for analysis and assessment the client's rehabilitation process

The workers described documentation as a tool to assist in the analysis and assessment the client's rehabilitation process. They justify this by the fact that documentation contains among other things basic information on the client, information of the client's well-being and changes occurring in rehabilitation and the worker's and the client's views on the client's rehabilitation process and actions in the course of this. With such detailed information, the worker can build an understanding and assessment on the client's rehabilitation process. They moreover help them in assessing what measures in the substance abuse rehabilitation have supported the client's rehabilitation and thereby help in directing future rehabilitation. In the excerpt below a worker sheds light on documentation as a tool for analyzing information:

Excerpt 5.

W1: But as I see it, documentation is in no way a bad thing; I think that it somehow helps to clear my thoughts. You get some thoughts sure enough when you sit there in the group and listen to other people's feedback and somehow that clarifies your own thoughts at the same time as you write them.

R: I was watching you there in the group that you were making a sort of analysis for yourself.

W1: Yes.

The worker explains documentation and reading records as helping to stay focused on the client's situation. Through documentation the worker is able to go through the client's rehabilitation process and try to break it down, form an image of it and comprehend the stages and the changes occurring there. This way documentation appears as a tool with which it is possible to consolidate information on the client and add one's own understanding of the client's rehabilitation process. On the other hand, the information documented about the client also helps the worker to distinguish what information is relevant and what is not from the perspective of the client's rehabilitation. Thus documentation serves as a tool for workers in the processing of rehabilitation information. In the following excerpt, the worker provides an explanation for how they utilize and analyze the information documented about the client in their work:

Excerpt 6.

W1: [...] when, let's say when I go to the net discussion or (I) have a telephone negotiation (on the client's affairs), I personally go through at least, and surely all the others also go through, what the client's rehabilitation has included. That's where the frame for that discussion comes from and the things that get discussed. And there you can see it, what tasks (the client) has done and how (the client's) thoughts have changed and how (the client's) actions have changed[...]

Documentation in the workers' accounts assumes a role in analyzing the client's rehabilitation process. In the excerpt, the worker explains how they use documented information to create an understanding of the client's substance abuse rehabilitation process and its stages. The worker can refer back to the documented information just before discussing the client's issues with other experts. The information in the client rehabilitation history serves as an analytical tool. With it, the worker can construct a framework, a picture of the changes occurring in the client's rehabilitation process in chronological order as well as forming an understanding of the client's thought patterns. The documented information also helps the worker's assessment of which measures in the rehabilitation of substance abuse issues have supported the client's recovery.

In excerpts five and six, workers make visible how they explain and position documentation as a tool used for the analytical structuring and assessment of client rehabilitation information. Workers can refer back to the information documented and stored in client information systems to create a picture and understanding of the client's rehabilitation process and its contents, as well as what has supported and aided the client's recovery. The structured information serves as the framework for collaborative discussions.

Documentation as a tool to enhance transparent language in substance abuse rehabilitation

In their accounts, workers position documentation as a tool to enhance transparent language and so also information transparency in inpatient substance abuse rehabilitation. The workers explain and justify the importance of information transparency through understandable language and legislative regulation: entries must be made in clear language, and they must contain information that is readable regarding both the client's and the professional's activities in substance abuse rehabilitation. In the following excerpt, workers explain how they write information about the client in client records and what aspects are important to consider in their documentation:

Excerpt 7.

R: In practice, how you do client documentation?

W1: Well, I try to write as much as possible of the client's own, the client's own language.

JD

R: Uuh.

W2: I write there ((in the client information system)) the challenges for future treatment. Then of course I write my own views, but I do go through these with the client, that the way I see it, your challenges are still these. It's based on my professional assessment. So I do make that professional assessment not just that I ((agree)) with the client. And I don't necessarily agree about something but I tell ((the client)) that this is my assessment, that in these things you still need support.

W1: So it's all out in the open.

W2: Yes, that's right. I don't write down anything there that I have not talked about with the client.

In excerpt seven, the worker (1) explains that they write up the client's substance abuse rehabilitation information in the client information system in the client's own language. We interpreted this to mean that the worker writes up information on the client in language that is clear and understandable language to the client and also as the client has expressed them. Another worker (2) mentions documenting their own assessment of the client's rehabilitation challenges after discussing them with the client. Although professional assessment is emphasized in documentation, the client's perspectives are taken into account and written in the records. In documentation, workers aim at transparency; the client knows what information is being recorded about them, where it is being recorded, and can read those entries. In the following excerpt, there is a description by a worker of how documentation practices may vary within the institution from one worker to another:

Excerpt 8.

R: You write that up in the client information system, but where in that system?

W1: This is a client case history, that is, we write everything if ((the client)) has participated in groups or if we ((workers)) have called the social workers or if ((the client)) has been in a discussion. And ((the client)) has made these personal assessments, assessment of the rehabilitation actions, these are all written there and all the debriefing of the ((client's)) tasks is written there. So there's a little variation in who is doing the documentation. Somebody may write that ((the client)) debriefed the final task.

R: Yeah.

W1: And I have generally included what ((the debriefing of tasks)) entails. Because then, if, for example, these are made into a rehabilitation plan, then you can sort of see if there ((in the client's rehabilitation)) there has been any progress made and what ((the client)) had paid attention to. If you think that at that point the client had objectives in the rehabilitation plan [—]

In the excerpt, the worker provides an account of what and how workers record client information in the client information system. The worker explains that they record everything about the worker's and client's actions in substance abuse rehabilitation in the client information system. Although, according to the worker, the ways in which workers write information vary depending on the worker's own writing style, nevertheless, the entries contain information about how the worker has promoted the client's rehabilitation and well-being, as well as what the client has done to advance their own recovery (e.g. [Buus, 2009](#)). Some workers record very detailed information, while others provide brief descriptions of the client's actions.

Excerpts seven and eight reveal how workers explain and position documentation as a tool that helps them write information in the client system transparently, clearly and comprehensively. Workers do not record information in the system that they have not discussed with the client.

Discussion

In this study we scrutinized documentation in inpatient substance abuse rehabilitation. Our data consisted of interviews with substance abuse rehabilitation workers analyzed using

content analysis and the concept of accounts. We asked how workers account for the documentation in the inpatient substance abuse rehabilitation unit and what kind of client information the workers record. When contemplating the research findings, it is important to bear in mind that the investigation included one single inpatient substance abuse unit in which the workers are socialized into a certain documenting culture.

The workers associated significance with documentation in four different ways in their accounts. Firstly, they regarded documentation as an important tool for compiling basic and rehabilitation information about the client, secondly, as a means of storing and transmitting rehabilitation information about the client. Thirdly, workers saw documentation as a tool that aids in the analysis and assessment of the client's rehabilitation process, and fourthly, as a tool for making institutional substance abuse rehabilitation linguistically clear and informationally transparent. When explaining the significance of documentation, the workers justified this through the legal requirement in rehabilitation work to write up information about clients. The clients' accounts have in common that documentation in client information system is a boundary object, a tool that helps and supports the workers' work and also helps workers to form a shared understanding of the client's situation in substance abuse rehabilitation (e.g. [Star and Griesemer, 1989](#); [McKenzie, 2004](#)). Documentation helps workers to gather, manage, monitor and transfer information about clients' rehabilitation effectively (e.g. [Savolainen, 2008](#); [Isah and Byström, 2020](#)).

The study highlights the significance of documentation as a tool for producing information in substance abuse care, a role that is often overlooked. Documentation is frequently seen as a necessary evil and a time-consuming task that takes away from face-to-face client work (e.g. [Kagle and Kopels, 2008](#)). In this study the workers perceived documentation as a tool in rehabilitation work which on the one hand supports and organizes their daily work (e.g. [Berg and Bowker, 1997](#); [Günther and Räsänen, 2022](#)). It does not constitute its own reality within substance abuse rehabilitation, but is firmly connected to its institutional tasks and practices (e.g. [Ames, 1999](#); [Isah and Byström, 2020](#)).

The worker explains documentation by the fact that it generates information as a basis for planning and supporting the client's rehabilitation (e.g. [Taylor and White, 2000](#); [Günther, 2015](#)). Workers write up information on the client's routine activities in substance abuse rehabilitation, such as how the client has coped with daily practical issues and with whom the client has been in contact. On the other hand information is written up on changes in the client's physical and mental well-being and on changes in the rehabilitation process, on improvements and relapses and also assessments of how the client's rehabilitation is progressing. Documented information provides the worker with a means to monitor and analyze the progress of the rehabilitation process over time. By comparing previous entries with new observations and results, the worker can assess which approaches in rehabilitation have been effective and make necessary adjustments to the client's rehabilitation program.

Detailed documentation enables clear and systematic management of client information in inpatient substance abuse rehabilitation. The worker can refer to documented rehabilitation information, store, manage and analyze detailed chronologically entered information about the client's well-being and changes in behavior. The client information system thus includes the client's rehabilitation history, as well as the client's well-being and current situation (e.g. [Iedema, 2003](#), p. 71). It is also noteworthy that documented information in substance abuse rehabilitation does not tell the whole story of the client's life and rehabilitation; rather, it contains periodic descriptions of the client's life situation and the work accomplished with the client (e.g. [Günther, 2015](#)).

Documentation can serve as a tool for communicating with other social and health care professionals. It enables the sharing of information and collaboration among different experts, which is important for the comprehensive rehabilitation of the client (e.g. [Isah and Byström, 2020](#); [Bronstein and Solomon, 2021](#)). Workers pass on information to other workers,

for example in team and network discussions and at the end of rehabilitation in the form of summaries or through final assessments. Thus the documentation also assumes a significant role in future written and spoken texts.

Our study shows that documentation also has concrete significance in the planning, implementation and monitoring of rehabilitation, as well as in making substance abuse rehabilitation visible and assessing its efficacy. In other words, documentation plays a meaningful part in the various stages of client-centred inpatient substance abuse rehabilitation. According to Vierula (2012), documented records form a complex network of spoken, interpreted and ultimately written words and meanings. These appear differently to the writer of the text than to the reader. Therefore, how and what is written in the documents is equally as essential as how they can be read (see Vierula, 2012, p. 150). Therefore in the future, it would be justified to focus research attention on the experiences and perspectives of clients as readers of documented client information. One could elicit the kind of impressions documented information conveys to clients regarding their rehabilitation processes and how they perceive detailed information entries. On the other hand, it would be beneficial for research to focus on client information systems and their functionality in substance abuse rehabilitation, exploring how they support and challenge the work of the professionals.

Conclusions

Documentation is intertwined with the institutional tasks and practices of substance abuse rehabilitation. Documentation becomes meaningful as a tool for gathering, producing, managing, storing and transmitting information in substance abuse rehabilitation. Workers see documentation as a practical tool for producing information and thus supporting and organizing their daily tasks, rather than as a separate part of substance abuse rehabilitation. In the client information system, workers write and store detailed information about the client's daily activities, changes in their physical and mental well-being and the overall progress of rehabilitation. The study shows that documentation has concrete significance in the planning of rehabilitation, in implementing rehabilitation, in monitoring changes and also in assessing the efficacy of substance abuse rehabilitation. The information documented in the client information system enhances transparency in inpatient substance abuse rehabilitation.

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