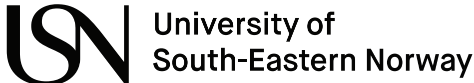

Therese Dwyer Løken

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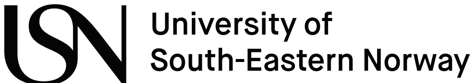
Dissertation for the degree of Ph.D
Person-centred Health Care

Faculty of Health and Social Sciences



Therese Dwyer Løken

The dynamics between policy and practice

A case study on the integration of municipal health and social care services for people with mental health and substance abuse challenges

A PhD dissertation in
Person-centred Health Care

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Faculty of Health and Social Sciences
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Abstract

This doctoral project examines the integration of municipal health and social care services for people with concurrent mental health and substance abuse challenges. The main aim is to explore how professionals and managers adapt to and operationalize policies regarding the integration of municipal health and social care services. This aim is explored through four specific research questions, which are addressed across three research articles.

The Norwegian health and social care sector faces sustainability and quality challenges while providing services to people with concurrent mental health and substance abuse challenges. These issues stem from the increasing number of people who seek help from the public services, and from the fragmentation of the service system. In fragmented systems, service recipients can experience difficulties in accessing care, maintaining continuity of services, and having their needs adequately met. Consequently, researchers and decision-makers promote the integration of health and social care services as a means to improve access, quality, and continuity of services, while mitigating the negative consequences of fragmentation.

The doctoral project is designed as a qualitative single-case study with participants recruited from three Norwegian municipalities. Data is gathered through various sources including: observation of meetings; individual in-depth interviews with professionals and managers; focus group interviews with professionals, managers, service recipients, and family caregivers; and individual telephone interviews with service recipients and family caregivers. The result of this is a comprehensive data set which enables the analysis of how factors at system, organization, and practice level influence the integration of municipal health and social care services. The findings from these analyses are presented across the three embedded research articles.

The first article explores how the values within public management principles influence organizational and financial structures as well as professional practices in municipal health and social care services. As such, this article connects central public management

values at the system, organizational, and practice levels. The second article consists of a competence framework required for the implementation of service integration, along with a discussion on the need for a collective approach to develop service integration competence. This article contributes to analyzing the impact of factors at the organizational and practice levels. The third article explores formal and informal integration. The article highlights how professionals' relational work related to networks and networking skills are important for achieving service integration. Thus, the third article illustrates the impact of factors affecting integration at the practice level.

Findings from the articles are integrated in this dissertation to explore how public management values influence the ways in which professionals and managers adapt to and operationalize policies regarding service integration. The economic and frugal values within government documents, stimulate municipal managers to structure health and social care services in a way that makes financial management, accountability, and reporting feasible. It also stimulates municipal managers to promote frugal approaches in decision making rather than integrated approaches. The policies directing service integration do not entail strong incentives, but appeal more to the autonomy granted to Norwegian municipalities. Municipalities who choose to structure and approach services based on the integrative values of adaptivity, flexibility, robustness, and resilience, succeed to integrate services to a great extent.

The dissertation also discusses the trust-control nexus between the Norwegian government and the municipalities. On the one hand, the controlling elements within performance management policies, creates sanctions and anxiety for the municipalities. On the other hand, Norwegian municipalities are granted autonomy to adapt to and operationalize service integration policies according to their contextual needs. This may be understood as a high level of governmental trust in municipalities' abilities and willingness to accommodate the aim of service integration.

Lastly, this dissertation points out that the trust-control nexus between the Norwegian government and the municipalities should be better balanced. This requires new tools for controlling and safeguarding qualitative policy objectives such as the integration of

municipal health and social care services. In this regard, this dissertation proposes that in the development of municipal health and social care, national authorities can consider controlling qualitative policy objectives by enabling professionals and managers to provide resilient services. Investing in the capacity of practice level managers and professionals to respond to evolving changes and challenges, can prepare for the national authorities' trust in Norwegian municipalities to provide safe and high-quality services for the wellbeing of citizens.

Key words: Welfare state, decentralization, fragmentation, service integration, municipal health and social care, mental health, substance abuse, public management values, competence, street-level diplomacy, resilience.

Sammendrag

Dette doktorgradsprosjektet studerer integrering av kommunale helse- og velferdstjenester til personer med samtidig rusavhengighet og psykiske utfordringer. Hovedmålet er å undersøke hvordan ansatte og ledere tilpasser seg og operasjonaliserer statlige retningslinjer knyttet til integrering av kommunale helse- og velferdstjenester. Dette målet blir undersøkt gjennom fire spesifikke forskningsspørsmål, som er behandlet i tre forskningsartikler.

De norske helse- og velferdstjenestene, inkludert de som ytes til mennesker med samtidig rusavhengighet og psykiske utfordringer, står overfor utfordringer knyttet til bærekraft og kvalitet. Årsaken til dette er for det første økningen i antall mennesker som søker om hjelp fra disse tjenestene. For det andre preges helse- og velferdstjenestene av fragmentering. I fragmenterte systemer kan tjenestemottakerne oppleve manglende tilgang til tjenester, manglende kontinuitet og at tjenestene ikke klarer å møte deres individuelle behov. Både forskere og beslutningstakere foreslår integrerte helse- og velferdstjenester for å forbedre tilgang, kvalitet og kontinuitet i tjenestene på en effektiv måte, samtidig som at de negative konsekvensene av fragmentering forebygges.

Doktorgradsprosjektet er utformet som en kvalitativ enkeltcase-studie med deltakere rekruttert fra tre norske kommuner. Data er samlet inn gjennom observasjon av møter, individuelle dybdeintervjuer med ansatte og ledere, seks fokusgruppeintervjuer med ansatte, ledere, tjenestemottakere og pårørende, samt individuelle telefonintervjuer med tjenestemottakere og pårørende. Dette har ført til et omfattende datamateriale som muliggjør analyser av hvordan faktorer på system-, organisasjons-, og tjenestenivå påvirker integrering av kommunale helse- og velferdstjenester. Funnene fra disse analysene presenteres i tre forskningsartikler.

Den første artikkelen utforsker hvordan verdiene innenfor offentlige styringsprinsipper påvirker organisatoriske og økonomiske strukturer og profesjonelle praksiser i kommunale helse- og velferdstjenester. Artikkelen knytter i så måte sentrale verdier på systemnivå, organisasjonsnivå og praksisnivå sammen. Den andre artikkelen omhandler

et kompetanserammeverk som kan brukes til å forbedre tjenesteintegrering. I tillegg diskuteres behovet for en kollektiv tilnærming til tjenesteintegreringskompetanse. Artikkelen gir innsikt i faktorer på organisasjonsnivå og praksisnivå. Den tredje artikkelen utforsker formell og uformell integrering. Artikkelen understreker ansattes relasjonsarbeid knyttet til nettverk og nettverksferdigheter, og betydningen det har for tjenesteintegrering. I så måte presenterer den tredje artikkelen faktorer på praksisnivå.

Artiklene brukes videre i avhandlingen til å diskutere hvordan og hvorfor verdier innenfor offentlig styring påvirker hvordan ansatte og ledere tilpasser seg og operasjonaliserer statlige retningslinjer knyttet til tjenesteintegrering. De økonomiske og nøysomme verdiene i nasjonale styringsdokumenter stimulerer kommunale ledere til å strukturere helse- og velferdstjenester på en måte som gjør økonomistyring, ansvarlighet og rapportering mulig. De samme verdiene påvirker også kommunale ledere til å fremme en økonomisk og nøysom tilnærming til beslutningstaking, til fordel for en integrert tilnærming. Samtidig så støtter nasjonale styringsdokumenter vedrørende integrering av tjenester opp under norske kommuners autonomi. Kommuner som velger å strukturere og tilnærme seg tjenester basert på de integrerende verdiene tilpasningsdyktighet, fleksibilitet, robusthet og resiliens, lykkes i stor grad med å integrere tjenestene.

Avhandlingen peker også på forholdet mellom kontroll og tillit, i relasjonen mellom de norske myndighetene og kommunene. På den ene siden skaper de kontrollerende elementene i nasjonale styringsdokumenter sanksjoner og engstelse for kommunene. På den andre siden viser nasjonale myndigheter en høy grad av tillit til kommunene ved at kommunene har autonomi med hensyn til å organisere tjenesteintegreringsarbeidet med utgangspunkt i egne lokale behov.

Til slutt påpeker avhandlingen at forholdet mellom tillit og kontroll i relasjonen mellom norske myndigheter og kommunene bør balanseres bedre. Dette krever virkemidler for kontroll og sikring av kvalitative statlige mål, som for eksempel integrering av kommunale helse- og velferdstjenester. I denne sammenhengen foreslår avhandlingen at man i utviklingen av kommunale helse- og velferdstjenester kan vurdere å kontrollere kvalitative statlige mål ved å sette ansatte og ledere i stand til å yte resiliente tjenester.

Investering i ansatte og lederes evne til å respondere på endringer og utfordringer vil legge grunnlag for at nasjonale myndigheter kan ha tillit til at norske kommuner vil levere kvalitetsmessig gode og trygge tjenester til befolkningen.

Nøkkelord: velferdsstat, desentralisering, fragmentering, tjenesteintegrering, kommunale helse- og velferdstjenester, psykisk helse, rusavhengighet, offentlig styringsverdier, kompetanse, bakkebyråkratisk diplomatiarbeid, resiliens.

List of articles

Article 1

Løken, T. D., Helgesen, M. K., Vike, H. & Bjørkquist, C. (2022). Being bound and tied by the ropes of frugality: a case study on public management values and service integration. *Journal of Health Organization and Management*, *36*(9), 95-111. https://doi.org/10.1108/JHOM-10-2020-0401

Article 2

Løken, T. D., Helgesen, M. K. & Bjørkquist, C. (2022). Collective Competence as an Enabler for Service Integration in Health and Social Care Services. *Journal of Multidisciplinary Healthcare*, *15*, 2817-2830. https://doi.org/10.2147/JMDH.S387719

Article 3

Løken, T. D. & Vike, H. (2023). Thinking and acting outside the box: The co-existence between formal bureaucratic integration and informal street-level integration in municipal health- and social care services. [Submitted to *Nordic Journal of Wellbeing and Sustainable Welfare Developments*, in review as of 29th of May 2023].

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Abbreviations

FACT: Flexible Assertive Community Treatment

GP: General practitioner

NAV: The Norwegian Labor and Welfare Organization

NPM: New Public Management

Post-NPM: Post New Public Management

SDI: Stepwise deductive inductive approach

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1 Introduction

Being born in Norway is often seen as winning the lottery of life because of the nation's high standards of living. Norway is a high-income country where citizens enjoy one of the highest per capita health expenditures in the world (Statistics Norway, 2018). Furthermore, Norway is characterized as a universal welfare state which means that all citizens, regardless of economic and social status, receive services from the welfare state in line with their needs, from "cradle to grave".

Despite this apparently "lucrative" context, the Norwegian health and social care sector faces multiple sustainability and quality challenges, as is the case for other western countries. Mental health and substance abuse services are among the service fields currently facing such challenges. An increasing number of people in Norway report low life satisfaction due to physical and mental health problems, as well as social problems (Støren, 2021). This is also reflected by the number of people who received treatment for such problems before, but especially after the Covid-19 pandemic (Hammersland & Barstad, 2022). In 2021, nearly 163 000 adults, 3% of the Norwegian population, received treatment for mental health diagnoses, which was an increase of 6% from the year before (Hammersland & Barstad, 2022). The number of people who received inter-professional specialized treatment for substance abuse problems was nearly 33 000, or 0.1% of the Norwegian population, which was an increase of 1% compared to the year before (The Norwegian Directorate of Health, 2022). Additionally, the number of deaths related to substance abuse is on an upward curve (Hammersland & Barstad, 2022).

Professionals working in mental health and substance abuse services have reported a growing number of individuals seeking assistance for mild to moderate mental health and substance abuse challenges (Øydgard et al., 2020). This rise can be attributed to the growing normalization and acceptance of seeking help for such issues (Elraz & Knights, 2021). Concurrently, these professionals also invest a great portion of their working day in service provision to service recipients with severe mental health diagnoses and heavy substance abuse challenges (Øydgard et al., 2020). To handle the increase in demand, many municipalities have established low-threshold services to improve access to

primary care treatment for people with symptoms of mild-to-moderate depression and anxiety disorders (Knapstad & Smith, 2021). Furthermore, the number of employees working in mental health and substance abuse services has increased from 13 936 employees in 2026 to 17 074 in 2022 (Ose & Kaspersen, 2022).

Despite the introduction of new service provisions and the expansion of the workforce, this situation presents capacity challenges and places substantial pressure on municipal health and social care services in Norway. With the Norwegian government bearing the responsibility for solving a great majority of its population's health and welfare related issues, these capacity challenges are likely to persist in the present and future, potentially exceeding the government's capacity to effectively address them (Vike et al., 2016). These sustainability challenges present researchers with good reasons to study conditions that influence health and social care services. Generating knowledge in this field can contribute to enhancing the quality and efficiency of these services for the greater good of citizens.

Living with mental health challenges increases the risk of substance abuse, and vice versa (Mueser & Gingerich, 2013). Often people experience challenges tied to physical health, mental health, and social life simultaneously, leading to complex life situations. Addressing these situations requires the collaboration of different professionals and organizational units within municipal health and social care services. National health supervision shows that this can be a challenging act (Norwegian Board of Health Supervision, 2019). For people with concurrent mental health and substance abuse challenges, integrated health and social care services have been promoted as a means to improve access, quality and continuity of services in a more efficient way (Valentijn et al., 2013). The integration of these services is done through different means and methods of coordination and collaboration (Keast et al., 2007). While research on integrated specialist treatment for people with concurrent mental health and substance abuse diagnosis is extensive, fewer studies have been done on the integration of municipal follow-up services for the same group of people. Studies on integration within this field, primarily focus on specific initiatives and practice level models such as Flexible Assertive

Community Treatment (FACT) (Bønes et al., 2023; Trane et al., 2022). Furthermore, little empirical research has been done on factors at different levels (e.g., system, organization, and practice), and on how these factors influence municipal service integration for people with concurrent mental health and substance abuse services. Thus, in this PhD-project, I link public management principles, organizational and financial structures, and professional practices, to study how municipal professionals and managers adapt to and operationalize policy regarding integration of services.

The empirical foundation for this dissertation is based on municipal services relevant for people who have concurrent mental health and substance abuse challenges. The dissertation is designed as a qualitative single case study, where the case is integration of municipal health and social care organizations. The data collection comprises of individual interviews, focus group interviews, individual telephone interviews, and observations. I will return to a comprehensive presentation on the choice of design and methods in chapter 6.

1.1 The ROPIT-project

The PhD-project is part of a bigger project called ROPIT (Integrated Services for Patients with Dual Diagnosis). This project was funded by the Research Council of Norway (NFR) (project number 273312) and lasted from 2017-2021.

ROPIT was a project that addressed the question of how to organize services for people with concurrent mental health and substance abuse challenges in ways that make these services more coordinated as seen by the service recipients. Eight researchers explored different research questions regarding the organization of services for these service recipients at local levels, with a particular focus on factors that promote or prevent the implementation of integrated services. In addition to the published research articles produced by the ROPIT-project, we wrote a peer-reviewed open access anthology called "Statlig politikk og lokale utfordringer: Organisering av tjenester innen rus og psykisk helse". [State politics and local challenges: organization of mental health and substance abuse services] (Bjørkquist & Ramsdal, 2021).

1.2 Aim and research questions

Given the multifaceted nature of mental health and substance abuse conditions, support for individuals experiencing such challenges needs to be multidisciplinary and integrated. This dissertation contributes to the scientific knowledge on integration of municipal health and social care services by developing empirical and theoretical knowledge through: the study of public management principles (system level), organizational and financial structures (organizational level), and professional practices (practice level). I have combined and integrated empirical material with organizational theory literature, as organizational approaches can be useful for understanding factors and processes that can impede or facilitate decisions and practices in health and social care (Denis & Lehoux, 2013).

The overall aim of this dissertation is to explore how municipal professionals and managers adapt to and operationalize policy regarding integration of health and social care services. To address this, four research questions were formulated and explored across three research articles. The research questions are:

1. How do public management values influence service integration in municipal health and social care organizations? (Article 1)
2. Which types of competence do stakeholders require? (Article 2)
3. How may collective competence promote service integration? (Article 2)
4. How do practice level managers and professionals work to achieve integration of mental health and substance abuse services? (Article 3)

The first article titled, “Being bound and tied by the ropes of frugality: A case study on public management values and service integration” (Løken, Helgesen, Vike & Bjørkquist, 2022), answers the first research question. Data for this article was gathered by observing collaborative meetings and through individual interviews with professionals and managers. By applying Hood’s (1991) framework for public management values to the data, the study found that the frugal and economic values in New Public Management

(NPM) doctrines strongly influenced organizational and financial structures as well as professional practices, thereby impeding service integration. Conversely, we found that service integration was achieved when either or both the organizational and financial structures, and the professional practices were aligned with integrative values of flexibility, adaptivity, robustness, and resilience.

The second article titled, "Collective competence as an enabler for service integration in health and social care services" (Løken, Helgesen, & Bjørkquist, 2022), answers the second and third research questions. The data was gathered through focus group interviews and individual telephone interviews with service recipients, family caregivers, professionals, and managers. The inductive part of the analysis resulted in four types of competence necessary for service integration: 1) Knowledge about individual life situations and organization and system; 2) Investigation competence; 3) person-centered collaboration competence; and 4) facilitating competence. From a theoretical standpoint we argued that the four competences could be approached as a collective competence framework. Furthermore, we suggested an additional principle to the theory on collective competence (Boreham, 2004), which involved legitimatizing extra-professional involvement.

The third article titled, "Thinking and acting outside the box: the co-existence between formal bureaucratic integration and informal street-level integration in municipal health- and social care services" (Løken & Vike 2023, forthcoming), answers the fourth research question. Data for this article was gathered by observing collaborative meetings, through individual in-depth interviews with professionals and managers, and through focus group interviews and individual telephone interviews with service recipients, family caregivers, professionals, and managers. In this article, we explored the co-existence of formal bureaucratic integration and informal street-level integration. Additionally, we demonstrated how street-level diplomacy (Gale et al., 2017) was used to achieve service integration when formal collaborative structures and arrangements were insufficient. The findings indicated that the commitment to the goal of service integration could be both symmetrical and asymmetrical between managers and professionals. The co-

existence of formal bureaucratic integration and informal street-level integration was feasible when the commitment between them was symmetrical.

Together, the three articles can provide insight into how professionals and managers adapt to and operationalize policy regarding integration of health and social care services. Apparent in the three articles is that the values within policies can shape the values within organizational structures and professional practices, and in turn, change the outcomes for service recipients. Thus, the collective contribution of the three articles prepares for an analysis and discussion of economic and frugal policy values on the one hand, and integrative policy values on the other, and how and why the two sets of values give different implications for operationalization of the policies. It also prepares for an exploration of the dynamics between economic and frugal policy values and integrative policy values. Lastly, the articles prepare for an exploration of why some professionals and managers succeed in achieving service integration, and how this achievement can contribute to resilience in municipal health and social care services.

1.3 Structure of the dissertation

This dissertation consists of three articles, which both separately and collectively contribute to the study of the main aim. The dissertation consists of eight chapters that bring the three articles together. The next chapter contextualizes the PhD-study through a presentation of the Norwegian health and welfare system, the people who have concurrent mental health and substance abuse challenges, policy changes that have had implications for mental health and substance abuse services, and the practical context. The third chapter connects the presented context with the challenge of fragmentation, defines the concept of integrating health and social care services and underscores the need for such integration. Furthermore, this chapter presents the current state of the art regarding research on the integration of municipal health and social care services at the macro, meso, and micro-levels. The fourth chapter is devoted to explaining the applicability of organizational theory to studying municipal health and social care services. Included in this, is a theoretical framework for this dissertation, that allows for analysis of factors at the system level, organizational level, and practice level. The fifth

chapter is the methodological chapter. It outlines my philosophical positioning, choice of research design, data collection methods, analysis, recruitment procedures, and analysis. It also presents a discussion on ethical considerations and the maintenance of quality in the dissertation. The sixth chapter then presents a summary of each of the three research articles that constitute this PhD-project. Subsequently, the seventh chapter is a discussion of the research findings, and this is divided into four parts. The first part illustrates how the two different types of values shape service integration practices from policy to service delivery levels. The second part focuses on the control-trust nexus between the government and municipalities. The third part explores the role of practice level managers and professionals in fostering resilience in the service delivery system through service integration. The fourth part entails a proposition for future development of municipal health and social care. Finally, chapter 8 concludes the dissertation, highlighting implications for future policy and practice, as well as the dissertation's strengths and limitations.

2 Background

In this chapter I place the PhD-study into context. First, I present the Norwegian health and welfare system, where I have a special focus on primary health and social care. Second, there is a presentation of what living with concurrent mental health and substance abuse challenges entails, including subsequent conditions that can occur for this group of people. Third, I present policy changes which are relevant for integration of municipal health and social care services to people with mental health and substance abuse challenges. Last, I present the practical conditions of municipal health and social care services to people with mental health and substance abuse challenges.

2.1 The Norwegian health and welfare system

The Norwegian government has gone longer than many other welfare states in expanding health and social care services that are publicly managed (Szebehely & Meagher, 2018). In the Norwegian welfare model, great emphasis is placed on public financing, oversight of welfare services, and the provision of high-quality public services (Kautto et al., 2001). The social democratic heritage and the quest for universalism are prominent features of the Norwegian welfare state (Esping-Andersen, 1990).

Furthermore, Norway has a decentralized organizational model, whereby the municipalities are responsible for implementing primary health and social care policies through the localized distribution of services to their populations (Baldersheim & Ståhlberg, 2002). This decentralized responsibility is meant to safeguard democratic influence and local adaptations of services (Sandvin et al., 2020).

While Norwegian municipalities are responsible for the distribution of many primary health and social care services, they do not control their own revenues and on the state's allocation and reallocation of funds to provide services. Most of their income comes from tax revenues and block grants (around 70% of total income) from the government, and some from user payments and fees from residents. However, once the annual allocation of funds is granted, the municipalities can dispose the block grants freely within the law's requirements regarding which services the municipalities must provide (Baldersheim &

Ståhlberg, 2002). In addition, the municipalities also receive certain earmarked transfers. These are grants that the municipalities must use for the specific purposes specified in the national budget (Hansen & Klausen, 2002; Ministry of Local Government and Regional Development, 2021). The municipalities have a high degree of autonomy in terms of organizing public welfare services and allocating the funding according to differences in political and administrative organization, size, financial position, geographical conditions, resources, and infrastructure (Aarre, 2018; Baldersheim & Ståhlberg, 2002).

2.2 People with mental health and substance abuse challenges

Having concurrent mental health and substance abuse challenges means that a person has at least one mental health challenge or diagnosis in combination with the misuse of at least one substance. This can be either a legal substance such as alcohol or prescribed medication, or an illegal substance such as amphetamine or cannabis (Evjen et al., 2018). The co-existence of two or more chronic conditions such as this is also called multimorbidity, which are often long-term health conditions requiring complex and ongoing care services. (WHO, 2016).

Living with mental health challenges increase the risk of substance abuse, and vice versa (Mueser & Gingerich, 2013). The exact number of people with concurrent mental health and substance abuse challenges in Norway is uncertain. In Brukerplan [User plan] 2019 there were 22 404 people registered with substance abuse challenges, and only 4 053 of these did not have concurrent mental health challenges (Veiviseren, 2022). This means that around 80% of the people who have substance abuse challenges, also have mental health challenges.

2.3.1 Subsequent conditions and challenges adding to the complexity

People with concurrent mental health and substance abuse challenges often have several subsequent conditions and complexities, thereby amplifying the complexity of multimorbidity. These issues can be divided into five categories. First, they have higher than expected rates of physical health problems such as cardiovascular diseases, infections, respiratory diseases, some forms of cancer, and non-insulin-dependent

diabetes (Robson & Gray, 2007). There is also a higher rate of mortality from physical diseases and medical conditions (Nishimura et al., 2020; Wahlbeck et al., 2011). Second, people with concurrent mental health and substance abuse challenges often encounter housing problems, including living in temporary housing and experiencing homelessness (Lie & Hustvedt, 2021). This is also tied to a third challenge, namely economic and employment related issues. Only 1% of people diagnosed with concurrent mental health and substance abuse challenges have paid employment, indicating that 99% of these receive economic benefits from The Norwegian Labor and Welfare Organization (NAV) (Lie & Hustvedt, 2021). Fourth, they have social network challenges, consisting of limited skills in relationship building and behavioral challenges. Lastly, having mental health and substance abuse challenges are also associated with criminal activities related to substance use and drug dealing, resulting in police interventions (van Kranenburg et al., 2020).

While service recipients may have unique life circumstances encompassing differing degrees of complexities from the abovementioned list, a common feature among them is the fact that they have complex challenges and needs. The personal experiences of these individuals with challenges and needs, and whether they are addressed or not, can exceed the limits of diagnosis and the specific services prompted by it (Stergiopoulos et al., 2018). In this study, diagnosis has not been part of the inclusion criteria. This is because the study has an inter-professional health and social care approach with a focus on the functioning of services, and not on diagnosis and clinical pathways.

2.3 Reforms and policy changes

Different reforms have resulted in policy changes that have affected municipal health and social care services, including services aimed at people with mental health and substance abuse challenges. In this section I outline the reforms and policy changes in a chronological order. The first period (1980s-2000) displays policy changes which have increased municipalities' responsibilities within financial accountability and discipline. The second period (2000-2023) displays policy changes which have implications for the integration of municipal health and social care services.

2.3.1 1980s to 2000

Like other Western countries, the Norwegian health and social care sector went through New Public Management (NPM) inspired reforms in the 1980s and 1990s (Nesvaag & Lie, 2010). The administrative label NPM is loosely termed, but can be useful as a shorthand name for the set of broadly similar administrative doctrines (Hood, 1991). To make management more efficient, NPM-like reforms applied business like methods, with coordination mechanisms such as management by economic objectives and output control. The reforms affected organizational and financial structures by dividing public health and social care organizations into single- or few-purpose organizations with separate funding streams, each pursuing defined sets of goals and tasks (Christensen & Lægreid, 2007). The NPM-reforms also enhanced municipal welfare responsibilities, putting the municipal services under high pressure to attain tight financial discipline and to organize their services in a cost-effective matter (Vabø, 2009). These changes applied to the municipal health and social care services in general, and thus, it also affected mental health and substance abuse services.

Another change in the 1980s was reform of the financial system for mental health institutions, and the downsizing of mental health institutions. This happened as a response to a more global critique of large mental health institutions, but without a consolidated national plan (Ramsdal, 2021). As a result, the earlier government grants, measured by the number of stay days in institutions, was replaced by block grants estimated with different criteria for needs as a point of departure (mainly age and area). The transition to block grants was connected to a health reform where a separate law for municipal healthcare was developed. In line with the NPM principle of seeking to the lowest effective care level, preferably in the homes of service recipients, municipalities received responsibility for providing services to people with mental health issues, who historically would receive services in a mental health institution (Pedersen, 2002).

From the beginning of the 1990s it became apparent that downsizing the mental health institutions was not accompanied by equivalent development of alternative services in the municipalities. To strengthen provision of services, earmarked grants were

introduced to the municipalities, accompanied by a white paper that offered a comprehensive review of the service offerings and which also addressed the challenges faced by public services. The white paper emphasized that mental health institutions should not serve as long-term housing. As a response to the challenges presented in the white paper, Opptrappingsplanen for psykisk helse [The Escalation Plan for Mental Health] was established in 1998 (St. prp. 63 (1997-1998)), leading to a considerable increase in resource allocation to municipalities (Pedersen, 2002).

2.3.2 2000-2023

In 2012, the Coordination Reform was introduced, in line with the international trend of addressing fragmentation challenges in the public sector. The main idea in this reform was to move services closer to where people live (Grimsmo et al., 2015). Economic incentives, legal mechanisms, and restructuring tasks and responsibilities between the specialist and primary healthcare sector were key tools for achieving better coordination and integration (Romøren et al., 2011). Through economic incentive arrangements, municipalities were taking over responsibilities for service recipients that were ready for discharge from hospital from the first day. Additionally, the reform aimed to aid in coordinating treatment and improving follow ups for chronically ill individuals, including those with concurrent mental health and substance abuse challenges (Orvik, 2015). The increased responsibility for municipalities were to be compensated through municipal block grants. However, research shows that after implementing The Coordination Reform, municipal managers experienced increasing pressure to care for severely ill service recipients who were discharged from hospitals at an earlier stage in their treatment, placing extra demands on professionals working at service delivery level (Tingvoll et al., 2016).

A year after the launch of the Coordination Reform, a white paper called Morgendagens omsorg [Future care], was released, which addressed the future challenges facing the Norwegian health and social care services. This white paper focused on the possibilities to further develop the Norwegian welfare state through innovation in municipal health and social care (Meld. St. 47 (2008-2009)). The government prioritized the integration of

different sub-services, and proposed co-location, reorganizations, and appointment of designated coordinators for people with complex and long-term needs as structural means. Formal meeting arenas and routines for exchange of knowledge and information, reflection, and guidance were also suggested as means to support integration (Meld. St. 47 (2008-2009)). Despite these suggestions, there was an absence of specific strategies or incentives for realizing the aim of service integration (Sandvin & Breimo, 2022).

The Norwegian Directorate of Health developed a guide and tool for use by municipalities and specialized health careproviders in 2014, called "Sammen om mestring: Veileder i lokalt psykisk helsearbeid og rusarbeid for voksne Et verktøy for kommuner og spesialisthelsetjenesten [Together around coping: A guide in local mental health and substance abuse work for adults]". This resource aimed to assist in the development and improvements of services for people with mental health and substance abuse challenges (The Norwegian Directorate for Health, 2014). In this document, a chapter was dedicated to integration, with a greater focus on coordination and collaboration between municipalities and specialized healthcare providers, instead of integration within the municipalities. The importance of coordination and collaboration between different services within municipal health and social care was underscored as something professionals working within these services were required to do through The Healthcare Act. However, the guide stressed that the means for coordination and collaboration were something that municipalities had to decide on based on their local conditions, thus, no specific strategies or means were suggested.

In 2015, Opptrappingsplan for rusfeltet [The Escalation Plan for the Substance Abuse Field] was introduced. As part of this plan, the government proposed to increase the grants to this field with 2,4 billion Norwegian kroner in the period between 2016 and 2020. The grants were principally to be financed through the municipalities' unrestricted incomes (block grants). The aim of this reform was to promote the effective allocation of resources based on local needs, enabling municipalities to establish substance abuse services in accordance with their own contextual functions and requirements. This

included arrangements for integrating the municipal substance abuse work with other health and social care services (Prop. 15 (2015-2016)).

Creating more coherent services for people with long-term and complex challenges remains a priority in Norway's health and social care policy. Consequently, the Norwegian government is currently working on a new escalation plan for mental health. This plan aims to place great emphasis on implementing broad and preventive measures and strengthening low-threshold services in the municipalities. (Meld. St. 23 (2022-2023)).

2.4 The practical context of municipal mental health and substance abuse services

Municipal health and social care services encompass a broad empirical field, including many different organizational units and groups of professionals. The ways in which these services are organized and approached varies. In the following section I will describe the contextual conditions on practice level under which this study was conducted.

This dissertation focuses on municipal health and social care services that are relevant for people with concurrent mental health and substance abuse challenges. The types of services that are included in this dissertation encompass mental health services, substance abuse services, housing services, and home nursing care. Due to the decentralized nature of primary care service provision in Norway, municipalities are free in choosing how they want to organize these services.

Practice level management of the aforementioned services refer to department or unit managers who often share the same professional background as the professionals that they supervise. The managers are responsible for organizing and managing service integration, while the professionals they supervise are responsible for the integration of services for people with concurrent mental health and substance abuse challenges.

In the field of mental health, treatment and follow-up services are provided through both in-office and outreach services. These services are primarily provided by nurses and social educators who have received additional education in mental health, along with some

healthcare assistants. These professionals are responsible for providing therapeutic conversations, conducting group therapy for depression and anxiety, and helping service recipients cope with their everyday life. Professionals in mental health services are regulated by Act on Municipal Health Services (The Healthcare Act) (The Healthcare Act, 2011).

Substance abuse services are also provided as a combination of in-office and outreach services, with the objective of empowering service recipients to become self-reliant in meeting their basic needs linked to economy, work, social network, living and housing conditions. These services encompass conversations to support individuals coping with addiction, accompanying service recipients to medical appointments, and offering assistance with various aspects of daily life such as financial management, keeping a tidy home, and grocery shopping. The substance abuse services are often provided by social workers and social educators, with and without further education in substance abuse. Professionals within substance abuse services are regulated by The Social Services Act (The Social Services Act, 2010).

Another important social service within this field is the housing departments which allocate housing and offers housing guidance to service recipients who need this form of support. Professionals working in this sector are usually social workers and social educators, who are also regulated by The Social Services Act (2010).

Last but not least, people with mental health and substance abuse challenges need physical health services. Treatment of physical health diagnoses are offered by general practitioners (GP), in the municipalities. If a person needs help with physical health on a regular basis, this is provided by nurses and healthcare assistants in home nursing care. If a person's state of health deteriorates to the extent that help cannot be provided by home nursing care, that person is given a place in a care facility. Such institutional care is provided by nurses and healthcare assistants. Professionals within physical healthcare are regulated by The Healthcare Act (2011).

It is widely preferred that the municipal services described above are provided in a person-centered way. This implies a high degree of user involvement, and individualization of services (The Norwegian Directorate of Health, 2021). Furthermore, family caregivers are expected to be involved in the services, but their degree of involvement depends on what role they have in the treatment and care situation. The more severe the situation is for service recipients, the more important it is for family caregivers to be involved. In addition, family caregivers also have their own needs that should be addressed by professionals (The Norwegian Directorate of Health, 2019). Managers and professionals within municipal health and social care also operate within resource-limited conditions. Thus, the ambitions of integrated and person-centered services are to be realized in a service field marked by capacity challenges and high pressure (Vike et al., 2016). This feature constitutes one of the main challenges for municipal professionals and managers.

3 The need for integration

The previous chapter contextualized Norwegian health and welfare at the system and practice levels. It was apparent that NPM-like reforms had implications for organizational and financial structures by dividing public health and social care organizations into single- or few-purpose organizations (Christensen & Lægreid, 2007). In this chapter I will explain fragmentation, which is a challenge on organizational level. Fragmentation arises due to various reasons, including NPM-like reforms. The purpose of this chapter is therefore to discuss these reasons together with the demand for integration of health and social care services. Included is also an overview of the current state of the art regarding international research on the integration of municipal health and social care services, presented at the macro, meso, and micro levels. Currently, there seem to be a knowledge gap regarding studies that analyze factors at these three levels with the use of empirical data. Thus, this dissertation may contribute to fill this knowledge gap through its empirical analysis.

3.1 Fragmentation due to differentiation

Fragmentation is a state of differentiation without the essential organizational and professional integration required to achieve unified effort (Axelsson & Axelsson, 2006). Organizations encounter many different conditions and elements in their environments, that lead to a need for internal differentiation. This differentiation involves the division of roles, work activities and responsibilities within the organization (Lawrence & Lorsch, 1969). The multiple health and social care needs of citizens is an example of such environmental conditions. Furthermore, differentiation within the health and social care sector includes both structural and functional differentiation. The structural differentiation involves the division of different government sectors like, healthcare, employment services, and social care. Functional differentiation concerns a division of responsibility within different government sectors. This can include differentiation of responsibility related to treatment, rehabilitation and preventive services within the health care sector, as well as those connected to housing, economics, and employment within the social care sector (Axelsson & Axelsson, 2006). All of these government

sectors, organizational units and departments have different formal structures and organizational cultures (Schein, 2010), as well as differences in attitudes and behaviors (Axelsson & Axelsson, 2006).

The NPM-inspired reforms presented in chapter 2 have increased differentiation. They caused the division of public health and social care organizations, separating them into single- or few-purpose organizations with separate funding streams, each pursuing defined sets of goals and tasks (Christensen & Lægreid, 2007). Such conditions increased the problem of fragmentation.

3.2 Fragmentation due to professional backgrounds and jurisdictions

People working in municipal health and social care services have different professional backgrounds and jurisdictions, or the areas of work over which professions compete (Abbott, 2014). This is something that can result in fragmentation because differences in interests and ethics is not well-aligned (Brewer, 2018), and such differences can challenge interprofessional collaboration (Pedersen, 2020). Through respective educational pathways, professionals are socialized to adopt a discipline-specific view of the services they are set to offer service recipients. Each educational pathway develops strong theoretical and discipline-specific frameworks for the practice of their respective professions. This gives access to professional jurisdictions that are often rigidly regulated. Consequently, professionals tend to maintain their professional autonomy instead of pursuing collaborative behavior (D'Amour et al., 2005).

3.3 Fragmentation due to complexity in life situations

As described in chapter 2, complexity refers to a service recipient's life situation which demands the simultaneous provision of services from several professionals and organizational units. Typically, the complex needs of a service recipient cannot be addressed by a single service or service provider; instead it requires the collaborative effort of multiple professionals across the differentiated health and social care field

(Larsen et al., 2017). For example, one service recipient might need: therapeutic conversations with a mental health nurse, housing guidance from a housing department, substance abuse services, daily delivery of pharmaceuticals from home nursing care, and health consultations by a general practitioner. If all these specialized efforts are provided in parallel, professionals can risk neglecting the complexity of service recipients' health and life situations. In turn, this can lead to needs not being met (Mangrum et al., 2006). Consequently, although service recipients will in theory receive various forms of support, the provision of isolated health and social care services may not contribute to improving their situation (Stange, 2009). It is therefore important to acknowledge the comprehensive situation of the service recipients, and to encourage professionals from various health and social care organizations to integrate their efforts through coordination and collaboration.

3.4 Consequences of fragmentation

In fragmented systems, service recipients can experience several unfortunate consequences. Firstly, fragmented systems impede access to services (Montenegro et al., 2011). People with mental health and substance abuse challenges who have complex needs, require multiple services simultaneously. This necessitates the provision of seamlessly integrated and continuous care by professionals and organizational units over a period of time (Weaver et al., 2017). This is called continuity, which leads us to a second consequence, loss of continuity.

Continuity refers to the long-term delivery of care, characterized by coordination among various services and targeted towards the current needs of service recipients (Puntis et al., 2015). Information continuity is especially important. This is the degree of communication between organizational units, professionals, and service recipients, as well as the level of consistency in care plans. Information continuity ensures that professionals have adequate information about service recipients and their current situation. Relational continuity is also an important factor, which relates to the establishment of a therapeutic relationship between one or more professionals and the service recipient (Weaver et al., 2017).

In addition to affecting access to services and the loss of continuity, the failure of services to meet service recipients' needs constitutes a third consequence. This arises when there is ambiguity about which organizational unit or professional should have the responsibility for observing changes in service recipients' needs (Montenegro et al., 2011). When services fail to meet service recipients' needs, it can lead to harmful and fatal consequences (Weiner et al., 2010). Fragmentation of health and social care services can be especially harmful for people with mental health and substance abuse challenges. This is because it increases incidences of coercion and compulsory treatment, homelessness, unemployment, and places added pressure on family caregivers (Nicaise et al., 2014; WHO, 2015).

3.5 Service integration

Integrated health and social care services have been promoted as a means to improve access, quality, and continuity of care in an efficient manner, while avoiding the negative consequences of fragmentation as described earlier (Keast et al., 2007; Valentijn et al., 2013; WHO, 2015). As such, the integration of health and social care services has become a priority for the Norwegian health and welfare system (Meld. St. 29 (2012-2013)), as well as internationally (WHO, 2015).

There is a plethora of literature on the integration of treatment and healthcare, and some literature on the integration of both health and social care services. The body of literature argues various definitions for this phenomenon. I will continue to present two definitions that are endorsed in this dissertation. According to Kodner and Spreeuwenberg (2002), integrated care is achieved by implementing a coherent set of methods and models at the funding, administrative, organizational, service delivery, and clinical levels. This framework aims to create connectivity, alignment, and collaboration within and between organizational units. Although this definition refers to the integration in healthcare settings, thus excluding the social care setting, the definition is applicable to the context of this dissertation, because it highlights the multiple levels at which integration-initiatives can be applied.

An alternative definition is put forth by Keast, Brown and Mandell (2007) who studied integration of public services and argued that integration may either have a vertical orientation or a horizontal orientation. The vertical orientation is authority-driven and entails formal structures for integration, whilst the horizontal orientation entails relationship-based approaches. The duality of this choice provides a range of integration mechanisms and policy options that can shape the implementation and guide future decision-making processes. Examples of vertical and formal integration are physical inter-organizational and inter-professional coordination meetings, digital communication systems, pooling of budgets and co-location. An example of horizontal and relationship-based approach is voluntary collaboration between professionals with different affiliations. The research in this dissertation responds to both orientations, which makes this second definition of integration also relevant.

Integration of services is not a term that is frequently used in Norwegian health and social care settings or in Norwegian studies in this field. Coordination and collaboration on the other hand, are familiar terminology in both the practice field and research field. Moreover, as Keast, Brown and Mandell's (2007) definition shows, integration of services is a term and concept that involves both coordination and collaboration. In this perspective, coordination is defined as the interaction between professionals, where formal linkages are mobilized to facilitate collective efforts aimed at achieving organizational goals. As such, coordination is a means for achieving integration at the system level. Collaboration on the other hand, serves as an integrative approach at the individual and relational level. Hence, collaboration is interaction between professionals, who work together to pursue complex goals based on shared interests and a collective responsibility for interconnected tasks which cannot be accomplished individually (Keast et al., 2007). The outcome of this should be a holistic health and social care in which care is person centered, relevant, planned, supportive of self-management, and that is regularly assessed, monitored and reviewed (Valentijn et al., 2013).

3.6 Overview of research on service integration

Health and social care reforms known as post-NPM, have aimed to address the challenges that have resulted from fragmentation by enhancing organizational integration and collaboration (Christensen, 2012). Although these reforms have introduced governance concepts to guide complex issues faced by public sector organizations, fragmentation remains a persistent challenge due to differentiation, specialization, and NPM-inspired approaches in service management (Steihaug et al., 2016). Actually, among five key primary care aspects (structure, accessibility, continuity, coordination and comprehensiveness), coordination has been identified as Norway's weakest dimension (Kringos et al., 2013). Moreover, integration of services targeted at people with concurrent mental health and substance abuse challenges is an especially challenging act (Bjørkquist & Hansen, 2018).

The subsequent section presents an overview of research on service integration within municipal health and social services, both from a broader perspective and more specifically on mental health and substance abuse services. In line with this study's aim of linking public management principles, organizational structures, and professional practices together, I will present current international research across the macro, meso, and micro-levels.

3.6.1 Macro-level integration

Macro-level integration can also be labelled as system integration. Here we find policies for management and organization of public health and social care services. In a literature review done by Reiter & Klenk (2019), some authors have characterized NPM as dead, coinciding with the announcement of a new reform trend called post-NPM. Trends within post-NPM reforms focus on improving coordination and functional integration along the horizontal dimension. These new reforms aim to address the substantial fragmentation of the public sector that has emerged as a result of NPM reforms.

Service recipients with complex needs can be eligible for multiple health and social care services simultaneously, however, boundaries between such services are not always clear

cut. Consequently, integrated services for people with complex needs could benefit from macro-level policies that stimulate integration of services across organizations and sectors (Hujala et al., 2017). Recommendations for such policies include those that incentivize coordination and collaboration through a reward system. This suggestion implies that such systems are currently lacking.

Within this context, cost-shifting processes become central. Alders and Schut (2019) point out that because of the silo-organized budgets, professionals and managers attempt to avoid taking responsibility for people with complex needs, and thus participate in cost-shifting processes. The same authors also address the problem of coordination responsibilities in similar situations. Absence of financial rewards or mechanisms for cost-sharing when coordinating activities between health and social care services, can lead to inadequate coordination or coordination by caregivers instead. As an alternative to silo-organized budgets, professionals and managers working in these services suggest incentivizing teamwork and inter-organizational collaboration, in addition to rewarding improvements in the quality of care (Danhieux et al., 2021). In line with this position, it is important for governments to acknowledge the development of innovative payment systems specifically for stimulating the integration of services. Such recognition may encourage more systematic development, research, and evaluation of such systems (Leijten et al., 2018).

One example of horizontal intra-municipal integration is the “One stop shops”. These are government offices where multiple services are offered , allowing people to access these services in a centralized location (McGorry et al., 2022). Another way of achieving integration is by establishing partnerships and networks that stimulate collaboration between organizational units. Both of these suggestions require direction from the political and administrative authorities (Reiter & Klenk, 2019). Regarding policies necessary for the integration of services, specifically for people with mental health and substance abuse challenges, there is an absence of clear directives (Fantuzzi & Mezzina, 2020).

Research on macro-level integration show that there is a need for policies that alter the ways coordination and collaboration activities are financed and rewarded. This also implies a re-shaping of management principles applied in municipal health and social care organizations.

3.6.2 Meso-level integration

Meso-level integration refers to organizational and professional integration, making the organizational structures a focal point at this level of integration. A scoping review by Leijten et al. (2018), shows that organizational structures can promote integration through different forms, ranging from fully integrated formal alliances or mergers, to informal collaboration agreements. Furthermore, the same review shows that the integration of services requires health and social care organizations to be structured for flexibility. This means that they should be ready to respond to unexpected situations, and therefore be capable of responding to and adapting to service recipients' needs.

Although organizational structures can promote integration, research has identified certain structural barriers, with silo-organization as one of them. Findings from a multi-jurisdictional study in Canada shows that structural re-organization and providing formal opportunities for collaboration in meetings were the main strategies for preventing structural barriers (Kreindler et al., 2022). The same study also pointed out that structural re-organization and formal collaborative arenas were insufficient without comprehensive work on relationship building.

A structural solution that can be considered is to encourage co-location, as this has the potential to improve inter-professional communication and collaboration (Bjørkquist & Hansen, 2018; Rousseau et al., 2017). Co-location should be accompanied by shared information systems and professional cultures marked by shared beliefs and values. This is because co-location alone cannot restore decades of silo-working (Lalani & Marshall, 2022). Another structural solution is to organize professionals into multi-disciplinary teams, as this can entail positive results for service recipients' outcomes but also for the professionals' working processes (Frost et al., 2020).

Regarding communication and information sharing through formal channels, research findings suggest that coordination between health and social care services can be improved through the use of digital documentation and communication systems (Danhieux et al., 2021). This has also proven to result in better outcomes for service recipients within mental health services (Iorfino et al., 2021). Currently, there are challenges in achieving coordination through digital solutions. To tackle this, researchers have suggested better organization of the work processes that foster integration, as well as better alignment of IT systems (Svensson, 2019).

As one can see from the research studies above, the structures of health and social care organizations have the potential to improve the integration of services. Structural changes alone, however, are not sufficient for integration as they need to be accompanied by a culture that fosters relational development and collaboration.

3.6.3 Micro-level integration

Micro-level integration encompasses professional practices and approaches. Health and social care organizations differ distinctively in terms of culture, professional roles, responsibilities, and how they provide services to people with complex needs (Danhieux et al., 2021). A literature review on services within mental health and substance abuse, showed that an integrated service approach was the golden standard. One of the studies highlighted the significant positive impact of extended and coordinated collaboration between professionals, distinguished by a reduction in symptoms of mental health illness and in substance abuse (Fantuzzi & Mezzina, 2020). Furthermore, coordination should be tailored to address the specific life challenges of every single service recipient (Leijten et al., 2018). To ensure the effective integration of mental health and substance abuse services for different service recipients, the care provision should be overseen by a designated coordinator at the municipal level (Shidhaye et al., 2015).

Professional approaches for integration also include holistic needs-based approaches (Danhieux et al., 2021), and shared decision making (Leijten et al., 2018). Person-centered and integrated services for people with multi-morbidity are based on a holistic

understanding of people's health and well-being, capabilities, self-management skills, needs, preferences, and the environment that they find themselves in. Attaining this holistic understanding is often facilitated by formal assessments, whereby professionals must encourage service recipients to define their personal goals, preferences and priorities (Leijten et al., 2018). This opportunity enables service recipients to partake in the decision-making process, which in turn should lead to individualized care plans and follow-up plans. Shared decision is therefore an important component in integrated services allowing professionals to make individual adaptations (Pii et al., 2020).

3.6.4 Identification of the knowledge gap in service integration research

The presented research reveals a lack of policies that entail incentives and award systems to promote coordination and collaboration initiatives and arrangements. Despite these shortcomings, municipalities continue to develop their organizational structures and professional practices. This is to better prepare for coordination and collaboration. Moreover, the current research shows how structures and practices can be both barriers and facilitators to integration.

Unlike research on the macro and meso-levels of service integration, research on the micro-level is targeted towards people with concurrent mental health and substance abuse challenges. This observation supports my initial impression about most studies on integration of mental health and substance abuse services are on specific initiatives and models at the practice level. Moreover, the current research in this field, mainly consisting of literature reviews, indicates a lack of empirical studies investigating integration at the system, organizational, and practice levels. This suggests a knowledge gap which this dissertation aims to contribute to through its empirical analysis.

4 Theoretical perspectives

This chapter presents the theoretical perspectives that underpins the research project. As presented in the previous chapter, to improve access, quality, and continuity of care in an efficient manner, and prevent the consequences of fragmentation, the integration of municipal health and social care services is recommended. In this PhD-project I have taken an organizational approach to study the of integration of municipal health and social care services, and I have attempted to connect factors at the system, organizational, and practice level. Subsequently, the overarching theoretical framework consists of theoretical perspectives on all three levels.

At the system level, I have elaborated on a theory regarding public management principles and values (Hood, 1991), which contributes to answering the research question in the first article (Løken et al., 2022). For studying factors at the organizational level, I turned to the theory of collective competence (Boreham, 2004), to answer the research questions in the second article (Løken et al., 2022). To examine practice level factors influencing integration in the third article, I applied organizational literature on differentiation and integration (Lawrence & Lorsch, 1967), literature on street-level bureaucracy (Lipsky, 1980; Zacka, 2017), and the concept of street-level diplomacy (Gale et al., 2017). Together with the empirical findings from the three articles, these theories and concepts facilitates and in-depth analysis of how policies on the integration of municipal health and social care services are adapted and operationalized.

The first part of the chapter is devoted to conceptualizing the application of organizational theory in this dissertation and its relevance to the study of municipal health and social care services. Following this, I present the theoretical perspectives and concepts that were applied across the three constituting research articles.

4.1 Organizational theory and its application for studying health and social care organizations

An organization is a body of individuals working under a defined system of rules, assignments procedures, and relationships designed to achieve identifiable objectives and goals (Greenwald, 2007). Although this is a relatively simple and general definition, it points to the important aspect that organizations are made of different actors who are set to work together. These actors are arranged in specific forms and with different roles, which in turn are structured in relationships. Together, organizational structures and actors (including roles and relationships) are related and contained in ways that ensure that the organization reproduces itself (Vincent & Wapshott, 2014).

4.1.1 Organizational structures and social processes

The aim of organizational research is to discover, document, explain, and explore observable structures and social processes that characterize the behavior within and of organizations (Maanen et al., 2007). This points to the study of both organizational structures and social processes, which is the focus in this research project. Early organizational research regarded structures as the context within which relational variables such as communication and attitudes could be studied. During the 1940s and 1950s organizational structures gained recognition as an independent variable worthy of study, which subsequently led to their attainment of theoretical status (Scott, 1975).

Organizational structures play a critical role in the differentiation and integration of an organization. As discussed in section 3.1, differentiation is essential for establishing specialized units within organizational structures. The myriad of conditions and elements that organizations face in their environments impose a demand for differentiation in order to establish specialized units within their structures. For the entire organization to be viable, these subunits need to function in an integrated manner (Lawrence & Lorsch, 1969).

A common organizational integration mechanism is hierarchy, which entails creating formal reporting relationships that allow managers to coordinate activities and resolve

problems by exercising their authority (Hatch & Cunliffe, 2013). However, adding hierarchical levels within an organization creates greater vertical differentiation, which subsequently requires more vertical integration. Although the hierarchy of authority may contribute to overall coordination, it cannot keep up with an organization's increasing demands for integration. Consequently, numerous integrating mechanisms have been devised to complement or potentially replace the hierarchy of authority (Hatch & Cunliffe, 2013). Examples of such mechanisms are formal rules and procedures, liaison roles, meeting arenas, cross-functional teams and direct communication between departments (Hatch & Cunliffe, 2013).

Organizational structures can also be regarded as boundaries between organizational units, professionals, and resources. A boundary represents the domain in which an organization interacts with its environment, for example other organizations (Kreindler et al., 2022). Professionals in various organizations, such as those in the field of mental health and substance abuse services, are involved in boundary-spanning activities such as collaboration and decision-making processes. More specifically in this field, such activities can include interprofessional collaboration in meetings (Kreindler et al., 2022), working in teams (Frost et al., 2020) and communication through digital platforms (Iorfino et al., 2021). As such, boundary-spanning activities are the social processes required to integrate organizational units across the units' boundaries. Organizational research is important for studying these social processes, as it can help us understand who we are and how we interact with others when we encounter them in different social contexts that we often take for granted (McAuley et al., 2007). The study of interorganizational collaboration can therefore generate valuable insights into how people within organizations establish relationships and contact (Tsasis, 2009).

To summarize, organizational research can improve service recipient outcomes, because it has the opportunity to study structures and processes as independent variables that are modifiable. By applying research-based knowledge, the findings and theoretical developments regarding these variables can inform decision-makers in health and social

care organizations, enabling them to effectively address their needs and drive change (Fraser, 2004)

4.2 Public management

Public management is by many regarded as a branch within the field of public administration. Public administration can be defined as government in action, the management of public affairs or the implementation of public policies (Shafritz et al., 2016). Public management however, can be defined as the approach to designing and operating public services, and the detailed work of executive government (Hood, 1998). Public management consists of a set of processes and tools aimed at achieving optimal performance in an organization dedicated to public service, and the concept can convey multiple meanings and messages. When emphasizing "public", the concept can appeal to those who think that there is something distinctive with government and public services, which require them to have own special knowledge and practice. If we emphasize "management", the concept can appeal to those who think that government and public services are areas that require the application of management methodologies from the repertoire associated with business-schools (Hood, 1998).

4.2.1 Public management principles and values

In the first article, I studied the values within public management principles. Public management principles are managerial principles over bureaucracy. They are the principles of organizational design which seek to enhance the capacities of managers to take action, to clarify missions and objectives, and to be responsive to both their service recipients and their employed professionals (Aucoin, 1990). These principles can emphasize the importance of structures for making managers manage in line with political priorities or not, and they can emphasize processes and practices for managing within the structures (Feldman & Khademian, 2001).

Values are of great relevance when studying public health and welfare services (Jørgensen & Bozeman, 2007), and the pursuit of one value when organizing and approaching services can limit the pursuit of other values (van der Wal et al., 2011).

Values provide a foundation for the purpose and goals of an organization and give direction to the multiple decisions made at all levels of the organization every day (Posner, 2010). In the context of this study, values within public management principles means the principles on which governments and policies should be based (Bryson et al., 2014).

Hood (1991) described three types of values that have influenced reforms and shaped public management principles, and that have also directed the organizational design of public services. In short, the Sigma-type values relate to economy and frugality, matching of resources to defined tasks and goals, and the fragmentation of organizations into single or few purpose departments and units. Theta-type values relates to honesty and fairness, and mutuality through prevention of distortion, inequity, bias, and abuse of office. Lambda-type values relates to security, flexibility, adaptivity robustness and resilience. The values within the Sigma-types are often associated with NPM-labelled reforms and have a reputation for having a negative effect on other important administrative values. Simultaneously, the values within the Lambda-types are associated with integration (Hood & Dixon, 2015), as the capacity for resilience is interconnected with the degree of integration between interdependent parts of the system. The first article applied the theoretical framework proposed by Hood (1991) to analyze the impact of Sigma-type values and Lambda-type values on organizational structures and professional practices aimed at integrating municipal health and social care services. Thus, the contribution of this theory to the dissertation though this analysis was to connect system level values with organizational and practical levels values.

4.3 Competence

Previous research has identified that competences needed to support integration of health and social care services are lacking (Stein, 2016). Subsequently, the second article aimed to explore how competence could be an advantageous organizational resource (Coates & McDermott, 2002) for improving the integration of municipal health and social care services.

In order to integrate services, professionals presumably need to approach competence needed for coordination and collaboration collectively rather than individually (Lingard et al., 2017). Thus, competence should be regarded as a collective attribute within and between organizational units (Curtin et al., 2020). In this dissertation, competence is defined as the essential knowledge-based acts that combine and mobilize knowledge, skills and attitudes with existing and available resources to ensure safe and high-quality outcomes for service recipients (Langins & Borgermans, 2015).

According to Miller (1990), within the concept of competence, knowledge refers to two questions: 1) what is required to carry out certain professional functions, and 2) how can knowledge be put into practice? Putting knowledge into practice is also known as skills, the second dimension of competence. Skills refers to organized sequences of activities and cognition (Von Krogh & Roos, 1995). Attitudes, the third component of competence, deals with the affective domain and influences professionals' choices of actions (Ajzen, 1991). Professionals' choices of action are in turn linked to their knowledge and skills in the performance of professional tasks in specific work situations (Baartman & de Bruijn, 2011). This makes attitudes important when professionals attempt to address service recipients' complex needs.

To study service integration competence, I needed a group-level approach to competence. Group-level competence has the potential to increase an organization's dependency on key individual competencies (Von Krogh & Roos, 1995). Thus, I will in the next section present the theory of collective competence.

4.3.1 The theory of collective competence

Service integration involves a high degree of interlinked activities between professionals and organizational units. Thus, the theory of collective competence was used in the second article. Boreham supported group-level competence, and took such competence a step further, by developing the theory of collective competence (2004). In the theory of collective competence, competence is emphasized as a collective attribute of a network within and between organizational units. The theory of collective competence

in turn builds on the cultural studies by Hofstede (1984) which distinguish between individualism and collectivism, and on Leontievs studies of activity (Boreham, 2011).

According to Hofstede (1984), individualism is the tendency to treat the self as the most significant social unit, and societies described as individualist, encourage self-directed learning and personal initiatives. This also implies that professional competence is an attribute of individuals. Collectivist societies on the other hand, treat the group to which one belongs as the most important social unit. They value subordination of personal wishes to the priorities of the group and encourage intra-group harmony rather than individual ambition. Accordingly, professional competence is an attribute of the group (Hofstede, 1984).

The activity theory by Leontiev (Boreham, 2011), portrays work as the function of a group that directs its effort towards a common object. The group known as the activity system, is driven by its members' consciousness regarding the aim of their activity, which Leontiev insists is collective. Furthermore, the effectiveness of the group's work depends on how it approaches and defines the aim of their activity. The prerequisite for activity theory in practice is therefore how precisely the group defines the aim of their activity (Boreham, 2011).

Boreham (Boreham, 2004) suggested three main principles to which an activity system must conform if it is to act competently: 1) To make sense of events in the workplace – to construct a shared understanding about the goals the network wants to achieve. 2) To develop and access a collective knowledge base – to reach the goals through coordinated activity, the group must have context-relevant and accessible knowledge in common. 3) To maintain a sense of interdependency – due to fragmentations in the network, professionals need a feeling of interdependency, a shared understanding of actions made by other professionals.

In the second article these principles were discussed together with the empirical findings, to argue the need for a collective approach to competence needed to integrate health and social care services. This article also offered a theoretical contribution, which was the

introduction of a fourth principle needed for collective competence in health and social care organizations. The fourth principle regarded inclusion of service recipients and family caregivers in the collective mind.

4.4 Street-level bureaucracy

The collective competence framework adopted in the second article displays the types of competences identified by service recipients, family caregivers, professionals, and managers as necessary. Following the understanding that professionals' actions are linked to their competence in performing professional tasks (Baartman & de Bruijn, 2011), I wanted to explore how professionals and managers actually carried out professional tasks needed for service integration. This provided the basis for my third article in this dissertation.

These professional tasks are often carried out in a context marked by scarce resources and continuous demands for efficiency and quality (Vabø, 2009), where formal integration can be challenging (Kringos et al., 2013). Given these circumstances, I anticipated that professionals were eager to engage in informal collaborative work to achieve important outcomes for service recipients. Consequently, in the third article I therefor applied theory on formal and informal integration, as both formal and informal integration are essential to effective organizational outcomes (Cohen & Cohen, 2021).

The theory on formal integration included perspectives on organization, differentiation, hierarchies, and formal integrative mechanisms by Lawrence & Lorsch (1967) and Hatch & Cunliffe (2013). This type of theory was expected to be suitable in the context of the hierarchical organization in Norwegian municipalities. These theories are presented in section 4.1.

The empirical material in this PhD-project is marked by numerous dilemmas faced by professionals and managers working closely with service recipients and their family caregivers. These professionals and managers are expected to be sensible moral agents who can interpret vague directives, come to a compromise between competing values and prioritize the allocation of scarce resources (Zacka, 2017). The responsibilities

professionals and managers have for delivering public services and enforcing the law, as well as the dilemmas they experience in doing so, are within the scope of street-level bureaucracy literature and research (Zacka, 2017). Thus, for analyzing the informal integration, literature on street-level bureaucracy and the concept of street-level diplomacy were applied.

Street-level bureaucracy research within public administration and public management communities grew in the 1990s and especially in the 2000s. The increase in number of publications reflect the growth of street-level bureaucracy as a research area in public administration (Chang & Brewer, 2022). Lipsky's (1980) research on street-level bureaucracy is based on the observations that street-level bureaucrats must balance achieving policy objectives while improvising and being responsive to individual service recipients. The need to improvise also comes from working in resource-limited conditions. To cope with uncertainties tied to such conditions, whilst being attentive towards changes in individual service recipients' needs, street-level bureaucrats invent and use routines and strategies suited for the local situation (Exworthy & Frosini, 2008). They may for example find workarounds if existing conditions offer barriers to their practice (Halbesleben et al., 2010). Thus, services may be delivered in ways unintended by policy makers or managers (Gale et al., 2017), and in this way, public policies are operationalized and made local in character (Exworthy & Frosini, 2008). This is also Lipsky's point when he argued that street-level bureaucrats who operate with a high degree of autonomy and discretion within resource-limited conditions can influence the outcomes of the policies they are employed to put into practice (Lipsky, 1980).

4.4.1 Street-level diplomacy

A study by Gale et al (2017) offers a new concept within street-level bureaucracy research, namely street-level diplomacy. This concept is a hybrid between Lipsky's description of street-level bureaucracy (as presented above) and the theory of multi-track diplomacy. This branch of diplomacy theory concerns enabling collaboration and gaining influence through communication at all levels through formal and informal mechanisms (Gale et al., 2017). Lipsky (1980) emphasizes the exercise of discretion in decision making,

and the development of rules and procedures within hierarchical systems. Diplomacy on the other hand, focuses on the communicative, adaptive, and cultural parts of 'street-level' roles in policy implementation within networks (Gale et al., 2017). Street-level diplomacy as such, focuses on fostering relationships and skills required to build trust, develop mutual understandings, and even to persuade other professionals within the network (McDonald, 2012). The goal of this kind of work is not necessarily to impose one's own will over another, but to facilitate, empower, and transform (Gale et al., 2017).

In the third article the concept of street-level diplomacy was applied to show how professionals and practice level managers use their networks, experience, discretion, and relational, and communicative skills to realize important goals regarding the welfare of service recipients. As such, this article investigated the relational aspects of integrative work, where networks and networking skills were necessary social capital in service integration processes.

4.5 Summary

In this chapter, I have synthesized an overarching theoretical framework, that enables the analysis of factors at the system, organizational, and practice level that influence the adaption and operationalization of service integration policies. Hood's (1991) framework for public management values is useful for studying how such values influence the organizational and financial structures as well as professional practices. This analysis is achieved in the first article which connects these values to all three levels of investigation. Furthermore, Boreham's (2004) theory of collective competence is relevant for the study of competence as an approach to increase and improve organizational and professional integration between health and social care services. This is addressed in the second article which primarily focuses on the organizational and practical levels of influence. Lastly, theory on differentiation and integration (Hatch & Cunliffe, 2013; Lawrence & Lorsch, 1967) in addition to literature on the concept of street-level diplomacy (Gale et al., 2017), were adopted to examine formal and informal integration. Thus, the third article play an important role in displaying the relational aspects of integrative work at practice level.

5 Methodology

Qualitative research encompasses a wide range of approaches, and qualitative methods provide researchers with diverse philosophies and toolkits for studying and theorizing the actions of organizations and their members (Gehman et al., 2018). In this chapter I first situate my research in philosophy of science. Then, I present and explain the design, data collection methods, recruitment procedures and analysis approaches applied in the three research articles that form the basis of this dissertation. Lastly, I present ethical considerations and how I have attempted to maintain quality in research.

5.1 Philosophy of science: critical realism

Qualitative research entail various theoretical and interpretive frameworks that enact our philosophical beliefs (Creswell & Poth, 2018). Philosophy of science concerns both ontological and epistemological questions. The ontological questions regard what we study, or the object of investigation. This includes questions about reality and what this is, how the world fits together, and how we make sense of it. Epistemological questions are about how we understand things. Epistemology addresses questions of the nature, sources and limits of knowledge (Della Porta & Keating, 2008).

This dissertation includes explorative research questions regarding how professionals and managers work across organizational structures and how they approach service integration. This can be regarded as social processes, situating my philosophical positioning within social science (Fleetwood, 2005). To further position myself as a researcher, and the PhD-study I conducted, I needed a philosophical paradigm that provided a way of thinking and understanding the social processes within municipal health and social care organizations.

With this as a backdrop I found the critical realist paradigm as a “philosophical home”. Critical realism is concerned with finding explanations through a focus on what people can achieve within the social context and structures in which they are operating (Stutchbury, 2022). Furthermore, critical realism is rooted in the understanding that society is not merely a construction, but also an external reality (Modell, 2009). However,

this is only partially visible to people, as reality involves multiple underlying casual mechanisms that give rise to experiences and events (Stutchbury, 2022). These underlying casual mechanisms can be studied through the interpretations of empirical observations with the aim of finding patterns and mechanisms that produce the experiences and events of members in these societies (Kjørstad, 2020). Even though critical realism is preoccupied with exposing underlying relations, it is more inclined towards exploration rather than prediction of reality (Kjørstad, 2020). This philosophical position aligns with the design of this study, which is qualitative single case study, aimed at the exploration of social processes rather than the explanation of causality and effects.

5.1.1 Ontology and epistemology

Critical realist ontology accepts that observable events are caused by activities within social structures. While these activities are not immediately observable, they can be accessed through research (Easton, 2010). This understanding makes this philosophical perspective well suited for studies of complex systems, such as health and social care organizations. Fleetwood (2005) stated that social entities, such as the processes and practices within this dissertation, can be harder to accept as real as opposed to material entities. However, these social entities are of significant interest in organizational research. The social reality of organizations involves different activities, actors, and temporal locations where these activities take place. The combinations of activities, actors, and locations, represent different phenomena within organizations that can be studied (Fleetwood, 2005). In this dissertation activities are expressed as assessments, observations, professional discretion, allocation of services, communication, collaboration, and coordination. The actors involved include different stakeholders in service integration processes, namely managers, professionals, service recipients, and family caregivers. Lastly, the temporal locations are municipal services within substance abuse services, mental health services and home nursing care. Together these activities, actors, and locations have been the point of departure for studying how service integration processes takes place.

In critical realism one wants to avoid reducing questions about "what is" to how we "can know". This implies a greater focus on ontology than on epistemology. Simultaneously, the assumption that there are realities that we cannot directly observe does not mean that we cannot study them. In fact, this paradigm is one of the least restrictive paradigms when it comes to accepted research methods (Schiller, 2016). Rather, one can acquire knowledge about these realities through conceptualization and theorizing what is observed in the empirical material. Thus, one can use theory to find the patterns and mechanisms that cause experiences and events. This means that it is important in critical realist studies to identify relations and emerging phenomena in changeable societies (Kjørstad, 2020). As an example of this, I do not seek to confirm whether public policies determine the quality of service integration, but rather to show how these two concepts relate to other factors such as values, organizational structures, competence, professional practices, and discretion.

5.2 Research design

In line with the critical realist focus on studying the less accessible underlying activities that can explain certain events, I took on a qualitative research approach in the PhD-project. Through a qualitative approach I anticipated to get hold of professionals' and managers' experiences with, and interpretations of the service integration processes, through in-depth investigations of them and their context (Bryman, 2003).

To obtain in-depth knowledge of the ways in which professionals and managers adapted to and operationalized policies regarding service integration, I needed a design that allowed for an in-depth investigation. Thus, the dissertation was designed as a qualitative single case study. As a research design and strategy, a case study provides the opportunity to develop in-depth understanding of dynamics present within social contexts (Creswell & Poth, 2018). These are also good conditions for theory development (Eisenhardt, 1989), resulting in analytical generalizations from the case under study (Langley et al., 2013). A qualitative single case study therefore allowed me to generate in-depth understandings about Norwegian municipalities' abilities to integrate health and

social care services, as well as allowing me to further the theories I presented in chapter 4.

The choice of adopting a single case approach as opposed to a multi-case approach was influenced by my objective of providing contributions to the theories and concepts adopted in the articles. According to case-study researchers, explorative concept, process, and practice theorizing are best achieved through single case studies (Gehman et al., 2018; Langley et al., 2013). In contrast, variance-based qualitative research that seeks to build generalizable and predictable theory, is best achieved through multiple case studies (Eisenhardt, 1989; Gehman et al., 2018). Subsequently, employing the single case study design in this dissertation, enabled me to develop in-depth understandings about municipal service integration, and to do theoretical exploration of this practice, resulting in analytical generalizations to the case (Langley et al., 2013) .

5.2.1 Defining the case

One of the most important tasks in applying a case study design is defining the case. A case can be a concrete entity, for example a group of people, an organization, or a municipality. However, it may also be more abstract entities, such as a certain relationship, interaction, or a decision-making process (Creswell & Poth, 2018). Providing in-depth knowledge of how municipal professionals and managers adapted to and operationalized policy regarding service integration was important, due to the current knowledge gap in this field. Accordingly, integration of municipal health and social care services was the non-tangible case, and three municipalities were chosen as units of analysis, or case organizations (Seawright & Gerring, 2008). The case-organizations provided richness and variation in the empirical material, which gave good conditions for empirical and theoretical exploration (Siggelkow, 2007).

5.2.2 Case study approaches to theory development

Siggelkow (2007) outlines the following three obstacles that case study researchers face: 1) having a sample that is too small, 2) non-representativeness of the data, and 3) the conclusions one can draw. In other words, the argument is that if the sample is too small,

it becomes challenging to generalize the findings, and this will consequently affect the validity of the conclusions. In such a situation, a study cannot stand on its descriptive feet alone, but must also provide a theoretical or conceptual insight, provided by theoretical or conceptual exploration. In turn, case studies displaying such insight, can be valuable across different contexts and situations (Tracy, 2010). Siggelkow (2007) addresses three important uses for case study research in order to provide theoretical or conceptual insight, which are motivation, inspiration, and illustration.

In case studies the researchers seek to uncover, describe, and theoretically interpret actual meanings that people use in real contexts (Gephart, 2004). Offering a theoretical *motivation* that is grounded in a real-life situation, is usually more appealing than a solely theoretical motivation (Siggelkow, 2007). I have therefore used organizational theory to understand the processes and systematic reasons that contribute to the occurrence or non-occurrence of specific characteristics involved in integrative work (Sutton & Staw, 1995).

Cases can also serve as *inspiration* for new ideas. Rich case data can help sharpen existing theory by recognizing and contributing to research (Siggelkow, 2007). As to my theoretical ambition as a novice researcher, Siggelkow's point here, is what I have aimed for. During analysis, certain concepts were developed, or I could find certain patterns that awakened my curiosity as to why this concept or pattern was occurring repetitively. It could for example be a certain structure, behavior, consequence for service recipients or an expressed frustration amongst the included participants. At this point in the analysis, I was abstracting from the particular in the data set to the more abstract patterns (Cornelissen, 2017), and in meetings with supervisors and other peers I could discuss the abstract patterns. These discussions often evolved around my findings in relation to existing theories that could be applicable in analysis.

Lastly, cases can, in the context of making a conceptual or theoretical contribution, be employed as *illustrations*. By seeing concrete examples of certain constructs employed in the conceptual arguments, the reader can more easily imagine how the conceptual argument might actually be applied to empirical contexts (Siggelkow, 2007). Finding

theoretical patterns involves translating "*rich narratives that enable representation of nuance and ambiguity into more structured analytical approaches that favour the articulation and replication of more abstract theoretical ideas*" (Langley et al., 2013). I tried to write the descriptive findings in the articles in a coherent manner that would be meaningful to the reader. This included providing a nuanced account and drawing on connections between the quotes, as well as aligning them with the argument I wished to advance. Additionally, I ensured that the descriptive findings were explicitly connected to the research questions and the theoretical framework. These steps were taken to use the descriptive findings as illustrations of the theoretical or conceptual arguments, as Siggelkow (2007) recommends.

5.3 The case-organizations

In organizational case-studies, researchers make a choice of case-organizations, also called units of analysis, where the data gathering is carried out (Seawright & Gerring, 2008). Given that this study is based on municipal services addressing challenges related to mental health, substance abuse, and physical health, it is important to situate the responsible municipal organizations. This section will present the unique contexts in which these municipal organizations operate and the different services they offer, across the three municipalities investigated in this dissertation. It is important to note that I did not select the municipalities as they were predetermined by the larger ROPIT-project in which I was employed as a PhD-candidate.

	Municipality 1	Municipality 2	Municipality 3
Area	Rural	Rural and urban	Urban
Population (approx.)	3000	30 000	52 000
Service recipients with concurrent mental health and substance abuse (approx.)	15	100	300
Mental health and substance abuse services (premises and staffing)	Integrated department. Inter-professional (nurses with further education in substance abuse, social educator, social worker, health worker with further education in mental health).	One unit with separate departments for mental health services and substance abuse services. Mono-professional departments. Mental health department: nurses with further education in mental health. Substance abuse department: social workers and social educators. Some with further education in substance abuse.	Mental health services in different departments within one unit. Substance abuse services within NAV. Two outreach teams. Mono-professional departments. Mental health departments: nurses with further education in mental health. Substance abuse department: social workers and social educators. Some with further education in substance abuse. Inter-professional in teams.
Social services (housing, employment, and financial support)	Housing guidance provided by mental health and substance abuse department. Handling of residing, employment, and financial support is done by NAV.	Housing guidance provided by the outreach substance abuse team. Caretaking of mismanaged homes by a designated unit. Handling of residing, employment, and financial support is done by NAV.	Housing guidance provided by the outreach follow-up team, and by a housing department. Caretaking of mismanaged homes by a designated unit. Handling of residing, employment, and financial support is done by NAV.
Types of physical health services	Home nursing care and one care facility.	Home nursing care and several care facilities.	Home nursing care and several care facilities.

Type of housing offers	In separate private apartments. Staffed housing for mental health and/or substance abuse through contracts with private for-profit companies.	In separate private apartments. Staffed housing for mental health.	In separate private apartments. Staffed housing for mental health. Staffed housing for mental health and/or substance abuse through contracts with private for-profit companies.
Types of granting authority	Decision-making authority on operational level.	Decision-making authority regarding mental health and substance abuse services on operational level. Decision-making authority regarding home nursing care and care facilities in separate allocation unit.	Decision-making authority regarding mental health and substance abuse services, and care facilities in separate allocation units. Decision-making authority regarding home nursing care on operational level.

Table 1: Municipalities included in the dissertation.

5.3.1 Municipality 1

The first municipality was large in area but had a small and scattered population. The mental health and substance abuse services were organized, financed, and managed as one department under a larger unit. The department consisted of nurses with further education in mental health or substance abuse, a social educator, a social worker, and a health worker. Together they provided outreach services in service recipients' homes as well as therapeutic dialogue in their offices. Other social services tied to economy, employment, and housing were provided by the local NAV-office. The municipality did not have a staffed housing complex for people with mental health and substance abuse challenges, but they had access to separate apartments, either owned by the municipality or by other citizens. They did not have institutions for people with severe mental health and substance abuse challenges and as such had to pay institutions owned and run by private for-profit organizations for admission. Physical healthcare was provided by general practitioners, home nursing care, and one care facility.

5.3.2 Municipality 2

This was a bigger municipality consisting of both rural and urban areas. The municipality had one unit for mental health and substance abuse, led by a unit manager. Here, the services were divided into a mental health department, a substance abuse department, and a staffed housing complex for people with mental health diagnoses. All these departments had separate department managers and budgets. The mental health department mainly consisted of mental health nurses who provided in-office therapeutic conversations. However, they also met service recipients at their homes if their situation required it. The mental health department also included an activity center where they also provided group therapy for mild to moderate mental health challenges. The substance abuse department consisted of social workers who helped service recipients with coping and controlling their abuse. They also offered outreach services by going to service recipients' homes. Other social needs tied to economy, work and housing were provided by the local NAV-office. Apart from the staffed housing complex, the municipality offered alternative housing in apartments owned by the municipality or by other citizens. Furthermore, the municipality had an outreach team who conducted in-depth assessment of people with concurrent mental health and substance abuse challenges. This team consisted of professionals from the municipality as well as from the specialist substance abuse services. Finally, physical healthcare was provided by general practitioners, home nursing care, and several care facilities.

5.3.3 Municipality 3

This was the largest municipality included in the dissertation, and it was an urban municipality with high population turn-over, referring to people moving to and from the district. The organizational and financial structures were complex. One unit contained all the mental health services: a mental health department; a staffed housing complex; three activity centers; one Flexible Assertive Community Treatment (FACT) team; and one mental health and substance abuse outreach team. The departments and teams had separate budgets, but the FACT team had joint funding with the district psychiatric center, which provided specialist healthcare. In this municipality, substance abuse

services were organized as a department under NAV. Here, the professionals were socially educated, and they mainly helped service recipients with practical issues tied to economy and housing. In relation to staffed housing for people with substance abuse problems, the municipality paid for housing provided by private for -profit companies, as they did not have their own housing arrangement of this type. Additionally, the municipality provided housing as apartments owned by the municipality or by other citizens. However, they faced shortage of number of apartments in relation to their demands. Physical healthcare was provided by general practitioners, home nursing care, and various care facilities.

5.4 Data collection

As I had an ambition to combine descriptive and explorative theoretical research questions, my data collection methods and practices had to partner well with the adopted theories (Tracy, 2010). The research questions for the three articles were: 1) How do public management values influence service integration in municipal health and social care organizations?; 2) Which types of competence do stakeholders require?; 3) How may collective competence promote service integration?; and 4) How do practice level managers and professionals work to achieve integration of mental health and substance abuse services?

All data collection took place in mental health services, substance abuse services, and home nursing care, in the three selected municipalities. To obtain rich descriptions of the organizational and financial structures that professionals and managers worked within and across, and the processes and practices they participated in, different forms of interviews were chosen as methods for collecting data. To enhance the possibilities for witnessing and understanding the professional realities and situations described by the participants, the interviews were complemented with observations of collaborative meetings. As such, this allowed me to triangulate data, which is advantageous to obtain a rich and comprehensive data material, because each included method reveal different aspects of the empirical reality (Patton, 1999).

5.4.1 Observations

Observations of meetings would allow me to get close to the field under study. By seeing and listening to the discussions in the meetings I could witness the professional realities that professionals and managers partook in (Creswell & Poth, 2018). Observational data was expected to provide parts of the in-depth knowledge regarding service integration processes and could also complement the data obtained through interviews. I observed twelve meetings in the three municipalities, and data from these were used in the first and third articles (see Table 2). The meetings were inter-professional and inter-agency meetings, where service recipients on individual and group level were discussed. The meetings were arenas where professionals and managers made assessments, and based on these, made decisions regarding allocation of health and social care services. I took a nonparticipant observer role that allowed me to get close to the field. In this role I could interpret the social reality where service integration processes took place, through witnessing actions and behaviors, while keeping the role of a guest (Ciesielska et al., 2018). There were two main reasons for the choice of a nonparticipant observer role. Firstly, my limited access and outsider role at the municipal sites was not compliant with taking a participatory and active role in the meetings. To do observations, I got temporary access to these meetings from the managers in the organizational units. A nonparticipant observer role could additionally reduce possibilities of me disturbing the genuine discussions and decision-making processes taking place in the meetings (Rosas, 2006). A nonparticipant observer role was therefore adopted out of respect for the participants in the meetings, and out of consideration for the reliability of the data. This type of observer role does not however eliminate researcher interference, and people tend to change their behavior just because they are aware of being observed (Creswell & Poth, 2018).

Secondly, I was invited to observe two meetings where service recipients participated. Thus, a non-participant observation role was an ethical decision to reduce any forms of discomfort and interruptions for service recipients. As a nonparticipant observer I seated myself in the most anonymous seat around the table, and in the meetings where service recipients were present, I chose not to sit around the table at all. From this anonymous

seat, I watched, listened, and took field notes. I anonymized the field notes by making codes for both municipalities and the participants in the meetings.

I sought to follow good observational procedures before and after the meetings I observed. This included a proper introduction of myself, provision of necessary information about the study and implications for the meeting participants, and a quiet but polite withdrawal when the meeting ended. The information I presented concerned the purpose of my study, my observer role, the use of the data, protection of personal information and accessibility to the study (Creswell & Poth, 2018).

Prior to the observations, I had made an observation protocol (Creswell & Poth, 2018) that outlined specific elements that I wanted to look for in the meetings. The elements were derived from research questions for articles 1 and 3, and included allocation processes, assessments (including the values, ideologies, competencies etc. that were the basis for the assessments), financial structures and types of reasoning. Hence, the observation protocol guided me in what to look for specific topics when observing the meetings. However, there were also discussions occurring in the meetings that I did not anticipate, which were relevant and taken note of.

Municipality	Title of meeting	Number of participants	Service recipient included	Interprofessional	Inter-agency
1	Responsibility team meeting	3	Yes	Yes	Yes
1	Responsibility team meeting	3	Yes	Yes	Yes
1	Decision meeting	5	No	Yes	No
2	Department meeting, mental health	4	No	No	No
2	Department meeting, substance abuse	5	No	No	No
2	Decision meeting, mental health	2	No	No	No
2	Decision meeting, addictions	2	No	No	No
3	Meeting based on statements of concern	5	No	Yes	Yes
3	Housing meeting	6	No	Yes	Yes
3	Housing meeting	8	No	Yes	Yes
3	FACT meeting	7	No	Yes	No
3	Collaborative meeting concerning patients being discharged from hospital	13	No	Yes	Yes

Table 2: Observed meetings.

5.4.2 Individual in-depth interviews

Individual in-depth interviews with professionals and managers were carried out for the first and third articles. As described earlier, I anticipated a dynamic relation between observational data and interview data. This meant that interview data could inform the processes I observed in the meetings, and the observational data could generate new questions and topics for the interviews. This combination of methods could give me an opportunity to find descriptions and explanations for the observed events in the interviews. I carried out 16 semi-structured in-depth interviews with 17 professionals, department managers and unit managers (see Table 3). All interviews except one, were carried out as individual interviews. Two professionals working with assessment and case handling asked to be interviewed together, as they wished to complement each other during the interview. This request was taken into consideration, and they were subsequently interviewed together.

The semi-structured interview approach was chosen as it allowed participants to describe their experiences with, and understandings of the topic under study (Kvale et al., 2015). This method resembles a conversation where two people are talking and discussing a topic of mutual interest, and where the conversation environment is relaxed, open and honest. I followed an interview guide to direct the conversation and followed up with other questions based on the answers that the interviewee provided. In this way, I was able to obtain as much data as possible from a person who had knowledge and experience about the topic under study (Morris, 2015). A semi-structured interview allowed me to ask questions about planned topics, but at the same time it gave the interviewees flexibility to discuss their thoughts about the topic. This approach allowed me to follow the interviewees engagement, expressions, and stories, along the context of my interview guide.

The interview guide consisted of three themes concerning organizational and financial structures and professional practices. These themes were: 1) allocation and assessment processes, 2) economy and economic reasoning, and 3) structures and boundaries. There were questions related to each theme that probed the exploration of how these themes influenced service integration. The themes and questions in the interview guide were inspired by the empirical and theoretical knowledge I held at the time.

All interviews were carried out in the participants' premises, either in a managers' office or in a meeting room at their department. I always started the interviews with a proper introduction of myself and the PhD-project. This included information about the purpose of my study, the audio recording of the interview, handling of material (both audio files and transcripts), the use of the data, protection of personal information and accessibility to the study (Creswell & Poth, 2018). After that, the participants signed an informed written consent. The interviews were audio recorded. The audio files were uploaded to my computer on a safe storage area directly after the interviews, and then erased from the sound recorder. I transcribed the interviews by myself and deleted the audio files from my computer when the interviews were fully transcribed.

Municipality	Educational background	Role	Department/unit	Age	Sex
1	Nurse	Professional	Mental health and substance abuse department	50-59	F
1	Nurse	Department manager	Home nursing	50-59	F
1	Nurse	Unit manager	Unit for family and health	60-69	F
1	Social educator	Department manager	Mental health and substance abuse department	50-59	F
2	Nurse	Professional	Department of mental health	40-49	M
2	Social worker	Professional	Department of substance abuse, and assessment team	50-59	F
2	Nurse	Department manager	Department of mental health	40-49	F
2	Nurse	Department manager	Department of substance abuse	40-49	F
2	Nurse	Unit manager	Unit for substance abuse and mental health	60-69	F
2	Social educator	Unit manager	Unit for generic services	50-59	F
3	Nurse assistant	Professional	Mental health and substance abuse team	50-59	M
3	Social educator	Professional	FACT team	40-49	M
3	Nurse	Professional	Department of mental health	30-39	F
3	Nurse	Professional	Department of mental health	40-49	F
3	Social educator	Department manager	Department of mental health	30-39	M
3	Nurse	Department manager	Department of substance abuse	30-39	M
3	Nurse	Department manager	Home nursing	50-59	F

Table 3: Participants for individual in-depth interviews.

5.4.3 Focus group interviews

For the second and third articles, I carried out focus group interviews with service recipients, family caregivers, professionals, and managers.[1] One of the strengths of focus group discussions is that participants have the opportunity and freedom to express their

[1] The original plan in the PhD project outline was to carry out focus group interviews for the method Group Concept Mapping https://groupwisdom.com/gcmrg. Due to the Covid-19 Pandemic, I was not able to proceed with this method. I therefore decided to approach this part of the data gathering as classic focus group interviews.

concerns related to all aspects within the services together with others who have similar experiences (Conners & Franklin, 2000; Windsor, 2013). This allows an interaction between the participants in the group that stimulates thinking and remembering and recalling experiences. However, prerequisites for good interaction are an open dialogue between participants (Sutherland & Katz, 2005) where the moderator of the group put participants' values, meanings, and safety in the center (Rodriguez et al., 2011). Focus groups with service recipients and family caregivers as participants have proven to be well-suited within mental health and substance abuse services, as individual interviews have the risk of being perceived as therapeutic conversations (Conners & Franklin, 2000).

The groups of participants were interviewed separately in homogenous groups. I anticipated that service recipients and family caregivers would express themselves more freely if they could do this without the service providers and decision makers present in the interview setting. In this way, service recipients and family caregivers did not have to worry about how their statements could possibly affect them negatively. In addition, homogenous groups offered opportunities for asking questions that were relevant and specifically targeted to the group of participants. An overview of the focus groups and the participants can be found in Table 4.

The interview guide and procedure were prior to the focus group interviews and individual interviews pilot tested on a group of colleagues in the ROPIT-project. The pilot test was carried out with learning purposes regarding the interview guide and the moderation of the interview process.

I used a semi-structured interview approach, which allowed participants to describe their experiences and understandings of integrated services and service delivery in their own words. The same interview guide was used in all focus group interviews, giving all participants equal opportunities for expressing their thoughts on the topic. The interview guide had both an inductive and deductive approach, to prepare for the analysis. In the inductive part I focused on the unique experiences and meanings of the participants through the initial question: "What must professionals be capable of in order to integrate services?" The elements in the follow-up questions were deductively driven, dealing with

components within the definitions of competence and service integration. Examples of components were types of knowledge, skills, and attitudes as well as collaboration, coordination, networks, relations, and considerations of individual needs. This way, I was able to encourage the participants to explain and reflect on their statements. As I attempted to avoid making an interview guide based on my preconceived thoughts on the topic of study, there were no elements in the interview guide that were based on earlier competence frameworks. The semi-structured interview approach allowed me to ask follow-up questions based on individual and collective statements made by the participants.

The focus group interviews were conducted and moderated by me, and a research fellow wrote down the participants' statements during the interviews, as I did not use a sound recorder. Clausen (2012) argues that audio transcriptions of qualitative research interviews can be replaced by taking notes, with no harm done to reliability, validity, and transparency. I chose to take notes because I wanted the participants in general, and service recipients and family caregivers specifically, to feel comfortable during the interviews. In earlier experience with doing qualitative interviews, I observed that participants got nervous or uptight when I took out the audio recorder, which is why I decided on taking notes instead of audio recording.

The focus groups were held in meeting rooms located in the mental health and substance abuse units. The focus group interviews lasted from 60 to 90 minutes. Before each focus group interview, I provided information about the purpose of the study, handling of data material, the use of data, protection of personal information and accessibility to the study. Furthermore, to prepare the participants for interviews, we discussed the concepts of service integration and competence with the participants to achieve a collective understanding of the topic.

Name of group	Municipality	Participant group	Number of participants
Focus group 1	Municipality 1	Service recipients	6
Focus group 2	Municipality 1	Family caregivers	3
Focus group 3	Municipality 1	Professionals/managers	5
Focus group 4	Municipality 2	Professional/managers	5
Focus group 5	Municipality 3	Service recipients	5
Focus group 6	Municipality 3	Professionals/managers	4

Table 4: Participants for focus-group interviews.

5.4.4 Individual telephone interviews

When the Covid-19 Pandemic broke out in March 2020 I was in the middle of doing the focus-group interviews. The restrictions affecting social proximity, prohibited me from being physically present at the municipalities, which affected both possibilities for recruiting participants and for doing interviews. A solution that allowed me to continue to do interviews, was by doing them from home. However, I could not assume that all participants had access to computers to participate in digital interviews. Thus, I decided to interview participants individually by phone.

Despite the limitations imposed by the pandemic, I recruited three service recipients and three family caregivers for the individual telephone interviews (see table 5). As such, there was an unevenness between the number of participants for the two types of interviews. This unevenness may have created methodological limitations for the study, by generating more data from some municipalities than others. Simultaneously, I included an equal number of professionals and managers and service recipients, and through this, a fair distribution of voices between these groups of stakeholders.

Municipality	Participant group	Number of participants
Municipality 2	Service recipients	3
Municipality 2	Family caregivers	2
Municipality 3	Family caregivers	1

Table 5: Participants for individual telephone interviews.

I used the same interview guide as I did for the focus group interviews. While carrying out the individual interviews, I simultaneously took notes. The interviews lasted from 30 to 45 minutes. Prior to the individual interviews, I had sent the participants an information and consent form which they signed and returned to me by mail. All postage was paid by the ROPIT-project. As in the focus groups, I provided information about the study initial to the interviews, and we discussed the concepts of service integration and competence to achieve a collective understanding of the topic.

In retrospect I assessed that the combination of focus-group data and individual interview data could have strengthen the data set as a whole. There is proof that group interviews can discourage participants who are reluctant to share experiences, thoughts, and feelings in front of other participants (Kelly, 2003). When conducting the focus group interviews, I experienced that I had to be attentive to the participants who were more silent and withdrawn than some of the other participants. The individual interviews on the other hand, gave each participant more time to provide rich descriptions of the topic under study, which generated more data and detail to add to the focus group data.

5.5 Selection criteria and participants

The social reality of organizations involves a combination of activities, actors, and locations (Fleetwood, 2005). Thus, I needed to access the types of locations where the service integration activities took place. Given the focus on integration of municipal health and social care services for people with concurrent mental health and substance abuse challenges, I included participants from both mental health and substance abuse services. As physical health challenges often add complexity to the life of people with mental health and substance abuse challenges, I included participants from home nursing care. Within these services I was able to access actors involved in service integration activities and processes, including professionals, managers, service recipients, and family caregivers. These were the actors that I expected could provide me with the in-depth knowledge needed to answer my four research questions for this PhD-study. Furthermore, to access some of the activities related to service integration, I included observations of collaborative meetings. The following section describes the selection and

recruitment of participants, as well as the selection of collaborative meetings for observation.

5.5.1 Articles 1 and 3

For the first article (Løken et al., 2022) and third article (Løken & Vike, 2023, forthcoming) I recruited professionals and managers for individual in-depth interviews, and I selected meetings for doing observations.

The inclusion criteria for professionals and managers were that they had over two years of experience in the services they worked in. This was to ensure that they had substantial knowledge about these services and the coordination and collaboration work within and between services. Another inclusion criterion was that their work involved assessment and allocation or management, and that they had possibilities to influence decision processes. The strategy for the recruitment of these participants can be characterized as purposive sampling (Creswell & Poth, 2018). Purposive sampling aims to select participants who can contribute with relevant knowledge and experience for answering the research questions (Campbell et al., 2020). To gain access to potential participants, I asked the managers in the services to assist me in the recruitment process. Thus, these managers became the physical and social bridge I needed to gain access to participants (Clark, 2011). This strategy yielded 17 professionals and managers for individual in-depth interviews.

To get hold of the discussions and decisions happening across organizational and professional boundaries, I sought to observe inter-professional and inter-agency meetings where people with concurrent mental health and substance abuse challenges were discussed individually and on group level. Furthermore, I wished to include meetings where these service recipients' situations were discussed, assessed, and allocated, and where decisions were made. The recruitment strategy here can be characterized as a combination of purposive sampling (Creswell & Poth, 2018) and snowball sampling (Marcus et al., 2017). To initially gain access to meetings, I turned to the practice level managers, who purposively selected meetings that fit my inclusion

criteria. I started with a small number of meetings, and during observations, professionals participating in these meetings, recommended other meetings that they thought I should observe. This process represented snowball-sampling for further observations.

The main challenge in the recruitment processes of this part of the study was the long waiting periods between my requests and the collaborating managers' responses. This is not an unusual challenge, as recruitment through managers and professionals can be limited due to lack of time, resource, and disruptions in work (Clark, 2011). The ROPIT-project had prepared for such challenges, by providing economic compensation for all research-based activities they participated in, including recruitment activities. I had initially anticipated that this economic compensation together with engagement in the project were sufficient prerequisites for effective recruitment processes. This was not the case. This points to what Sheik et al (2009) calls "gatekeeper fatigue" which is a phenomenon that arises when the same people in the services are expected to collaborate in research activities on top of their daily work. The challenge of time tied to recruitment has provided me with valuable learning outcomes that I will consider in future research projects.

5.5.2 Articles 2 and 3

For articles 2 (Løken, Helgesen, & Bjørkquist, 2022) and 3 (Løken & Vike, 2023 forthcoming), I recruited service recipients, family caregivers, professionals and managers for both focus group interviews, and individual telephone interviews. The professionals and managers recruited worked within mental health and substance abuse services. This included outreach services in the service recipients' homes as well as follow-up services in forms of individual and group conversations. The inclusion criterion for this part of the study was that these service providers had over two years of experience working in these services. The service recipients recruited were either current or former receivers of these services. Subsequently, the inclusion criterion for them was that they had over two years of experience with receiving these services. Inclusion criteria for family caregivers were that they were familiar with the same services as the recruited professionals, managers, and service recipients, and that they had over two years of

experience being a family caregiver. Service recipients and family caregivers were given a universal gift card of 300 NOK as a reward for participating in interviews.

The initial recruitment strategy for the focus groups and individual telephone interviews was purposive sampling (Creswell & Poth, 2018). Within a few weeks I had recruited professionals and managers in all three municipalities. This was not the case when recruiting service recipients and family caregivers. I was only able to effectively recruit service recipients and family caregivers in municipality 1. Here they gave me access to an already established conversation group for service recipients. This group had meetings regularly and were familiar with each other and trusted each other, which is characterized as advantageous when recruiting service recipients (Dyas et al., 2009). The manager "earmarked" an hour of one of their meetings for carrying out the focus group interview. In municipality 2 I eventually received an e-mail from a newly employed manager who had managed to recruit three service recipients. Due to the Covid-19 pandemic I had to carry out interviews as individual telephone interviews with these participants. Since I did not have access to any family caregiver at that point, I used snowball sampling to recruit them. As service recipients often referred to a family caregiver in their interviews, I used the opportunity to ask if they thought that their family caregiver could be interested in participating in a similar interview. This resulted in recruiting three family caregivers. In municipality 3 I received an e-mail from a service recipient who wished to participate in my study. She had been declared too sick to participate by professionals in the services, but she did not agree to this. When I had corresponded with less than a week, she offered to help me recruit others, as she had several people in her network who received the same health and social care services as she did. This woman became a great resource for me, as she managed to recruit four additional service recipients. For this effort she was rewarded with an extra gift card.

My experiences with recruiting service recipients and family caregivers are in line with other researchers' experiences with recruiting people who can be characterized as "hard to reach". I refer to a book chapter I have written for further reading about these experiences (Løken, 2021). The position of the researcher is as an outsider in relation to

participants, and establishing trusting relationships with participants can be demanding (Emmel et al., 2007). In these situations, interested people within the group one wants to reach becomes important resource people, as they can have possibilities and abilities to introduce and vouch for the researcher. This is due to the trust that they already have established with other suitable participants (Elliott et al., 2002). Another learning outcome for me stemming from this process is that there should be a greater focus on service recipients as resources in recruitment processes.

5.6 Analysis

"*And this is where the challenge lies: moving from a shapeless data spaghetti toward some kind of theoretical understanding that does not betray the richness, dynamism, and complexity of the data but that is understandable and potentially useful to others*." (Langley, 1999). There are several different strategies to choose from to analyze qualitative data. So, how do we move from a shapeless data spaghetti towards a theoretical understanding? As described, case studies are particularly suitable for exploring and developing theory, and the single case study design directed the selection of analytical approaches. In the following, I will describe these analytical approaches I have used in this dissertation.

5.6.1 Abductive analysis and stepwise deductive-inductive approach

I found abductive analysis as applicable to my aim of generating both empirical and theoretical findings. Abduction is a creative process aimed at producing new hypotheses and theories based on surprising research evidence (Tavory & Timmermans, 2014). Abductive analysis is one-part empirical observations of a social world, and the other part a set of theoretical propositions. The analysis is carried out as a back and forth process between the research evidence and considerations of theory, in other words, there is a conversation between the empirical observations and the theoretical propositions (Rinehart, 2021). To have such conversations, one must utilize theory in several stages of the analysis, and eventually one can develop new theoretical contributions (Tjora, 2019).

The analysis strategy applied to articles 1 and 2 was Stepwise deductive-inductive (SDI) approach, where abduction is central (Tjora, 2019). This is an analysis method where the researcher works in steps from raw data to concepts or theories. The upward process is inductively driven, as one works from data towards theory. The downward process is viewed as deductive, as one checks the conceptual or theoretical developments with the empirical (Tjora, 2019). It is a highly systematic method, where choices are made based on professional reasons without shortcuts and premature conclusions. There is both an inductive curiosity where one works with the empirical data as a defining point of departure for what is considered interesting, together with the aim of generalization and theory development (Tjora, 2019). In the abductive part of SDI, the researcher applies a theoretical concept on the empirical material, to test if it is relevant for the phenomenon observed in the material.

I applied the SDI-method to analyze articles 1 and 2, in a moderate way. In the original "recipe" of SDI, the generation of concepts and theories are inductively motivated in line with Grounded Theory, which SDI is inspired by (Tjora, 2019). I had a more flexible approach to the analysis and used inspiration from existing theories and academic discussions as influences in the analysis process. The specific theories are described in chapter 4. Atkinson (2017), writes that researchers are influenced by what they see (read) and hear (talk about) in the process of conducting their research. Furthermore, he claims that ideas will definitely not 'emerge' just from our repeated inspection of notes and transcripts. Despite adopting a moderate approach to the SDI-method, the upward and downward steps of the process facilitated meaningful connections between the empirical observations and the theoretical propositions that I found useful, relevant, and inspirational. Consequently, I was able to conduct abductive analysis, whereby testing theoretical concepts against empirical material, I illustrated the connection of my empirical data to relevant theory and to my own theoretical propositions.

5.6.2 Deductive thematic analysis

Thematic analysis was adopted for the analysis if data in the third article (Braun & Clarke, 2006). There are various thematic analysis approaches for identification and sense

making of patterns of meaning across datasets. In line with the ambition of doing theoretical elaborations, I used a deductive thematic analysis approach. This meant that existing theories provided a lens through which I have analyzed and interpreted my data (Braun & Clarke, 2021).

By the time where I started analyzing the data in the third article, I had already worked with the data material from the two previous studies. This made me very familiar with the content in the data set, as I had already identified patterns of formal and informal integration processes. My curiosity towards formal and informal integration processes directed me in the choice of theoretical foundation. I applied theory on differentiation, hierarchies, and integration (Hatch & Cunliffe, 2013; Lawrence & Lorsch, 1967) to the pattern of formal integration, and theory on street-level bureaucracy (Lipsky, 1980; Zacka, 2017) and street-level diplomacy (Gale et al., 2017) to the pattern of informal integration. The data was read in the light of this theoretical foundation, and patterns of meaning were generated from the data using this pre-existing theory (Braun & Clarke, 2021).

5.7 Ethical considerations

At the start of this PhD-project, I reported the study to the Norwegian Centre for Research Data (NSD), and the study was approved on the 17th of April 2019 (ref. no. 300488). At the time of this application, research projects that involved activities which revealed information about individual service recipients, such as names and diagnoses, had to apply for exemptions from the duty of confidentiality. I therefore applied for this exemption to the South-Eastern Norway Regional Committee for Medical and Health Research Ethics, and the exemption was granted the 11th of April 2019 (ref. no. 2019/299 REK Sør-Øst).

All participants received information about the study both orally and in writing. Although the participants had received information about the study ahead of our appointment, I always went through the written information in the consent form with the participants before the signing-procedure. This way, the participants could ask questions, and I could

explain the information that they found difficult to understand. The written informed consent form was identified as difficult to understand by the first service recipient I recruited, and she offered to collaborate with me in formulating the information in a more understandable way. This resulted in a written information sheet that was used for recruiting service recipients and family caregivers for focus group interviews and individual telephone interviews.

In line with the shift from a paternalistic to a person-centered model of care, and the debate about how to describe and refer to the people who receive services (Costa et al., 2019), I use the term “people/person who receives services” in oral communication . However, when writing research, it can be practical to use certain labels to refer to the person or group of people one writes about. The names “client” and “service- user” have been suggested as more empowering, implying greater equality between participants in decision-making processes (Neuberger, 1999). This is in line with newer research on terminology preferences, promoting this as a more empowering and stigma-reducing way of addressing people who receive mental health services (Lyon & Mortimer-Jones, 2021). “Client” or “service user” is also the recommended way of addressing people who received substance abuse services (Gazzola et al., 2022). In this dissertation I refer to people who received services as “service recipients”.

5.7.1 Service recipients and family caregivers as participants

Involving service recipients and family caregivers as participants in interviews raised ethical dilemmas for me as a novice researcher. Firstly, I did not want their participation to result in discomfort. Although the questions in the interview guide revolved around coordination, collaboration and integration of services, the discussions could potentially generate feelings of uneasiness among the participants. I ended the interviews by asking if any of the participants had questions or inputs that they wished to clarify before ending the interview. I also made clear to the participants that they could contact me via telephone (calling or texting) if they wished to withdraw from the study after the interview, or if they had any issues or concerns. One service recipient contacted me by SMS a couple of hours after a focus group interview, but it was to give me additional input

on the questions I had asked in the interview. She allowed me to use the input in the SMS as data material if I wished to do so.

Secondly, there was the issue of not including service recipients who were too sick to participate. I appealed to the professionals and managers in the services to help me recruit service recipients. This was helpful to some extent, but I also had to rely on the snowball method as presented in section 5.6.2. In retrospect, recruiting through a service recipient was very effective, but I had no way of safeguarding whether the potential participants were healthy enough to participate. For future research involving service recipients but also their family caregivers, I wish to be more thorough when assessing eligible participants, to make sure that their health complies with participation in research. At the same time, it is important that service recipients and family caregivers are aware of their possibilities to participate in research. Moreover, they should get the opportunity to participate without any prejudice about their health- and socially related challenges. As researchers and professionals, we can have a desire to protect possible participants from potential burdens associated with participation, but this should be balanced with a respect for their autonomy, integrity, freedom and co-determination (Løken, 2021).

5.8 Research quality

In qualitative research we need additional quality criteria than the typical criteria of credibility, validity, and reliability used in quantitative research. Qualitative research is a complex landscape, as it entails numerous approaches and methods. To appropriately evaluate qualitative research featured in case studies, Tracy (2010), suggests a set of universal criteria that take the complexity of the qualitative landscape into consideration. Thus, to address credibility, validity, and reliability in this PhD-project, I use Tracy's eight criteria for quality in qualitative research. The criteria are 1) a worthy topic, 2) rich rigor, 3) sincerity, 4) credibility, 5) resonance, 6) significant contribution, 7) ethical considerations, and 8) meaningful coherence (Tracy, 2010).

The topic should be relevant, timely and interesting (Tracy, 2010). As I presented in the introduction of this dissertation, there is a knowledge gap regarding integration of municipal services for people with concurrent mental health and substance abuse challenges. Additionally, little empirical research has been done on factors at the system, organization, and practice-level, and how these factors influence integration of health and social care services. As, such the topic and main aim of this dissertation seems both relevant and timely.

I have combined several types of interviews with observations. I have also included the voices of service recipients, family caregivers, professionals, and managers from three Norwegian municipalities. The rigor in this dissertation is thus maintained through the triangulation of methods, voices, and contexts, which has resulted in a rich and comprehensive data set. In turn, this data set prepares well for development of in-depth knowledge about how professionals and managers adapt to and operationalize policy regarding integration of health and social care services. The strategies and procedures for obtaining this data set is thoroughly described in the methods chapter, with the aim of providing transparency and being sincere. The triangulation of methods, multivocality, and thick descriptions present in the data set can also provide credibility to my research (Golafshani, 2003).

Tracy (2010) refers to the term resonance for describing how research can affect an audience. Resonance can emerge through a study's potential to be valuable across different contexts and situations. This can be achieved through transferability when the reader recognizes the story within the study. By writing thick empirical descriptions and combining these with theoretical and conceptual insight, I have aimed at making the research transferable for the readers of this dissertation. This combination has also laid the groundwork for generating new empirical and theoretical insight and understanding (Tracy, 1995) of how professionals and managers adapt to and operationalize policies regarding integration of health and social care services.

I have maintained universal ethical standards when working with the dissertation by applying for approval to do the research, and also for exemption from the duty of

confidentiality. I have also attempted to be reflexive in all stages of the research. This means that I have reflected on my own values, understandings and wishes, and tried to act out of the moral intention of "doing good" (Titchen et al., 2017). Throughout the research process, I have prioritized the welfare of the service recipients, family caregivers, professionals, and managers involved. This approach reflects and important aspect of person-centered researchers (Jacobs et al., 2017). One example of this, is how I have altered the language I have used when informing service recipients and family caregivers about the study, both orally and in writing. This has resulted in a more comprehensible language, which is a prerequisite for making an informed consent.

Lastly, I have attempted to achieve a meaningful coherence in the dissertation by including and using methods that partner well with the main aim and the adopted theories. I hope that by being reflexive in the multitude of methodological decisions (Tracy, 2010), I have been able to develop a dissertation that achieve sufficient answers to the main aim and associated research questions.

6 Summary of articles

The overall aim of the dissertation has been to develop knowledge on how municipal professionals and managers adapt to and operationalize policy regarding the integration of health and social care services. This chapter presents the summaries of three independent research articles that collectively contribute to achieving this aim.

6.1 Summary of the first article

Løken, T. D., Helgesen, M. K., Vike, H. & Bjørkquist, C. (2022). Being bound and tied by the ropes of frugality: a case study on public management values and service integration. *Journal of Health Organization and Management*, *36*(9), 95-111. https://doi.org/10.1108/JHOM-10-2020-0401

The aim of this first article was twofold. The first aim was empirical and involved the investigation into how organizational and financial structures, as well as professional practices, hinder and enable service integration. The second aim was theoretical, focusing on exploring the impact of public management values on structures and practices in relation to service integration. Based on these aims, the overall research question was: How do public management values influence service integration in municipal health and social care organizations?

The empirical material consisted of 15 semi-structured individual interviews with seven professionals and ten managers working in mental health services, substance abuse services, and home nursing care, one semi-structured dyadic interview with two professionals working in mental health services, and observations of 12 collaborative meetings. The transcribed interviews and observation reports were analyzed inductively and deductively. There was a dynamic interplay between observation reports and the interviews, where the latter informed the processes observed in the meetings. The analysis was carried out with the use of stepwise deductive inductive approach (SDI) (Tjora, 2019). The inductive part of analysis resulted in three main themes: 1) variations in approaching and organizing integration in mental health and substance abuse services; 2) structures and practices hindering access to physical healthcare; and 3) structures and

practices hindering allocation of housing. The findings showed that professionals were often unable to fulfil their mandate on behalf of the service recipients. Their ability to assess, allocate, and deliver integrated services was often limited because the dominance of performance management tools impeded these actions. We also found that when organizational and financial constraints were minimized and the context was small and manageable, professionals found it easier to meet service recipients' needs using person-centered and integrated service approaches. In contrast, larger municipalities with greater complexity in organizational and financial structures had stronger hierarchical management and barriers to integration requiring them to be more frugal in decision-making processes.

The second part of the aim was answered by abductively applying Hood's (1991) public management values to the findings, to explore how these values influenced structures and practices. This theoretical analysis resulted in four combinations of values in structures and practices: 1) Frugal and economic values in both structures and professional practices, which hindered integration; 2) Frugal values in structures and integrative values in professional practices, which enabled integration to some extent; 3) Integrative values in structures and frugal values in professional practices, which challenged integration; and 4) Integrative values in both structures and professional practices, which enabled integration.

We concluded this article by arguing that service integration was impeded by the frugal and economic values in NPM doctrines. These values strongly influenced organizational and financial structures as well as professional practices in Norwegian municipal health and social care services. At the same time, we found examples of how the post-NPM goal of integration was realized when either or both organizational and financial structures, as well as the professional practices were fused with integrative values. To enable integration, the ropes of frugal and economic values should be loosened up, allowing professionals to use their discretional abilities to assess, allocate and deliver integrated services. This implied that organizational and financial structures, along with professional practices, should prioritize the values of flexibility, adaptivity, robustness, and resilience.

6.2 Summary of the second article

Løken, T. D., Helgesen, M. K. & Bjørkquist, C. (2022). Collective Competence as an Enabler for Service Integration in Health and Social Care Services. *Journal of Multidisciplinary Healthcare*, *15*, 2817-2830. https://doi.org/10.2147/JMDH.S387719

In the second article I was interested in finding out whether the professionals and managers in mental health and substance abuse services could adapt to service integration policies through a collective approach to competence. The aim in this article was therefore to explore which types of competence stakeholders required, and how collective competence could promote service integration. This was guided by two research questions: 1) Which types of competence do stakeholders require for integrating services?; and 2) How may collective competence promote service integration?

The dataset consisted of six focus group interviews with a total of 28 participants including service recipients, family caregivers, professionals, and managers. Additionally, there were six individual telephone interviews with three service recipients and three family caregivers. Both types of data were analyzed synchronously. The SDI model (Tjora, 2019) was used to analyze the data and this resulted in four main themes: 1) Knowledge about individual life situations and organization and system; 2) Investigation competence; 3) Person-centered collaboration competence; and 4) Facilitating competence. These four themes formed the basis for a competence framework that could be used to promote service integration. The findings showed a high degree of consensus between service recipients, family caregivers, professionals, and managers regarding the specific competences required to enable service integration. However, there was disparity between the competences needed for service integration and the actual situation in municipal mental health and substance abuse services. This was due to the lack of coordinating mechanisms at the system level. Thus, the responsibility for integration was decentralized to the professional level, resulting in more collaboration than coordination. Given that both coordination and collaboration are required to integrate services, service

managers should establish coordinating mechanisms and initiate a collective approach to acquiring service integration competence.

In the abductive stage of analysis, we applied Boreham's (2004) triadic theory to test it was relevant for the four main themes. We used three principles, presented in chapter 4.3.1, to explore how collective competence could promote service integration. The first principle emphasized a common goal around which to construct a shared understanding. Based on our empirical findings, we suggested that service recipients' own goals were the core of activities in collaborative networks. Thus, the common goal for the collaborating professionals were also the service recipients' individual goals. The second principle suggested context-relevant knowledge, accessible by all participants in the collaborative network, as a prerequisite for reaching common goals through coordinated activities. Based on this principle, we promoted integrated knowledge of service recipients' individual life situations and of organization and system as central parts of a collective knowledge base in health and social care services. The third principle concerned the importance of a sense of interdependency between professionals in the collaborative network. In this regard, the discussion highlighted that professional needed to be familiar with each other's contributions and actions in order to be interdependent. Being aware of each other's contributions and actions were however dependent on a collective culture for collaboration and learning.

Additionally, we offered a fourth principle for collective competence within health and social care organizations, which was to legitimate extra-professional involvement. The empirical findings showed that service recipients and family caregivers should be included as active agents in decision-making processes. Thereby they should also be regarded as legitimate extra-professional parts of the collaborative network.

We concluded the article by arguing that when service integration competence was approached as a collective attribute of a network within and between organizational units, the organization could facilitate this competence by encouraging an active exchange of knowledge between professionals. We also argued that a collective

approach to service integration competence could increase interdependency between professionals and organizational units.

6.3 Summary of the third article

Løken, T. D. & Vike, H. (2023). Thinking and acting outside the box: The co-existence between formal bureaucratic integration and informal street-level integration in municipal health- and social care services (submitted to *Nordic Journal of Wellbeing and Sustainable Welfare Development.* In review as of 29th of May 2023).

This article aimed to display how managers adapt and operationalize service integration policies by establishing formal bureaucratic integration arrangements, and also how professionals adapt and operationalize through street-level integration. The research question was: "How do practice level managers and professionals work to achieve integration of mental health and substance abuse services?"

For this article we used the entire dataset gathered for this dissertation. This included 16 in-depth interviews with professionals and managers working in mental health services, substance abuse services, and home nursing care, one dyadic in-depth interview with two professionals working in mental health services, observations of 12 collaborative meetings, six focus group interviews with service recipients, family caregivers, professionals, and managers, and individual interviews with three service recipients and three family caregivers. This comprehensive data set was analyzed with a deductive thematic approach (Braun & Clarke, 2021), which resulted in two themes: 1) formal bureaucratic integration; and 2) informal street-level integration.

The findings showed that managers committed to service integration to different extents. Mainly, they prepared for service integration by establishing formal coordination mechanisms and arrangements such as formal meetings, digital documentation systems, team organization, and collaboration agreements. Managers in the smallest municipality also promoted a collaborative culture within the mental health and substance abuse department and with other relevant actors in the municipal organization. The professionals who provided mental health and substance abuse services utilized these

formal channels to coordinate, while also finding them to be insufficient. By this they meant that the formal and bureaucratical way of collaborating often were time consuming and did not result in the desired outcomes that service recipients required. Consequently, they regularly moved outside of official channels, both to collaborate in ad hoc situations as well as to establish informal collaborative alliances.

The empirical findings prepared for a discussion of symmetrical and asymmetrical commitment to service integration. Symmetrical integration was our conceptualization of processes of mutual commitment that emerged when managers met professionals' needs for service integration arrangements. Such integration could be achieved through formal coordination channels such as inter-professional and inter-organizational decision meetings and digital communication systems. We also applied the concept of street-level diplomacy (Gale et al., 2017) in the discussion. The concept of street-level diplomacy focuses on relationships, communication, and the ability to be adaptive. This elucidated the ways in which street-level bureaucrats in our data used their knowledge, skills, and professional discretion to build trustful relationships with other professionals in their network. We complemented this concept by arguing that street-level diplomacy within health and social care organizations also involves the ability to be creative and flexible, to "think and act outside the box".

We concluded the article by arguing that formal bureaucratic integration and informal street-level integration can co-exist in a symbiotic relationship. This can be achieved if there is a symmetrical commitment between managers and professionals to the aim of service integration set forth by the Norwegian welfare state. Additionally, we recommended networking skills as a necessary social capital in service integration processes, which also should be emphasized in health and social care professionals' educational pathways.

7 Discussion

Given the lack of empirical research addressing service integration in the mental health and substance abuse field from policy to service delivery level, this dissertation sought to address this gap. The three articles summarized in the previous chapter contribute to furthering understandings on how professionals and managers in municipalities adapt to and operationalize policies regarding the integration of health and social care services.

What the findings of these articles suggest, is that values permeate policies, organizational structures, and professional practices. There is already an established understanding that changes in the external authorizing environment, in this case the Norwegian government, can lead to changes in organizational values and practice (Destler, 2016). Thus, in the following I will discuss how policy values can shape the values that direct organizational and financial structures and professional practices, and in turn, change the outcomes for service recipients.

The discussions in this chapter are presented in four parts. First, I present two system approaches that exemplify how structures and practices look like if we cultivate economic and frugal policy values on the one hand, and integrative policy values on the other. Second, I discuss the policy values' implications for the operationalization of these policies. In the third part, I explore how professionals and managers contribute to develop resilience in the service delivery system by adapting and operationalizing service integration policies. In the fourth, and last part, I make a proposition for the future development of municipal health and social care.

7.1 The impeding and the enabling system approaches

Findings from the three articles allowed me to extract central features regarding economic and frugal values and integrative values from policy level throughout to practice level. To illustrate how these two sets of values shape integration practices from policy level to practice level, I will delineate these as two distinct and separate system approaches: the impeding system approach and the enabling system approach. I use

findings from the three articles in addition to other relevant literature to make this distinction between the two approaches.

7.1.1 The impeding system approach

Values within this system approach are frugality, control, matching of resources to goals and tasks, and organizational break up (Hood, 1991). Policies regarding economic performance and consequently, municipalities' duties of financial management and the effective utilization of resources, are inevitably informed by economic and frugal values. The Norwegian government's tool to reduce the risk of municipal over expenditure is to hold municipal managers legally obliged through The Act relating to municipalities and county authorities (The Local Government Act), chapter 14, to report information about revenues and expenditure (The Local Government Act, 2018). The reporting is done through the national information system called KOSTRA (Ministry of Local Government and Regional Development, 2021). In this information system the national authorities can control and supervise municipalities' financial management. This feature aligns with the value of control. Economic performance policies and its associated tools for control, which are rooted in legal acts with binding rules and obligations, allows for a characterization of these as "hard governance" (Oberthür, 2019). In this system approach, managers on the highest levels in the municipal hierarchy, who are responsible for the overall municipal budget, expect managers close to the service delivery level to comply with their financial accountability responsibilities. This expectancy was described several times in the in-depth interviews as something that professionals and managers were highly familiar with (Løken et al., 2022a).

Organizational and financial structures informed by economic and frugal values are accommodated to protect the financial resources of the organizational units particularly, and the municipal budget in general. Here, differentiation of services into single- or few-purpose organizations with separate funding streams, each pursuing defined sets of goals and tasks, is a common strategy (Christensen & Lægreid, 2007). Municipality 2 and 3 were identified as highly differentiated, with mental health and substance abuse services organized separately. This type of organizational design is considered a cost-effective way

to organize (Vabø, 2009), as each organizational unit is held responsible for their own expenditure. This displays the values of organizational break-up and the matching of resources to goals and tasks. The differentiated organizational structures make it easier to provide services to people with well-defined and relatively simple needs rather than those with complex needs. Consequently, service recipients with complex needs receive services for either their mental health challenges or their substance abuse challenges. This is also known as sequential services (Fodstad & Christiansen, 2014). In other situations, service recipients with complex needs, receive parallel services, meaning that they receive services from two or more organizational units simultaneously, without these services being seen in connection to each other (Fodstad & Christiansen, 2014). Both sequential and parallel services can be useful when service recipients' challenges are characterized as mild and well-defined. However, for service recipients who have complex challenges, such as concurrent mental health and substance abuse challenges, integrated services are the recommended approach (Mueser & Gingerich, 2013).

The economic and frugal values in organizational and financial structures also impede access to required services, due to the rigid distribution of responsibilities and financial resources between organizational units (Løken et al., 2022a). In situations where service recipients have complex needs that must be met through several services, it is challenging for decision-makers to decide on the most adequate services. As an example, one service recipient can have needs tied to mental health and substance abuse challenges in addition to needs for physical healthcare services. Regarding financial structures, two issues arise. Firstly, service recipients with multiple and complex needs are regarded as costly. To avoid taking the main responsibility for costly service recipients and to protect their own budget, professionals and managers try to negotiate their way out of such responsibilities (Løken et al., 2022a). Secondly, because it is considered too costly to deliver integrated mental health and substance abuse services, managers tend to allocate services sequentially instead. Thus, integrated approaches are impeded (Løken et al., 2022a).

If service recipients with multiple and complex needs require institutional help, professionals and managers often experience that these service recipients do not properly fit in anywhere. This is also due to the rigid distribution of responsibilities and inclusion criteria for getting admitted into institutions. Professionals and managers describe the decision-making processes for such situations as struggles, where they try to negotiate themselves away from taking responsibility for service recipients (Løken et al., 2022a). As a result, service recipients are thrown back and forth in the system, experiencing multiple rejections (Løken et al., 2022a; Montenegro et al., 2011).

Another feature of organizational and financial structures informed by economic and frugal values is the insufficiency in integrative arrangements and mechanisms. Consequently, in differentiated organizational landscapes, there is a lack of adequate information sharing among professionals, which leads to limited awareness about each other’s efforts when working with the same service recipients. This situation can affect the continuity of care for the service recipients (Løken et al., 2022b; Puntis et al., 2015), and professionals fail to meet their needs (Montenegro et al., 2011). This in turn, can lead to harmful and even fatal consequences for the service recipients (Weiner et al., 2010).

As elaborated, economic and frugal values within The Local Government Act stimulate municipal managers to structure the health and social care services in a way that makes financial management, accountability and reporting feasible. It also stimulates municipal managers to promote approaches that prepare for frugality in decision making rather than integrated approaches. Managers closer to the practice level as well as professionals working directly with service recipients, take on a territorial behavior by partaking in processes marked by responsibility-shifting. In conclusion, economic and frugal values impede integration of municipal the health and social care services.

7.1.2 The enabling system approach

Values within this system approach are security, flexibility, adaptivity, robustness, and resilience (Hood, 1991). In the enabling system approach, the government’s tool for safeguarding the integration of health and social care services is white papers and

guidelines, i.e. “Morgendagens omsorg” [Future care] (Meld. St. 29 (2012-2013)) and “Sammen om mestring: Veileder i lokalt psykisk helsearbeid og rusarbeid for voksne. Et verktøy for kommuner og spesialisthelsetjenesten [Together around coping: A guide in local mental health and substance abuse work for adults] (The Norwegian Directorate for Health, 2014). The policies which are found in the content of these white papers and guideline display the use of “soft governance” tools. These are recommendations and measures that are meant to stimulate municipalities to structure and approach their services in a way that realizes service integration (Ramsdal & Bjørkquist, 2021). The economic resources for the integration of mental health and substance abuse services are financed through the municipalities’ unrestricted incomes, which allow municipalities to utilize these resources according to their own needs (Prop. 15 (2016-2020)). This type of financial arrangement indicates the presence of flexibility and adaptivity as values in these policies. These white papers and guidelines promote coordination and collaboration between organizational units and professionals to enhance health and social care (Meld. St. 47 (2008-2009); Meld. St. 26 (2014-2015)). However, they lack the control mechanisms on how municipalities should actually prepare for and organize this. Different measures, such as co-location and reorganizations, are suggested to inspire and stimulate municipalities in the planning of service integration. Thus, these policies convey the value of flexibility rather than control, and they appeal to the municipalities’ autonomy.

Organizational and financial structures informed by integrative values provide a suitable environment for the implementation of integrated service delivery approaches. Departments and units that integrate the delivery of both mental health and substance abuse services, have desirable circumstances to help service recipients with severe and complex needs (Løken et al., 2022a). Since these departments and units consists of different professional groups, the professionals can help and guide each other in their daily work (Løken & Vike, forthcoming). This fosters good conditions for continuity of care, as service recipients can receive comprehensive services for both mental health and substance abuse challenges from the same professional (Løken etal., 2022b). Moreover, since integrated mental health and substance abuse departments share the same budget

and manager, professionals and managers are not compelled to partake in decision making processes where they feel the need to evade responsibility for service recipients with complex needs. Instead, the enabling system approach highlights service recipients' needs for comprehensive services.

When robust structures for coordination and collaboration are in place, it may also prepare for information exchange and collective reflection across departments and units. Such structures can be digital platforms for documentation and information sharing, securing all relevant actors' access to the digital platforms, physical meeting spaces for dialogue, and co-location (Løken et al., 2022b). Such structures may promote the continuity of care since the professionals who are involved can get access to each other's contributions and thus, obtain updated information about service recipients. Subsequently, such structures give professionals and managers opportunities to discuss and reflect upon individual service recipients particularly, and provision of health and social care services in general.

An important point to make about this system approach is that structures designed for integration hold little value unless the professional approaches are inspired by integrative values. As the first article showed, integrative structures can only enable service integration to some extent (Løken et al., 2022a). Once the structures are constructed, they also must be utilized. The findings from article 2 suggest collective competence as a professional approach to service integration. In a collective competence approach, professionals are willing to take collective action in collaborative networks with and around service recipients and their family caregivers. Furthermore, such an approach involves interprofessional and holistic work in the process from mapping, assessing, allocation of services, and direct service delivery. Professionals are flexible towards service recipients' needs, and they are capable of, and willing to make individual adaptations in line with the needs (Løken et al., 2022b). Hence, collective competence is directed by flexibility and adaptivity, which are values that should direct the professional approaches to service integration. Furthermore, in an integrative service system, service recipients have the same coordinator over a longer period of time. This allows them to

meet professionals who consider their holistic wellbeing instead of their isolated challenges (Løken et al., 2022b). This displays the value of security. Flexibility by professionals is also accompanied by creativity, when they find alternative ways of collaborating in systems where formal coordinating structures are not sufficient (Løken & Vike 2023, forthcoming).

I have argued that the policies directing service integration do not entail strong incentives, but appeal more to the autonomy given to Norwegian municipalities. Municipalities who choose to structure and approach services based on integrative values succeed to integrate services to a great extent. The result of this is the establishment of integrated departments and units with robust conditions supported by collective budgeting and management. This is further reinforced by an interprofessional work force and collective approaches to mapping, assessing, allocating of services and service delivering. As a result, service recipients receive services marked by continuity of care and involvement. In summary, the enabling system approach shows a service field with professionals who are resilient towards service recipients' complex and frequently changing needs. Ultimately, integrative values promote the integration of municipal health and social care services.

7.2 The control-trust nexus between the government and municipalities

The two distinctive system approaches show that economic and frugal values have the potential to impede the integration of municipal health and social care. Equally evident is that integrative values may indeed enable integration. The two system approaches are cultivated versions of organizational and financial structures, as well as professional practices, and can consequently not serve as versions of reality. They can however serve as illustrations of how the dominance of certain policy values can affect organizational and financial structures and professional practices. In this section I will discuss how and why values within the policies that direct the two system approaches have different implications for the operationalization of policies.

As described earlier, the primary source of municipal revenue is derived from tax income and block grants allocated by the government. This type of financial allocation requires a high level of trust from national authorities. This is because decentralization allows municipalities to distribute this unrestricted income based on their different political and administrative organization, size, financial position, geographical conditions, resources, and infrastructure (Baldersheim & Ståhlberg, 2002). Meanwhile, the Norwegian governments' tool to reduce the risk of municipal overspending, is to control municipalities' performance of financial management, accountability, and responsibility (Ministry of Local Government and Regional Development, 2021). This twofold situation displays an interesting relationship between control and trust, a topic that has been subject to much debate in the Scandinavian countries in recent years (Bentzen, 2019; Bringselius, 2021).

Trust is characterized by the willingness of one party to be vulnerable to another party's actions based on expectations that the latter will fulfill their obligations, irrespective of the trustor's ability to exert control (Mayer et al., 1995). Furthermore, trust is necessary when the actors are interdependent (Jagd, 2010). In this case, the decentralization of responsibility for public services in Norway, makes the government dependent on the municipalities for providing primary health and social care services. However, the government's control-fixated performance management tools disturbs the picture of a high-trust relationship between the national authorities and municipalities in Norway (Ligthart & van Oudheusden, 2015).

Control can be viewed as a process that regulates the behaviors of individuals within an organizational, with the aim advancing organizational goals (Costa & Bijlsma-Frankema, 2007). Scholars distinguish between formal and informal control. The formal approach focuses on formal rules, procedures, and policies to monitor and alternatively reward desired performance, or penalize undesired performance. In contrast, the informal approach focuses on the mandated power of organizational norms, values, culture, and the respective organizations' goals that direct the desired outcomes (Costa & Bijlsma-

Frankema, 2007). The performance management tool of financial reporting can be placed within the formal approach to control.

7.2.1 Control, sanctions, and anxiety

National authorities exercise control over municipalities' financial management through the implementation of sanctions. If a municipality's treasury shows an cumulative excess consumption from the operating account greater than 3 % of the operating income, the municipality will be recorded in The Register of Conditional Approval and Control (ROBEK) (The Local Government Act, 2018). During the time a municipality is listed in this register, it is prohibited from taking loans or entering into rental agreements without approval from The Ministry of Local Government and Regional Development (The Local Government Act, 2018). Municipalities in the ROBEK-register are subject to stronger governmental control and must enforce stricter budgetary policies to be removed from the register (Hopland, 2014). Thus, the sanction for poor economic performance significantly affects municipal autonomy.

Norwegian municipalities try to avoid being registered in ROBEK to maintain their autonomy. However, being preoccupied with the risks of overspending, can lead to professionals and managers experiencing what Schein (2010) calls "survival anxiety". Public organizations who have high levels of "survival anxiety" also adopt greater performance values in response to economic performance reforms (Destler, 2016). As exemplified through the impeding system approach, professionals and managers tend to adapt and operationalize more to economic performance polices, by organizing and approaching services to avoid overspending. This is done by maintaining a highly differentiated form of organization, where each organizational unit is responsible for their own financial limits. Alternatively, professionals and managers can engage in decision-processes where they try to evade responsibility for service recipients that they consider costly. Additionally, as in municipality 2, especially managers attempted to avoid allocation of integrated mental health services and substance abuse services (Løken et al., 2022a). Hence, these risk mitigating tactics reinforce the value of control within municipal health and social care organizations, impeding the integration of services.

An interlaced concept within this part of the discussion is risk. While performance management tools obviously exist to reduce the risk for municipal overspending, there is also risk involved in building trust. There is risk both for the autonomy granting authority and for the organization, unit or professional who accept that autonomy (Six, 2018). Trust in the form of local autonomy will not guarantee that municipalities will take the risk of accepting it, because increased autonomy may also produce increased responsibilities (Bentzen, 2019).

7.2.2 Trust and autonomy

As the discussion of the enabling system approach showed, the national authorities use soft governance tools when providing policies regarding the integration of health and social care services. The policies are provided as recommendations and advice within white papers and guidelines. Thus, policies regarding service integration do not entail the same control mechanisms as economic performance policies (Ramsdal & Bjørkquist, 2021). Without government control mechanisms, higher-level municipal managers can choose how and to what extent they will prepare for the integration of health and social care services. While the absence of control and the granting of autonomy may be associated with a high level of governmental trust in municipalities' abilities and willingness to accommodate the aim of service integration (Bentzen, 2019), it can also be a pragmatic choice. This is because excessive control will lower the necessary latitude for municipalities to adapt to service integration policies according to their contextual needs (Bentzen, 2022). Nonetheless, absence of control grants municipalities the autonomy to be flexible and adaptive in how they organize and approach the integration of health and social care services.

While policies that offer the values of adaptivity and flexibility for the respective municipalities seem attractive, they are not devoid of challenges. One of the aims of a public welfare state built upon universal and egalitarian ethos is to ensure access to equal services provision regardless of one's place of residence (Sellers & Lidström, 2007). This aim is jeopardized when municipalities are given the autonomy to operationalize government policies and distribute services in accordance with their contextual and

demographical needs. The high level of autonomy granted to Norwegian municipalities has consequently lead to the current situation, where the total service offer and how it is organized varies between municipalities in Norway (Ladner et al., 2016). This variation is also a central feature in the findings of this dissertation.

The three municipalities studied, have different approaches to the integration of services. Services in municipality 2 and 3 were characterized by differentiation without the necessary integrative mechanisms, or cultures for ensuring access and continuity of care for service recipients (Løken et al., 2022a). Municipality 1 was the only one who exhibited integrative values in both its organizational and financial structures as well as it's professional practices. This did not imply that this municipality was devoid of economic constraints or did not practice economic reasoning. However, the professionals and managers had the welfare of service recipients as a central value in the practices, a value that served as a point of departure in operationalizing policies for service integration(Løken et al., 2022a; Løken et al., 2022b). Moreover, being a small municipality provided better conditions for integrative work needed to ensure better access and continuity of care for service recipients (Løken et al., 2022a).

Another implication of policies that grant municipalities a high degree of flexibility and autonomy is that they may not be regarded as important. The absence of national oversight and control over municipalities' approaches for integration contributes to it not being a priority. The lack of integrative mechanisms and cultures, leading to poor coordination and continuity of care in municipalities 2 and 3 (Løken et al., 2022b) can be viewed as reflections of this phenomenon.

7.2.3 Balancing the control-trust nexus

Economic performance policies and the associated tool of management performance control seems necessary to reduce the risk of municipal overspending (Verbeeten, 2008). However, such policies and tools create challenges for policy objectives provided through soft governance tools, as in the case of service integration objectives. As I have discussed in this section, the control tools for economic performance policies impede the

integration of health and social care services. It is therefore important for future policy development to recognize the tension between hard and soft governance along with their respective tools for achieving policy objectives.

A central question after this part of the discussion is: how do we adjust the trust-control nexus between the government and the municipalities? One solution can be to implement policy changes that entail financial measures and incentives targeted at integration of health and social care services. An example of this could be financial rewards for coordination and collaboration activities, as well as establishing systems for sharing of costs (Alders & Schut, 2019). This will however also involve elements of control, as there needs to be an assessment of which municipalities and/or services that are eligible for such awards, and which are not. Another way of balancing the trust-control nexus is to find other means of controlling qualitative policy objectives, such as the integration of municipal health and social care services. In the final section of this chapter, I propose an alternative way of controlling and safeguarding qualitative policy objectives.

7.3 The agents of resilience

In previous sections of this chapter, I described how economic performance policies impose challenges for service integration. Additionally, I pointed to the fact that Norwegian municipalities seem to face resource limitations when it comes to meeting the increased demand for mental health and substance abuse services (Gautun & Syse, 2017). Despite these challenging conditions, the findings of this study show that some of the professionals and practice level managers succeed in integrating municipal health and social care services (Løken & Vike 2023, forthcoming).

In this section, I give attention to these professionals and managers, and how their approach to service provision embodies the integrative values of adaptivity, flexibility, robustness, and resilience (Hood, 1991). These values were identified in the first article as being prerequisites for achieving service integration (Løken et al., 2022a). Simultaneously, recent research has identified the same values as important for the sustainability of health and social care services (Ellis et al., 2019; Haraldseid-Driftland et

al., 2021; Ree et al., 2021; Wiig et al., 2020). This recent research addresses resilience as a new paradigm within public health and social care that seeks to understand success factors for increasing quality and safety in service provision, and in turn, use this understanding to improve the care of service recipients. To achieve resilience, it is necessary that both the system and the professionals and managers in it are adaptable, flexible, and robust (Ellis et al., 2019). Furthermore, coordination and collaboration are proposed as important for fostering resilience in healthcare, because service recipients' often need services at different care levels and settings (Wiig et al., 2020). Thus, in this part of the discussion, I explore how the professionals and practice level managers foster resilience in municipal health and social care services by integrating services. The agents of resilience in this discussion are therefore professionals and practice level managers who through adapting to and operationalizing service integration policies, contribute to the development of resilience in the service delivery system (Akpinar & Özer-Çaylan, 2022).

7.3.1 Resilience in the context of municipal health and social care services

Research on resilience in health and social care examines how complex adaptive systems cope, respond, and adapt to pressure, changes, and disruptions (Haraldseid-Driftland et al., 2021; Wiig et al., 2020). As earlier mentioned, the research on resilience in health and social care services is a new paradigm. In this paradigm, people are viewed as positive resources for handling changes and disruptions in complex organizations. However, resilience is also important at the system level. This refers to the system's capacity for flexibility, robustness and adaptability as a response to changing conditions, so that the desired performance is maintained (Ellis et al., 2019). Hence, the resilience paradigm regards both people and systems as resilient, a view that is endorsed in this dissertation. This implies that professionals and managers can be resilient by being adaptive, flexible, and robust in their everyday work, which often involves frequent changes. Furthermore, service systems can also be adaptive, flexible, and robust, enabling it to offer resilient services to the citizens.

In the context of this dissertation, the purpose of resilience is to guarantee access to necessary services, ensure adequate provision of services in line with service recipients' needs, and to maintain continuity of care in the health and social care services. The changes and challenges that professionals and systems should have capacity to respond and adapt to exist at the individual and the organizational level. At individual level, this can be changes in service recipients' health situation, such as worsening of mental health condition or increase in substance abuse. At the organizational level, resilience can be demonstrated as the collective ability to meet the needs of increasing service recipients, especially those with complex life situations who require services from two or more sub-services simultaneously. Professionals and practice level managers are responsible for providing services addressing these changes and challenges (Willumsen et al., 2012). Thus, they are also important resources for fostering resilience through service integration, along with sufficient structures for coordination and information exchange, and arenas for collaborative dialogue.

To foster resilience in health and social care services, it is necessary to cultivate resilience among professionals and managers who manage changes and disruptions in the services (Ellis et al., 2019). As such, in the next two sections I will explore how professionals and practice level managers contribute to fostering resilience in the health and social care services.

7.3.2 How practice level managers foster resilience through service integration.

Managers play an important role in building resilience capacity in professionals, and thereby strengthening resilience in the services (Ledesma, 2014). Resilience researchers have argued that managers support resilience through the strategies they use to engage people in coordinated and collaborative processes. These are processes where possibilities for learning and development are required to maintain high-quality care (Ree et al., 2021). In the following section, I discuss how practice level managers play an important role in building resilience within the services by preparing for coordination, collaboration, and collective learning.

Practice level managers build resilience-capacity in professionals by establishing formal structures and arenas where professionals can be adaptive. The first article illustrated that the integrative values of robustness, flexibility, adaptivity, and resilience are important in organizational structures (Løken et al., 2022a). Furthermore, findings in the third article showed that managers try to build such structures by establishing formal bureaucratic structures for coordination and collaboration (Løken & Vike 2023, forthcoming). Professionals rely on these formal structures to integrate knowledge about individual service recipients' situations with knowledge about organization and system. This allows them to adapt services according to the service recipients' needs (Løken, et al., 2022b). Furthermore, arenas for collaborative dialogue are necessary for reflection and discussion of both individual service recipients as well as service provision in general (Løken et al., 2022b). Both formal structures for coordination and arenas for collaborative dialogue provide professionals with opportunities to collectively adapt to the changing needs and circumstances of service recipients. This individual adaptation can in turn reduce potential risks while increasing service quality and safety for service recipients (Haraldseid-Driftland et al., 2021).

Another important dimension to how practice level managers foster resilience through the integration of services is collective competence. Resilience in health and social care systems is dependent on collaborative dialogue and learning processes across different levels and organizational units (Haraldseid-Driftland et al., 2021). In the second article, I promoted collective competence (Boreham, 2004) as an approach that may enable integration of municipal health and social care services. The findings showed that collaborative dialogue, allow professionals to learn from each other's knowledge. Professionals expressed that they needed to be able to guide and educate each other, and that this should be viewed as a collective responsibility (Løken et al., 2022b). The findings also showed that a collective approach to service integration competence can increase interdependency between professionals with different affiliation. Hence, I posit that through establishing formal structures for coordination and arenas for collaborative dialogue, managers can also contribute to building resilience by simultaneously fostering collective competence (Løken et al., 2022; Ree et al., 2021).

Another important strategy for managers when building resilience through service integration is to promote a collaborative culture (Ree et al., 2021). It is not given that professionals solve problems collectively merely because there are available structures (Kates et al., 2011). Findings in the third article showed that managers who in addition to establish structures, also invested in a collaborative culture, tended to achieve a collaborative environment marked by openness, trust, and respect (Ambrose-Miller & Ashcroft, 2016). This can in turn provide professionals with robust conditions for coordination and collaboration.

7.3.3 How professionals foster resilience through service integration

Findings in this dissertation show that professionals utilize the formal bureaucratic structures that managers establish, and that they need such structures for the development of collective competence required for the integration of health and social care services (Løken et al., 2022). The first article showed that when formal structures for coordination and collaboration are present, this can contribute to service integration to some extent (Løken et al., 2022a). This article also showed that the structures needed to be accompanied by professional approaches marked by the integrative values of flexibility and adaptivity. In the third article I demonstrated how professionals are creative, flexible, and adaptive when they resort to informal ways of collaborating to accomplish important outcomes for service recipients. I used the concept of street-level diplomacy (Gale et al., 2017) to show how two specific diplomacy skills are used when professionals need to increase the efficiency of collaboration, by collaborating outside of the formal structures. These are to build lasting collaborative alliances and to be flexible and creative (Løken & Vike, 2023, forthcoming).

One way that professionals respond and adapt to changes is by building lasting collaborative alliances. The professionals who act as street-level diplomats build relationships through their active approaches to networking, with the purpose of realizing important outcomes for service recipients (Moore et al., 2019). They emphasize the use of communication and respectful attitudes to build trust and commitment in relationships with collaborative partners (Løken & Vike 2023, forthcoming). Through this,

they are enabled to establish lasting collaborative alliances that are useful for provision of services to groups of service recipients as well as individual service recipients. This shows that professional networks and networking skills are not only an important form of social capital in the context of integrative work, but also for resilient services. This is because the collaborative alliances are robust enough to survive for longer periods of time, and they contribute to safeguard access to services and service levels, ensure adequate provision of services, and maintain continuity in the health and social care services (Montenegro et al., 2011; Weaver et al., 2017).

Professionals were creative and flexible when they tried to achieve desired outcomes for service recipients. Creativity and flexibility were used in ad hoc situations to adapt to the changes in service recipients' health conditions, and to establish the collaborative alliances mentioned above. Professionals used creative and flexible ways of collaborating because they experienced the structures for coordination and collaboration as insufficient. One example of this was a GP who initiated an interprofessional collaborative alliance with a private practicing psychiatrist. Subsequently, the GP and psychiatrist were able to give the service recipients a comprehensive treatment which led to recovery (Løken & Vike 2023, forthcoming). As such, the GP improved the service quality and safety for this service recipient. The improvement of service quality and safety is an important aim within the resilience paradigm. Creativity and flexibility therefore constitute important components within professional discretion in both service integration processes, as well as in the fostering of resilience in health and social care (Haraldseid-Driftland et al., 2022)

A key aspect to consider in this part of the discussion is that professionals who exercised street-level diplomacy in their work, had many years of experience in the service field. Street-level diplomacy requires knowledge and experience, and as such newly educated professionals can lack these resources to do this type of diplomacy work.

7.4 A proposition for the future development of municipal health and social care

Research on resilience provide knowledge required to increase and improve quality and safety for service recipients. To understand and promote resilience, we need to explore the underlying collaborative learning mechanisms of adaptation or improvisation, which is happening when people in the services act on changes and challenges (Wiig et al., 2020). In this regard I argue that street-level diplomacy can contribute as a concept to understand how professionals adapt and improvise to address changes and challenges. Valuable insights can be gained focusing on professionals and managers who actually succeed in integrating services, as they thereby play an important role in fostering resilience within these services.

Furthermore, I propose that future development of municipal health and social care should focus on empowering professionals and managers to provide resilient services. Challenges arising from addressing the growing number of service recipients with complex health conditions, can lead to capacity limitations and compromise the safety and quality of municipal health and care services. However, by investing in the capacity of practice level managers and professionals to respond to such issues, national authorities can trust Norwegian municipalities to provide safe and high-quality services. On the same note, service integration can also foster resilience in municipal health and social care services to overcome some of these challenges. It is therefore imperative that service integration is at the forefront of future qualitative policy objectives.

Investing in the capacity of practice -level managers and professionals to respond to changes and challenges can be done in the education of health and social care professionals. Moreover, the importance of continuous interprofessional and interorganizational learning may indicate a need to invest more resources to this type of educational work. It is essential to prioritize the knowledge and skills related to integrative work, including street-level diplomacy, as this can contribute to the better integration of services as explained earlier.

8 Conclusion

The overall aim for this dissertation was to explore how municipal professionals and managers adapt to and operationalize policy regarding the integration of health and social care services. Adapting to, and operationalizing these policies is not a straightforward administrative process, but something that must be accomplished at all levels of the municipal organization.

Researchers have argued that professionals' and managers' accountability to organizational objectives have liberated them from dilemmas regarding autonomous decision-making (Taylor & Kelly, 2006). I would rather argue that accountability to economic objectives increases the number of dilemmas in their everyday work. Performance management tools within economic performance policies prevent professionals and managers from effectively adapting to policies regarding the integration of services. This situation needs to be addressed in the future design of policies for service integration, as well as other proposals for quality improvement in municipal health and social care services. Furthermore, the integrative values of adaptivity, flexibility, robustness, and resilience should be at the forefront of policy development.

The Norwegian government's trust in municipalities to realize the policy objective of integrated health and social care services seems to exceed the actual capacity of some municipalities to achieve this. This dissertation unveiled the different operationalizations of government policies through the distinct organizational pathways and approaches three municipalities adopted for service integration. This resulted in variations in how health and social care services were provided to service recipients with concurrent mental health and substance abuse challenges. Such variance raises the question of whether there is a need to reevaluate the decentralized organizational model, where municipalities are responsible for implementing primary health and social care policies on behalf of the government. Additionally, this variance in care services between municipalities has implications for the underpinning ideology of universalism in the Norwegian welfare state. When service recipients receive integrated services in one

municipality but not in the next, one may conclude that the aim of universalism is under great pressure.

The findings in this dissertation point to professional approaches and organizational cultures as the cornerstones of a sustainable and resilient service system. Furthermore, the findings highlight professionals' and managers' capacity to respond to changes and challenges, for the sake of fostering resilience in health and social care services. This highlights the importance of directing resources towards education, training, enabling, and empowering of professionals and managers, rather than towards costly re-organizations. There should be a greater investment in developing resilient professionals who can contribute to resilience in municipal health and social care services.

8.1 Strength and weaknesses of the dissertation

This dissertation focused on a small sample of three municipalities, which represents a small fraction of the total number of over 350 Norwegian municipalities. This means that not all Norwegian municipalities can fit the descriptions provided in this study. While this may limit the representativeness of the findings, the findings offer important theoretical and practical insights into the adaptation and operationalization of integration policies for municipal health and social care services. The strength of a single case study lies in the cogency of the theoretical reasoning. Thus, I have attempted to motivate, inspire and illustrated the empirical findings with the use of theory (Siggelkow, 2007). This has given me the opportunity to have conversations between the empirical material and the theories. The combination of empirical and theoretical analysis has hopefully contributed to findings that are perceived as transferable to readers with different professional backgrounds and mandates.

The Covid-19 pandemic affected the data collection for this PhD-project. This resulted in fewer participants for the second article than originally planned. Additionally, I did not get the opportunity to carry out all the planned focus-group interviews and had to resort to individual telephone interviews instead. This may entail methodological limitations for

the dissertation, which may be seen as detracting the reliability. Simultaneously, I have taken great care in including the voices of all the included stakeholders.

The decision to include service recipients and family caregivers as participants in the data collection was important for this study, because they have valuable knowledge concerning the municipal services, and how these services are perceived. However, during data collection I spent more time together with professionals and managers than I did with service recipients and family caregivers. This is because it was challenging to recruit service recipients and family caregivers as participants. If I were to do this PhD-study again, I would be better prepared for the recruitment challenges, and try other strategies to include even more service recipients and family caregivers for interviews.

The triangulation of contexts, methods, and voices resulted in a comprehensive data material which may be viewed as a strength for this dissertation. This is because the data enabled analysis of how factors at the system, organization, and practice-levels influence the adaptation and operationalization of service integration policies. To my knowledge, there are few empirical studies currently available, that display the interrelationship between these levels within the field of service integration research. This dissertation can therefore contribute to fill this knowledge gap.

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Articles

Article 1

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Being bound and tied by the ropes of frugality: a case study on public management values and service integration

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Abstract

Purpose – New Public Management (NPM) has increased fragmentation in municipal health and social care organizations. In response, post-NPM reforms aim to enhance integration through service integration. Integration of municipal services is important for people with complex health and social challenges, such as concurrent substance abuse and mental health problems. This article explores the conditions for service integration in municipal health and social services by studying how public management values influence organizational and financial structures and professional practices.

Design/methodology/approach – This is a case study with three Norwegian municipalities as case organizations. The study draws on observations of interprofessional and interagency meetings and in-depth interviews with professionals and managers. The empirical field is municipal services for people with concurrent substance abuse and mental health challenges. The data were analyzed both inductively and deductively.

Findings – The study reveals that opportunities to assess, allocate and deliver integrated services were limited due to organizational and financial structures as the most important aim was to meet the financial goals. The authors also find that economic and frugal values in NPM doctrines impede service integration. Municipalities with integrative values in organizational and financial structures and in professional approaches have greater opportunities to succeed in integrating services.

Originality/value – Applying a public management value perspective, this study finds that the values on which organizational and financial structures and professional practices are based are decisive in enabling and constraining service integration.

Keywords Service integration, Public management values, Organizational structures, Financial structures, Professional practice, Mental health and substance abuse

Paper type Research paper

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Introduction

Health and social care reforms are aimed at organizational renewal (Pollitt, 2013), and they carry public management values that change both working conditions for professionals and services for service recipients (Franco *et al.*, 2002). The purpose of this study is to demonstrate how these values influence service integration in municipal health and social care organizations.

As in other Western countries, several elements in the health and social care reforms in Norway have been inspired by values of New Public Management (NPM) (Nesvaag and Lie, 2010). These reforms affected organizational and financial structures by dividing public health and social care organizations into single- or few-purpose organizations with separate funding streams, each pursuing defined sets of goals and tasks (Christensen and Lægreid, 2007). The reforms also increased municipal responsibilities, placing professionals and managers under great pressure to achieve tight financial discipline and to organize their services in a cost-effective manner (Vabø, 2009). In response, later health and social care reforms known as post-NPM aimed to address the challenges brought on by fragmentation, by enhancing organizational integration and collaboration (Lægreid *et al.*, 2015). Although these reforms offer additional governance concepts to guide the complex issues that public sector organizations are required to handle, fragmentation due to organizational structures still is a challenge (Steihaug *et al.*, 2016).

Integrated health and social care services have been promoted as a means to improve access, quality and continuity of services in a more efficient way (Valentijn *et al.*, 2013). This can be done through a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels in order to create connectivity, alignment and collaboration within and between organizational units (Kodner and Spreeuwenberg, 2002). This implies delivery of coordinated services that require collaboration, along with effective and efficient information transfer and resource management. This enables professionals to ensure that services are holistic, person-centered, relevant, well planned and supportive of self-management (Ehrlich *et al.*, 2009; Montenegro *et al.*, 2011).

Without integration, service recipients risk poor access to services, lack of continuity and inadequate provision for their needs (Montenegro *et al.*, 2011). Integration is especially important for people with complex health and social challenges, such as people with concurrent substance abuse and mental health problems, henceforth called "service recipients" (Mueser *et al.*, 2003). They often have complex and multiple needs in connection with their substance abuse and mental health challenges, in addition to physical health problems (Dickey *et al.*, 2002) and social challenges related to housing, finances and employment.

Internationally, the NPM doctrines have shaped the structures and practices of municipal health and social care organizations, but there are few empirical studies of the actual effects of NPM reforms on public service provision (Lapuente and Van de Walle, 2020). At the same time, there is a growing recognition that the organizational and financial structures are impeding patient access and outcomes (Miller, 2016; Stokes *et al.*, 2018). The aim of this article is twofold. The first part is empirical, where we investigate how organizational and financial structures and professional practices hinder and enable service integration. The second aim is theoretical, where we aim to explore public management values' influence on structures and practices in relation to service integration. The question to be answered is as follows: how do public management values influence service integration in municipal health and social care organizations?

Norway follows a welfare model where public financing and high and equitable service quality standards are key factors (Kautto *et al.*, 2001). Through the well-established principle of local self-government (Baldersheim and Ståhlberg, 2002), the ambitions of the Norwegian welfare state are to a great extent carried out in municipalities that vary in organization, size,

finances, geography, resources and infrastructure (Baldersheim and Ståhlberg, 2002). While Norwegian municipalities in principle have considerable responsibility for public health and social care, they are dependent on state allocation and reallocation to provide services (Sørensen *et al.*, 2007).

Theoretical framework

Health and social care reforms carry values that change organizational and financial structures, and these structures provide the division of tasks and hierarchies that determine professional practice and discretion (Drucker, 2007). This means that the structures, by effectively limiting professionals' power, control their ability to make choices among possible courses of action. In this way, the structures can both constrain and enable professionals in assessing, allocating and delivering integrated services.

There seems to be a lack of knowledge in terms of a suitable theory to link the concepts of public management values, organizational and financial structures and professional practices. Hence, our theoretical aim seeks to tie these concepts together and demonstrate the implications for service integration. Hood (1991) described core values that influence reforms and shape the organizational design of public services. According to him, values related to economy and frugality are often associated with NPM, with matching of resources to defined tasks and goals, and breaking up organizations into single- or few-purpose units. Such values emphasize trimming of expenditure, frugality of resource use and heavy emphasis on economic reporting, and they are often carried out in organizations with mechanistic structures (Hood, 1991). They also have a reputation for having a negative effect on other important values. On the other hand, values associated with the post-NPM goal of integration are flexibility, adaptivity, robustness and resilience. Capacity for resilience is related to the extent to which interdependent parts of the system are integrated in decision and information terms (Hood and Dixon, 2015). A suitable organizational design for such values is one that recognizes that a certain degree of slack is needed in order to provide spare capacity in uncertain environments (Vabø, 2009) and with a task division structure organized for collective thinking rather than silo thinking (Hood, 1991).

Hood's theory on public management values focused on the shaping of organizations' structural design. We propose that service integration needs to be conceptualized in terms of structures *and* professional practices driven by values that promote integration. We aim to elaborate on Hood's theoretical concept of core values by showing how these values shape and affect both structures and professional practices, and why this has implications for *service* integration. We do this by applying the public management values associated with reforms labeled NPM and those labeled post-NPM to the findings. These are henceforth called frugal and economic values and integrative values. In the discussion, our findings inform how different combinations of frugal and economic values and integrative values within organizational and financial structures and professional practice either conflict or harmonize and therefore have different implications for service integration. As public management values are drivers for change in the field of service delivery (Ackroyd *et al.*, 2007), the study of these can enhance understanding of integration in the complex and unstable environment in which public health and social care services operate (Jørgensen and Bozeman, 2007).

Research design and methodology

As we wanted to dig deep into service integration processes and bring evidence together from multiple sources, qualitative case study was a suitable design. Moreover, our aim to use the in-depth understanding of a "case" to build theory and offer new contributions to the existing knowledge base was coherent with the aims of case studies (Yin, 2009). Public management

values' influence on service integration in municipal health and social care organizations formed the case, with three Norwegian municipalities as case organizations. In order to gain sufficient amount of information about integration processes, we used purposive sampling to include municipalities with diversity in organizational structure and professional practice (Seawright and Gerring, 2008). These two elements were given equal status throughout the research process and enabled understanding of the researched phenomenon. In this study, the degree of complexity in organizational and financial structures and professional practices increased with the size of the municipality.

Context and participants

Municipality 1. Approximately 3,000 inhabitants and 15 people registered with concurrent substance abuse and mental health challenges. Mental health and substance abuse services are organized, financed and managed as one department under a larger unit with a unit manager. The municipality has no specific housing for the target group. Physical healthcare is provided by home nursing and one care facility.

Municipality 2. A population of approximately 30 000 and around 100 people registered in the target group. There is a unit for mental health and substance abuse, led by a unit manager. The services are divided into a mental health department, a substance abuse department and a staffed housing complex for people with mental health diagnoses; all of these have individual department managers and budgets. There is also an assessment team, which collaborates with specialist substance abuse services. Physical healthcare is provided by home nursing and several care facilities.

Municipality 3. Approximately 52 000 inhabitants and over 300 people registered in the target group. The organizational structure is complex. One unit contains all the mental health services: a mental health department, a staffed housing complex, three activity centers, one Flexible Assertive Community Treatment (FACT) team and one mental health and substance abuse outreach team. The departments and teams have separate budgets, but the FACT team has joint funding with the district psychiatric center, which provides specialist healthcare. Here, substance abuse services are organized as a department under the Norwegian Labor and Welfare Administration. Physical healthcare is provided by home nursing and various care facilities.

The empirical data consist of observations of 12 meetings (see Table 1) and 16 semi-structured in-depth interviews with 17 professionals, department managers and unit managers (see Table 2). Recruitment was purposive, through the managers of these services (Creswell and Poth, 2018). Data collection took place from May to August 2019.

When seeking meetings to observe, we wanted to include interprofessional and interagency meetings where services for people with concurrent substance abuse and mental health challenges were discussed, assessed and allocated and where decisions were made. Managers who knew the organizations well were responsible for selecting the meetings, and the size of the municipality was a contributing factor in the selections. In the small Municipality 1, there were few interprofessional and interagency meetings to observe. This resulted in opportunities to observe two meetings where service recipients also participated, although this was not a selection criterion. The same opportunity did not occur in Municipalities 2 and 3. The observations were

Municipality	Title of meeting	Number of participants	Service recipient included	Interprofessional	Interagency
1	Responsibility team meeting	3	Yes	Yes	Yes
1	Responsibility team meeting	3	Yes	Yes	Yes
1	Decision meeting	5	No	Yes	No
2	Department meeting, mental health	4	No	No	No
2	Department meeting, addictions	5	No	No	No
2	Decision meeting, mental health	2	No	No	No
2	Decision meeting, addictions	2	No	No	No
3	Meeting based on statements of concern	5	No	Yes	Yes
3	Housing meeting	6	No	Yes	Yes
3	Housing meeting	8	No	Yes	Yes
3	FACT meeting	7	No	Yes	No
3	Collaborative meeting concerning patients being discharged from hospital	13	No	Yes	Yes

Table 1.
Observed meetings

performed by the first author, with an overt nonparticipant observation role (O'Reilly, 2012). Field notes were taken and coded to maintain participant anonymity. In our presentation of observational data, the service recipients have been given pseudonyms.

For the interviews, we recruited participants with over two years of experience and substantial knowledge of the services, whose work involved assessment and allocation or management. The recruitment resulted in seven professionals, seven department managers and three unit managers, all of whom had influential power in the observed meetings. We conducted the interviews at the participants' workplaces. The interview guide contained three themes concerning organizational and financial structures and professional practices, with follow-up questions depending on what the participants stated. All interviews were individual, except for one where two consultants wished to be interviewed together, due to their work schedule. Interviews were audiotaped, transcribed and anonymized.

The study was approved by the Norwegian Center for Research Data (ref. no. 300488), and exemptions from the duty of confidentiality were granted by the South-Eastern Norway Regional Committee for Medical and Health Research Ethics (ref. no. 2019/299 REK Sør-Øst). Comprehensive information about the study was provided orally and in writing to managers in the departments and units of interest and distributed to the participants. The participants signed an informed written consent.

Analysis

The dataset, consisting of observation reports and transcribed interviews, was analyzed both inductively and deductively. There was a dynamic interplay between the observation reports and the interviews, where the latter informed the processes observed in the meetings. This gave us an opportunity to find descriptions and explanations for the observed events in the interviews, and of that reason, both types of data were analyzed synchronously. In the

Municipality	Educational background	Role	Department/unit	Age	Sex
1	Nurse	Professional	Mental health and substance abuse department	50–59	F
1	Nurse	Department manager	Home nursing	50–59	F
1	Nurse	Unit manager	Unit for family and health	60–69	F
1	Social educator	Department manager	Mental health and substance abuse department	50–59	F
2	Nurse	Professional	Department of mental health	40–49	M
2	Social worker	Professional	Department of substance abuse, and assessment team	50–59	F
2	Nurse	Department manager	Department of mental health	40–49	F
2	Nurse	Department manager	Department of substance abuse	40–49	F
2	Nurse	Unit manager	Unit for substance abuse and mental health	60–69	F
2	Social educator	Unit manager	Unit for generic services	50–59	F
3	Nurse assistant	Professional	Mental health and substance abuse team	50–59	M
3	Social educator	Professional	FACT team	40–49	M
3	Nurse	Professional	Department of mental health	30–39	F
3	Nurse	Professional	Department of mental health	40–49	F
3	Social educator	Department manager	Department of mental health	30–39	M
3	Nurse	Department manager	Department of substance abuse	30–39	M
3	Nurse	Department manager	Home nursing	50–59	F

Table 2.
Participants for interviews

inductively driven coding process for the empirical part of our aim, we were inspired by a stepwise deductive-inductive approach (Tjora, 2019). In this phase, we searched the material for patterns and discussed the development of codes, code groups, themes and concepts. The initial analysis resulted in 244 empirically close codes, which we developed into five code groups. For example, the empirically close codes "The municipality has no staffed housing for people with substance abuse problems" and "We lack sufficient resources in terms of housing and staff" were categorized in the code group "Financial aspects affecting integrated services in housing and care facilities". Later, the code groups were recategorized and refined, resulting in three main themes: (1) variations in approaching and organizing integration in mental health and substance abuse services, (2) structures and practices hindering access to physical healthcare and (3) structures and practices hindering allocation of housing. The findings in these main themes are presented by each case organization in the results. As public management values influence structures and practices (Drucker, 2007), we were interested in studying how they specifically influence integration of municipal health and social care services. To explore this in the deductive phase, we applied public management values (Hood, 1991; Hood and Dixon, 2015) to the findings. To work systematically, we made a table (see Figure 1) that shows four different combinations of public management values in organizational and financial structures and professional practices and searched the material for representations of these combinations. By doing this, we could address the possibilities and limitations the values have for service integration and thereby outline some implications.

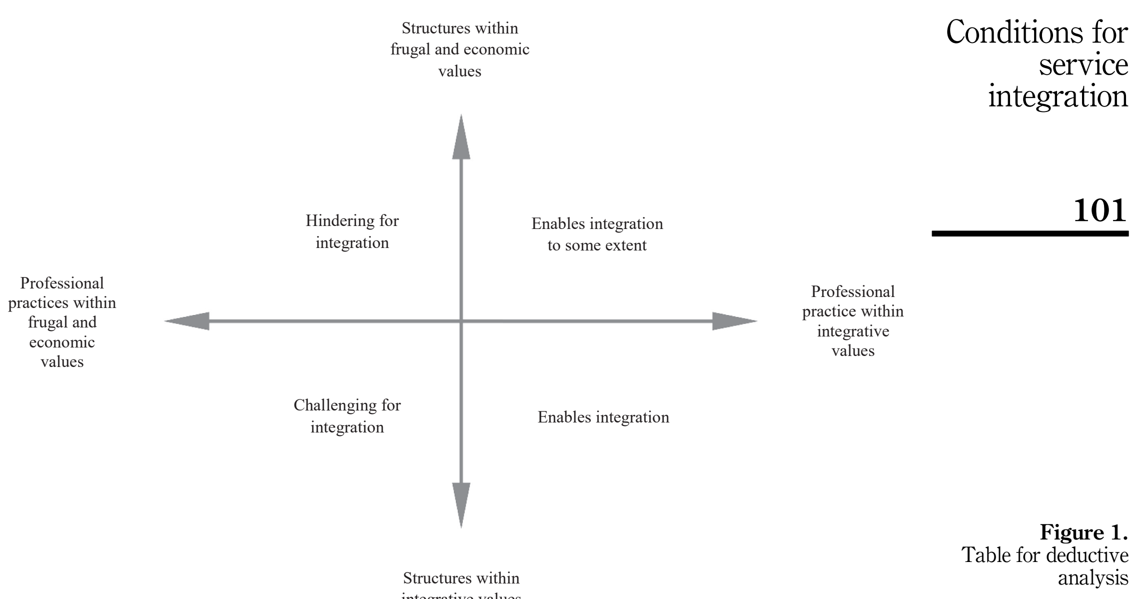

Figure 1. Table for deductive analysis

Findings

Variations in approaching and organizing integration in mental health and substance abuse services

The small size of Municipality 1 enabled professionals to maintain a good overview of the service recipients' situation and of their service providers. In the integrated mental health and substance abuse department, we observed that the professionals utilized their respective competencies through daily discussions in order to help and guide each other and performed interprofessional assessments of new service applicants.

> I think we've now found a system that works. It's all based on consent. That puts the patient in the center. They're the ones who control this. (Department manager, M1)

Putting the service recipient in the center laid the groundwork for service user involvement. The following extract demonstrates this approach:

Together in a meeting with Bobby were his municipal substance abuse counselor and a social worker from a specialist outpatient clinic. They were planning for detoxification and rehabilitation. Bobby talked about the changes that had happened after he started receiving municipal help. He had gotten a better and tidier apartment, was eating healthier food and had sorted out some of his finances, and now he felt more motivated to become drug-free. The substance abuse counselor kept Bobby's needs, worries and motivations at the center of their discussion by asking questions, supporting him and adjusting the plan according to his needs. (Extract from field notes)

The person-centered approach was noticeable through the involvement of Bobby and constant adjustments throughout the meeting. When asked about how the substance abuse counselor approached Bobby's mental health challenges, she explained as follows:

> I ask questions to my co-workers in department meetings, since I do not have further education in mental health. We help and guide each other in our respective cases. (Professional A1)

The structural division in Municipality 2 into two mono-professional departments meant that professionals and managers could more easily help people with well-defined and relatively simple needs than those with complex needs. The department managers alone decided which department new service applicants were to belong to, based on what they perceived to be the dominant problem. It was considered too costly to provide services from both departments simultaneously.

> We have to think about what the patient needs. And then money's part of it, because they're not really supposed to get both mental health and substance abuse services at the same time. (Professional A11, substance abuse department)

Although we observed in meetings that the service recipients often had dual challenges, they received services for either their mental health needs or their substance abuse.

The departments were organized as one unit; *however, they* never integrated resources.

> There's no reason why I cannot ask someone in the substance abuse department to work in the mental health department. But we do not have a lot of resources, and I'll only move someone if they want to move. (Unit manager M6)

The integrative possibilities in the structures were not utilized. The co-location allowed for collaboration between the departments, an opportunity that was only used in ad hoc situations and not through systematic information exchange and decision-making.

Municipality 3 had many service recipients with complex life situations, a variety of services to offer and different ways to access them. This meant that people often received services in an arbitrary manner. The substance abuse department rarely found that people applied for their services. It was rather a situation where people approached them if they had financial or housing problems. By contrast, the mental health department received many applications, which were assessed comprehensively.

> They describe their wishes and needs to the municipal services, and then we have to find out from where, from the lowest to the highest level, we can cover it. (Professional A9, mental health department)

Professionals and managers arranged various interagency meetings in order to coordinate services, exchange information and make decisions across the structural divisions. Despite the meetings, coordination and continuity was challenging. A professional in an observed meeting expressed as follows:

We have to reflect upon the fact that these people are very sick. We have to see the consequences of actions and decisions, and approach the entirety of the situations. (Extract from field notes)

The professional experienced that the services failed to provide continuity for severely ill service recipients. Meanwhile, another integrative mean was the establishment of interprofessional teams. One manager characterized the framework for interprofessional outreach teams as advantageous for service recipients.

> They're like glue and lightning conductors for many other services. They do not have many clients compared to other services and they work evenings too, so I reckon the clients who have that team are lucky. (Manager M11, mental health department).

The framework enabled teams to be flexible in the time they spent on service recipients, which they argued was necessary to adapt to the complexity and uncertainty in service recipients' lives. This involved taking responsibility for coordination and being supportive and actively involved in contact with other relevant services. Because of this, the professionals in the outreach team prioritized building close relationships with their partners within and outside municipal services.

Structures and practices hindering access to physical healthcare

Professionals in all three municipalities reported challenges when service recipients also had physical healthcare needs. The criteria for access as well as attitudes towards the service recipients could make access difficult.

As many of the mental health and substance abuse staff only worked day shifts, responsibility for service recipients' unanticipated needs was often handed to home nursing, which had round-the-clock services. Home care nurses reported challenges in fulfilling these responsibilities.

> The necessary information is unavailable. We work 24/7 and we have to deal with people in all kinds of settings. We feel insecure if there is not good enough information about how they function and about the challenges. (Manager M4, home nursing)

The lack of available information could result in professionals feeling insecure with service recipients, which could affect the quality of service provision.

Municipality 1 had one care facility with good capacity for new patients and was not as strict regarding admission criteria as the two other municipalities. However, the professionals reported that the facility lacked competent staff to take care of service recipients with severe mental health or substance abuse problems. Since the municipality lacked a suitable care facility for these service recipients, they had to pay for admission to private facilities.

Even though they had a variety of care facilities and residential care homes, some of the participants in Municipality 2 described barriers to access for service recipients.

> There are no residential care homes for people with mental health problems or substance abuse and they are not a group that necessarily fits in or is wanted everywhere. (Manager M5, substance abuse department)

This quote points to certain criteria for fitting in and that these people may be unwanted, which are barriers to access to general healthcare facilities. One manager described the decision-making processes for such facilities as a struggle. Due to both criteria and attitudes, service recipients were thrown back and forth in the system, experiencing multiple rejections.

A discussion concerning Peter's situation in an interagency meeting based on statements of concern showed similar processes in Municipality 3:

Present were managers of five organizational units. Peter was 67 years old and lived in a private for-profit staffed housing complex due to his mental illness. He did not fulfill the criteria for continuing to live there, as he had developed a need for physical healthcare, which the mental health professionals did not provide. Peter was on a waiting list for admission to a care facility for people with substance abuse, even though he was currently clean. One manager questioned this, as it meant that he did not fulfill the admission criteria there either. Another manager expressed frustration that he "fell between two stools." Eventually, they decided on a short-term stay in a general care facility, although they were aware of the unfortunate consequences for Peter, due to staff numbers and lack of competence. In the end, a manager suggested that it would be better if Peter was in active substance abuse, as this would make him entitled to the admission he had applied for initially. (Extract from field notes)

This can be understood as an example of adapting service recipients to organizational structures, instead of structuring the services according to service recipients' needs. In Peters' case, his needs always diverged from the criteria.

Structures and practices hindering allocation of housing

All three municipalities experienced an increase in the number of service recipients, due to different reforms and incentives. One example was the process of downscaling residential

institutions. This reform shifted the responsibility for severely ill people from specialist healthcare to municipal services and increased pressure to allocate staffed and independent housing. In addition to fulfilling a common basic need, people's homes were also a setting to receive municipal care services. For people with complex situations, who were not entitled to treatment in specialist healthcare, municipalities occasionally paid for staffed housing in private facilities.

The main challenge for Municipality 1 was its status as small and rural. There were no homeless people, but also no municipal staffed housing. The mental health and substance abuse department was responsible for two people for whom they had to pay for housing in private facilities.

> Because the person was declared untreatable, specialist healthcare could not pay for it. *It* soon broke our budget, because we do not have that money. (Unit manager, M2)

When this person was declared untreatable, the responsibility was shifted to the municipality. The money for this was to be found within the unit, which led to overspending. Accordingly, this situation required cost cutting in other departments and an extra focus on prioritizing resources. As the municipality was very small, the establishment of staffed housing was not an option.

Municipality 2 had staffed housing for people with mental illness, but none for people with substance abuse problems and had no financial resources to pay for housing in private facilities. Instead, the professionals tried to meet the service recipients' needs with home-based services, as this was considered more cost-effective. Not all service recipients could handle such a solution, as they were too unstable to be able to live alone and receive help from different providers simultaneously. Managers close to service delivery level who were responsible for the budget felt pressure in such situations.

> There's a lot of silo thinking here in decision making. And they really make you responsible for your budget. I often find people shift responsibility for particular service recipients. Especially when they cost a lot of money. (Manager M8, physical healthcare)

The complex situations of some service recipients necessitated comprehensive services, generating high costs. Because a well-balanced budget was a key measure of success, the managers and professionals tried to negotiate themselves out of taking responsibility for service recipients, thus protecting their finances. The following quote illustrates this protective behavior:

> In meetings, it's easy to pass the buck. You do not say, 'How can we solve this together?' I mean the holistic approach. A bit more willingness and effort to help the person to get better. And then we have to work together. And I think that's all connected to the system. (Professional A12, mental health department)

This professional observed that shifts of responsibility were common in decision-making processes and called for both attitudinal and structural changes.

In Municipality 3, we observed John's situation being discussed in a housing meeting. This illustrated the demanding situation and the possible unintended consequences of a lack of independent and staffed housing for service recipients.

John had a heavy substance abuse problem and a severe psychotic disorder. He had recently been discharged from hospital and was on a waiting list for admission to private nonprofit staffed housing. A manager who knew John well expressed emotional and engaged thoughts about many service recipients being too sick to endure long periods of waiting for housing. John had been discharged against the manager's will. The manager had been furious in a meeting with the hospital earlier that day, advocating for John's need and right to treatment. Due to the lack of suitable municipal apartments during the waiting time for

admission, John was left homeless and became more psychotic. Now, the manager sadly stated, John had been missing for quite some time, and the manager was afraid he was dead. (Extract from field notes)

In this case, the manager expressed his concerns about how the lack of housing could lead to tragic outcomes. He wished for a greater emphasis on holistic and integrated approaches *to* prevent similar situations in the future.

Due to the lack of staffed housing, the municipality purchased such services in private facilities. The units and departments never integrated resources, and the process of deciding which unit or department should pay for these costly services was often left to the managers close to direct service delivery:

> It's not good when the budget for substance abuse is here and dual disorders are both mental health and substance abuse. Sometimes we discuss what actually came first so we can avoid paying. (Manager M9, substance abuse services)

The discussions referred to in the quote were a common way of trying to avoid financial responsibility for services provided to certain service recipients. The decision-making processes were described as shifts of responsibility in an attempt to protect the budget of each unit. This was regarded as ethical dilemmas, which often hindered service recipients' access to suitable housing.

Discussion

The findings draw a picture of professionals being unable to fulfill their mandate on behalf of the service recipients. Opportunities to assess, allocate and deliver integrated services were limited because the most important aim was to meet the financial goals and avoid red numbers in the budgets. At the same time, we found that when organizational and financial constraints were reduced and the context was small and manageable, as in *Municipality 1*, it was easier for professionals to meet service recipients' needs with person-centered and integrated service approaches. In contrast, the two larger municipalities with greater complexity in organizational and financial structures had stronger hierarchical management and barriers to integration and needed to be more frugal in decision-making processes. However, the largest Municipality 3 had a greater range of means at its disposal to enable integration, such as coordination through interagency meetings and establishment of interprofessional teams with strong coordination functions. Finally, we found that there were challenges for Municipality 2, who was in the middle ground between simple and complex organizational structure. It was too large and complex to possess the same contextual advantages for integration as Municipality 1 and too small and simple to have such a wide range of integrative measures as Municipality 3.

We found hindering and enabling factors for service integration in both organizational and financial structures and professional practices and were interested in studying how they are influenced by public management values. Our theoretical aim is to link the concepts of public management values, organizational and financial structures and professional practices and demonstrate the implications for service integration. We found four different combinations of frugal and economic values and integrative values in structures and practices, which we will further elaborate on below.

Frugal and economic values in both structures and professional practices

When organizational structures are characterized by frugal and economic values, these strongly articulated values incentivize the professionals or force them to adapt to these structures with the same values. This combination of values results in territorial behavior,

preventing professionals, units and departments from sharing and integrating resources (Axelsson and Axelsson, 2009).

For home nursing in the three municipalities, accessible and available information is part of the organizational support structures essential for feeling safe in interaction with service recipients. Disaggregation, an outcome of organizational structures within frugal and economic values, challenge sufficient information exchange, as units and departments are organized with different purposes, budgets and management, creating single-purpose units (Ashkenas *et al.*, 2002). Such structures reduce the capacity for resilience, as the professionals act independently of each other. When home care nurses lack helpful organizational and financial structures and an organizational culture with values that promote collaboration, integration of home care will be hindered.

The value of frugality by matching resources to tasks and goals materializes as criteria for access to physical healthcare facilities in Municipality 2 and 3. In this way, some service recipients, such as Peter, neither fit in nor are welcome. Due to separate financial and management structures, the professionals lack common objectives, which creates incentives to shift service recipients and costs to other units and departments (Kalseth *et al.*, 2015) rather than encouraging interdependency in decision making. This often results in rejections of service recipients, which can be regarded as structural stigmatization (Knaak *et al.*, 2017), an unfortunate outcome due to frugal values within the structures. The financial structures in particular are too tight around the discretionary latitude. This prevents professionals from adequately assessing needs for integrated services (Ponnert and Svensson, 2016) because the frugal values in the structures simply will not allow it.

Similar processes also occur regarding allocation of staffed housing in the same two municipalities. Since they do not have municipal staffed housing facilities, they consider buying this from private for-profit organizations if the service recipient has a severe and complex life situation. This is a solution that generates high costs, and the professionals are forced to adapt to the organizational and financial situation with frugal strategies by trying to meet service recipients' needs with comprehensive home-based services instead. Although the latter solution is considered the most cost-effective, both solutions generate high costs, which encourages territorial behavior and shifts of responsibility (Axelsson and Axelsson, 2009), instead of preparing for interdependency between professionals. This behavior usually entails discussing whether the mental health challenges or substance abuse challenges are most dominant in an attempt to avoid responsibility for the financial burden involved. This, in turn, has proven to have a major impact on which services people receive and which they are unable to access (Groenkjaer *et al.*, 2017).

Despite displaying frugal values in decision-making, professionals and managers call for integrated approaches, as in the tragic case of John. This demonstrates the conflict between values within organizational and financial structures on the one hand and values within professional practices on the other hand. Frugal values challenge professionals' opportunities to exercise discretion in order to work in an integrated manner because their discretionary latitude is limited. The financial structures in particular ensure that the decision-making processes are consistent with the objective of cost-efficiency and balancing budgets, which implies that professionals have few alternative courses of action to frugal strategies.

Frugal values in structures and integrative values in professional practices

In this combination of values, we find frugal and economic values within the organizational and financial structures and integrative values in the professional practice. The managers and professionals adapt to the frugal organizational and financial structures by establishing integrative initiatives, which may enable integration in some cases, as found in Municipality 3. This large municipality, consisting of many independently structured units and departments,

with sharply defined responsibilities, forms a highly complex and fragmented organizational landscape (Glouberman and Mintzberg, 2001). The complexity makes integration difficult when professionals attempt this through coordination in interagency meetings. At the same time, the coordinating role of professionals in interprofessional teams is an important contribution we bring to the research on integration. These teams have organizational structures where health educated and social care educated staff are integrated, and they have more robust financial structures than in the rest of the service system. In this way, the municipality creates smaller organizational units where professionals work interdependently, within an otherwise complex and fragmented organizational landscape. When coordinators work within such structures, they are able to be flexible and adaptive (Vabø, 2009) and to breach the structural boundaries for the service recipients (Santos and Eisenhardt, 2005), all of which are important values in integrative work. This is done by prioritizing close professional collaboration, as the coordinator builds integrated networks in processes with and around service recipients (Darcis and Thunus, 2020). This gives us reason to argue that when the values robustness, flexibility and adaptivity are emphasized in professional practice, service integration can be enabled.

Integrative values in structures and frugal values in professional practices

In this combination, we find the integration, robustness and flexibility in organizational structures, which accommodate integration. Professionals and managers adapt to these structures with frugal and economic values, associated with NPM. Findings in this relationship can indicate that although the structures accommodate integration, professionals and managers think and act based on the values of NPM doctrines (Lapuente and Van de Walle, 2020).

The mental health and substance abuse services in Municipality 2 are co-located and organizationally structured as an integrated unit with a unit manager. Although integration of financial resources has proven to increase robustness and promote collaboration (Tsiachristas *et al.*, 2013), the services in Municipality 2 are managed and financially structured as two mono-professional departments. In the absence of management that promotes visions and goals for the entire unit, the professionals continue to work in silo fashion, even though they are co-located (Bussu and Marshall, 2020). Their poor collaboration in information exchange and decision-making and the structures of financial distribution constrain their capacity to achieve integration. In the case of Municipality 2, this results in service recipients receiving services for either challenges related to substance abuse or mental health. When services is marked by an authoritarian barrier to collaborative culture in the hierarchical structures (Hood, 1991), the result is a professionally fragmented service system with no professional interdependency, which is highly detrimental to service integration (Willumsen *et al.*, 2012).

Integrative values in both structures and professional practices

When the values represented by organizational and financial structures and professional practices are both integrative values, integration is enabled. We find this combination of values in Municipality 1, who due to the small and easily overviewed context have a relatively simple organizational structure with resources and staff for both mental health and substance abuse services integrated in the same department. This prepares for interdependency, which allows professionals to exercise discretion together and take alternative courses of action, instead of exercising territorial behavior. As financial constraints have proven to counter adaptivity (Vabø, 2009), we demonstrate that financial robustness through integrated resources enables professional practice to be flexible and adaptive. This implies that removing the financial barriers between mental health and

substance abuse services can enable integration, which in turn allows for a person-centered service approach, as in the meeting with Bobby.

The robustness is also recognized in care facilities, where good capacity minimizes the need for strict criteria-based access, except for service recipients with severe and complex problems, for whom it is necessary to pay for private facilities. Further, with integrated organizational and financial structures between mental health and substance abuse services, shifts of responsibility become a nonissue. This implies that integrative values in the structures reduces the tensions that often prevent professionals and managers from co-creating values essential for meeting service recipients' needs (Anderson *et al.*, 2016), while also increasing their capacity for resilience.

The small context of Municipality 1 entailed methodological limitations for this study. The small population meant that we could observe two meetings involving service recipients. As we had no other options for observations, we had to use the few opportunities provided. In the other two municipalities, we did not observe meetings with service recipients present, which may be seen as detracting the credibility for this study. However, in addition to being a methodological explanation for the selection, it can underscore the fact that size is actually an important factor. At the same time, it could very well be that the small, transparent context, along with the effects of the integrative values in both structures and practices, allows professionals to take alternative courses of action, including in research collaborations such as this. Future studies are needed in order to provide more substantial answers. Another limitation is that the findings do not enable generalization to all municipalities that fit the descriptions of the municipalities in this study. We are, however, able to make an analytical generalization based on organizational and financial structures and on how they control professionals' ability to exercise discretion. Our study provides theoretical and practical insights into the implications of public management values for service integration but might also provide impetus for further research into this complex research area.

Conclusion

Integrated services are aimed to be accessible for individuals with complex and comprehensive needs, yet this is a challenge for most welfare states. Although our empirical field is Norwegian municipal health and social services, this problematic area may be of interest for other countries. Our theoretical contribution indicates that public management values have implications for organizational and financial structures and professional practice. Here, we argue that integration is impeded by the frugal and economic values in NPM doctrines that still strongly influence organizational and financial structures as well as professional practices in Norwegian municipal health and social care services. Regarding the implications for policymakers and managers, our contribution points out the incompatibility between the demands of economic management principles and the goal of integration. Professionals are bound and tied by the rope of frugality, giving them few alternative actions to frugal strategies. At the same time, we find examples of how the post-NPM goal of integration is realized when either or both of the organizational/financial structures and the professional practices are fused with integrative values. In order to enable integration, the ropes of frugal and economic values must be loosened up, allowing professionals to use their discretional abilities to assess, allocate and deliver integrated services. This implies that the values of flexibility, adaptivity, robustness and resilience must be at the forefront of organizational and financial structures and professional practices. Additionally, interdependency between organizational units and professionals is important for service integration. This seems to be more achievable within small and relatively simple organizational structures as opposed to large and complex organizational structures.

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Article 2

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ORIGINAL RESEARCH

Collective Competence as an Enabler for Service Integration in Health and Social Care Services

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Purpose: Fragmentation in health and social care services can result in poor access to services, lack of continuity and inadequate provision for needs. A focus on integration of services are thus suggested to prevent negative consequences of fragmentation for service recipients. There are, however, few studies that explore the competence needed for integration of services in municipal health and social care organizations. This study explores which types of competence stakeholders require and how collective competence can promote service integration.

Methods: This is a single-case study, and the data consist of focus group interviews and individual interviews with service recipients, family caregivers, professionals and managers. The data were analysed both inductively and deductively.

Results: The analysis resulted in four main themes: 1) Knowledge about individual life situations and organization and system, 2) investigation competence, 3) person-centred collaboration competence and 4) facilitating competence. The themes form the basis for a collective competence framework that can promote service integration.

Conclusion: As service integration involves a high degree of interlinked activities between professionals and organizational units, a collective approach to the concept of competence is presumably applicable. When service integration competence is approached as a collective attribute of a network within and between organizational units, the organization can facilitate this competence by encouraging an active exchange of knowledge between professionals. We also argue that service integration competence increases connectivity and interdependency between professionals and organizational units, and includes service recipients and family caregivers as legitimate extra-professional parts of the collaborative network.

Keywords: fragmentation, care coordination, interdependency, extra-professional involvement, health and social services, municipal services

Introduction

Fragmentation can result in poor access to services, lack of continuity and inadequate provision for needs.[1] For people with mental health challenges and substance abuse, fragmentation also increase incidences of coercion and compulsory treatment, homelessness, unemployment, and increased pressure on family caregivers.[2,3] A focus on integration of services that organizational units are set to deliver are suggested to prevent negative consequences of fragmentation.[4] However, more research is needed on professional competence necessary for integration of municipal health and social care services,[5] which is what we explore in this article. Our empirical contribution is a collective competence framework based on inputs from multiple stakeholders in these services, namely service recipients, family caregivers, professionals and managers. Thus, we demonstrate how a collective approach to competence can enable service integration and integration of service recipients and family caregivers into collaborative networks.

Norwegian municipalities can in some countries be compared to a city that has corporate governance. Norway has a decentralized health and welfare system, where municipalities are responsible for provision of primary health and social care services.[6] This includes provision of primary mental health, substance abuse and physical health care services. As other western countries, the Norwegian health and welfare system have gone through reforms inspired by New public management. These reforms entailed processes where central government became more fragmented and sectorized, due

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to controlling elements through management-by-objectives-and-results.[7] In order to satisfy government requirements of reporting, public health and social care organizations were divided into single- or few-purpose organizations with separate funding streams, each pursuing defined sets of goals and tasks.[8] This way of organizing reinforced fragmentation,[9] a challenge that later reforms have attempted to solve, with organizational integration through coordination and collaboration.[10]

Furthermore, two other issues contribute to fragmentation. Firstly, there are differences regarding professional backgrounds and jurisdictions.[11] Through respective educational pathways, professionals are socialized to adopt a discipline-specific view of the services they are set to offer and the service recipients. Consequently, professionals tend to maintain their professional autonomy instead of pursuing collaborative behaviour.[12] Secondly, complexity marks service recipients' life situation which demand services from a number of professionals and organizational units simultaneously. People with concurrent mental health and substance abuse challenges often also possess physical health problems and social challenges related to work, housing, economics and social networks.[13] This complexity creates difficulties for integration of services for this specific group of people.[14,15]

Service Integration

Integration of services involves coordination and collaboration. Coordination is defined as interaction between professionals in which formal linkages are mobilized because collective efforts are needed to achieve organizational goals.[4] As such, coordination is an integrative means on system level. Collaboration on the other hand, is an integrative means on the individual and relational level. Collaboration is interaction between professionals who work together to pursue complex goals based on shared interests and a collective responsibility for interconnected tasks which cannot be accomplished individually.[4]

Professionals and managers working close to service recipients and their family caregivers are often responsible for integrating services.[16] Thus, service integration competence can be valuable to carry out this responsibility.[5,17] Both coordination through formal linkages and the collective nature of collaboration has potential to promote close interaction between different stakeholders, ie between professionals, and with service recipients and family caregivers. Involvement of service recipients and family caregivers is a decisive part of service integration,[18] and Norwegian policy documents are in line with this.[19,20] Thus, professionals also need competence on how to involve and activate service recipients and family caregivers,[21] and on how to build networks that is supportive of service recipients' individual goals.[22]

The Concept of Collective Competence

Competence is defined as the essential knowledge-based acts that combine and mobilize knowledge, skills and attitudes with existing and available resources to ensure safe and high-quality outcomes for service recipients.[23] Knowledge covers both knowledge about facts and concepts (what) and knowing how to do something.[24] Putting this knowledge into practice requires certain skills,[25] which are organized sequences of activities and cognition. Competence also involves attitudes, which deal with the affective domain and influence professionals' choices of actions.[26] Professionals can address the complexity in service recipients' situations with a reflective and holistic approach, when their attitudes are linked to knowledge and skills in the performance of professional tasks in specific work situations.[27]

Collective competence builds on the cultural studies by Hofstede which distinguish between individualism and collectivism. According to him, individualism is the tendency to treat the self as the most significant social unit, and societies described as individualist, encourage self-directed learning and personal initiatives. This also implies that professional competence is an attribute of individuals. Collectivist societies on the other hand, treat the group to which one belongs as the most important social unit. They value subordination of personal wishes to the priorities of the group and encourage intra-group harmony rather than individual ambition. Accordingly, professional competence is an attribute of the group.[28]

In line with collectivist societies, the theory of collective competence argues that competence very well can be regarded as an attribute of a group, team or organization. Research does not undermine the need for individual competencies; rather, it argues that we should recognise both individualistic and collectivistic ways of construing competence, and apply them consciously.[29]

Although individual and profession-specific competence is needed to deliver high-quality health and social care services,[30] research shows how competent individual professionals can combine to create incompetent collaborative networks, due to divergent knowledge bases, cultures and expertise.[31] Thus, in order to integrate services, professionals presumably need to approach competence needed for coordination and collaboration collectively instead of individually. When competence is regarded as a collective attribute of a network within and between organizational units, and assessed as embedded in the collective approach of the organization, the organization can facilitate collective competence by encouraging an active exchange of information between professionals.[32] Collective competence is comprised of three principles, namely:

- To make sense of events in the workplace – to construct a shared understanding about the goals the network wants to achieve.
- To develop and access a collective knowledge base – in order to reach the goals through coordinated activity, the group must have context-relevant and accessible knowledge in common.
- To maintain a sense of interdependency – due to fragmentations in the network, professionals need a feeling of interdependency, a shared understanding of actions made by other professionals.[29]

We will elaborate on these principles in the discussion, where we also argue that there is a need for an additional principle of collective competence in health and social care organizations. Thus, our theoretical contribution is the introduction of a fourth principle, which regards inclusion of service recipients and family caregivers in the collective mind.

Against the described background and theoretical foundation, we ask: 1) Which types of competence do stakeholders require for integrating services? 2) How may collective competence promote service integration?

Materials and Methods

Single case study design was chosen as we wanted to study service integration competence in social units that were defined in time and space[33] and it enabled us to gain information from several stakeholders and organizations within one case.[34] In order to increase possibilities for variations in the data, we recruited participants from three municipalities that diverged in municipal size and organizational structures (See Table 1).

From the municipalities, we recruited 14 service recipients, six family caregivers, eight professionals and six managers. We followed a purposive sample procedure based on inclusion criteria. The inclusion criterion was over two years of experience in their respective roles. The recruited professionals and managers worked within mental health

Table 1 The Municipalities from Which the Participants Were Recruited

Municipal Code	Municipal Characteristics
Municipality 1	• 3000 inhabitants • 15 registered with concurrent mental health and substance abuse challenges • Mental health and substance abuse services are organized and managed as one department
Municipality 2	• 30,000 inhabitants • 100 registered with concurrent mental health and substance abuse challenges • Mental health and substance abuse services are organized and managed as two different departments within a joint unit.
Municipality 3	• 52,000 inhabitants • 300 registered with concurrent mental health and substance abuse challenges • Mental health and substance abuse services are organized and managed as two different departments in separate units.

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and substance abuse services, including outreaching services in the service recipients' homes as well as follow-up services in forms of individual and group conversations. The recruited service recipients were current or former receivers of these services, and the recruited family caregivers were familiar with these services.

In the data collection we combined focus group interviews and individual interviews. These took place from January to April 2020. Focus group interviews were chosen so participants could share experiences and values with others with similar

Table 2 Focus Group Interviews

Name of Group	Municipality	Participant Group	Number of Participants	Participant Characteristics (Gender, Age, Profession or Family Relations).
Focus group 1	Municipality 1	Service recipients	6	1. Male, between 40–49. 2. Male, between 60–69. 3. Male, between 50–59. 4. Male between, 50–59. 5. Male, between 60–69. 6. Male, between 40–49.
Focus group 2	Municipality 1	Family caregivers	3	1. Female, between 50–59, ex-wife. 2. Male, between 70–79, father. 3. Female, between 70–79, mother.
Focus group 3	Municipality 1	Professionals/managers	5	1. Female, between 50–59, mental health nurse. 2. Female, between 60–69, assistant nurse. 3. Female, between 40–49, social worker. 4. Female, between 50–59, nurse/substance abuse counsellor. 5. Female, between 40–49, social educator.
Focus group 4	Municipality 2	Professional/managers	5	1. Female, between 30–39, social worker. 2. Female, between 30–39, social worker. 3. Female, between 50–59, assistant nurse. 4. Male, between 20–29, social educator. 5. Male, between 30–39, psychologist.
Focus group 5	Municipality 3	Service recipients	5	1. Female, between 30–39. 2. Female, between 50–59. 3. Male, between 30–39. 4. Male, between 40–49. 5. Male, between 60–69.
Focus group 6	Municipality 3	Professionals/managers	4	1. Male, between 40–49, mental health nurse. 2. Female, between 20–29, psychologist. 3. Female, between 40–49, social educator. 4. Male, between 30–39, mental health nurse.

Table 3 Individual Telephone Interviews

Municipality	Participant Group	Number of Participants	Participant Characteristics (Gender, Age and Family Relations).
Municipality 2	Service recipients	3	1. Male, between 30–39. 2. Female, between 40–49. 3. Female, between 70–79.
Municipality 2	Family caregivers	2	1. Male, between 30–39, son. 2. Female, between 60–69, mother.
Municipality 3	Family caregivers	1	1. Male, between 40–49, brother.

experiences in a safe environment.[35,36] Individual interviews were chosen to add more detailed accounts of participants' knowledge and experience.[37] Twenty-eight of the 34 participants participated in a total of six focus group interviews (see Table 2). Three service recipients and three family caregivers participated in individual interviews (see Table 3).

The uneven number of focus groups and individual interviews per municipality is due to limitations provided by the Covid-19 Pandemic, and not a methodological decision as such. When lock-down occurred, we had just accomplished the focus group interviews. Restrictions affecting social proximity, prohibited us in being physically present in the municipalities, which affected both possibilities for recruiting participants and for doing individual interviews. This unevenness may create methodological limitations for the study, by generating more data from some municipalities than others. Simultaneously, we included an equal number of professionals/managers and service recipients, and through this, a fair distribution of voices between these groups of stakeholders.

The first author, a PhD-candidate with eight years of experience in doing qualitative interviews, conducted and moderated the focus group interviews, and a research fellow wrote down the participants' statements during the interviews. The focus groups were held in meeting rooms located in the mental health and substance abuse units. The individual interviews were carried out by telephone by the first author, due to the Covid-19 Pandemic. The focus group interviews lasted from 60 to 90 minutes, and the individual interviews lasted from 30 to 45 minutes.

Before each interview we discussed the concept of service integration and competence with the participants to achieve a collective understanding of the topic. Further, the use of a semi-structured interview approach allowed participants to describe their experiences and understandings of integrated services and service delivery in their own words.

As we attempted to avoid making an interview guide based on our preconceived thoughts on the topic of study, there were no elements in the interview guide that were based on earlier competence frameworks. The same interview guide was used in all focus group interviews and individual interviews, giving all participants equal opportunities for expressing their thoughts on the topic. The interview guide had both an inductive and deductive approach, to prepare for our analysis. In the inductive part, we focused on the unique experiences and meanings of the participants through the initial question: "What must professionals be capable of in order to integrate services"? The elements in the follow-up questions were deductively driven, dealing with components within the definitions of competence and service integration. Examples of components were types of knowledge, skills and attitudes as well as collaboration, coordination, networks, relations and considerations of individual needs.[23–27,38] In this way, we could encourage the participants to explain and reflect on their statements. Concurrently, we asked follow-up questions based on individual and collective statements made by the participants. In conclusion, we gave the participants equal opportunities for expressing their thoughts, concurrently as we integrated their role as service recipient, family caregiver, professional or manager in to the interview, resulting in a rich and comprehensive data material. The interview guide and procedure were prior to the focus group interviews and individual interviews pilot tested with the use of colleagues in a research group.

The study was approved by the Norwegian Centre for Research Data (ref. no. 300488), and exemptions from the duty of confidentiality were granted by the South-Eastern Norway Regional Committee for Medical and Health Research Ethics (ref. no. 2019/299 REK Sør-Øst). Information about the study was provided orally and in writing to managers in the organizational units of interest and distributed to the participants. All participants signed an informed written consent allowing us to use anonymized responses for scientific publication. The authors were not familiar to any of the participants prior to the study.

Analysis

The combination of data from focus group interviews and individual interviews was a productive strategy to enhance descriptions of the inquired topics' characteristics,[39] where the latter added more depth and detail to the data generated from the focus group interviews. Hence, both types of data were analysed synchronously.

We used a stepwise deductive-inductive approach for our analysis.[40] Empirically close codes were developed line by line. We worked back and forth to find similarities and differences in the data set, and attempted to limit the possibilities of researchers forcing a preconceived result. This led to 23 empirically close codes. We organized these codes in a data code structure based on our research expertise, the topic of inquiry and existing theory. In this sense, we anticipated certain core concepts or codes in the data set. The code structure was tested on parts of the data set, and subsequently on the whole data set. On the basis of this testing, we refined and restructured the codes and code structure to ensure that the

Table 4 Analysis Structure

Quotes That Support Analysis	Empirically Close Codes	Categories	Main Themes
"There is a lack of competence on addictions in mental health services" (professional).	Knowledge about substance abuse and mental health.	Human complexity competence.	
"Service recipients often do not have knowledge about how to live an ordinary life. We must have information about their economic situation and living conditions" (professional).	Knowledge about social challenges.		Knowledge about individual life situations and organization and system.
"We have to see the whole person, also their physical challenges" (professional).	Knowledge about physical health.		
"Also necessary is knowledge about the service recipients' local environment and network" (family caregiver)	Knowledge about context		
"I like when they show that they respect me" (service recipient).	Supportive attitudes.	Human qualities.	
"In mapping we try to see the service recipient in their context, and we try to understand this context. Both the historical account and their current situation and goals are included. We let them tell their stories, and we are open to what they tell" (professional).	Listening and understanding.	Inquiry competence.	Investigation competence.
"Not everybody knows the important skill of being observant" (family caregiver).	Observation and mapping.		
"The team talks with me and not about me and they involve me in the discussion. They listen to me, and we find solutions" (service recipient).	Involvement.	Empowerment Competence.	
"They all have individual needs that need to be considered" (family caregiver).	Individual adjustments.		
"Motivation is decisive. We can for example use motivational interviews" (professional).	Motivation.		
"I need them to speak a language I can understand. Not this expert-language" (service recipient).	Understandable communication.		
"I should not have to wait for months to get a substance abuse counsellor" (service recipient).	Handling waiting periods.	Resource management competence.	Person-centred collaboration competence.
"We must manage the gap between what the hospitals recommend for municipal follow-up and what we can offer (manager).	Handling hospital discharge challenges.		
"Resources must be available, staff and housing. But sometimes, through collaboration, we can find solutions that otherwise would be inaccessible" (professional).	Sufficiency/robustness.		
"The professionals are shaped by New Public Management thinking, which prevents us from getting attached to them" (service recipients).	Economic constraints shape the behavior of the professionals.		

(*Continued*)

Table 4 (Continued).

Quotes That Support Analysis	Empirically Close Codes	Categories	Main Themes
"One coordinator throughout the follow-up would be good. I have had to switch many times" (service recipient).	Coordination.	Organization and interaction competence.	Facilitating competence.
"This walk to Canossa is very oppressive, with many battles to fight" (service recipient".	Continuity.		
"When we do assessments, we should also discuss this inter-professionally" (professional).	Inter-professional collaboration		
"Early intervention! Assess the situation and build a team around them with all relevant actors (family caregiver).	Team around service recipients.		
"I think more of us would show up to meetings if there were possibilities for attending digitally" (service recipient).	Technology and information.		
"Professionals should be able to think outside the box. To make things happen" (family caregiver).	Efficiency.		
"Peer-expertise is as much for the professionals as it is for us" (service recipient).	Peer-expertise.		
"We must talk about what we do, and there should be a mutual responsibility for health and social care professionals to guide and teach each other" (manager).	Knowledge transfer.		

codes were accommodated in the structure. This resulted in four themes: 1) Knowledge about individual life situations and organization and system, 2) Investigation competence, 3) person-centred collaboration competence and 4) facilitating competence (see Table 4).

In the deductive stage, we applied the triadic theory of collective competence[29,41] to the four code groups. We use the three principles within this theory to discuss how collective competence may promote service integration.

Results

The themes form the basis for a collective competence framework that can be used to promote service integration. The first theme concern knowledge needed for service integration, which constitutes as knowing what. For professionals to put this knowledge into action, knowing how, they require skills and attitudes needed for service integration. This is presented in the second, third and fourth theme.

Knowledge About Individual Life Situations and Organization and System

According to all groups of participants, knowledge about individual life situations concerned individual service recipients and their life with multiple and complex needs and challenges tied to mental health, substance abuse, physical health and social life. This was expressed by a professional in the following way:

> "We need to get hold of the service recipients" perspectives. They are the experts on their own lives, although they miss the experience of living ordinary lives' (Professional 2)

Service recipients and family caregivers enhanced the importance of knowing the distinctiveness of each persons' situation, including individual history, wishes, goals, abilities and resources. Professionals and managers agreed to the importance of having such knowledge. Multiple diagnoses created complex challenges and needs, which required thorough and in-depth knowledge of all aspects of a person's life.

Knowledge about organization and system concerned knowledge about all the different organizational units, the types of services they offer, the different groups of professionals working in the units, their expertise and responsibilities. Although the three municipalities varied in size and structures, service recipients and family caregivers in all municipalities found it difficult to navigate in the system and to know how to reach out and apply for help. Consequently, they were dependent on professionals' knowledge on this.

Service recipients and family caregivers also found the lack of knowledge and awareness of physical health in mental health and substance abuse services challenging, and vice versa.

> There must be more focus on physical health in mental health and substance abuse services (Family caregiver 3)

Thus, family caregivers and service recipients called for all parts of the municipal services to include professionals with knowledge about physical health, mental health and substance abuse challenges.

Investigation Competence

The focus within this type of competence was for professionals to obtain comprehensive knowledge about service recipients' life situations. This was something that professionals did individually or in pairs. The professionals and managers emphasized skills within mapping and assessing as important here. These skills required professionals to be thorough and analytical. A thorough investigation of service recipients' life situations required a holistic approach, which meant inclusion of all areas of a person's life that could constitute challenges and resources.

> In mapping we try to see the service recipient in their context, and we try to understand this context. Both the historical account and their current situation and goals are included. We let them tell their stories, and we are open to what they tell. (Professional 9)

This statement shows how professionals were preoccupied with the attitude of openness in investigative dialogues and when establishing goals. This complied with service recipients' and family caregiver's request of being listened to, understood and taken seriously. According to them, investigative dialogues worked best in a safe communication environment, which was contingent on professionals being honest, friendly, calm and without prejudice. A barrier to open and honest communication was when professionals expressed being squeezed between limited available time and time-consuming service delivery, as this was stressful for service recipients. Thus, professionals needed to be attentive towards how one's own way of being affected other people, in order to obtain knowledge about individual life situations.

The professionals claimed that when mapping was performed inter-professionally, this would allow for complementary perspectives, and greater probability of service integration. However, in order to further integrate services, individually obtained knowledge needed to transfer from an individual to a collective level, which leads us to the next theme.

Person-Centred Collaboration Competence

The aim of this type of competence was for professionals to integrate knowledge about individual life situations with knowledge about organization and system, in order to adapt services according to service recipients' needs. Person-centred collaboration competence should be carried out through attentive dialogue and collaboration with other professionals as well as with service recipients and family caregivers, which created a potential to move knowledge from an individual level to a collective level.

In addition to knowledge about individual life situations, professionals needed knowledge about organization and system. Service recipients and family caregivers in two of the focus groups called for professionals to communicate more with each other in order to obtain this type of knowledge, and professionals and managers agreed:

> We must talk about what we do, and there should be a mutual responsibility for health and social care professionals to guide and teach each other (Manager 3)

Obtaining knowledge about organization and system was in this view a collective responsibility. In order for individual knowledge about own competence and responsibility to become collective, professionals needed spaces for dialogue so

they could communicate their individual knowledge to professionals with other affiliations. Such communication involved skills in keeping oneself and other professionals updated, paired with a willingness to do so.

> We need fora for collaboration, because we need to know each other. It is also important to be good at establishing relationships with service recipients and their families, but also with our professional partners. (Professional 10)

Through establishment of coordination means, collaboration fora and professional relationships, professionals could exchange information, knowledge, and expertise, and be available for each other. Person-centred-collaboration was, however, dependent on mutual respect and trust between organizational units and professionals. As an example, professionals and managers in one of the focus groups explained how self-reflection regarding how they referred to other agencies in the municipal organization was a decisive skill when building relationships.

Inter-professional dialogue in meetings, enabled professionals to integrate service recipients' expert knowledge on own situations within the scope of their professional competence, to achieve a holistic and collective understanding of the individual life situations. This strengthened professionals' abilities to solve complex challenges collectively, which lead to solutions.

The integrated collective knowledge was considered applicable for finding a good fit between service recipients' needs for help and the types of services to offer them. In other words, to make individual adaptations. To do this, all groups of stakeholders emphasized participation and involvement of service recipients and family caregivers as important strategies. The service recipients and their family caregivers wished for more focus on needs and goals but also on individual resources, which reflected a view of service recipients as active agents and not as passive receivers.

> The team talks with me and not about me, and involves me in the discussion. They listen to me and we find solutions (Service recipient 7)

The team referred to here was a responsibility group, which was a coordination arrangement on system level. It was a fixed group of professionals who the service recipient trusted, and who involved the service recipient. These conditions allowed for person-centred collaboration between the service recipient and the professionals, where both parties contributed with knowledge and experience. This laid the foundation for a collective understanding of the situation, and thus for meaningful solutions for the service recipient. In this way they were able to individually adapt the services to needs, wishes, goals and resources.

In addition to these conditions, participation and involvement required equitable communication. According to discussions with service recipients in one focus group and with one family caregiver in an individual interview, this meant to avoid the highly professionalized and bureaucratic language that was used orally and in writing. Incomprehensible language prevented them from being active agents in collaboration with professionals. This indicates a need for professional skills in adapting language and communication to individual service recipients and family caregivers, in order to reduce power asymmetry and increase involvement.

Facilitating Competence

Integrated collective knowledge needed to be continuously upheld at a collective level through continuity and coordination of professionals' knowledge and efforts. Thus, this type of competence concerned knowledge, skills and attitudes needed to plan, arrange for and manage continuity and coordination of services. The aim was to ensure professional and organizational integration, with the desired outcome of a connected, aligned and collaborative network with and around service recipients. Service recipients in two focus groups talked about how lack of coordination and continuity was experienced by them:

> One coordinator throughout the follow-up would be good. I have had to switch between many therapists, doctors and consultants, and it is very tiring. Having to tell the same stuff over and over again. This walk to Canossa is very oppressive, with many battles to fight. (Service recipient 2)

The walk to Canossa, as a figure of speech, points to penance. Disruptions in continuity lead to people having to re-tell their story repeatedly. This was a stressful process, perceived as punishment. However, there were examples of the opposite. Three of the individually interviewed service recipients and family caregivers talked about a general practitioner who had initiated collaboration with a private psychiatrist to be able to provide patients with necessary treatment and continuity. They had consultations together, organized their work schedule to fit service recipients' needs, and coordinated the services around them. This example point at the attitudes of flexibility and creativity when facilitating for coordination and continuity. According to the service recipients and family caregivers these were important driving forces for finding good service solutions.

The professionals and managers added that coordination and continuity required professionals to work systematically and structured. One way of doing that, was through digital documentation systems.

> Collaboration is better with the care services now that we can create collective journals (Professional 5)

Collective journal was a coordinating means on system level that facilitated collaboration between professionals. Here, professionals could register their individual knowledge about service recipients and make it accessible for other professionals in collaborative networks. Thus, knowledge was made collective, and professionals could coordinate their efforts according to each other.

It did however require professionals to have skills in using collective journals. The service recipients wished for correct and accurate information in their digital records. Otherwise, they experienced a constant need to rectify the facts about themselves, adding to the feeling of walking to Canossa. This showed that coordinating means such as digital collective journals also could create disruptions in continuity, if not the users of the digital solution had necessary skills in registering correct and accurate information.

Discussion

Based on the presumption that service integration require professionals to approach competence needed for coordination and collaboration collectively, we apply the principles of the triadic theory of collective competence to the discussion. These are to make sense of events in the workplace, to develop and access a collective knowledge base and to maintain a sense of interdependency. Additionally, we add a fourth principle, to legitimate extra-professional involvement, which we argue is needed for the development of collective competence in health and social care services.

To Make Sense of Events in the Workplace

Professionals in municipal health and social care services often find themselves working with different goals.[17] This creates situations where professionals with different affiliations have conflicting goals of their activities.[42] Thus, they act on behalf of themselves and their organizational unit, instead of making collective sense of shared goals.

The first principle emphasizes a common goal around which to construct a shared understanding.[41] Based on our results, we suggest service recipients' own goals as the core of activities in collaborative networks. Accessing these individual goals is dependent on professionals' abilities to obtain them through investigative dialogue. This means that professionals should create a safe and caring environment, as this can activate service recipients and let them define their own goals.[43]

Service recipients' specific goals direct which services to allocate and which professionals to include in the collaborative network with and around service recipients. As described in the results, such choices are contingent on professionals' knowledge about organization and system. Our results suggest physical meeting spaces and dialogue for professionals' and managers' transfer of knowledge about own expertise and responsibility areas. Physical meetings play an important role in strengthening relationships and building trust, as well as in creating familiarity between professionals.[44] In addition to facilitating for knowledge transfer, these are also appropriate conditions for establishing common goals.[45]

Person-centred collaboration competence supports building relationships, trust, respect and familiarity. However, for professionals to utilize this competence, they need organizational support structures. Establishment of physical meeting spaces is a coordinating means, in which responsibility lies on management level. However, municipal managers

establish interprofessional meetings to various extents, although it is proven that such structures support service integration.[46]

To Develop and Access a Collective Knowledge Base

The second principle suggests that context-relevant knowledge, accessible for all participants in the collaborative network, is a prerequisite for reaching common goals through coordinated activities. Based on this principle, we suggest integrated knowledge of individual life situations and of organization and system as central parts of a collective knowledge base in health and social care services. This is context-relevant knowledge that become accessible and owned by the organization through a collective approach.[47]

We have already established that person-centred collaboration in physical meeting spaces creates good conditions for transferring and obtaining knowledge about organization and system. Additionally, the results point to the importance of knowledge transfer through digital communication. Digital documentation systems are coordinating means on system level, where professionals register individually obtained knowledge about service recipients and make it accessible for their collaborative networks. Accordingly, digital documentation systems increase the likelihood of development of a collective knowledge base,[48] and enhance collaboration.[49] Through facilitating competence, professionals maintain collaboration through coordinating means established on system level.[50] To sum up, collaboration through both physical meetings and digital coordination means gives good conditions for professionals to obtain and integrate knowledge about individual life situations and about organization and system.

A collective and accessible knowledge base contributes to service integration for two reasons. Firstly, a collective knowledge base can enable interactions and collaboration that lead to concrete plans for service recipients.[51] Secondly, the coordinating and collaborative activities that are needed in order to develop the knowledge base are central requirements for integration of services.[4]

To Maintain a Sense of Interdependency

The third principle states that to maintain a state of collective competence, the members of a collaborative network need to find ways of preventing fragmentation brought on by different perspectives on the common goal of activities.[41] To strive against fragmentation, professionals need to maintain a sense of interdependency, which requires that they know about other professionals' contributions and actions. Professionals in Norwegian municipal health and social care services are part of multiple collaborative networks that can change over time. Thus, these networks do not always entail fixed memberships, which can be fragile structures for collective action,[52] and can fragment the network into a collection of individuals with different goals.[41] This point to the need for a collective culture where professionals act with regard to each other's actions, and all actions are centred around the same goal.[53]

Being aware of individual actions is thus a prerequisite for integration. This requires professionals to make individual contributions available for the collaborative network. However, this depends on professionals' ability to plan, arrange for and manage continuity and coordination, as in the example of the general practitioner referred to in the results. He used his facilitating competence to initiate collaboration with a private psychiatrist to improve coordination and continuity. The example also shows how the general practitioner moved away from an autonomous way of working with patients with concurrent substance abuse and mental health challenges, towards an interdependent way of working, together with the psychiatrist. Their close collaboration prepared for a shared understanding of their respective actions, and thus, a sense of interdependency.[54]

Helping service recipients with multiple and complex needs to reach their goals is not an individual responsibility. As shown, a sense of interdependency has the potential to coordinate inputs from different actors in the collaborative network so that the desired outcome for the service recipients can be achieved satisfactorily.[55]

To Legitimate Extra-Professional Involvement

Collective competence is traditionally the concern of professionals. However, the results show that service recipients and family caregivers are included as active agents in the shared understanding, and are thereby legitimate extra-professional parts of the collaborative network. Street et al call such involvement a therapeutic alliance, which is characterized by

mutual trust among the parties, coordinated and continuous services, and service recipients feeling respected and cared for.[56] To realize such a collaborative alliance, researchers recommend educational workshops between service recipients, family caregivers and professionals, in order to improve communication and understanding of boundaries.[57]

In line with the recommendation above, we state that collaboration between the parties must be individually adapted to the needs of service recipients,[58] which can be done through person-centred collaboration competence. This includes adapting the communication environment and language according to service recipients' and family caregivers' prerequisites and needs. A comprehensible language that reduces power asymmetry gives service recipients and family caregivers a voice that they have not traditionally had in collaborative research.[31] This activation is key to real involvement of service recipients and family caregivers as active agents, allowing them to influence decisions that concern them. Thus, extra-professional involvement integrates service recipients and family caregivers into the collaborative network.

Conclusion

Regarding essential service integration competence, the results show a high degree of consensus between service recipients, family caregivers, professionals and managers. Simultaneously, there were a gap between consensus on what competence that were needed and the actual situation in municipal mental health and substance abuse services, due to lack of coordinating means on system level. Thus, responsibility for integration was decentralized to professional level, resulting in more collaboration than coordination. As both are required in order to integrate services, an implication for service managers is to prepare for service integration by establishing coordinating means as well as initiating a collective approach to acquisition of service integration competence.

When service integration competence is approached as a collective attribute of a network within and between organizational units, the organization can facilitate this competence by encouraging an active exchange of knowledge between professionals. We also argue that a collective approach to service integration competence can increase interdependency between professionals and organizational units. Lastly, we recommend managers and professionals to include service recipients and family caregivers as legitimate extra-professional parts of the collaborative network.

The uneven number of focus groups and individual interviews per municipality entails methodological limitations, which may be seen as detracting the credibility for this study. Another limitation, due to the design, is that the findings do not enable generalization to all municipal contexts. We are, however, able to make an analytical generalization based on required service integration competence, and the implications of a collective approach to this.

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Article 3

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Thinking and acting outside the box: The co-existence between formal bureaucratic integration and informal street-level integration in municipal health- and social care services.

Abstract

Integration of health and social care services is the recommended approach for people with concurrent mental health and substance abuse challenges. Integrated service approaches can however be difficult to achieve. This is a study of practice level service integration in municipal health and social care organizations. More precisely we study the co-existence between formal and informal integration in a service field which is threatened by cost-savings and cuts in resource use.

The study is designed as a qualitative single-case study, with three Norwegian municipalities as case organizations. The empirical material consists of a combination of in-depth individual interviews, focus group interviews and observations of decision meetings. This material is analysed with a deductive thematic analysis approach based on theories concerning formal integration and street-level diplomacy.

The findings reveal that commitment to the goal of service integration can be both symmetrical and asymmetrical between managers and professionals. Co-existence between formal bureaucratic integration and informal street-level integration is possible when the commitment is symmetrical.

Introduction

Integration of health and social care services are the recommended approach for people with complex and intertwined health and social needs (Valentijn, Schepman, Opheij & Bruijnzeels, 2013; WHO, 2015), such as people with concurrent mental health and substance abuse challenges. National health supervision and research shows that integrated approaches can be challenging (Bjørkquist & Hansen, 2018; Norwegian Board of Health Supervision, 2019). To address challenges in future planning of municipal health and social care, we need research on how health and social care managers currently prepare for integration and how professionals work to achieve it. This is also known as practice-level integration (WHO, 2015).

To obtain knowledge on practice-level service integration it is of value to study both formal coordination and informal collaboration (Keast, Brown & Mandell, 2007). Thus, this is a

study on formal and informal integration of municipal health and social care services to people with concurrent mental health and substance abuse services. We aim to display the co-existence between formal integration and informal integration in a service field threatened by cost-savings and cuts in resource use, and we do this by using empirical data and theories on formal bureaucratic integration and informal street-level integration. Our research question is: "How do practice level managers and professionals work to achieve integration of mental health and substance abuse services?"

Background

Universalism is the trademark of the Nordic welfare-state model, and Norway in particular, is steered by universalism goals (Second author, 2018b). Simultaneously, Norway has gone through several reforms inspired by New Public Management (NPM) (Nesvaag & Lie, 2010). These reforms have affected organizational and financial structures by dividing public health and social care organizations into single- or few-purpose organizations with separate funding streams, each pursuing defined sets of goals and tasks (Christensen & Lægreid, 2007). This way of organizing reinforced fragmentation (Gui, Chen & Pine, 2018), and research has shown that the values within these reforms shape the organization and practice of health and social care services in ways that impede service integration (First author et al., 2022).

Norway has a decentralized health and welfare system, where municipalities are responsible for provision of primary health and social care services (Baldersheim & Ståhlberg, 2002). This decentralization implies that ambitions within primary care policy objectives are municipal responsibilities. The NMP inspired reforms placed municipal professionals and managers under great pressure to achieve tight financial discipline and to organize their services in a cost-effective manner (Vabø, 2009). Under such conditions, the ambition of universal services is challenged.

In 2012 the Norwegian government introduced The Coordination Reform. The reform's white paper described services to people with complex health and social care challenges as too fragmented and poorly coordinated (Helse- og omsorgsdepartementet, 2009). Thus, central within this reform was prioritizing primary health care while simultaneously promoting a more collaborative and multidisciplinary approach to health care (Tingvoll; Sæterstrand & McClusky, 2016). One of the main aims of this reform was to transfer more responsibility from specialist health care to municipal health and social care (Kjosavik, 2018). However, professionals in Norwegian municipalities report that resources and competence warranted to

attend to the increased responsibilities and associated workload is lacking (Gautun & Syse, 2017). Although The Coordination Reform has been gradually implemented, it is still evident that coordination and collaboration between organizational units and professionals is challenging (Vik, 2018).

Formal and informal integration

There is a common agreement among scholars that both formal and informal integration is essential for effective organizational outcomes (Cohen & Cohen, 2021). Both coordination through formal linkages and the collective nature of collaboration has potential to promote close interaction between different stakeholders, i.e. between professionals, and with service recipients and family caregivers (Struckmann, Leijten, van Ginneken, Kraus, Reiss, Spranger, Boland, Czypionka, Busse & Rutten-van Mölken, 2018).

Coordination is defined as interaction between professionals in which formal linkages are mobilized because collective efforts are needed to achieve organizational goals (Keast et al., 2007). Collaboration on the other hand, is an informal integrative means on individual and relational level. Collaboration is interaction between professionals who work together to pursue complex goals based on shared interests and a collective responsibility for interconnected tasks which cannot be accomplished individually (Keast et al., 2007).

Formal bureaucratic integration

Lawrence and Lorsch (1969) suggested that organizations confront different conditions and elements in their environments, which creates pressure for differentiation in to specialized units inside an organization. These specialized functions produce internal complexity in organizational structures, which allows the organization to meet the demands in the environment. Simultaneously, it produces pressure to integrate across the differentiated tasks, which adds structural complexity, requiring managers to coordinate the expanding units and responsibilities within the organization. In this view, differentiation and integration are complementing mechanisms that managers can resort to for the realization of organizational goals (Lawrence & Lorsch, 1967).

One common formal integration mechanism is hierarchy, which create formal reporting relationships that allow managers to coordinate activities and resolve problems by exercising their authority. Other formal integration mechanisms are rules, procedures, standardisations, meetings, and teams. Although the hierarchy of authority makes a substantial contribution to

overall coordination, hierarchy alone cannot keep up with an organization's endless and ever-increasing demand for integration (Hatch & Cunliffe, 2013).

Public agencies such as municipal health and social care, are amongst the most complex organizations known in contemporary society, and managers at different levels in the hierarchy play a vital role in governing integration (Glouberman & Mintzberg, 2001). Managers' solution to operationalization of integration policy is to prepare for necessary structures through which professionals can operate (Farmanova, Baker & Cohen, 2019). In this way they can report back to national authorities that they have responded to the aim of integration. Additionally, because of the economic performance pressure that municipal managers face, these managers also structure the services in a cost-effective manner (Vabø, 2009), which can be challenging for integrative work (First author et al., 2022).

Informal street-level integration

Professionals and managers working close to service recipients and their family caregivers are often responsible for integrating services (Willumsen et al., 2012). These professionals and managers are referred to as street-level bureaucrats, as they are responsible for delivering public services and enforcing the law, and as such, serve as the face of the state for citizens (Zacka, 2017). Lipsky (1980) observed that street-level bureaucrats' work is a combination of achieving policy objectives simultaneously as their work require improvisation and responsiveness to individual service recipients**.** This they can do due to a high degree of autonomy, and thus they can influence the outcomes of the policies they are employed to enact (Lipsky, 1980).

Street-level bureaucrats face dilemmas in their everyday working life. They are expected to be sensible moral agents who can interpret vague directives, come to a compromise between competing values, and prioritize allocation of scarce resources. Additionally, they are expected to fulfil these demands within a challenging and complex working environment (Zacka, 2017). To cope with this uncertainty, street-level bureaucrats invent and use local routines and strategies when operationalizing policy (Exworthy & Frosini, 2008). Services may therefore be delivered in ways unintended by policy makers or managers (Gale, Dowswell, Greenfield & Marshall, 2017), as professionals may find 'workarounds' if existing conditions offer barriers to their daily practice (Halbesleben, Savage, Wakefield & Wakefield, 2010).

A new concept to the theory on street-level bureaucracy, namely street-level diplomacy (Gale et al., 2017), can be applicable to study how street-level bureaucrats use their professional relationships to achieve service integration in health and social care services. Street-level diplomacy is a hybrid between Lipsky's theory on street-level bureaucracy combined with theory on multi-track diplomacy. While Lipsky's focus on bureaucracy stressed the exercise of discretion in decision making and the development of rules and procedures within hierarchical systems, multi-track diplomacy focuses on the communicative, adaptive and cultural parts of 'street-level' roles in policy implementation in networks (Gale et al., 2017). Multi-track diplomacy theory seeks to understand the processes of building successful and productive relationships between two or more communities, or in this study, between two or more organizational units. It focuses on the use of "soft power" through collaboration and gaining influence, which is done by communicating on all levels, and via both formal and informal tracks (Diamond & McDonald, referred to in Gale et al 2017). The goal of this type of diplomacy is to reach desirable outcomes through facilitation, empowerment, and transformation.

As we will demonstrate below, street-level diplomacy, in this conceptualization, can be understood as a process whereby actors assemble and use their experience, knowledge, creativity, networks and professional, cultural capital to realize organizational goals in practical and meaningful ways (Gale et al., 2017). By doing this, they don't necessarily break any rules or pursue hidden agendas; rather, most commonly they combine the use of particular personal resources with unconventional methods to achieve organizational goals that tend to appear more as good intentions than real priorities (Kelliher & Anderson, 2010). Thus, insofar as we may see such strategies as "informal", they are not "non-formal" but rather alternative ways of linking resources to alternative methods, bypassing formal barriers and establishing linkages across organizational and professional abysses to become able to utilize latent potential in social relationships, strengthen mutual commitments and motivation. The most acute challenge faced by street-level diplomats, we assume, emerges from the possibility that leaders regard the autonomy these diplomats tend to maximize as a threat to hierarchical asymmetry (as sabotage, failure of executing orders, disloyalty, unwanted prioritization, inequal treatment of users, etc.), or that formal orders (rights, rules, procedures linking means to ends) prevent the potential of symmetrical commitments among diplomats from developing (Second author, 2018a).

Research design, material, and methods

We chose a single-case study design (Yin, 2009), where the case is service-integration on practice level. We wanted to bring evidence together from multiple sources and to offer new contributions to the existing theories on formal and informal integration, which we find to be coherent with the aims of case studies (Eisenhardt, 1989). We purposively selected (Seawright & Gerring, 2008) three Norwegian municipalities as case-organizations. Accordingly, we recruited three municipalities with diversity in size, demographics, organizational structures, and professional practices (see table 1).

The data material consisted of individual in-depth interviews with professionals and managers, focus group interviews with service recipients, family caregivers, professionals, and managers, individual telephone interviews with service recipients and family caregivers, and observations of inter-professional and inter-agency meetings. The data gathering process lasted from May 2019 to May 2020.

Interviews

For all types of interviews, we recruited participants with over two years of experience in their respective roles. The recruited professionals and managers worked within mental health services, substance abuse services, and home nursing care. This included outreaching services in the service recipients' homes as well as follow-up services in forms of individual and group conversations. Further inclusion criteria for professionals and managers were that they had substantial knowledge of the services, and whose work involved assessment and allocation or management. The recruitment resulted in 17 professionals and managers for individual in-depth interviews, and 14 professionals and managers for focus group interviews. We recruited mental health nurses, social workers, social educators, psychologists, and health workers. Amongst these there were 22 women and nine men, and their age varied from 32 to 65.

The recruited service recipients were current or former receivers of the services that the recruited professionals and managers worked in, and the recruited family caregivers were familiar with these services through their role. We recruited 11 service recipients and three family caregivers for focus group interviews, and three service recipients and three family caregivers for individual telephone interviews. Included were ten male and four female service recipients with age ranging from 34 to 74. The family caregivers were parents, siblings and one ex-spouse. Amongst these there were three men and three women, and their age ranged from 36 to 79.

All types of interviews except from the telephone interviews were conducted in meeting rooms and offices in the municipal services. The individual in-depth interviews lasted from 45 to 90 minutes, and they were audiotaped and transcribed. In the focus group interviews the first author conducted and moderated the discussions, and a research-fellow wrote down the participants' statements. These interviews lasted from 60 to 90 minutes. In the telephone interviews, the first author both conducted and wrote the statements down. These interviews lasted from 30 to 45 minutes. All participants were anonymized with codes in the transcripts.

The interview guide for the individual in-depth interviews with professionals and managers contained three themes concerning organizational and financial structures and professional practices, with follow-up questions depending on what the participants stated. In the interview guide for focus group interviews and individual telephone interviews we focused on the unique experiences and meanings of the participants through the initial question: "What must professionals be capable of in order to integrate services"? The elements in the follow-up questions were deductively driven, dealing with components within the definitions of competence and service integration. Examples of components were types of knowledge, skills, and attitudes as well as collaboration, coordination, networks, relations, and considerations of individual needs.

Observations

When seeking meetings to observe, we wanted to include interprofessional and interagency meetings where services for people with concurrent substance abuse and mental health challenges were discussed, assessed, and allocated and where decisions were made. Managers who knew the organizations well were responsible for selecting the meetings, and the size of the municipality was a contributing factor in the selections. The first author performed the observations, with an overt nonparticipant observation role (O'Reilly, 2012). Observations were written down as field notes that was coded to maintain participant anonymity.

Analysis

Our theoretical interests in the alternating utilization of formal and informal coordination and collaboration formed the basis of the analysis. The dataset, consisting of transcribed interviews and observational notes were accordingly analysed with a deductive thematic analysis (Braun & Clarke, 2006). We searched the empirical material for patterns and wrote a situation description based on these patterns. Firstly, we identified a bureaucratic pattern consisting of formal structures and mechanisms for coordination, provided by managers.

Examples of formal structures were housing meetings, digital communication channels, and establishment of mental health and substance abuse outreaching team. Secondly, we identified ways in which professionals resorted to informal ways of collaboration, where they used discretion to solve challenges on behalf of service recipients in ways that were not expected by managers. Together, these patterns formed the basis for two main themes: 1) formal bureaucratic integration and 2) informal street-level integration (see Figure 1).

Ethical considerations

The study was approved by the Norwegian Centre for Research Data (ref. no. 300488), and exemptions from the duty of confidentiality were granted by the South-Eastern Norway Regional Committee for Medical and Health Research Ethics (ref. no. 2019/299 REK Sør-Øst). Comprehensive information about the study was provided orally and in writing to managers in the departments and units of interest and distributed to the participants. The participants signed an informed written consent prior to the data gathering.

Results

The big municipality had many registered service recipients with concurrent mental health and substance abuse challenges, which also had physical health challenges, and several of them had unrestrained behaviour. Their complex life situation that made residing them a challenge. This challenge was also due to the municipality's capacity for available apartments. Finding suitable housing required coordination and collaboration, which is why managers had established meetings concerning allocation of housing.

The participants in the housing meetings pointed out coordination problems between The Norwegian Labour and Welfare Administration (NAV), the housing office, mental health and substance abuse services, and housing support services. Responsibilities tied to housing and living were divided between these different organizational units, and questions arose: Why did people get help with allocation of housing but rejection on applications for economic benefits? Why did not NAV get oral or digital information when service recipients' rent, and electricity bills remained unpaid? Why did professionals work hard at getting people housing but failed to make sure that that they kept their housing? The participants discussed these questions and addressed the need for closer collaboration, to prevent service recipients from losing their homes.

Service recipients affected by the capacity challenges experienced long waiting periods tied to applications for economic benefits. Hence, they found it hard to collaborate with NAV. In a focus group interview, service recipients said that they had little human contact with NAV and believed that professionals there tried to protect themselves from service recipients due to their busy work. Professionals in the follow-up services perceived service recipients` frustration with contact and collaboration frequently. A professional employed in a mental health and substance abuse outreaching team gave the following account:

The service recipients often express their frustration to us. We see that they get sicker and sometimes angry and even violent when they cannot reach certain services, especially NAV. Of that reason, I fixed us a shortcut to NAV. I knew the director and met her to discuss if we could get entrance cards to NAV, although I knew that this was strict. She accepted the suggestion because this would prevent violent and threatening behaviour targeted at the professionals at NAV. So now, we cross three security check points, and go straight to the case worker and handle situations straightaway. This arrangement improves efficiency in case handling and reduces stress and unwanted events among service recipients (...). We are good at working unbureaucratically in our team, and frequently use our network. There was this one service recipient where I showed up directly at his doctor's office at the hospital and asked if he had 5 minutes. I knew him because I had worked in the municipality for years. I explained this complicated case where the service recipient raged and started fighting in the emergency room, and the doctor immediately admitted the man to the hospital. This worked out better for the service recipient and for the whole system. He was calmer when he could go straight into the hospital instead of scaring the whole emergency room.

The type of commitment demonstrated by the team member was regarded positive by service recipients and family care givers. They wished that more professionals could be flexible and "think outside the box," and not just respond to the bureaucratic processes tied to service delivery. These processes were viewed as rigid and not well suited for people with concurrent mental health and substance abuse challenges.

The team members in the outreaching team valued close contact, respect and trust with service recipient, family caregivers and collaborative partners. A manager explained that the team members were hand-picked based on their personal traits and attitudes rather than on how many ECT's they had. Through years of relationship work the team members had thorough knowledge of, and even personal relationships with the people they collaborated

with. The manager claimed that this why this team was so successful with the follow-up of severely ill service recipients.

The two main themes in this description are 1) formal bureaucratic integration and 2) informal street-level integration. We will in the following further elaborate these and illustrate with the use of more empirical data.

Formal bureaucratic integration

As the illustrative description shows, managers in the big municipality committed to service integration by arranging and attending physical meetings, and they provided digital communication platforms. However, information transfer through these channels did not work optimally.

The smallest municipality had an integrated mental health and substance abuse department, and the manager and professionals here valued a collaborative culture. The manager in this department had also initiated and formalized collaborative meetings with other care services. The home nursing care manager appreciated how the dialogue in these meetings often lead to solutions. The following observational notes describes the close relationships between professionals in the mental health and substance abuse department:

"Today they are discussing new service applicants, and although there are different opinions concerning one applicant, the professionals decide on a solution that they all seem satisfied with. I identify an including and safe atmosphere in this meeting where they can express their opinion. The professionals seem to care for each other, which is apparent when they help and guide each other in respective cases. They even include me in their friendly company, and I feel genuinely welcome and included."

The closeness between professionals gave results for service recipients:

"They have knowledge within each their own field. Addictions, mental health, and some have both. But I have had the same consultant all along" (Service recipient, Municipality 1).

The accounts show how the manager-initiated culture for dialogue created continuity for service recipients, as they could receive help with needs triggered by mental health challenges and substance abuse challenges by the same professional.

In the medium sized municipality, mental health and substance abuse services were co-located but organized as two separate departments. The co-location was intentional, as managers

expected professionals to have more dialogue when they worked under the same roof. Simultaneously, the managers had not established any formal coordination meetings between departments, and they had a rule of not allocating both mental health services and substance abuse services to the same service recipient due to financial restrictions:

"We have had lack of resources which forced us to be strict. But we could to a greater extent make use of our respective competencies. This is dependent on us, I would think. We sit in the same corridor but are not good enough at taking advantage of each other" (Professional, substance abuse department).

This statement points at a tradition for economic reasoning which undermined collaboration with and around service recipients. Co-location was thus not sufficient for interprofessional dialogue and work. Managers exercised caution with resource use, which resulted in lack of formalized coordination and collaboration arrangements. This situation illustrates a greater managerial commitment to economic responsibilities than to integrative responsibilities.

The professionals' commitment to integration was recognized as a pattern in all three municipalities**.** However, it was only in the biggest and smallest municipality that managers committed to integration through establishment of formalized coordination and collaboration arrangements in a way that seemed symmetrical with professionals' commitment. In the medium sized municipality, managers avoided to establish essential coordination and collaboration arrangements due to economic considerations. This resulted in an asymmetrical relationship between managerial and professional commitment to integration.

Informal street-level integration.

Formal coordination and collaboration arrangements were not always sufficient. Thus, professionals found alternative ways to collaborate outside official channels. The collaborative processes presented by the team member were informal collaboration based on trust and goodwill, which also improved the efficiency for professionals in the units he established contact with. Another example of was found in the medium sized municipality. Here, several service recipients and family caregivers shared their experiences concerning a general practitioner (GP). The following account was given by one of these service recipients:

«I had psychosis in 2017 and was in and out of the hospital. I have not got much good to say about the hospital. The number of staff and the competence was not good, and the ways I

were treated were criticisable. Psychosis demands a lot of communication with professionals, and that do not fit in with the modern system. I got thrown back and forth in the system. In the psychiatric outpatient clinic, I had five different psychiatrists. I did not progress in my treatment; I gradually became more ill, and the amount of medication increased. In 2018 my GP over my whole treatment, together with a private practicing psychiatrist that the GP initiated a collaboration with. We had frequent triangular conversations, where I got a comprehensive treatment plan. We worked on my mental issues and a gradual reduction in medications. After four months I was back at work 25 % and I could get my driver licence back» (Service recipient, Municipality 2).

The GP had identified weaknesses in the ways his patients with mental health diagnosis were treated in specialist health care. Instead of accepting this weakness, he took the matter in his own hands and initiated an interprofessional collaborative alliance with a private practicing psychiatrist. Thus, he was able to give his patients a comprehensive treatment which led to recovery. This reflects commitment to the task of helping service recipients in their situation.

Another way of committing was to do work tasks after ordinary working hours. A professional in the small municipality said the following in an interview:

Professional: Sometimes if I assess a situation as acute, I must work overtime, or I take the work phone home after work. We are good at being flexible.

Interviewer: Do you get paid for this?

Professional: No, but I get compensatory time off, also for working overtime. We never get overtime payment.

Interviewer: So, your additional workload does not cost the municipality anything?

Professional: no

Overtime was usually due to coordinating work, for example writing meeting summaries that was forwarded to actors collaborating around individual service recipients. The account shows that additional work affecting professionals' time off, was motivated by commitment to the wellbeing of service recipients' and not by money.

Professionals did not protest formal coordinating and collaboration arrangements. It was rather a situation where formal arrangements were insufficient. Professionals used their years of experience in the field to assess situations, and to decide on the type of informal help they

would offer and who in their network they would collaborate with. This meant taking on more responsibility than what was expected by managers. Professionals neither involved managers in decisions about collaboration outside official channels or hide it from them. The manager which had managerial responsibilities for the outreaching team in the big municipality expressed this:

"The team has particularly good routines that they have developed over time. They also have close contact with case workers at NAV and other services. They have a kind of personal relationship to the people they collaborate with. This makes them well suited for working with severely ill people" (Manager, Municipality 3).

This statement demonstrates that managers were aware of the informal collaboration that professionals participated in. It also demonstrates the value of experienced professionals with capacious collaborative networks, and how they hold valuable competence for the services and for service recipients.

Discussion

Above, we have shown that formal and informal aspects of bureaucratic institutions may be combined in diverse ways. The two aspects always coexist, but as has been well documented in theory and empirical research the relationship between them may emerge as antagonistic, and even parasitical (Collins, 2011; Tilly, 2005). First, as organizations are complex systems that no single interest, actor, or type of knowledge can grasp and control in any direct sense, non-intended effects of good intentions – which often tend to come in the form of increasing formalization as means for achieving specific goals – may multiply. Alternatively, informal networks may appropriate organizational resources for their own ends. Both processes are intimately linked to organizational authority and hierarchy (Eaton, 2003). In the empirical material presented above we have seen that organizational authority and hierarchy, when granting, legitimating, and facilitating experiments in street-level diplomacy by securing relative autonomy on the part of professional "diplomats," may enable the informal properties and potential to free and activate resources that make formal goals attainable in practice. In the cases described, the freeing of institutional social "capital" is made possible as "diplomats" combine resources in particular, context-sensitive ways and convert value (autonomy, experience-based knowledge, dedication to clients' concerns) into desirable

outcomes (opening doors, connecting relevant actors, enabling services to be adapted to specific needs).

Symmetrical and asymmetrical commitment

Symmetrical integration is our conceptualization of processes of mutual commitment that may emerge when managers meet professionals' needs for service integration arrangements. Such integration may be achieved through formal coordination channels such as inter-professional and inter-organizational decision meetings and digital communication systems (Gupta & Govindarajan, 2000). These arrangements and systems can be regarded as formal and bureaucratical, as they are managerially initiated and the channels in which managers expect professionals to coordinate activities (Lawrence & Lorsch, 1967). Formal integration can safeguard collective action to a certain extent. However, it is not given that professionals solve problems collectively merely because there are available structures for this (Kates, Mazowita, Lemire, Jayabarathan, Bland, Selby, Isomura, Craven, Gervais & Audet, 2011). Formal systems and arrangements should therefore be accompanied with collaborative cultures marked by shared beliefs and values (Lalani & Marshall, 2022). Our empirical material shows that managers who establish arenas to reflect, discuss and reach collective understandings, and who invest in a collaborative culture, tend to achieve a collaborative climate marked by openness, trust, and respect (Ambrose-Miller & Ashcroft, 2016). This shows that managers who commit to both formal and informal integration, as in the small municipality, contribute to symmetrical commitment to service integration.

The outreaching team in the big municipality is an example of a managerially initiated arrangement that were formally structured for informal collaboration. Here, professionals were handpicked because of their abilities to build relationships with service recipients, family caregivers and collaborative partners, and they were given a high degree of autonomy. Thus, symmetrical commitment to service integration resulted in a team that according to our findings worked "as planned", where personal commitment and dedication seemed to be more important than formal competence.

Asymmetrical commitment became manifest when managers did not prepare sufficiently for service integration. In the medium-sized municipality there were neither managerial initiated structures in place (except from co-location) nor focus on collaborative cultures. Responsibility for collaborating activities in situations that required it was left to the professionals. As street-level bureaucrats, professionals balance limited resources,

professional ethical standards and service recipients' needs for individually adapted services every day. In addition, professionals often aim to meet service recipients' complex needs by including measures found in the local community and even their private lives. Such situations has previously been conceptualized as personal inundation for professionals (Bjørkquist & Ramsdal, 2021). The asymmetrical commitment discussed above contribute to establishing vulnerable conditions for service integration, and a responsibility overload for professionals working in the services, which in turn can lead to burn out (Chen & Liu, 2022).

Street-level diplomacy work.

Although it is not given that professionals compensate for weak formal structures by applying informal methods, our material strongly indicate that in many cases they do compensate, which is vital for achieving service integration. We found that professional's resort to informal ways of collaborating independent of degree of formalized arrangements present, and two specific diplomacy skills were evident in the material: active approach to networking and use of alternative methods.

Our findings display experienced professionals who had built networks, developed their relational skills, and developed their ability to find solutions in demanding and resource limited conditions. Thus, they utilized their professional networks actively. These professionals demonstrated a high degree of relationship building and active approach to using the network to their advantage for realizing important outcomes for service recipients (Moore, Prentice, Crawford, Lankshear, Limoges & Rhodes, 2019). Professionals in this study invested in relationships by building trust and commitment through communication and respect (Gale et al., 2017). In this sense, professional networks and networking skills are important social capital (Strömgren, Eriksson, Bergman & Dellve, 2016) in service integration processes. Another decisive factor here is that diplomacy work is something than comes with experience. Newly educated professionals can lack both experience and networks to do excellent diplomacy work.

The use of alternative methods may be conceptualized in general terms as "acting outside the box". Professionals were creative and flexible when they contrived ways of achieving desired outcomes for service recipients. On system level this creativity and flexibility was displayed in the example of getting entrance cards to NAV and the GP who had established a collaborative relation to a private practicing psychiatrist. On the other hand, creativity and flexibility was used in ad hoc situations when professionals brought the work phone home,

and when they got service recipients admitted to the hospital through the "back door". This signalizes a great willingness to "push the envelope" on behalf of service recipients. As such, creativity and flexibility constitute as important components within professional discretion used in service integration processes.

Conclusion

There are implications for practice to be addressed when we conclude our discussion. Firstly, there are two prerequisites important for service integration processes. The commitment to the policy aims of integration must be symmetrical between managers and professionals. This means that managers should prepare for formal coordination arrangements and informal collaboration arrangements, to meet professionals' needs for systems and arenas for collective problem solving. Additionally, as we find creativity and flexibility as decisive components of professional discretion, there should be room for such approaches both on system level and in ad hoc situations. Secondly, one should consider networks and networking skills as necessary social capital in service integration processes. Thus, we recommend that this should be taken into consideration when further developing systems and approaches for service integration, and even in health and social care professionals' educational pathways.

In conclusion we argue that formal bureaucratic integration and informal street-level integration can co-exist in a symbiotic relationship, if there is a symmetrical commitment to the Norwegian welfare states' aim of service integration between managers and professionals.

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Appendecies

Appendix 1: Approval from The Norwegian Agency for Shared Services in Education and Research (SIKT).

Appendix 2: Dispensation from the duty of confidentiality (REK).

Appendix 3: Observation protocol.

Appendix 4: Interview guide sub-study 1 and 3.

Appendix 5: Interview guide sub-study 2 and 3.

Appendix 6: Information and consent sub-study 1 and 3.

Appendix 7: Information and consent sub-study 2 and 3, professionals and managers.

Appendix 8: Information and consent sub-study 2 and 3, service recipients and family caregivers.

Appendix 9: Initial information to service recipients and family caregivers sub-study 2 and 3.

Vurdering av behandling av personopplysninger

Referansenummer
300488

Vurderingstype
Standard

Dato
17.04.2019

Prosjekttittel
Services to Persons with Dual Diagnosis

Behandlingsansvarlig institusjon
Høgskolen i Østfold / Avdeling for helse og velferd

Prosjektansvarlig
Therese Dwyer Løken

Prosjektperiode
01.09.2018 - 31.12.2021

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 31.12.2021.

Meldeskjema

Kommentar
Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet 17.04.2019 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde: https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html
Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle særlige kategorier av personopplysninger om helse og alminnelige kategorier av personopplysninger frem til 31.12.2021.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 a), jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

TREDJEPERSONER
Spørsmålene i intervjuene er formulert for å unngå tredjepartsinformasjon, men det vil kunne fremkomme enkelte opplysninger om andre ansatte og ledere. Eventuelle opplysninger vil være av lite omfang, og ikke av sensitive art. Om tredjepersonopplysninger fremkommer vil de bli anonymisert i transkripsjon.

NSD vurderer at samfunnets interesse i at behandlingen finner sted klart overstiger ulempen for den enkelte. Lovlig grunnlag for

behandlingen av opplysninger om tredjepersoner vil være allmenn interesse, jf. personvernforordningen art. 6 nr. 1 bokstav e, jf. art. 6 nr. 3, jf. personopplysningsloven § 8.

DISPENSASJON FRA TAUSHETSPLIKTEN
Prosjektet skal følge kommunalt ansatte i deres daglige arbeide ved tildeling av tjenester innenfor rus og psykisk helse, og har derfor søkt om fritak fra lovpålagt taushetsplikt. REK har innvilget dispensasjon fra taushetsplikt for opplysninger til forskning jf. jf. helsepersonelloven § 29 første ledd og forvaltningsloven § 13 d første ledd (2019/299/REK sør-øst C).

Dispensasjonen gjelder tilgangen til observasjonen, det skal ikke registreres personopplysninger om brukere under observasjonen.

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20). Tredjepersoner vil i tillegg ha rett til protest (art. 21).

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

For tredjepersoner vurderer vi at det kan unntas fra retten til informasjon jf. personvernforordningen 14 nr. 5 bokstav b, ettersom det vil kreve en uforholdsmessig stor innsats sett opp mot nytten de registrerte vil ha av å informeres.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

Concept Systems Incorporated er databehandler i prosjektet. NSD legger til grunn at behandlingen oppfyller kravene til bruk av databehandler, jf. art 28 og 29.

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/ pågår i tråd med den behandlingen som er dokumentert.

Lykke til med prosjektet!

Kontaktperson hos NSD: Kajsa Amundsen
Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Anders Strand	22845511	11.04.2019	2019/299/REK sør-øst C
			Deres dato:	Deres referanse:
			12.02.2019	

Vår referanse må oppgis ved alle henvendelser

Therese Dwyer Løken
Høgskolen i Østfold

2019/299 : HELHETLIGE TJENESTER TIL PERSONER MED SAMTIDIG RUSAVHENGIGHET OG PSYKISKE UTFORDRINGER

Forskningsansvarlig institusjon: Høgskolen i Østfold
Prosjektleder: Therese Dwyer Løken

Vi viser til søknad om dispensasjon fra taushetsplikt i ovennevnte prosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 21.03.2019. Vurderingen er gjort med hjemmel i forskrift av 02.07.09 nr.989, helsepersonelloven § 29 første ledd og forvaltningsloven § 13 d.

Prosjektomtale
Formålet med studien er å undersøke hvilke faktorer innenfor kompetanse og finansiering som fremmer organisering av helhetlige tjenester til personer med ROP-lidelser. Det skal også undersøkes hvordan forvaltningen av disse to ressursene er med på å fremme og hemme helhetlige tjenester til samme gruppe personer. Forskningsspørsmålene er som følger: 1. Hvordan påvirker de økonomiske ressursene levering av helhetlige tjenester? Metoder: Observasjon, dokumentanalyse og individuelle intervjuer. Deltakere er ansatte på kommunenes tildelingskontorer og deres ledere. 2. Hva slags kompetanse blant fagfolk i kommunens tjenester fremmer levering av helhetlige tjenester? Metode: concept mapping. Deltakere er tjenesteytere,ledere, brukere og pårørende. 3.Hvordan påvirker styringen av økonomiske og kompetanseressursene helhetlige tjenester på kommunenivå? Metode: individuelle intervjuer. Deltakere er ledere av kommunale tjenester innenfor rus og psykisk helse.

Vurdering
Prosjektet skal benytte deltagende observasjon og skal intervjue tjenestemottakere, og søker derfor om fritak fra lovpålagt taushetsplikt. Komiteen har vurdert slikt fritak i lys av at opplysninger om at en gitt person er tjenestemottaker er taushetspliktbelagt, og at det er en reell mulighet for at andre taushetspliktbelagte opplysninger kan komme forskerne for øre under deltagende observasjon.

Studien er samtykkebasert, men det omsøkte fritaket for taushetsplikt vil være nødvendig for å kunne gjennomføre studien med de beskrevne metoder. Komiteen har vurdert fritak etter helsepersonnelloven §29, sett i sammenheng med kravene for fritak som fremkommer i helseforskningsloven §35. Studien antas å ha vesentlig samfunnsnytte, og hensynet til deltakernes velferd og integritet fremstår som vel ivaretatt. Prosjektet omhandler tjenestene som mottas, og tjenestemottakere som intervjues vil ikke selv stå i fokus for prosjektet. Komiteen anser derfor vilkårene for fritak fra lovpålagt taushetsplikt å være oppfylt, og innvilger slikt fritak med hjemmel i helsepersonnelloven §29.

I søknaden oppgis det at koblingsnøkkel skal oppbevares på eget hjemmeområde ved Høgskolen i Østfold.

Komiteen anbefaler, med henvisning til behandlingsansvar etter GDPR, at oppbevaring og behandling av personopplysninger i prosjektet gjennomgås, og eventuelt revideres i lys av interne retningslinjer og kravene i personvernforordningen (GDPR).

Komiteen bemerker også at det følgende ikke lar seg kombinere «Det vil være full anonymisering av alle deltakere og alle kan på hvilket tidspunkt som helst trekke sin deltakelse fra studien og også få sine opplysninger slettet.» (fra søknadsskjema punkt 4e). Opplysninger er ikke å anse som anonyme dersom det foreligger koblingsnøkkel, og koblingsnøkkel er nødvendig for å kunne slette deres opplysninger dersom deltagere trekker seg fra studien.

Vedtak
Med hjemmel i Forskrift av 2.7.2009 nr. 989, Delegering av myndighet til den regionale komiteen for medisinsk og helsefaglig forskningsetikk etter helsepersonelloven § 29 første ledd og forvaltningsloven § 13d første ledd, har komiteen besluttet å gi fritak fra lovpålagt taushetsplikt for tilgang til journalopplysninger slik dette er beskrevet i søknad og prosjektbeskrivelse.

Dispensasjonen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknad og vedlegg.

Dispensasjon fra taushetsplikten gjelder til 31.12.2021.

Komiteens avgjørelse var enstemmig.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jfr. helseforskningsloven § 10, tredje ledd og forvaltningsloven § 28. En eventuell klage sendes til REK sør-øst C. Klagefristen er tre uker fra mottak av dette brevet, jfr. forvaltningsloven § 29.

Med vennlig hilsen

Britt Ingjerd Nesheim
professor dr. med.
leder REK sør-øst C

Anders Strand
Rådgiver

Kopi til: theresdl@hiof.no, Høgskolen i Østfold ved øverste administrative ledelse: postmottak@hiof.no

Observation protocol

Allocation process (routines, proceedures, processes)

Assessment (courses of action, co-determination, professional discretion, person-centred focus)

Financial and/or organizational considerations (boundaries, organizational structures, economic reasoning, coordination arrangements)

Municipal income (block grants, ear marked income, project funding)

Collaboration/partnership/networks (ACT, FACT, TSB, other specialist health care collaborations, general practitioner, private for-profit companies etc.)

Institutions (care facilities, KAD, housing offers, private for-profit, specialist care)

Interview guide sub-study 1

Research question: How do public management values influence service integration in municipal health and social care organizations?

Allocation processes and assessments.

Can you describe how a typical allocation process is carried out? Who is involved?

What types of assessments motivate the types of services that a service recipient receives? Why?

What motivates the decision of allocation of either mental health services or substance abuse services?

Do you follow certain routines, proceedures or assessment tools?

How much discretion do people who assess and allocate services have?

Does the professional background of the person who assess and allocate influence in these processes?

Do you see that anything could be different in your municipal service system regarding achievement of integrated services? Why?

Are there potentially outcomes that you feel that you fail to achieve in the municipal service system? Why?

How do you collaborate to achieve the desired outcomes of service recipients?

Financial aspects.

Does economy affect the assessments that allocation of services are based on? If so, why and how?

Have you experienced situations where economic considerations have impeded integrated services for service recipients?

Do you experience that there are any economic incentives for allocation of certain services?

Do you have any examples of cases where the municipality's available services or resources have decided the service offer instead of the service recipient's actual needs?

Other features and aspects.

Different ways of structuring budgets (pooling of budgets, project funding etc.).

What happens when project funding come to an end?

Ear marked grants within mental health and substance abuse.

Are there certain services that are considered more expensive than others?

Activities releasing expenditure at the expense of the time spent with direct service delivery (participating in meetings, coordinating activities, digital communication etc.).

Partnerships with other actors (voluntary organizations, specialist health care, private for-profit organizations).

The use of municipal emergency day care units for people with mental health and substance abuse challenges.

Payment for patients who are ready to be discharged from hospital wards.

Interview guide sub-study 2

Research question: what types of competence is are needed in order to integrate services?

One open start-up question:

"What must professionals be capable of to deliver integrated services?"

Theme	Examples of questions
Knowledge	- Are there certain things you think that professionals should know to create continuity/ to collaborate/ to better coordinate? - Do you think professionals have the knowledge they need for working with mental health/substance abuse/ physical health?
Skills	- What skills are required to integrate services? - Are there certain skills that are important for coordination and collaboration?
Attitudes	- What types of professional attitudes do you appreciate? - Are there attitudes that can prohibit coordination/collaboration?
Profession specific competence	- How would you say that the level of substance abuse competence is in mental health services and vice versa?

	- What about competence within mental health and substance abuse within physical health services, and vice versa?
Organizational competence	- Does it matter if professionals have knowledge about the organization they work in or not? Why? What should they have knowledge about?
Competence on all levels	- Are there certain types of knowledge, skills or attitudes that are important for managers when it comes to coordination and collaboration?
Lack of competence	- Do you experience that there are certain types of competences that lack? Which ones? Why? - What can be done in order to obtain the lacking competence?

FORESPØRSEL OM DELTAKELSE I STUDIEN: HELHETLIGE TJENESTER TIL PERSONER MED SAMTIDIG RUSAVHENGIGHET OG PSYKISKE UTFORDRINGER.

HVA INNEBÆRER STUDIEN?

Formålet med studien er å undersøke hvilke faktorer innenfor kompetanse og finansiering som fremmer organisering av helhetlige tjenester til personer med ROP-lidelser. Dette gjøres gjennom studier av tjenestetilbudet for denne gruppen av personer i tre kommuner. Studien vil bestå av observasjoner, intervjuer av ansatte samt gjennomgang av dokumenter. Dette er et doktorgradsprosjekt med stipendiat Therese Dwyer Løken, ved Høgskolen i Østfold, som ansvarlig.

HVORFOR FÅR DU SPØRSMÅL OM Å DELTA, OG HVA INNEBÆRER DET?

Du er spurt om å delta fordi din kommune deltar i ROPIT-prosjektet og du jobber med tjenester til ROP-pasienter. Din deltakelse innebærer at stipendiaten deltar som observatør i aktuelle møter hvor tjenester innenfor ROP diskuteres og hvor vurderinger og beslutninger tas, og/eller et individuelt dybdeintervju på 45-60 minutter. Deltakelsen innebærer ikke tap av lønn eller fritid for deg som ansatt.

HVA SKJER MED OPPLYSNINGENE OM DEG?

Intervjuene blir tatt opp med lydopptaker, mens observasjonene noteres for hånd av stipendiaten. Lydfilene blir deretter gjort om til tekst og lagret digitalt sammen med notatene i forbindelse med observasjonene. Alle opplysningene om deg blir behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste som lagres i tråd med Høgskolens retningslinjer. Det er kun stipendiaten som har tilgang til denne listen. Det er stipendiaten og hennes to veiledere som vil ha tilgang til de opplysningene du oppgir, og de slettes etter prosjektslutt. Resultatene vil bearbeides for publisering. All publisering og informasjon knyttet til prosjektet vil bli gitt på en slik måte at enkeltpersoner ikke kan gjenkjennes.

FRIVILLIG DELTAKELSE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen. Du kan når som helst og uten å oppgi noen grunn trekke din deltakelse. Dette vil ikke få konsekvenser for deg som ansatt. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede opplysninger hvis ikke opplysningene allerede inngår i analyser eller vitenskapelige publikasjoner.

DINE RETTIGHETER

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- å få innsyn i hvilke personopplysninger som er registrert om deg

- å få rettet personopplysninger om deg
- få slettet personopplysninger om deg
- få utlevert en kopi av dine personopplysninger
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger

VED SPØRSMÅL TIL STUDIEN ELLER DINE RETTIGHETER:

Therese Dwyer Løken ved Avdeling for helse- og velferd, Høgskolen i Østfold, telefon: 920 629 44, e-post: therese.d.loken@hiof.no.

Personvernombud ved Høgskolen i Østfold Martin Gautestad Jakobsen, telefon 69 60 80 09, e-post: martin.g.jakobsen@hiof.no.

NSD – Norsk senter for forskningsdata AS, telefon: 55 58 21 17, e-post: personverntjenester@nsd.no.

SAMTYKKE TIL Å DELTA I STUDIEN

Jeg har mottatt og forstått informasjon om studien, og har fått anledning til å stille spørsmål. Jeg samtykker til å delta i intervju. Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, 31.desember 2021.

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

Jeg bekrefter å ha gitt informasjon om studien.

Sted og dato

Signatur

Stipendiat og prosjektansvarlig

FORESPØRSEL OM DELTAKELSE I STUDIEN: HELHETLIGE TJENESTER TIL PERSONER MED SAMTIDIG RUSAVHENGIGHET OG PSYKISKE UTFORDRINGER.

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HVORFOR FÅR DU SPØRSMÅL OM Å DELTA, OG HVA INNEBÆRER DET?

Du er spurt om å delta fordi din kommune deltar i ROPIT-prosjektet og du 1) jobber med tildeling av tjenester til ROP-pasienter 2) jobber i tjenester innenfor rus og psykisk helse 3) er leder for kommunale tjenester innenfor rus og psykisk helse.

HVA SKJER MED OPPLYSNINGENE OM DEG?

Data fra begge fasene registreres i et eget program som heter Concept Systems Ink. Alle opplysningene om deg blir behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det er stipendiaten og hennes to veiledere som vil ha tilgang til de opplysningene du oppgir, og de slettes etter prosjektslutt. Resultatene vil bearbeides for publisering. All publisering og informasjon knyttet til prosjektet vil bli gitt på en slik måte at enkeltpersoner ikke kan gjenkjennes.

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SAMTYKKE TIL Å DELTA I STUDIEN

Jeg har mottatt og forstått informasjon om studien, og har fått anledning til å stille spørsmål. Jeg samtykker til å delta i Workshop på Høgskolen i Østfold. Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, 31.desember 2021.

Sted og dato | Deltakers signatur

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HVORFOR FÅR DU SPØRSMÅL OM Å DELTA, OG HVA INNEBÆRER DET?

Du er spurt om å delta fordi du er/har vært mottaker av kommunale tjenester innenfor rus og psykisk helse eller er pårørende til noen som har mottatt slike tjenester. Din deltakelse innebærer å delta på en elektronisk undersøkelse. I denne skal du ikke informere om noe fra egen sykehistorie eller andre sensitive opplysninger om egen situasjon. Det er de kommunale tjenestene vi vil vite noe om. Undersøkelsen tar 30-60 minutter og du kan velge selv om du vil gjøre den alene på egen PC eller om du vil gjøre den sammen med prosjektansvarlig.

HVA SKJER MED OPPLYSNINGENE OM DEG?

Alle opplysningene om deg blir behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste som lagres i tråd med Høgskolens retningslinjer. Det er kun stipendiaten som har tilgang til denne listen. Det er stipendiaten og hennes to veiledere som vil ha tilgang til de opplysningene du oppgir, og de slettes etter prosjektslutt. Resultatene vil bearbeides for publisering. All publisering og informasjon knyttet til prosjektet vil bli gitt på en slik måte at enkeltpersoner ikke kan gjenkjennes.

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Vil du dele dine erfaringer med oss?

Forskningsprosjektet ROPIT, ved Høgskolen i Østfold søker deltakere til gruppeintervju.

Vi ønsker å studere kompetanse i kommunale tjenester til mennesker med utfordringer innenfor psykisk helse og rusavhengighet. Hvis du har slike utfordringer og mottar eller har mottatt kommunal hjelp på grunn av dette så ønsker vi å høre fra deg. Hvis du er pårørende til noen som har utfordringer innen psykisk helse og rusavhengighet så er vi interessert i å høre fra deg også.

Deltakelsen innebærer å møte opp til en gruppesamtale i Halden to ganger i løpet av desember og januar. Hver gruppesamtale varer i underkant av 1 time. Som takk for hjelpen mottar du et universal gavekort på 300 kroner per gang du deltar.

Hvis du er interessert i å vite mer og/eller melde din interesse så kan du ringe eller sende SMS til Therese Dwyer Løken ved Høgskolen i Østfold på nr. 92 06 29 44 eller mail til theresdl@hiof.no

The dynamics between policy and practice
Therese Dwyer Løken

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