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**THE ONLY CONSTANT IS CHANGE –  
EXPLORING THE EVOLVEMENT OF  
HEALTH AND SOCIAL CARE  
INTEGRATION**

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# The only constant is change – Exploring the evolvement of health and social care integration

## THESIS FOR DOCTORAL DEGREE (Ph.D.)

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*Till min familj*

*“You can’t stop the waves,  
but you can learn how to surf.”*

*John Kabat-Zinn*



## ABSTRACT

**Introduction:** Health and social care services, in Sweden and worldwide, struggle to provide comprehensive care and support for people with complex needs. As these services are currently structured, it is difficult to provide service users with such care. This difficulty is especially acute for patients with mental illness. However, many challenges exist in the effort to achieve cross-sectoral cooperation of health and social care services. This thesis addresses one of these challenges: the evolvement of long-lasting integrated health and social care services in mental health care.

**Aim:** This thesis explores the organisational dynamics of long-term health and social care integration.

**Methods:** A qualitative research approach is taken in a longitudinal case study. The research consists of three studies on integrated health and social care: two studies take an organisational (managerial) perspective; one study takes a service user perspective. Data were collected in individual and group interviews and from steering committee minutes.

**Findings:** The findings from the three studies are summarized using four theoretically and empirically based themes related to the evolvement of long-term mental health and social care integration.

*Shared structure and ongoing refinement:* The integrated services were co-located under co-leadership management. A shared mission on the value of integrated health and social care was essential for establishing a culture of shared values and for sustaining the required long-term collaboration and cooperation.

*Continuous learning:* The continuous exchange of competencies and experiences was prioritized. Forums were established in which the various stakeholders could exchange information, interact, and learn in a culture of improvement. Team members were encouraged to help find effective solutions to the problems encountered when providing equal health and social care.

*Cooperation as a guiding principle:* The integration of health and social care services, which was based on the principle of cooperation, encouraged the participation of informal caregivers and of other parties such as stakeholder/service user associations, service user representatives, and municipal and county representatives.

*Service user centeredness:* The central role of the service user was formalized by an agreement that specified the individual care and rehabilitations plans. Attention was paid to service users' holistic needs and to their abilities and strengths in the focus on finding best-possible solutions to their individual circumstances.

**Conclusion:** This thesis identified three main factors that proved to play a central role in the achievement of long-term integration of health and social care services.

First, partnership building between the health and social care services, as well as with service users and service user associations, enabled the sharing of responsibility for the integrated services and a long-term orientation in decision-making. The formulation of an overall agreement, a shared mission, and the involvement of all stakeholders in the steering committee of the integrated services were activities that exemplified this.

Second, person-centeredness was important in the design and provision of the integrated services, as well as during encounters with service users. Co-location of services, co-leadership, and interprofessional-teams were some of the strategies that were used to meet service users' holistic needs.

Third, organisational learning was a strategy to overcome obstacles resulting from cross-sectoral cooperation, and to continually adapt and align services to the changing needs of service users.

In conclusion, the findings in this thesis suggest that the emergence and long-lasting integration of health and social care services were based in the capacity to manage differences and changes by relying on the concepts of partnership, person-centeredness, and continuous learning.



## LIST OF SCIENTIFIC PAPERS

- I. Klinga, C., Hansson, J., Hasson, H., & Sachs, M. A. (2016). Co-leadership – A management solution for integrated health and social care. *International Journal of Integrated Care*, 16(2):7.
- II. Klinga, C., Hasson, H., Sachs, M. A., & Hansson, J. (2018). Understanding the dynamics of sustainable change: A 20-year case study of integrated health and social care. *BMC Health Services Research*, 18:400.
- III. Klinga, C., Hasson, H., Sachs, M. A., Hansson, J., & Wannheden C. Through the eye of the service user representative: What key components contribute to value in integrated mental health and social care services? *Submitted (2018) to Health and Social Care in the Community*.

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## LIST OF ABBREVIATIONS AND DEFINITIONS

CAS	Complex adaptive system theory
DSF	Dynamic sustainability framework
Evolvement	Gradual change and development
Integrated care	In this thesis an umbrella term comprising integrated mental health and social care
ICT	Information and communications technology
NHS	National Health Service
Operational management	Managers who have both a formal responsibility and at the same time exercise leadership
Organisational dynamics	Patterns of change/movement occurring over time within an organisation (i.e. services)
Service user	Patients and clients
Social Services	Social care, social work, social assistance, social protection
SUA	Service user association (in Study II, referred to as stakeholder association) including associations for patients, clients, informal caregivers and others who are interested in the health and social care of a specific target group within mental health
SUR	Service user representative
Sustainable integration	Continuation of cross-sectoral services in accordance with contemporary needs of service users and requirements in terms of evidence, policies and regulations
UoA	Unit of analysis
WHO	World Health Organisation

# 1 PROLOGUE

*“Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion.”*

*Florence Nightingale*

When I began my journey as a PhD candidate I had a Bachelor’s degree in social work from Stockholm University, Department of Social Work. Thereafter I earned a Master’s degree in Clinical Medical Science and a Master’s degree in Medical Management from Karolinska Institutet. My empirical experience as a counsellor derives from my work in municipal social services and at a university hospital. During my eight years of social work, I witnessed all-too-often the situation in which people with complex health and social care needs experienced apprehension, uncertainty, long waiting times, unmet expectations, and surprises. Many of them also fell through the gaps in care and welfare services. My perception as a practitioner was that interprofessional collaboration was hampered by the strong professional boundaries and that cross-sectoral cooperation was hampered by differences in jurisdictions, vocabulary used, and the objectives of the services. The coordination of health and social care activities was similarly hampered. Based on this empirical experience and my formal education, I recognize that fragmentation in health and social care and other welfare services negatively influences service users’ health and social care experiences and outcomes. However, I am also aware of the many challenges that increased collaboration and cooperation entail. For this reason, I find the research about health and social care integration both interesting and important.

This research should be of interest to anyone who seeks an increased understanding of the areas and concerns just described. This research is specifically aimed at managers and professionals in integrated care services, especially those working in mental health and social care. In addition, this research is aimed at professionals in other welfare services who meet the same service users and policy makers in the process of planning and developing reforms.



## 2 INTRODUCTION

In this thesis, entitled “*The only constant is change – Exploring the evolvement of health and social care integration*”, the complex phenomenon of integrated health and social care services is studied in its natural context with special emphasis on organisational sustainability. The research area of *integrated care* involves several disciplines [1] even though considering it as a distinct scientific discipline is currently debated [2]. Thus, to study and understand the full nature of integrated care, several research fields must be addressed. In this thesis, the literature on implementation, leadership, organisational change, and quality improvement is a primary focus. The three studies of this thesis address complementary perspectives on integrated health and social care services.

The research was conducted at the Medical Management Centre, Department of Learning, Informatics, Management and Ethics, Karolinska Institutet. The thesis aligns with the mission of the Medical Management Centre: “*Improve health care by developing useful knowledge on organizing and managing health care, to promote safe, high-quality and cost-effective medical services*”. Thus, this thesis focuses on the following areas: the role of operational management in terms of co-leadership, the overall organisational management, and the experiences of the integrated services from the service users’ point of view. The thesis also aims to increase our understanding of organisational and managerial features of how long-term maintenance of cross-sectoral cooperation (i.e. continuation of integration) can be achieved in a Swedish public-sector setting. I gratefully acknowledge the financial support for the research for this thesis: *European Commission (GA, 305821 – INTEGRATE)*, *Swedish Research Council (521-2014-2710)* and *Forte (2012-1688)*.

## 2.1 AIM

The aim of the thesis is to explore the organisational dynamics of long-term health and social care integration.

## 2.2 OVERVIEW OF THE THESIS

The research, which was conducted in integrated health and social care, examines the area from the organisational and service user and informal caregiver perspectives. An overview of the research context and the specific research questions is presented in Figure 1.

This thesis uses integrated care as an umbrella term that comprises cross-sectoral, mental health, and social care integration. Integrated care is described in greater detail (including reflections on the concept) in Section 2.6.

Domain	Perspective	Target group	Study and research questions
Integrated Health and Social Care	Organisation	Co-leaders at operational management level	Study I. What are the essential preconditions in fulfilling the co-leadership assignment, its operationalization and impact on the provision of sustainable integration of health and social care?
		Steering committee representatives	Study II. What contributes to sustainable integration of health and social care from a steering committee perspective?
	Service users and informal caregivers	Representatives for service user associations	Study III. What contributes to value for service users in integrated health and social care services, based on the perceptions of service user representatives?

Figure 1. Overview of the thesis



## 2.3 WHY STUDY INTEGRATED CARE WITH EMPHASIS ON SUSTAINABILITY?

*“The best big idea is only going to be as good as its implementation.”*

*Jay Samit*

Health and social care, as provided in Sweden and many other countries, faces several challenges in meeting the expectations of people with complex care needs. To consider health from a bio-psychosocial perspective, disease is acknowledged as simultaneous social, psychological, and medical problems [3]. This view of health is in line with one suggested underlying philosophy of integrated care that advocates fundamental person-centeredness. According to this philosophy, integrated care should respond to people’s holistic needs [4].

Cross-sectoral cooperation in traditional health and social care is confined to separate, organisational silos in the welfare system, is administered by different governmental jurisdictions, and is guided by various missions. This scenario presents a complicated situation [5]. Also, this organisational structure creates barriers for collaboration between professions and organisations [6]. The structure with specialized providers and different principal organisations can lead to difficulties in following the service users’ path through the health care system and other welfare services. This situation results in high demands on managers, leaders, professionals, and, not the least, the service users.

The county councils and the municipalities in Sweden have experienced constant pressure over a long period of time with respect to health care systems because of recurrent performance reviews and increased demands for cost containment [7]. Internationally, the increase in the aging population (with often-complex health care problems) has called attention to the need for improved integration in such systems. There have been calls for more complex care skills and greater knowledge among health care professionals as well as increased specialization among such professionals in order to provide more comprehensive care. However, no single professional group can meet all the needs of its service users [8]. In addition, more development is needed in the areas of self-care, prevention, and primary care with an emphasis on more consistent standards and better coordinated and integrated care [9, 10].

The World Health Organization (WHO) proposes a reorientation of health services towards greater people-centeredness and more integration of services. This proposal implies a fundamental shift in health care funding, management, and delivery [11]. The WHO argues that increased collaboration, coordination, and cooperation can allow health services to take a

more holistic approach to people's needs. Research has revealed that integrated care can be a means to reduce fragmentation and health care utilization. The result could be lower public costs, improved care coordination and continuity, and better access, quality, and outcomes for service users [9, 12–19].

One major challenge for today's organisations, in the attempt to find innovative solutions for increased cooperation by integrating complex health and social care services, is to maintain the achieved levels of organisational change while adapting to constantly shifting needs, priorities, and expectations [20]. Many attempts fail, which is a waste of resources and therefore not economically justified. A second major challenge is the general inattention to sustainability that prevents the subsequent scale-up of evidence-based health care innovations [21]. Hence, a longitudinal exploration of health and social care integration aimed at long-term sustainability could make a significant contribution to our understanding of the governance and management of such services. The scope of this thesis is in line with identified gaps in the current knowledge on the evolvement of cross-sector collaboration and its governance over time [22–26].

## **2.4 INTEGRATED CARE AS A COMPLEX ADAPTIVE SYSTEM**

Health care can be described as complex. To gain deeper understanding about what makes health care complex and how complexity can be understood, I explored some of the complexity literature. In particular, I was inspired by the complex adaptive system (CAS) theory, which helped shaping my understanding of integrated care as a complex adaptive system. The theory on complex adaptive system is based on chaos theory, nonlinear dynamics, and adaptation/evolution [27]. The following sections briefly explain and exemplify how integrated care can be viewed as a complex adaptive system. Thereafter, the perspective of complex leadership is introduced, which underpins the analyses of the empirical data concerning leadership in this thesis.

It is argued that health care can be viewed as a complex adaptive system [28]. Various factors and circumstances influence the system, such as interactions between professionals and service users on a micro-level, leadership and structural arrangements on a meso-level and legislation and policies on a macro-level, just to mention a few. In addition, these levels are intertwined by complex interrelationships. If we look at organisations as complex adaptive systems, different parts of the systems are understood as independent, interdependent and self-adjusting [29]. This is true for integrated care, where interdependency is established through the cooperation between two different independent systems – health care and social

care. The characteristics interdependency and independency make a complex adaptive system act collaboratively and competitively [30]. While collaboration and cooperation are central for enabling integration between the health and social care sectors, competition may arise. Health care and social care are based on different missions and cultures and governed by different jurisdictions and regulations. Moreover, complex adaptive systems are linked with other systems and, together, learn and change through co-evolution [30]. For instance, health and social care services influence and are influenced by the national social insurance and employment services. As complex adaptive systems evolve, they pass between states of order and disorder (disequilibrium) [31], which also makes it challenging to study such systems.

A study of five industries – aerospace, retailing, automotive, telecom and health care – found that health care was the most complex [32]. As described above, health care is only one part of an integrated care system in which ideas may emerge at any time and may be proposed by anyone. Therefore, local processes, structures, and patterns (e.g., mental models, relationships and behavioural attractors) should be considered when changes are proposed. What may have worked elsewhere may not work at the organisation under consideration [28]. This makes the work of improving integrated care very extensive work. It is not enough to invest in medical innovations unless it is compatible with the overall system [33], research, professional development, information management, and education [29]. A primary challenge in the administration of health care systems, and thus also in integrated care systems, is to recognize that such systems are complex and adaptive. Making changes in them requires expertise in many areas including management and leadership [34].

#### **2.4.1 Complexity leadership**

The design of complex and adaptive systems is challenging because a tendency among the change agents to learn, adapt, and self-organise exists within such systems. This makes the management of these systems difficult. Therefore, a human-centered perspective that emphasises the various stakeholders' abilities, limitations, and inclinations is recommended for the management of complex and adaptive systems [33]. The stakeholders' natural creativity, organisational expertise, positive attitude towards change, and constructive relationships should be considered, especially when differences of opinion arise and mutual agreement is not assured [35].

The number of components, the so-called agents who interact, adapt, and learn within a system, is often large [36]. The role of leadership, referred to as complex/complexity leadership, is crucial [31, 37] in advancing the interactive dynamics that exist in organisations

[34]. Uhl-Bien and McKelvey [38] (p. 314) write: *Leadership only exists in, and is a function of, interaction [...] leadership is too complex to be described as only the act of an individual or individuals; rather, it is a complex interplay of many interacting forces.* Furthermore, it is argued that organisations create leadership in greater extent than the leaders who manage and guide the system. [31].

The complexity leadership concept offers guidance in how to work with increasingly complex and adaptive systems in organisations [39]. The concept of complexity leadership assumes the creation of necessary conditions that favour the emergence and the adaptability of learning in organisations versus conditions that directly favour the organisation as a whole. In addition, the concept offers guidance on how a bottom-up management approach can encourage self-organisation and innovation. Such leadership can make the organisation far more responsive and adaptive [40].

Traditional organisation management is based on three key assumptions: positivism (the idea that reality is objective rather than subjective), linearity (the idea that linear relationships between cause and effect means that outcomes are predictable), and reductionism (the idea that knowledge is acquired through the senses). Moreover, traditional organisational management focuses on prediction, control, and stability [31]. In contrast, leaders in CAS take a different role. Instead of providing answers and direction to subordinates (i.e. professionals), these leaders establish harmonious conditions in which their subordinates can resolve issues, create structure, and offer innovative ideas [34]. Moreover, CAS theory encourages professionals in organisations to assume leadership responsibility. In this way, the organisation benefits from a broad range of ideas and opinions [40].

In CAS, traditional organisational management is neither possible nor desirable because the characteristics of CAS differ from those in traditional management systems. Marion and Uhl-Bien [37] redefine the leadership role using the following five examples of complexity thinking for leaders (summarized):

*Foster network construction:* Leaders learn to manage and develop networks as they make new connections and improve current connections inside and outside the organisation.

*Catalyse bottom-up network construction:* Leaders help catalyse bottom-up network building by allowing subordinates to participate in decision-making by providing them with resources and other support.

*Become leadership tags:* Leaders become leadership “tags”, which means they function as symbols, influence and draw people together around a common philosophy, and promote

organisation ideals and attitude.

*Drop seeds of emergence:* Leaders promote knowledge centres in the organisation as a way to encourage information-sharing and creativity.

*Think systematically:* Leaders see the broader patterns in events (the systematic whole) and thus create conditions that promote adaptive interactions throughout the organisation.

CAS is moreover proposed as suitable for treating illness (and well-being) because these systems support complex, dynamic, and unique connections among the various system components. Therefore, a holistic health care approach is effective in clinical decision-making. Such an approach is capable of dealing with unpredictable situations and conditions because it is based on the rather subtle components in the entire system [41].

## **2.5 ORGANISATIONAL CHANGE MANAGEMENT**

*“Change is the heartbeat of growth.”*

*Scottie Somers*

The ability of organisations, as well as their professionals, to work with continuous change is essential for dealing with the ever-increasing developments in many areas, including medicine, technology, and professional expertise. Successful management of change is particularly important for any organisation that risks survival in an ever-evolving environment in which changes in several forms, sizes, and shapes occur. Both internal factors and environmental factors can trigger change [42]. It is argued that organisational change in health care should be understood as both situational and psychological. This means that all organisational changes impact the individuals involved in the change [43]. Todnem By [42] lists change characteristics based on their origin and whether the change was a planned, emergent, contingent, or chosen change.

All changes can be a starting point for a movement from traditional, silo-based services to integrated services. Regardless of the starting point, however, this movement requires that the relevant managers and professionals make a number of organisational changes. Changes in general are often planned as if the processes were linear and orderly despite the fact that in reality changes are typically messy and complex. Organisational change is complex because change itself is complex.

In cross-sectoral integration of health and social care services, the organisational complexity increases, and this, in turn, places high demands on management and leadership. It is extremely challenging to manage and lead complex organisations that provide health and social care to people with complex needs in a constantly changing environment [11]. This is

especially the case with the increased demands for greater cost effectiveness, improved delivery of evidence-based practices, and more organisational sustainability.

Many proposed organisational changes are not implemented and therefore never achieve long-term sustainability [44]. Obstacles for implementation exist at the levels of policy, organisational structure, professional cooperation, and service access [45]. It is argued that the focus should shift in change management from the change itself to the people facing the change because managing change means managing people [46]. From this perspective, the principal task in change management is the continuous renewal of the direction, structure and capabilities of the services offered according to the wishes and needs of the users.

To maintain services over time, adaptations and refinements (i.e. changes) are required. Therefore, one can argue that sustainability is an important element in any organisational change effort [47]. In implementation science, implementation and sustainability are viewed as distinct phases [48, 49] in which change is a natural part of both. In the implementation phase, changes are made in order to introduce, for example, new methods or processes; in the following phase, changes are made with adaptations and refinements of existing methods or processes aimed at sustainability.

Coblentz [50] and Chambers et al. [49] argue that sustainability, which means continuation, is an ongoing process that requires continual effort over time [20]. For this reason, sustainability cannot be viewed as a state of accomplishment. For an organisation, this means that change is incorporated into an ongoing process of carrying on and continually enhancing the organisation's processes towards a predefined mission and goal. The organisation's ability to be maintained at a certain rate (i.e. to deliver needs-based and appropriate services) is related to its ability to become different when required by its environment. Only then can the organisation achieve sustainability in relation to its overall mission. In fact, change and sustainability serve their individual purposes and, additionally, serve a joint overall purpose.

Sustainable health care systems are essentially built around their systemic learning mechanisms that allow ongoing improvements and adaptations [30]. One challenge is identifying the fine line between the two focuses – change and sustainability – so that one is not emphasised more than the other. If the focus on change is over-emphasised, there is a risk that the overall mission may be subordinated. On the other hand, if the focus on sustainability is over-emphasised, the organisation may become so rigid and enclosed that current needs are not met. Sustaining integrated care is further complicated by the fact that it often involves coordination of services across multiple sectors, organisations, and health care professionals.

In the next sections, integrated care and organisational sustainability are described in greater detail (including reflections on the concepts) to further illustrate the complexity of the phenomena.

## 2.6 WHAT IS INTEGRATED CARE?

*“Your integration is my fragmentation.”*

*Walter Leutz*

The concept of integrated care is fundamentally about optimizing care and treatment through the combination of parts in order to capture the whole [2]. This process involves closing the traditional division between health and social care [51]. In 2003, the WHO stated that the progress towards building health systems that promote collective health improvement was insufficient. Integrated care was suggested as a key path to improving care in general and primary care in particular [52].

### 2.6.1 Definitions of integrated care

There is neither a universally accepted definition of integrated care nor a general understanding of what it implies in practice. There is no one-size-fits all model that can be followed [1, 53]. One study, which identifies 175 alternative definitions and concepts of integrated care, concludes that the lack of an agreement on what integrated care means complicates any assessment of the field [12]. Some research on integrated care proposes the creation of a framework aimed at benchmarking current and future initiatives as well as identifying the working mechanisms of quality improvement [54]. At the same time, the multiplicity of different definitions and understandings of integrated care is highlighted as a strong point because this means integrated care is not addressed as a purely theoretical concept [55]. Which definition to choose depends on the observer’s perspective on integrated care. In short, does the observer take the perspective of the service user, provider, manager, care professional, policymaker, evaluator, or regulator? Interestingly, the different definitions emphasize the central role of populations and of individual needs [56].

Four definitions of integrated care are presented next.

A process definition:

“... a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors... [to]... enhance quality of care and quality of life, consumer satisfaction and system efficient for patients with complex problems cutting across multiple services, providers and settings.”

An outcome definition:

“... the search to connect the healthcare system (acute, primary medical, and skilled) with other human service systems (e.g., long-term care, education, and vocational and housing services) to improve clinical outcomes (clinical, satisfaction, and efficiency).”

Leutz [58]

A user definition:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

Redding (National Voices, London, UK) [59].

A health system-based definition:

“Integrated health services are health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs, throughout their whole life”.

WHO [13]

## 2.6.2 Dimensions of integrated care

In addition to their various definitions of integrated care, researchers and other commentators often discuss different intensity levels of care integration. These intensity levels, referred to as dimensions or types, imply a certain level of integration indicating that integrated care may have different origins, goals, and forms. The process of integrating care can involve a complete transformation of the service level or more limited shifts in the service level. One way to describe coordination is by reference to activities conducted at the clinical and service delivery level. Another way is by reference to activities conducted at the managerial and organisational levels [60].

Delnoij et al. [61] describe three divisions of integrated care levels: (1) *functional integration* at the macro level of the systems, which refers to the coordination of the financing and regulation of prevention, cure, care, and social services; (2) *organisational and professional integration* at the meso level of the systems, which refers to different kinds of strategic alliances or mergers between health and social care services and between health and social care professionals; and (3) *clinical integration* at the micro level of the systems, which refers to a care delivery process characterized by co-operation, continuity, and coherence [61]. As



Delnoij et al.'s classification reveals, it is quite easy to be confused when reviewing the literature because of the various meanings given to the concept of integrated care.

Goodwin (103) discusses different types of integration where *clinical integration*, as I understand it, includes *professional integration* aimed at creating coherent processes of health and social care. *Functional integration* is described as integration of back-office functions and non-clinical support (i.e. the factors at the policy level are excluded). Goodwin's description of *organisational integration* is consistent with that of Delnoij et al. However, Goodwin adds *service integration*, which is the integration between various clinical services at an organisational level using multi-disciplinary teams. Goodwin describes two additional types of integration: *normative integration*, which refers to shared values that promote trust and collaboration, and *systemic integration*, which refers to an integrated delivery system consistent with the coherence of policies and rules at all organisational levels.

Another way to describe integrated care is to highlight certain key elements. In their assembly of the most essential elements of integrated care, Valentijn et al. [3] agree with the descriptions by Delnoij and Goodwin. Valentijn et al., however, add *horizontal integration* and *vertical integration*, which refer to strategies that link similar as well as different levels of care.

Integrated care is described as a way to address potential barriers to organisational change as such care often consists of multifaceted interventions that comprise various organisational changes such as in quality management, multidisciplinary teams, revised professional roles, and use of computer systems [19]. For the sake of efficiency and equality, health care coverage must be integrated at several interconnected levels. Such coverage is needed between the people delivering care and the people seeking care – across multiple sectors of society, among primary caregivers and specialists, across the trajectory of each person's life, and within each person's social network. Common values and a shared vision of the future are essential if integrated care is to succeed across all these levels [62].

Bottom-up initiatives, co-location of teams, and sufficient capacity and resources are pointed to as facilitating factors along with management and leadership support, sufficient information technology, and effective communication channels [63, 64]. In 2014, the International Foundation of Integrated Care developed a set of 16 core guiding principles for use in future health system reforms. These principles reflect a common set of goals and aspirations aimed at creating more people-centred systems and more integrated services [4].

### 2.6.3 Concepts of integrated care

It is a challenging endeavour to try to understand a complex, interdependent phenomenon such as integrated care. As the previous review revealed, many different illustrative conceptualizations of integrated care can be found in the literature [51]. Moreover, several hospital-based models and primary care-based models are described [65]. To further demonstrate its complexity, next, four concepts of integrated care will be described.

Figure 2 illustrates *the continuum of care*. It is an extended model by Ahgren and Axelsson [66] based on Leutz [58]. The authors suggest that the model is useful when studying intra-organisational integration as well as in studying inter-organisational integration.

Goodwin et al. [67] made a similar typology that illustrates the management of diverse networks of health and social care (Figure 3). The image reflects information sharing to procurement networks (in which contracts are used between care and other services), to co-ordinated networks, and to management arrangements that unite organisations.

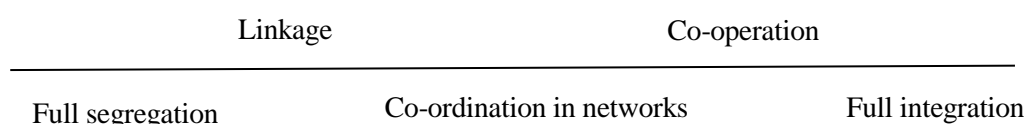


Figure 2. The continuum of care (Ahgren & Axelsson, 2005)

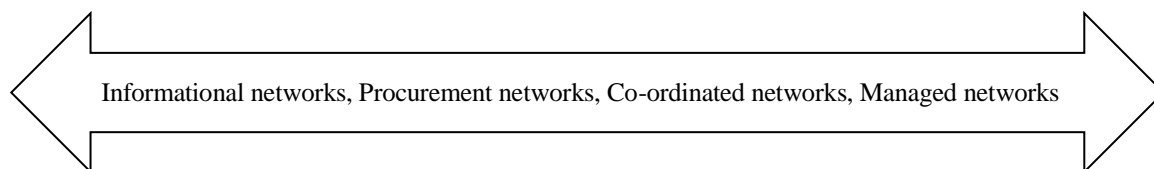


Figure 3. Care networks (Goodwin, Peck, Freeman, & Posaner, 2004)

Figure 4 illustrates *the rainbow model* developed in 2013 by Valentijn et al. [3]. This model is a comprehensive, conceptual framework based on the integrative functions of primary care. In this framework, the goal is to achieve integration across the care continuum through person-focused and population-based care. In an article published in 2015, Valentijn et al. [68] developed a taxonomy for integrated care based on their rainbow model.

Figure 5 illustrates *the WHO framework on integrated people-centred health services – WHO 2016* [69] – in which people and communities rather than diseases are placed at the centre of health systems and are delivered so that people receive a continuum of care and support throughout their entire life.

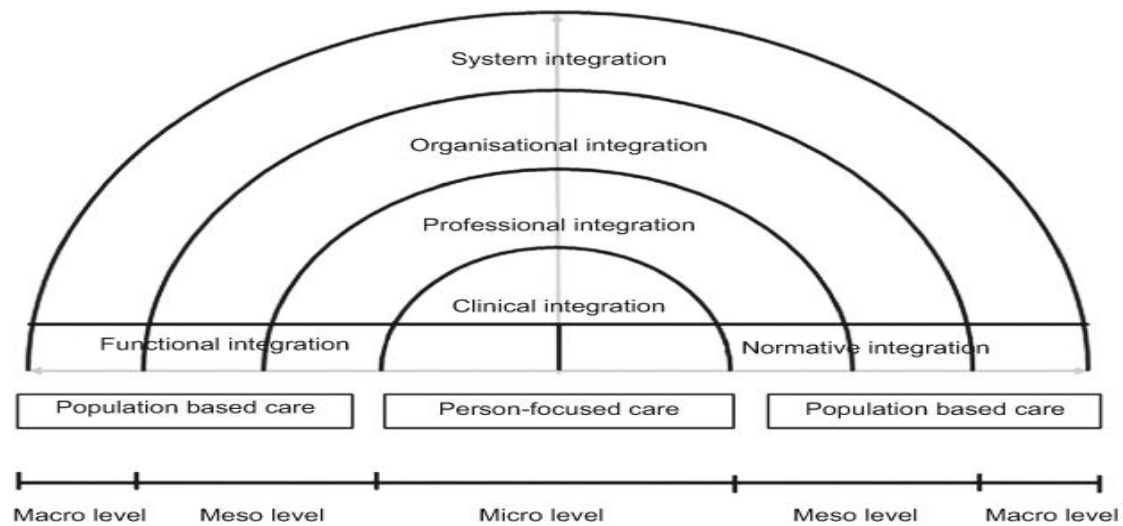


Figure 4. The rainbow model (Valentijn, Schepman, Opheij, & Bruijnzeels, 2013)

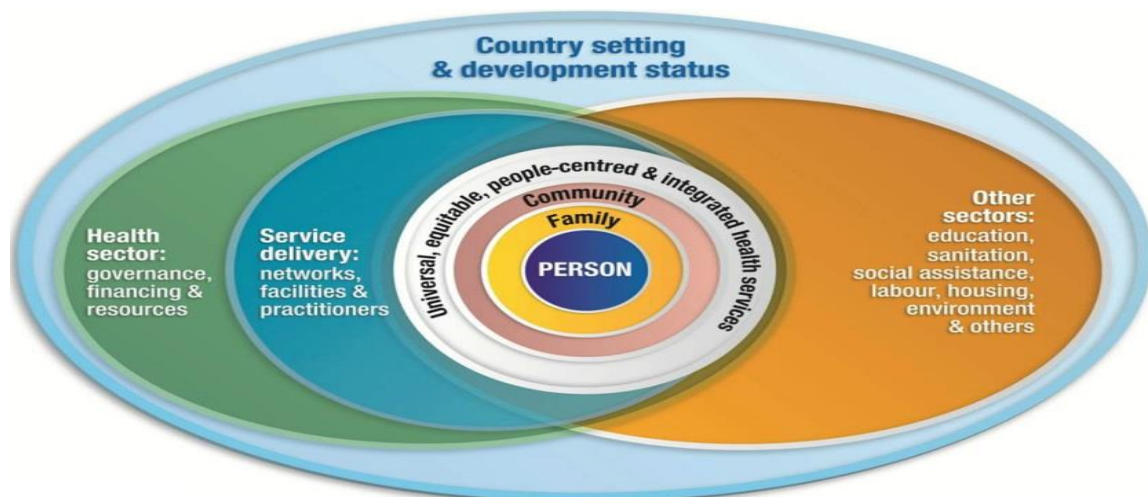


Figure 5. WHO Framework on integrated people-centred health services (WHO, 2016)

In summary, based on this review and foremost, analysis of the evolvement of integrated care made by Evans et al. [70], the following six major, inter-related shifts in care integration strategies have occurred. (1) A shift from horizontal integration to vertical integration; (2) A shift from acute care and institution-centred integration models to community-based health and social services; (3) A shift from economic justifications for integration to improvements in care quality and advancements in value creation; (4) A shift from integration assessments with an organisational perspective to more assessments with a patient-centred perspective: (5) A shift from adapting organisational and environmental structures to changing ways of working and to influencing cultures and values; and (6) A shift from integration of all patients in specific regions to integration of care for specific groups of patients.

#### **2.6.4 Remaining knowledge gaps in the study of integrated care**

Despite the amount of research that describes the benefits of integrated care, there is also research that emphasizes the remaining knowledge gaps and shortcomings about integrated care [71]. Some researchers found vague and unclear clinical and organizational outcomes for joint working in health and social care [64, 72, 73]. In addition, more vigorous evaluations of the effectiveness of integrated care and of the acceptance of such care by service users and service carers are needed [74]. Research is also needed on optimal funding models [63].

The literature on integrated care often reports on the benefits of cohesive care. However, a systematic review of care measures used to evaluate integrated care models in primary care finds a total absence of measures concerning service user safety. Moreover, only few measures of accessibility, equitability, and timeliness in care have been identified [75]. On the other hand, researchers have questioned the quality of the systematic reviews of integrated care programmes because they only assess some components and only show consistent benefits for some outcomes and not for others [76].

It is argued that the evidence supporting joint working is unconvincing because it lacks an appreciation of the objectives of care integration and even reveals some hostility towards the concept [77]. Moreover, a review of the evidence on the effectiveness of integrated care interventions aimed at reducing hospital activity reveals that such interventions rarely produce unambiguously positive outcomes. There are still questions about the importance of integrated care with respect to policy and about the size of the possible benefits with respect to hospital cost reductions [78]. Yet another review finds insufficient evidence of improved health care delivery or health status as the result of greater care integration. Thus, some evidence suggests that full integration very likely decreases the knowledge and utilization of specific services and, furthermore, may not produce improvements in patient health [79].

Recent literature highlights the various uncertainties and the lack of evidence in integrated care. However, we can probably agree that fragmented and silo-based health and social care does not meet the complex health and social care needs of certain service users in an optimal way. For this reason, there is much potential in making improvements in many contemporary health and social care systems. Accordingly, further research is needed to increase our understanding and knowledge of what kind of health and social care works, for whom, why, and when.

### 2.6.5 Challenges in pursuing integrated care

Continuous reforms in the social and health care sector as well as differences among the professions have posed challenges to several initiatives aimed at integrating services. The research needs to address these challenges if we are to understand the criticism of joint working [80].

The term *integrated care* is complex because of its reference to the patients' perspective as well as to the technological, managerial, and economic implications of service integration. This is further complicated by the confusion between the terms *integration* and *integrated*. Integration refers to the combination of processes, tools, and methods that facilitate integrated care, whereas integrated refers to the outcome of integration (i.e. the processes that directly benefit service users and communities). Integrated care should be viewed as a way to improve quality and not as an end in itself [81]. It is suggested that integrated services are best understood as processes situated in CAS [62, 70].

A view of integrated care as a process implies such care must be led, managed, and nurtured over time. To ensure that community-based integrated care through health partnerships will become a reality, consideration should be given to health system design, incentive structures, and population-based performance measures [82]. Innovative initiatives aimed at integrating cross-sectoral services often have to navigate between, and overcome, existing organisational silos [53]. Far too often, inefficient interaction persists due to inherent differences between health and social services [57, 83–87]. Such differences include the lack of economic incentives, separate funding streams, different information and communication systems, and poorly harmonized legal frameworks [88]. Moreover, differences in resource availability, organisational cultures, and perceptions of responsibilities, management, and the leadership role have been identified as obstacles to cross-sectoral interaction and collaboration [80, 89, 90].

A recent review identified 20 types of context-specific, interconnected barriers to integrating care in inter-organisational settings. The barriers were categorised in six groups: administration and regulation, funding, inter-organisational domain, organisational domain, service delivery, and clinical practices. In addition, these barriers may emerge either passively due to institutional or structural arrangements or actively when created by certain actors [91].

Another way to understand the challenges facing the integration of health and social care is to view it from the institutional logics perspective. From this perspective, the various logics of

the various sectors, organisations, and professionals pose a challenge to cooperation. These institutional logics represent frames of references (including unique principles, symbols, cultural norms, beliefs, and vocabulary) that influence the actors' conditions and actions in the system. These logics shape how reasoning takes place and how rationality is perceived and experienced [92]. Research has found that differences in the workforce's conceptual models of mental health care create a barrier to the integration of services [93]. However, the research also reveals that collaborative relationships may be used to manage the inevitable rivalries among such logics. This is best accomplished when the participants maintain their independence within a system that still encourages cooperation around a mutually desired outcome [94]. Such relationships have been called "cross-sector social partnerships" [95].

A study of integrated care, using theories on institutional logics, revealed that a movement from professional-centered care to more person-centered care was accomplished through strategic inclusion of institutional entrepreneurs and the development of partnership capacity via relationship building [96]. The co-production literature suggests a similar shift is taking place on societal and organisational levels. This shift, which is described as the movement from a service-dominant approach to a citizen-capability approach, requires different thinking about the roles in civil society and in government [97].

There are a variety of concepts, models, and theories related to integrated care. However, empirical examples show that, unless change takes place at all levels (from policy to individual actors), delivery of the services may be hindered by legal boundaries, reimbursement systems, information and communication systems, etc. A holistic approach to integrated care is needed that considers integrated services from the CAS perspective. This approach is needed to understand the entire system's various parts and inter-related connections [2].

### **2.6.6 Challenges in studying integrated care**

In addition to the challenges in pursuing integrated health and social care, there are also challenges in its study. Integration is based on different aims, is delivered in different contexts, and is provided for different patient groups [90]. Major obstacles to integrated care in both theory and practice are the lack of conceptual clarity on the concept [57], the lack of uniform definitions, and the vaguely described interventions. All these obstacles impede the research on integrated care programmes [15]. Due to the complexity of care integration, it is also difficult to describe it in all its forms [98]. Accordingly, the complex nature of integrated care challenges our ability to capture all mechanisms, factors, and components that may be of

interest or to explain a certain output or outcome. For practical reasons, one needs to make delimitations in the research design in studies on integrated care.

Integrated care solutions to integrated care problems are complicated. Kessler and Glasgow describe these problems as follows: “. . . *complex problems of complex patients embedded in complex healthcare systems in complex and changing communities that require complex interventions embedded in changing socioeconomic-political conditions and health policies*” [99] (p. 643). Complexity as described by Nardi et al. [100] “*involves the intricate entanglement of two or more systems*” such as in integrated health and social care. Currently researchers are examining ways that may benefit policy- and decision-makers by providing them with an accessible group of indicators and tools for measuring health system integration in various contexts and cultures [101].

Despite these challenges, much research has been conducted and published on integrated care over the years. The research began to increase around 1990. In 1996, the MeSH term ‘Delivery of health system, integrated’ was introduced. In 2000, the open-access peer-reviewed scientific journal, *International Journal on Integrated Care*, began to focus on critical examinations of the policy and practice of integrated care and its impact on cost-effectiveness, user experiences, and quality of care [1].

What is the state of knowledge on integrated care today? Evidence demonstrates that health care organisations that operate in a people-centered way stimulate better cooperation, coordination, and social trust, and, as a result, function well [62]. This evidence is supported by the research (from a different perspective) that shows that cross-sectoral, inter-professional collaboration results in more people-centred and holistic care [55]. However, critics complain that too much research has focused on the analysis of integrated care as a process and too little research has focused on the potential for integrated care to fundamentally challenge the current and future design of care systems [4]. Critics also complain that the aspect of long-term organisational sustainability of integrated care has received insufficient attention [64].

## **2.7 HOW CAN ORGANISATIONAL SUSTAINABILITY BE UNDERSTOOD?**

*“Begin with the end in mind.”*

*Stephen Covey*

The question of why and how some organisational integration initiatives last and others don’t is of great interest in times when fragmented care causes difficulties for an ever-growing group of people with complex health care needs. When thinking of sustainability as

continuity of care, three types of continuity can be reflected on (1) informational continuity in which information on past events and personal circumstances are used to tailor care to the individual; (2) management continuity in which a consistent and organised approach is taken that responds to the patient's changing needs; and (3) relational continuity in which an evolving therapeutic relationship exists between the patient and one or more care providers [102].

In the study of organisational sustainability, the organisation's operational environment should be considered because changes in context have a major effect on the organisation. In fact, many organisational success factors lie outside the organisation itself. Insufficient empirical evidence exists on the frameworks, theories, and approaches related to the successful implementation and management of organisational change [42]. Accordingly, a dynamic perspective on sustainability that focuses on an improvement trajectory, instead of the maintenance of methods and outcomes, is recommended. Thus, the concept of sustainability may have different meanings in different contexts and at different times [103].

Sustainability should be considered in both the initiation phase and the subsequent evaluation phase. A scoping review over literature of sustainability in health promotion and public health conducted in the initiation phase extracted ten key sustainability elements that offer guidance for decision-making in intervention planning and practice [104]. The ten elements are the following: planning for sustainability, gathering the evidence, seeking commitment and support, engagement and partnership, programme champions, building capacity – organisational and community, embedding into core policy, evaluation, evolution and adaptation, and funding. The ninth key element seems to emphasize how change is part of sustainability by continuous evolution and adaptation. In the evaluation phase, when sustainability is measured as a project outcome, four conceptual approaches are suggested: continuing project activities in the funded organisation, maintaining benefits for intended clients, retaining the capacity for a collaborative structure (e.g. a coalition), and calling attention to the issues addressed by the programme [105]. In addition, the idea is emphasised that sustainable effectiveness should have an explicit purpose and that the capacity to adapt should be an explicit goal for the emergence of sustainable systems [30].

Some researchers argue that organisational sustainability depends on the social and economic conditions in the communities in which the organisation operates. At the same time, many investment decisions are based on short-term profit motives [106]. Moreover, it is argued that organisational survival in a continuously evolving environment is highly influenced by the successful management of change although management tends to be reactive, ad hoc, and



discontinuous. Thus, the identification of critical success factors for the management of change is essential [42]. Furthermore, at the next organisational level, the complexity of the change seems to influence the employees' perception of sustainability and their perceptions of the benefits expected from change. Research has found that providing information about a change and allowing participation in the change process influence employees' perceptions of change [47].

### **2.7.1 Current state of knowledge about sustainability**

In general, projects that target systems redesign have been found to be less challenging than more complex changes such as primary care and mental health integration [47], which require a range of nuanced sustainability strategies [20]. Overall, the number of successful long-term, sustainable organisational changes is quite low [107]. In addition, there is limited understanding of how to make health care improvements and quality health care sustainable in routine services [21]. A review of the perspectives on sustainability found that no single prescription exists for successful management of sustainability. However, strategies that are sensitive to context, ambiguity, uncertainty, complexity, and competing stakeholders (with their wide variety of possible influences) were important. Moreover, the review claims that sustainability is contingent on many external factors, not just on internal management control and decision-making [103].

Research on the first stages of the implementation processes (e.g., initiation, resistance, and implementation) has increased rapidly since the 1990s. [20, 103, 107–110]. The concepts of sustainability and sustainable innovations are more often addressed in conceptual studies than in empirical studies [111]. Mainly, sustainable innovations have been studied using randomized controlled trials without a focus on the organisational contexts of implementation and sustainability [112]. Contemporary research highlights the equal importance of studying implementation and sustainability, particularly from the perspective of time, fiscal investments, and the general public health effect [113].

Neither research nor practice seems to take a long-term perspective, which is very likely due to strong short-term profit motives [106]. Despite recognition of the importance of a long-term perspective, most existing care models do not take such a perspective. Thus, effective referral channels and follow-up strategies are not addressed [65].

### **2.7.2 Challenges in studying organisational sustainability**

There are several challenges in achieving long-term organisational sustainability and in studying sustainability. Because these topics encompass an umbrella of concepts, approaches,

and implications, various terms for sustainability are used in the literature. These terms include stabilization, resilience, persistence, normalization, maintenance, integration, incorporation, embedding, durability, confirmation, continuation, and appropriation. The most frequently used terms are sustainability, institutionalization, and routinization. ‘Sustainability’, which has the broadest meaning, implies the stability of deep-rooted change and the dynamism of continuing change [48]. Fleischer et al. [48] imply a broad conceptualization of sustainability by addressing benefits, routinization or institutionalization, and development. They further suggest including factors related to innovation, process, leadership, and context when studying sustainability. As a consequence, no single approach or theoretical model seems to capture the embedded complexity of sustainability.

Despite the differences in terminologies, some shared factors appear essential for long-term organisational sustainability: context, process, capacity to sustain, plus the interrelations and interactions among these factors [107]. Political support, visionary leadership, and the promotion of common values are needed to support strategies leading to long-term organisational sustainability [114]. Some research findings indicate that the successful initial implementation of an organisational programme does not guarantee long-term programme sustainability. Without the persistent, complementary, and aligned actions of committed leaders, at various levels throughout the organisation, long-term organisational sustainability seems impossible to achieve. Further, to achieve sustainability, leaders need to consider a broad conceptualization of sustainability. This conceptualization extends beyond programme institutionalization due to the need for further development of the programme [115].

Leaders’ ability to give staff the opportunity to participate in the change process and to provide staff with information on the change process has shown positive correlation with staff commitment to change and to the achievement of organisational sustainability [47]. In a study of leadership, Osborn et al. [116] state that context is essential since leadership is context-embedded. Leadership is socially constructed in and from a context where patterns over time must be considered and where history matters.

Research on complex service innovations, such as integrated health and social care, that primarily focus on sustainability is limited [117]. Implementation science-based theories are often used to describe and/or guide the translation process from research to practice (process models), to describe and/or explain the influences on the implementation outcomes (implementations theories, determinant frameworks, and classic theories), and to evaluate the implementation (evaluation frameworks) [118]. Nevertheless, the majority of the usually

cited models of implementation include sustainability as a key element, which is described as the final stage in the implementation process or as a final outcome [119].

### **2.7.3 Models and frameworks to study organisational sustainability**

Several models and frameworks are available that describe sustainability and how it is achieved. Both societal and organisational levels of sustainability are addressed in these models and frameworks. Podian et al. [120] argue that society should take a systemic level perspective and should have a clear vision and practical plan in order to understand and approach the numerous problems that health care and related institutions face. Only then can a sustainable future for society be achieved. On a system and organisational level, a model entitled Organizational Readiness for Change (ORC) was developed by Simpson and Flynn [121] with a focus on facilitating factors for sustained innovation implementation. Directed at public health programmes, a generic conceptual framework for sustainability was developed by Scheirer et al. [112]. This framework emphasizes dependent and independent variables in the social, policy, and financial environment of the intervention.

Aarons et al. [119] developed a conceptual model of implementation phases and factors affecting implementation in public service sectors. In the model, the last of the four phases deals with sustainability. The Availability, Responsiveness and Continuity (ARC) model developed by Glisson and Schoenwald [122] also has sustainability as a phase in which the authors call for self-regulation. The Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) model, which was developed by Glasgow et al. [123], addresses the sustainability of health care in the maintenance phase.

In addition to viewing sustainability as a phase, it can also be viewed as an outcome of effective implementation as described by Damschroder et al. [124]. Using the conceptual framework developed by Proctor et al. [111, 125], sustainability is viewed as one of eight implementation outcomes. Sustainability is also described as one of four important components for the incorporation of interventions in routine work called reflexive monitoring in normalization process theory [126].

Maher et al. [127] at the National Health Service (NHS) developed a sustainability model to measure sustainability at the level of a specific planned or an ongoing improvement initiative or project. This model is not meant to be used for the assessment of whether a department, whole organisation, or health community is likely to sustain change in general. Another model for programme sustainability with a focus on organisational routines was developed by Pluye et al. [128]. In 1998, Shediak-Rizkallah and Bone [129] proposed concepts and

strategies for sustainability planning for community-based health programmes. Scheirer and Dearing [112] argue that explicit definitions of outcome variables and possible influences on those outcomes are needed to accumulate the findings as generalizable research or to disconfirm findings about predictors of sustainability.

#### **2.7.4 The Dynamic Sustainability Framework**

In this thesis, the concept ‘sustainable integration’ is used with the framework recently developed by Chambers et al. [49] that is called the Dynamic Sustainability Framework (DSF). When looking at a change that has lasted over an extended period of time, this framework emphasizes adaptation, organisational learning, and quality aspects. Traditional fidelity dimensions and conceptual frameworks do not deal with questions of how an intervention should be adapted while still retaining its effectiveness [130]. The DSF differs from the frameworks described above by its emphasis on the organisation’s interaction with the environment as a way to understand how organisational sustainability is achieved despite constant efforts to improve its interventions. This approach is in line with other research that claims sustainability should be studied as a distinct and dynamic phenomenon [129, 131].

In the field of implementation science the traditional linear process of implementation is questioned as far as its ability to explain more complex interventions and the use of the systematic approach to health and social care. Linear thinking leads to the creation of manuals that are meant to provide assurance that the interventions follow the original initiative. Hence, attempts are made to reduce deviations from the interventions. Consequently, this way of implementing new interventions may lead to a lack of consideration and, thus, to a failure to observe potential gaps between the intervention and its multi-level context. The sustainability of the intervention can thereby be jeopardized. Therefore, this way of conceptualizing sustainability may sub-optimize the conditions of the intervention and its goals. Nowadays, the idea of co-existence of fidelity and adaptation is supported. However, the question of how to create a successful balance requires further investigation [130].

## **2.8 THE SWEDISH HEALTH AND SOCIAL CARE SYSTEM**

*“Fragmentation is the default setting  
for most health care settings.”*

*Chris Ham*

The Swedish health and social care system is characterized by high decentralization in which the decision-making power is concentrated at the county council and municipality levels. This

means differences exist in the ways and times services are performed, developed, and reformed throughout the country. Data on health system performance reveal variations among the counties, but no clear connections have been found between a specific approach and the quality of service provided [132]. The multiple levels – the state, the county councils and the municipalities – have complicated the development of the Swedish health and social care system.

The care for people with psychiatric disorders and mental illnesses is provided by two different systems: the county councils' mental health services and the municipal social welfare services. In addition, people with mild to moderate mental health problems are referred to primary care while people with more serious mental illnesses are referred to psychiatric care. Due to the distinct division of responsibilities and roles, collaboration and coordination of these care activities are very important [133]. However, this is complicated by the regulated competition that motivates providers to optimize their individual organisational goals instead of focusing on improving the general population's health from a community perspective [134].

According to the OECD [135], the greatest challenge in Sweden's health and social care system is the lack of adequate coordination among hospitals, primary care, and social services. Despite the generally good health and social care provided in Sweden, major shortcomings in the coordination exist, and, in some cases, Sweden's results are not as positive as in comparable countries.

In Finland, which has a history of strong, independent sub-systems (as does Sweden), cooperation has not been an easy task when it comes to cooperation across several sectors. One suggestion in this country is to adopt a “hybrid coordination model” that can be used to affect integrated services and processes. The idea is that this model can include the unique features of each sub-system [136]. This model may have applicability in Sweden where many attempts to create cross-sectoral cooperation have been unsuccessful. Other examples from other countries reveal the challenges likely to be encountered when integrating services. A review of mental health and social care in Spain describes the diversity in the development of a country-wide system that met resistance stemming from the autonomy of various regions. The review concludes that health and social care should be more harmonised and integrated [137]. This conclusion has relevance for health and social care in Sweden [138].

One possible reason for these challenges may be the extensive body of legislation on mental health care in Sweden that includes the following: The Health and Medical Services Act

(1982:763), The Forensic Mental Care Act (1991:1129), The Compulsory Mental Care Act (1991:1128), The Act for support and services for persons with certain functional impairments (1993:387), and The Social Services Act (2001: 453).

The leading causes of mortality and morbidity in Europe are chronic health conditions, diseases [139], and multi morbidity (two or more chronic morbidities), all of which are increasing worldwide [140]. Sweden is no exception. About one million people in Sweden have complex health needs requiring cross-sectoral interventions. In addition, because these people have a reduced ability to coordinate their own care, they require more comprehensive health care services [141]. Both researchers and institutions such as the WHO recommend integration of services as one way to address the challenges caused by service fragmentation.

### **2.8.1 The mental health care reform in Sweden**

During the 1990s, several health care policy changes were made in Sweden. Three of the most comprehensive changes concerned care and support for the elderly (Ädelreformen, 1992), care for the physically disabled (Handikappreformen, 1994) and care and support for persons with mental illness – *mental health care reform* (Psykiatrireformen). The latter, which was launched in 1995, was preceded by a few years of preparatory investigation of the then-current situation. This investigation resulted in comprehensive reform of how Sweden's municipalities and county councils would provide services for people with long-term psychiatric disorders [5].

Inpatient care at psychiatric clinics in general hospitals, with the support of small nursing homes and half-way houses, replaced the closed-environment mental health institutions [133]. Accordingly, the municipalities took some responsibility for the care of people with long-term psychiatric disorders after their discharge from closed-environment mental health institutions. The reform clarified the municipalities' responsibility for housing, support and employment, and some forms of care. The county councils retained responsibility for health care. State subsidy was provided to both the county councils and the municipalities during the policy's establishment period (1996-1998). However, to access this funding, they had to present a mutually agreed upon plan for how the money would be used to make organisational and operational changes aimed at improving interaction between psychiatric care and social services [142].

This reform's primary goal was to support long-term psychiatric patients who had left the hospitals and were living in other community facilities. It was expected that psychiatric units and social service agencies would increase their efforts around coordinated care and support,

given that social services was responsible for housing, daily activities, and rehabilitation in the community. It was also expected that adequate treatment methods would be developed in specialised psychiatric care, and families and individuals would increasingly be involved in this care [143].

A review of the implementation of Swedish mental health care reform reveals the difficulty encountered when trying to draw an overall picture of health and social care for people with mental illness. There are shortcomings in the cooperation between different levels of care and in the coordination between social services, primary care, The Swedish Public Employment Service, and The Swedish Social Insurance Agency. The focus has been on different components rather than the whole. The Swedish mental health care reform has transformed into individual projects with a large number of experimental activities that involve great uncertainty for all concerned, not least for the users [144].

### **2.8.2 Mental health and social care in Sweden and Europe**

One of the main public health challenges in Europe, as measured by the prevalence and burden of disease and disability, is mental disorder, which affects about 25% of the population every year. Mental disorder, which is a main reason for work disability and early retirement in many countries, presents an enormous economic problem to society. Therefore, policy action is necessary [145]. In addition, research reveals that physical and mental health comorbidity is very common [140].

Between 20% and 40% of the Swedish population of just over 10 million, report suffering from some degree of mental health disorder. Between 5% and 10% of the population warrant psychiatric treatment for mental health disorder. Nevertheless, only 3% to 4% of the populations actually seek psychiatric health care. The rate of mental disorders varies significantly as far as age group, gender, and education. However, around 1 500 to 2 000 people have some form of psychosis, and less than 1% of the population develops bipolar disorder. The risk of developing schizophrenia is around 0.8% [143].

Deinstitutionalisation and improved social services have made improvements in the quality of life for many people who have severe mental disorders. Yet, while mental health disorders have significantly increased since the 1990s, the occurrence of these disorders in the Swedish population has remained relatively unchanged. However, mental disorders (primarily mild and moderate) have increased in certain groups, especially among young people and employees. It is also alarming that psychiatric diagnoses and suicide attempts by

children and adolescents have increased. As a result of these trends, specific actions have been taken in recent years to address these problems [143].

Human service organisations in the public sector in most countries today are not designed for optimal support of people with complex mental health and social care needs. For most people living with a mental disorder, the need for support exceeds the sectoral boundaries such as exist in Sweden between counties that provide health care and municipalities that provide social services [5]. Moreover, disabled persons are expected to seek assistance by themselves, which imposes high demands on people with long-term mental illnesses [133].

One way to tackle this problem of care fragmentation is to integrate health and social care services. Integration is suggested as the only possible avenue for improving the care of mental disorders, especially in low- and middle-income countries [146]. Some research concludes that successful integration increases access to [147] and satisfaction with [147] mental health services and significantly improves people's general health more than unintegrated care services [148]. Other research argues that more investigation of collaborative care in the treatment of severe mental disorders is needed before conclusions on its effectivity can be drawn [138]. Studies on the sustainability of integrated models in mental health services are also needed [149].

In most countries, this integration of care is often accomplished by national initiatives and local joint service delivery efforts. In Sweden, there are several examples of national initiatives for specific groups. An example of these groups is the frailest elderly group. Care and support for these people in recent decades has improved because of increased cooperation. However, multi-professional teamwork still is rare, and the use of consumer choice models has created difficulties in inter-organisation integration [150]. Studies have even shown that inter-organisation integration increases the problems among patients with complex needs. A government investigation [151] and research [152] show that implementing integrated care for those with complex needs is difficult. It is argued that possibly the most severe challenge in care fragmentation is the emphasis on acute and episodic care [153]. Thus, worldwide, not just in Sweden, reforms are needed in the continuity and coordination of care for people with multi-morbidities [140].

Swedish authorities understand that mental ill health is a vital national issue. Mild-to-moderate and severe mental disorders represent a significant portion of mental ill health disorders in Sweden. The greatest number of mental disorders – mild and moderate mental health problems – have continuously increased in recent decades [143]. Mental ill health



imposes a vast burden on people and on economies [154]. Mental health care that is poorly coordinated with behavioural health services leads to higher total health care and disability costs [155]. Many people with mental disorders are treated in primary care. However, people with chronic or more severe psychiatric disorders and disability often have both medical and social needs and thus require contact with services across the health and social care sectors. Seeking assistance requires the ability and power to act, which can be challenging for this population. If the support and help that is needed is scattered among several different care providers, the task easily becomes overwhelming.

The extent of the interaction between providers varies in Swedish mental health and social care. Many initiatives of cross-sectoral cooperation in mental health and social care are local [144]. Kathol et al. [156] lists five critical components for outcome improvements in integrated care for patients who have medical-psychiatric comorbidity: psychiatric assessment in primary care, active screening, coordination/integration, case management and the ability to apply proven and effective psychotherapeutic, pharmacotherapeutic, and psychosocial interventions. The OECD (119) emphasizes the importance of recognizing that mental ill health-related problems cannot be solved without strong coordination between policies and institutions. Indeed, seamless continuum of care is essential for achieving health care provider collaboration [82]

### **2.8.3 Remaining challenges in mental health integration**

The literature identifies various obstacles to mental health integration at structural, organisational and operational levels in different national contexts [139]. In England, for example, difficulties in services integration were found at the local level owing to the failure at the overall systems level. For instance, powerful centralized control, the prioritization of single agency priorities over time, and rapidly changing policy context [157] have hampered the integration of services. Furthermore, different reimbursement systems have distorted the creation of more coherent mental health care [158].

The experience in Sweden is to some extent similar. Silfverhielm [133] found difficulties in six areas in the Swedish mental health system. First, severe population ignorance and stigma create difficulties even though significant improvements have been made in this area. Second, difficulties are caused by differences between ideologies (i.e. differences about the etiology of disorders, effective treatment, and services) and by territorial disputes. Third, unclear roles and responsibilities among social, psychiatric, and vocational rehabilitation cause difficulties when no authority can assume complete responsibility for meeting the needs of the mentally

ill. Fourth, difficulties arise because of knowledge gaps in the areas of mental health and psychiatry. For example, more is known about physical illness than mental illness. Fifth, inadequate collaboration among care givers and lack of continuity of care create difficulties. Sixth, patients and their families experience difficulties when they participate in and influence treatment and service decisions [133].

Development of electronic patient record systems has been impeded by the fragmentation in health care. For this reason, there are numerous information and communications technology (ICT) offerings, many of which are homemade systems [32]. In 2014, the possibility of keeping health and social care documentation for the frailest elderly using a process-ID was investigated in Sweden. The results of the investigation showed that the possibility for a process-ID that included both health and social care is very limited because practical and legal prerequisites are lacking. There is a confidentiality agreement between social services providers and health care practitioners that does not permit the exchange of information. As health care and social services are performed by different organisations and are governed by different laws, the individual processes for patients and users are designed in different ways [159].

## 3 METHODOLOGY

### 3.1 MAIN RESEARCH STRATEGIES

The general research design for this thesis is a qualitative longitudinal case study. Table 1 presents an overview of the methodology used in the three studies.

Table 1. Overview of the methodology for the three studies

	<b>Aim</b>	<b>Design</b>	<b>Source</b>	<b>Analysis and theory</b>
<b>I</b>	Investigate co-leadership in integrated health and social care, identify essential preconditions in fulfilling the management assignment, its operationalization and impact on provision of sustainable integration of health and social care	Analytic cross-sectional study design	Semi-structured pair interviews with operational managers (co-leaders) conducted in two stages (n=8)	Directed content analysis (Hsieh and Shannon, 2005) Respondent validation (Crescentin and Mainardi, 2009) Deductive approach
<b>II</b>	Explore the dynamics of sustainable changes in integrated health and social care through an analysis of local actions that were triggered by a national policy.	Retrospective case-study design	Steering committee meeting minutes from 1995 through 2015. (n=98)	Thematic analysis (Braun and Clarke, 2006) The Dynamic Sustainability Framework (Chambers et al., 2013) Abductive approach
<b>III</b>	Identify key components that contribute to value for service users in an integrated mental health and social care service in Sweden.	Exploratory cross-sectional study design	Semi-structured group interviews with representatives from SUA (n=12)	The Framework method (Gale et al., 2013) Inductive approach

### 3.2 THE EMPIRICAL CASE

The three studies in this thesis were conducted in an integrated mental health and social care service in the region of Stockholm, Sweden, which started its joint operations in 1995. The municipality has approximately 96,000 inhabitants, of whom more than 50% have foreign backgrounds (are born abroad or have two foreign-born parents). The average age is 38.4 years. The employment rate for persons between 20-64 years is 71.5% [160].

These integrated services were chosen for study because they had implemented and refined a shared model of governance between psychiatric services provided by the county council and by the municipal social services. This shared model had achieved long-lasting, close cooperation. Current studies extend previous research on the same case [161–163]. Services are offered to persons over 18 years who have chronic and severe mental illness that results in permanent disabilities and who need both mental health care and social services.

When the thesis research began, the overall integrated services consisted of one general psychiatric rehabilitation unit, three geographically co-located centres (mainly for persons

with psychoses), and several teams for different target groups in mental health. The centres were managed by two leaders (co-leaders) who came from the two organisations. Although managed as a single integrated service, the centres were regulated by separate legislation: The Swedish Health and Medical Care Services Act (1982:763) and The Swedish Social Services Act (2001:453). The health and social care offered by the centres was organised into interprofessional teams of 10-20 employees from the mental health services provided by the county council and by the municipal social services. The professional groups mainly included nurses, social workers, physiotherapists, occupational therapists, and psychiatrists.

These integrated health and social care services should not be seen as a permanent organisation like the traditional organisation with its clear external borders. Therefore, 'services' is the descriptive term used in this thesis. Although the municipality and the county have integrated their mental health services, both retain their original affiliations with the municipality and the county council. The integrated services are based on a collaborative structure at an overall organisational level through jointly produced formal agreements and co-designed services. At service level, the co-leaders and the interprofessional teams manage the co-located services. The overall cooperation was renegotiated and modified annually. The content of local services provided is constantly adapted to the changing needs of service users.

### **3.2.1 Case study research design**

In studying real world systems, including their dynamics and functions, attention should be paid to the context in which they operate [164]. However, the complex nature of systems, dimensions, and layers, which in various ways are interrelated, poses challenges in such studies. In addition, contexts change over time. In the literature, case study research design is suggested as a suitable strategy when the focus of inquiry is an organisation, process, or programme [165]. This design is especially suitable for small-scale studies because they provide an opportunity to obtain a holistic view and at the same time to examine complex social phenomena in depth. The objective is to make recommendations, relate concepts, and propose hypotheses that can explain what is happening and why in an environment [166]. The number of cases that can be studied is often limited by the scientific interest in studying specific cases with specific characteristics in real-world contexts [167], as in the case studied in this thesis. The number of cases determines which cases to use and therefore whether to use a single or multiple case design. The former is considered particularly appropriate when the case is unique [165], such as the case studied in this thesis.

Case study research design is regarded as a complex strategy that uses multiple research methods [168]. In this thesis, this complex phenomenon of integrated health and social care services was systematically explored using a combination of research methods: group interviews, respondent validation by telephone, and document analysis. In addition, case studies can be subdivided into holistic (single-unit analysis) or embedded (multiple-unit analysis). This thesis has an embedded design in which three units of analysis (UoA) are examined. See Figure 6.



Figure 6. Single case study with embedded units of analysis (UoA)

In case study research design, the objective is to acquire knowledge and understanding of issues and circumstances specific to the case. For this reason, the analytic focus is the in-depth investigation of specific instances of the phenomenon [165]. The case in this thesis can be considered complex because it reflects cross-sectoral cooperation. To increase our understanding of the case, various perspectives should be taken. Therefore, in order to achieve the overall aim of the research, three perspectives were chosen: the operational management perspective in terms of co-leadership exerted at the units; the overall organisational management perspective in terms of the steering committee's work over time; and the service users' and informal caregivers' perspectives. The generalisations drawn from case studies are conceptual or analytic, rather than numeric or sample-to-population [167].

This case can be described as *Intrinsic* because the case (the integrated health and social care services) is the focus. It is an example of the phenomenon studied. The case has value in itself (not least because of the feedback from research to practice). The case can also be described as *Instrumental* because the case leads to an understanding of related situations. The findings are analyzed and compared with existing theory (DSF) for development and contribution to "the overall knowledge".

### **3.2.2 The perspectives and target groups in the thesis**

This section presents a brief explanation of the chosen perspectives and the target groups. From a research perspective, understanding how to predict and maximise the sustainability of community health collaborations is of great value in the effort to improve people's health and the quality of their health care, especially at the local level [169]. Hence, the study of actual examples of local integration initiatives can provide valuable information.

One main goal of the research was to study the organisation from two managerial perspectives. Operational managers (the first target group) have deep knowledge of internal processes as well as the responsibility and decision-making power related to the direction and development of organisational activities. A number of studies emphasise the importance of management in sustainability efforts and programs such as, for example, the achievement of long-term sustainability of evidence-based interventions [170], the intervention effects [104], the sustainability of community-based health programs organised by local cross-sectoral coalitions [171], and the achievement of organisational sustainability [172]. Politicians and civil servants also have decision-making power. However, operational managers were best suited to explain how the services were managed on a daily basis why they were included.

In addition, there were established collaborations with people in leading positions within the integrated services who enabled access to services. They were very welcoming, courteous, and interested in contributing to this research. They agreed to participate in interviews and to provide documents of interest. However, no financial dependencies existed between the researchers and the people mentioned above.

With our access to the steering committee's meeting minutes over a long period of time, we could follow the evolvement of the services based on the organisation's overall management level. The decision to follow the work of the steering committee (the second target group) was based primarily on the fact that the committee consisted of a group of key actors in the development of the integrated health and social care services.

A second main goal of the research was to explore the service user and informal caregiver perspectives. The underlying motive was our interest in interviewing representatives from the Service User Associations (SUA) about the organisational aspects of the services. These representatives had deep knowledge not only of the present organisation but also of its development over time because they had participated in the steering committee for a long time, some even from the beginning. In their role as the SUA representatives, they pursue issues related to improvements in mental health and social care for specific target groups.

Moreover, most SUA representatives were informal caregivers and had personal experience with the integrated care services. Furthermore, prior research has identified the need for more research on the views of patients that have the potential to influence the course of the integration at service delivery point and the effect on community health of this integration [79].

### **3.2.3 Data collection**

The three studies of this thesis explore the same case. Each study had its own research questions that guided the choice of research methods. The entire thesis data were gathered from multiple sources using complementary research methods. The aim was not to seek an absolute “truth” but rather to use this data to explore complementary perspectives so as to better understand the full picture of the studied phenomenon [168].

First, *data triangulation* [164] was used to collect data from different sources at different times. These sources were the line managers (i.e. the co-leaders), the steering committee members, and the SUA representatives. The co-leaders and the steering committee members shared a common organisational (i.e. managerial) perspective whereas the SUA representatives had a service user perspective. Second, *method triangulation* [164] was used for group interviews, follow-ups in one-to-one telephone interviews, and in document analysis. Third, *analyst triangulation* [164], also referred to as investigator triangulation [173], was used when several research team members participated in various phases of the research.

The three studies of this thesis are cross-sectional studies [174], which means that data were collected at specific points in time. However, Study II has a longitudinal and retrospective design although the data were collected at a given time point. Examination of the document data, which were prepared over a period of 20 years, allowed us to retrospectively follow the evolution and dynamics of the studied phenomenon over time.

Cross-sectional design, which is especially suitable for empirical, small-scale studies, are used in both qualitative research and quantitative research [166]. The benefit of cross-sectional studies is that knowledge comes directly from reality. Although the knowledge is derived from small cases, several studies together may reveal findings about developments in a specific area.

### **3.2.4 Data sources, methods for data collection, and analysis**

This section describes the methodological approaches taken in the three studies of this thesis. Study I and Study III are described jointly because they have several methodological similarities. Study II, which does not share these similarities, is described separately.

#### **Study I and Study III**

The target groups (i.e. sources) for Study I were the operational managers acting as co-leaders. The target groups for Study III were the SUA representatives.

The data collection methods used for the two studies were semi-structured, multi-format interviews. Study I used pair interviews (i.e. dyadic interviews) [164]. The original idea in Study III was to use group interviews [175]. In Study I, two participants interacted in response to open-ended questions and in Study III, the number of participants was between 2 and 6. The main advantage in dyadic or group interview is the interaction that occurs between participants belongs to a particular population who discuss a particular topic in a focused way. This format encourages self-disclosure by the participants [176]. A comparison between one-to-one interviews and group interviews shows that numerous types of personal and sensitive disclosures are more likely in a group interview. Some sensitive themes are not addressed in one-to-one interviews at all [177].

The participants in a group interview may not necessarily represent the entire population. However, they should be well suited to provide qualitative data on a specific issue [178]. Accordingly, purposeful sampling strategy [164] was applied to strategically choose participants who could provide the requested data. In research, they are described as *information-rich cases* [164].

In both Study I and Study III, we used previously existing groups. This decision is particularly suitable when researchers are trying to identify commonalities and shared patterns in which the participants' experiences are relatively homogeneous. Purposeful sampling can be conducted in different ways. Both studies used homogeneous sampling as the participants had some characteristic in common [179]. In Study I, the participants were the co-leaders. In Study III, the participants were the SUA representatives. Therefore, in both studies, the participants could provide information from their unique perspectives. However, in Study I, the participants included the entire target group (n=8), a total population sampling [179]. In Study III, we used reputational sampling (n=12) [164] to select key participants with relevant knowledge and experience of integrated health and social care services. In Study III,



only one group of six participants was conducted; the other three groups consisted of two participants each.

A moderator and an observer participated in both Study I and Study III. The role of the moderator was to ask questions and to guide the discussion. As the name of the observer role suggests, the observer observed the participants. In Study III, the observer's role was also to take notes on the group interviews. The participants chose the locations for the interviews. In Study I, all interviews were conducted at the co-leaders' workplaces. In Study III, three interviews were conducted at municipal facilities, and one interview was conducted at the university. All interviews were recorded and transcribed verbatim.

Both Study I and Study III used semi-structured interview guides. For Study I, which addressed four themes, a number of questions were asked about co-leadership. The first theme was the relationship and the practical work (responsibility and power distribution, communication, collaboration, decision-making, conflict management). The second theme was co-leadership in general: its pros and cons, strengths and weaknesses. The third theme was the management of interprofessional teams. The fourth theme was developments and changes over time, key issues at the beginning, and future challenges.

The semi-structured interview guide for study III addressed two themes. The first theme, which was the present and future situations for service users and informal caregivers, addressed perceptions on the functionality of integrated health and social care and the difference between good and bad health and social care. The second theme addressed the creation and importance of value for patients and informal caregivers and how ideal health and social care should be organised.

Directed content analysis [180] was used in Study I. This type of analysis structures the analytical process. There are two coding strategies in directed content analysis: to begin by reading and highlighting all text that appears interesting based on the study's aim, or to begin by coding directly using predetermined codes. We used the former strategy to ensure that all essential aspects were captured. The process of coding, subcategorizing, identifying key themes, and developing general categories responded only partially to the study's aim. The categorization did not allow for any sufficiently reliable conclusions on the impact of co-leadership on the provision of sustainable integration of health and social care. Therefore, respondent validation [181] was performed to respond to that aim. To identify the final categories and themes, the research team together analysed the data using the process of negotiated consensus [182].

Study III used the Framework method developed by Gale et al.[183]. Although the Framework method was developed for use in health care research, the Framework method occurs in several other research fields with some differences in content and name. For example, the method is referred to as *approach* in nursing [184] and *analysis* in qualitative psychology [185] and applied policy research [186].

In Study III, we began the analysis by reading the transcripts and the observer notes to form an idea of the content. Subsequently, a coding framework was developed through open coding of the group discussions based on the transcripts. The coded text was subjected to inductive analysis aimed at revealing key components that contribute to value for service users. Qualitative analysis software (QSR Nvivo, Version 9) was used to identify meaning units that were labelled with descriptive codes. The descriptive codes were then exported to the open-source mind-mapping software, FreeMind, which was used for the iterative categorization process. The research team discussed the evolving subcategories. Then the interpretations of the underlying meanings in the sub-categories were grouped into categories for the main components of integrated mental health and social care services that contribute to value for service users.

Despite several similarities between Study I and Study III, one major difference was that Study I included second-stage interviews, so-called respondent validation [181] or so-called member checking [174]. The researchers conducted this phase of the study by telephone with one co-leader from each pair. The aim was to clarify and elaborate on how our initial findings contributed to sustainable integration of health and social care. The decision to conduct this respondent validation by telephone was made because the co-leaders had already received the questions in advance. They could jointly discuss the responses that would be given when the telephone follow-up interviews were held.

The respondent validation was formulated as a scale intended to capture the co-leaders' opinions on whether the specific organisational prerequisites and their own performance had contributed to cohesive improvements in health and social care. All questions began with the following phrase: "To what extent do you think XX contributes to cohesive care?" Respondents chose their answers on a five-point scale ranging from "Very little extent" to "Very large extent".

## **Study II**

In Study II, the data consisted of documents – minutes from steering committee meetings from 1995 through 2015. The minutes could be read in digital form (n=98; approximately

three to five meetings per semester). The original purpose in the exploration of the steering committee meeting minutes was to record what the committee had discussed and decided and how responsibility had been distributed. Although the minutes were prepared primarily for internal use, they were available to cooperating partners outside the services and to other interested stakeholders. The same person, a member of the steering committee, produced all the minutes, which followed the same basic structure. However, some variations in content occurred depending on the topics on the agenda. These variations explained the committee's composition at the meetings. In addition to the permanent steering committee members – representatives from the county, the municipality, and the SUA – other relevant stakeholders were sometimes present.

These steering committee minutes, which are factual, provide a glimpse into the inner workings of a cross-sectoral steering group over a long time period. They reveal insights into actual events. However, there are some limitations related to these documents. First, they offer a limited perspective on the integrated services. Second, they may reveal only what the committee allows the public to know so as to maintain the image of the integrated services. Third, because no conflicts or disagreements were found in the documents, they should be read with a critical eye.

Thematic analysis [187] was used. The analysis was theoretically guided by the DSF (Section 2.7.4). Because document analysis often includes materials that are written for a purpose other than research [188], as in this case, the first step was to assess the relevance of the documents in relation to the study's aim. After the first reading, we concluded that the content was sufficiently relevant. Thematic analysis is suggested as an appropriate semantic approach for managing extensive data sets, as in our case. The analysis was conducted in two stages. In the first stage, the analysis, which was explorative and inductive, we mapped the steering committee's actions. Codes were searched for, and meaningful groups were identified. Actions not directly linked to integration were excluded. Our analysis was intended to illustrate the trend in integration over time and to provide a basis in the second stage for further analysis. In the second stage, we tried to match our results to the key elements of the DSF. This procedure resulted in a detailed data analysis that was useful in identifying the empirical themes from the narrative description.

### **3.2.5 Ethical approval and guiding principles**

The Regional Ethical Review Board in Stockholm (Protocol number 2014/612-31/5) approved this research. The rules and guidelines for research from The Swedish Research

Council were followed [189] with its four ethical principles aimed at protecting the individual's right to privacy: *the information-, the consent-, the confidentiality- and the utilization requirement* [190].

Before the interviews, the participants received *information* by telephone or in writing on the research project, depending on how they wished to be informed. The information explained the aim of the study, described the interviewer, and explained how the interviews would be conducted. The participants were also told their participation was voluntary and only those people directly involved in the study would have access to the data. Furthermore, they were promised anonymity. The audio files and the transcripts would be stored securely. Last, the participants were informed that the results would be presented at an aggregated level in scientific publications (*confidentiality- and utilization requirement*). This information was repeated at the interviews. In addition, the participants were told they could end their participation at any time and could always ask for clarifications if any question was unclear. They also received this information in writing and were asked to sign an informed *consent* before the interviews began.

## 4 FINDINGS

The findings from the three studies are summarized in this section using four theoretically and empirically based themes relevant to the evolvement of long-term mental health and social care integration. These themes (e.g., *shared structure and ongoing refinement, continuous learning, cooperation as a guiding principle and service user centeredness*) were originally found in Study II and are here used as an umbrella for presenting findings also from Study I and Study III. The organisation perspective and the service user perspective are used to present these findings.

The numbers in brackets refer to Studies I, II, and III.

### 4.1 SHARED STRUCTURE AND ONGOING REFINEMENT

The individual organisations had a history of collaboration prior to the cross-sectoral cooperation. Hence, when the national mental health care reform was launched, they were aware of the need for change, especially from the service user perspective. To begin, they established structures aimed at interlinking the municipal and county services at both structural and functional levels with the goal of jointly delivering services (II).

The services were specified in formal agreements that also presented a shared mission for mental health and social care services (II). Two guiding principles in the mission statement were the following: “*what we do, we do together*” and “*all service users should be at the centre of – and participate in – planning of care and support*” (II). The co-leaders emphasized the importance of the shared mission because it guided and supported the daily work (I). The shared mission was also important for the service users and the informal caregivers who were required to be involved in a dialogue with the professionals (III).

One fundamental aspect of the integrated services was co-location (II) and the sharing of workplaces. The co-leaders observed that these features were enabling preconditions for the management of the integrated health and social care services (I). Moreover, the co-leaders emphasized the importance of co-location to teamwork and the benefit for the service users (I). The service users agreed on the importance of co-location (III) because it facilitated the physical integration of health and social care services.

The strongly supported idea of co-leadership (on every managerial level) as a management solution was critical to the success of the co-leadership (I). Two project managers, who had a central role in establishing integration, made key contributions to the creation of a culture of shared values (II). In addition, the project managers (also referred to as champions) played an

important role in maintaining collaboration and cooperation by continually promoting the idea of integrated health and social care (III). These project managers, who supervised the line managers, were role models (I). The co-leaders, as opinion leaders and cultural carriers, had strong symbolic value. They were role models also because of their close cooperation in their co-leadership (II).

The needs and conditions of the organisations were considered in the development of a long-term outlook for the care integration. Differences in procedures were addressed. For example, in the decision-making process, which was based on dialogue and negotiation (II), attempts were made to achieve consensus (I). Efforts were also made to harmonize the two organisations' economic steering mechanisms. The organisations' equal status, specific duties, and cost responsibilities were clarified (II). The SUA representatives emphasized the importance of collaborative financial planning using formal agreements (III). Local guidelines clarifying the shared responsibilities were developed for several groups of service users in the overall target group (II).

## **4.2 CONTINUOUS LEARNING**

Establishment of formal structures, a focus on learning, and continuous exchange of competencies and experiences were prioritized (II). The formal, scheduled forums where various stakeholders could exchange information, interact, and learn were emphasized as important by the SUA so as to promote a culture of improvement (III). For the team members, it was crucial to achieve a sense of solidarity, to become involved in finding cross-sectoral effective solutions, and to participate in the forums (I). Similarly, it was crucial for the managers who exercised co-leadership to participate in joint meetings as they worked to achieve a common approach to providing equal health and social care (I).

The creation of a joint culture that unified staff was important for the success of the integrated care services (I). This objective was evidenced by the effort to develop consistent terminology and the effort to adopt a common job title – coordinator – for all employees, regardless of profession. The intent of the coordinator title was to emphasize that cooperation was essential, and that responsibilities could not be transferred across organisations (II).

Over the years, learning had played a central role in the integrated services (II). For instance, data from all levels of the organisation were continuously collected to assess progress. Another example was compulsory education for all inter-professional team members. Furthermore, the financial support for learning activities was used to promote and develop integration. For instance, the previous year's savings were spent on financing additional

training for facilitating the handover of service users from external locations to the local municipality's care (II). Learning was also used to overcome challenges such as, for example, managerial difficulties arising from differences in managers' decision-making mandates at the two organisations. To meet these challenges, additional training and support were offered in how to manage integrated projects and how to design processes for shared service planning (II).

### **4.3 COOPERATION AS A GUIDING PRINCIPLE**

The importance of cooperation was emphasized continually at all levels (I). Integrated care was based on cooperation (II). Dedication at all levels was perceived as essential in helping service users and informal caregivers feel secure (III). In addition, the SUA saw how the integrated services encouraged informal caregivers' participation (III).

The steering committee sought out the stakeholders' views on the integrated services. They invited partners, stakeholder/service user associations, and service user representatives to discuss the services and the organisational development that was co-created over the years in the dynamic process (II). The steering committee meetings were seen as an appreciated and well-functioning forum for continuous improvement (III). Permanent committee members were representatives from the mental health services at the municipality and the county plus the SUA representatives. Temporary committee members varied, depending on the agenda of the meetings (II). The support from the overall organisation was perceived as essential for the success of the co-leadership (I).

The perception of management's role as a facilitator of a collective activity, with a shared understanding of the purpose of integrated health and social care, was important. In daily operations, this required that the co-leaders were willing to "give and take" and occasionally even step back (I). In addition, it required them to understand the service users' holistic situation (III). The holistic approach, in turn, was achieved by combining different competencies, missions, and responsibilities among the co-leaders and team members (I). As a group, these individuals had a broad knowledge-base (III).

The managers were innovative in implementing new working methods and functions before the national government mandated these methods and functions. This also included new forms of employment when innovative solutions were devised. For instance, a position as a manager on the psychiatric addiction team was decided based on the selected candidate's profession. In another example, a new integrated employment category was created when the

county council agreed to share the cost of a municipal employee's salary when that employee's services were used (II).

Several actions were taken to increase integration, to simplify the daily work, and to increase collaboration. For instance, social workers and assistance officers were located at the centres and co-location was planned for some administrators. Moreover, a transfer of housing support at the unit level was planned. The purpose of this transfer was to gain closer proximity to the service users and to improve the collaboration among the social workers, assistance officers and the occupational therapists (II).

#### **4.4 SERVICE USER CENTEREDNESS**

Very early in the cooperation around integrated services, the steering committee announced its goal of achieving collaboration with each service user. The committee members recognized the interdependence of physical, psychological, and social factors in health and illness. This central role of the service user, which was formalized in an agreement, was to be achieved by individualised care and rehabilitations plans (II) that were described as a cornerstone of service users' control over their situations (III). Co-location and the cross-sectoral co-leadership were thought to contribute to faster decisions about health and social care interventions (I).

Another indication of the centrality of the service users was the increased emphasis on their holistic needs and their need to be aware of their own abilities and strengths (III). This emphasis was consistent with the goal in integrated care services that stressed the equal value of the service users' existential, medical, psychological, and social well-being (II). The service user-related work was perceived to benefit from the holistic approach that was achieved through different competencies, missions, and responsibilities between the county council services and the municipal services (I).

The idea of service user centeredness, which was a guiding principle in the provision of health and social care services, was practically applied in the co-production of the care content and support according to individual care and rehabilitation plans (II). Further evidence of this practical application was the varied roles and functions (case managers, professional peers, housing supporters, and cross-sectoral teams) that supported everyday life in the service users' home environment and the integration of the service users into society (III). All service users were assigned a coordinator from each organisation who shared the responsibility for the service users' health and social care planning. Service users with highly complex needs were assigned a multi-case manager (II).



Service user centeredness was achieved by ongoing stakeholder involvement through local service user groups at the service centres, at stakeholder/service user associations, and in the steering committee meetings where the role and the revision of the services were often discussed (II). The meetings enabled the capture of the service users' perspective on improvement projects, which were supported by the SUA (III). Depending on the discussions items on the steering committee meetings, stakeholders outside the integrated services were invited to participate and cooperate. In this way, the committee opened up its services to others' influences and gave credibility to others' knowledge (III). The SUA representatives saw the additional support and welfare service that stretched beyond the responsibilities of health and social care as important (III).

Data on the service users' needs, using the Camberwell Assessment of Needs (CAN) scale, were used to tailor health and social care services to the service users' individual needs. In addition, all service users' needs were repetitively collected through questionnaires. The analysis of these questionnaires informed the organisations about whether their services should be revised to provide more flexible and better needs-based support (II)

The focus on finding solutions best suited for the service user was stressed as essential at all levels of the services (I). For instance, individuals enrolled in a housing for people with long-term substance abuse and extensive care needs were able to retain their accommodation, regardless of which organisation had formal responsibility for the individual (II).

## 5 DISCUSSION

Four themes were identified in the exploration of the evolvement of the organisational dynamics in long-term health and social care integration. These themes were the following: *shared structure and ongoing refinement*, *continuous learning*, *cooperation as a guiding principle*, and *service user centeredness*.

This section discusses the interpretation of the structural and functional changes related to each theme in connection with previous research and with complex leadership theory. In addition, methodological and ethical considerations are addressed.

### 5.1 SHARED STRUCTURE AND ONGOING REFINEMENT

A major structural change that was implemented when the county and municipality integrated their services in the mid-1990s was *co-location* of services. This change reflected the ambition and the vision of close cooperation and enabled the practical, cross-sectoral collaborative work at the functional level. Co-location has been identified as a way to bridge the gap between health care and social care in community settings for people with complex needs and as a way to overcome barriers to cooperation [153]. Moreover, co-location has been identified as strategy that can foster [57] and enable [64] integrated care as well as promote service innovation [191].

Our research, which was conducted at the operational management level, found that the co-leaders thought co-location provided them with good opportunities to offer the services jointly. Co-location also provided good conditions for the inter-professional teamwork. Other research has found that co-location promotes more formal and informal team time, which in turn makes the teams work in a more integrated manner [192].

Yet other research has found that co-location is insufficient for the creation of integrated services in practice. Because of competing priorities, differing performance indicators, and alternative strategic plans a great deal of time and many resources are needed to build the trust and teams required if a new cultural identity for co-located services is to be created [193]. Moreover, researchers have also found that organisational arrangements may be less important than professional skills in the joint working between disciplines. The explanation is that different understandings of joint working and differences in organisational cultures may hamper collaboration [6, 194]. To create more cohesive health and social care, a common professional culture is highly recommended [144] which was also one of the priorities among the leaders of the studied case.

Given the challenges of integrating two organisations that provide services based on different cultures, missions, policies, regulations, and accountability and reporting requirements, it may be assumed that the task is very complex. Therefore, structural prerequisites may be insufficient to overcome these challenges. Previous research has shown that management control is a factor that can increase the possibilities of integration [195]. It has been proposed that a focus on the creation of shared mental models consisting of integration tasks, system roles, and integration beliefs is important [196].

The literature on institutional logics describes strategic inclusion of institutional entrepreneurs at the organisational and clinical level as of great importance in the promotion of integrated care. Such people can break old, institutional rules and practices and can make new rules and practices [96].

In the research of this thesis, two persons were identified as having the function of institutional entrepreneurs because they played a central role in the creation and achievement of long-lasting integration of services by continually promoting the idea of integrated health and social care. They were the *project managers*, also referred to as champions. They demonstrated new and innovative ways to develop and manage practices consistent with the literature on complexity leadership and CAS. For instance, in their separate roles as the county manager and as the municipality manager, they combined their different areas of expertise, emphasised differences in the prerequisites and needs of each organisation and, thereby, were better equipped to see the broader pattern of events.

The two project managers also seemed aware of their limitations as far as determining and directing the services by themselves. For this reason, they arranged opportunities for others to interact and network. This arrangement facilitated the emergence of the organisational system with respect to behaviours, attitudes, and direction. In other words, the project managers thought and acted systematically, which is a key feature of complex thinking by managers in practice [37].

Moreover, the project managers were seen as role models for collective leadership. Previous research shows that continuous encouragement and promotion of shared leadership and of leaders who act as internal coaches in operational management can support co-leadership as an embedded part of organisational culture [197]. In CAS theory, this is described as a leadership tag by the symbolic representation of the organisation's philosophy, personality, and ideas that bind people together [37]. Leadership tags promote and articulate an idea and

an attitude [37] by continually reminding, facilitating, and developing cooperation. Thus, the project managers advanced and sustained the core values of integrated care.

The integrated services enabled cooperation between the co-leaders and the inter-professional teams and also facilitated the provision of comprehensive health and social care for the service users and the informal caregivers. Service users are very positive about such cooperation [65]. The research indicates that co-location has an impact on the process of service delivery for service users who see they are diagnosed and treated more quickly when the professional groups communicate and share their findings and opinions [198]. Our findings demonstrate that co-location allowed the organisation of services around each service user's unique needs rather than around the system's common practices and procedures.

## **5.2 CONTINUOUS LEARNING**

The amount of changes achieved over the years created possibilities for continuous learning among the integrated services, at both formal and informal levels. The steering committee members, who understood the value of learning, developed an explicit strategy to prioritise continuous exchange of competencies and experiences among the professionals, service users, and the steering committee itself. In CAS theory, this is referred to as fostering network construction [37]. The services evolved over the years through the co-creation efforts implemented by the constellations of networks and groups that included key actors inside and outside the services. This appeared at all levels in the integrated services, which in turn contributed to relationship building and the promotion of a culture of improvement. The literature conceptualizes the transformation to integrated care as a process and as an organisational learning experience that requires learning on different levels among cross-disciplinary teams [199]. Moreover, this focus on relationships is a key factor in the development, evolution, and sustainability of networks [200].

The research on teams in integrated care shows that knowledge exchange is essential. When knowledge becomes trans-disciplinary across teams, the members can use this knowledge to solve special cases, to refer to a large body of practice and experience, and to specify each member's role and duties inside and outside the organisation [201]. Knowledge exchange facilitates the use of complexity principles and the assumption of responsibility for improving existing relationships and creating new relationships [37]. This outcome was observed in the steering committee where the stakeholders from various welfare services, school principals, researchers, and evaluators were invited to participate – to mention only a few of the invitees.

According to CAS theory, innovative ideas can emerge and develop from such structured networks [37].

In the application of the principles of complex leadership, organisations can create an environment that is favourable to participative interaction and network building. Such an environment can create conditions in which employees are willing to share their ideas and to problem-solve together [34]. A common approach to managing services at the centre of this research is to include all team members in the process of finding cross-sectoral solutions that advance common responsibility and solidarity.

The research has found that giving people opportunities to participate in change processes is an important part of sustainable change efforts [47]. The decision to promote service development based on inter-professional groups (rather than profession-based groups) revealed a willingness to embrace significant differences. This is an essential step in the management of CAS [34] and in successful cooperation [202]. Moreover, the literature highlights the effectiveness of encouraging organisational identity that reflects both self-similarity and variation and that resists destructive possibilities [27].

Forums for various stakeholders were established in which participants could exchange information, interact, and learn from each other. In addition, informal learning was promoted by the co-location of the services. In the literature, the use of integrated care can be seen as an organisational learning experience. Adopting and implementing integrated care means the professions must work in trans-disciplinary teams, at different care levels, and often for different health and social care organisations. All this takes time and effort [199]. In this research, the long-term orientation towards integrated care was facilitated by the decision of the steering committee to use funds left over from one year for training in the following year. In addition, the long-term orientation appeared at all management levels as evidenced by the co-leadership structure. The co-leaders were convinced the managerial form created room for “forward-thinking” and a long-term work perspective. This is an idea that research also emphasizes [202].

The fostering network construction also appeared in the service users’ work. For instance, members of the service users’ network were invited to all meetings with the professionals. Another example of network fostering was the service user groups that were created at each centre to provide them with a place to discuss the development of the services that would best meet their needs. A review of large-system transformation in health care emphasizes the importance of involving patients and families in change efforts. Such efforts often result in

advances in health literacy, better ways to set priorities, better health outcomes and overall improved health services [203].

The advantage of traditional linear change models generally lies in their contribution to creating a structure. On the other hand, when applied in real life, they have their limitations by being too simple to serve as a guide in explaining organisational development within complex organisations. Episodic change which follows the sequence "unfreeze-change-refreeze" does not correspond with a complex reality in which sustainable change rather is a question of continuous change [204]. DSF allows a way of understanding sustainability as an ongoing process [49], also described as continuous change, which follows the sequence freeze-rebalance-unfreeze [204]. DSF takes into account both the organisation and its context. Also, the fit between the interventions and the multi-level contexts and the organizational learning is especially emphasized as important for achieving sustainability which is supported by our results. Our case is an example of continuously ongoing change and adaptation as illustrated by the four themes and especially this theme, "continuous learning".

### **5.3 COOPERATION AS A GUIDING PRINCIPLE**

Cooperation was a key guiding principle of the integrated services and a central feature in the development of a partnership. For instance, formal agreements stated this principle on a structural level, inter alia, as follows: *What we do, we do together*. The agreements also emphasised the equal status of the two organisations that required continuous cooperation. The composition of the steering committee (municipality, county and service user associations) can also be seen as an expression of the willingness to build the services on cooperation. Decision-making and its environment have central roles in the process of achieving sustainable partnerships in integrated care [205]. The steering committee had a rather open structure because of its practice of inviting temporary members to their meetings. This inclusive approach, which presupposes cooperation, was also reflected at the functional level of the services that were characterized by cooperation and shared responsibility. Some examples of contexts where this cooperation was evident are the following: the service user encounter, the inter-professional team, and the development of services. This distribution of power is discussed in studies on integrated care as a shift from governance to governmentality. This shift implies that power, that was once centralised, is dispersed, negotiated, and reproduced in a range of networks, actors, and societal structures [206].

The work of encouraging and providing resources for professionals in the integrated services is consistent with complexity leadership because such work builds networks among professionals, organises their interaction, broadens their decision-making power, and trusts them to take responsibility [37]. In CAS theory, this is referred to as catalysing bottom-up network construction [37]. Maintaining a balance between structures that are sufficiently close facilitates consensus-oriented decision-making. The balance should also ensure the inclusion of stakeholders who can assist in sustaining the collaboration over a period of time [207].

Trust occurs repeatedly as an important piece of the puzzle for the maintenance of relationships and networks. For example, this was emphasized in the findings between service users and professionals, between the steering committee and the SUA, and between the co-leaders. To establish trust between co-leaders, three factors have been suggested as important: an attitude of non-prestige, the presence of common values, and mutual trust [202]. Trust also features in the partnership literature on joint working by various professionals [198] and in literature on health and social care for persons with complex needs [153].

The integrated care services providers in this research appear to have created and maintained trustful relationships. Based on the theory of institutional logics, such relationships in integrated care require that the competing logics are reconciled in a setting of “institutional complexity” [208].

The integrated services (i.e. managers and professionals) created a logic of, and the capacity for, partnership by fostering relationship building practices. One example of the logic of partnership was the management model of co-leadership, which was reflected at all levels of leadership action. A second example was the central role of service user involvement in all stages of care and support. A third example was the service user associations’ participation in the steering committee meetings. In other words, there were several venues where different logics could meet and be discussed.

Some researchers on inter-organisational collaboration argue that the collective activities of professionals in collaborative arrangements within and between fields shape new institutional fields. Collaboration, the argument goes, is the foundation that offers opportunities for involvement and strategically influences the direction of development [209]. One study of integrated care demonstrated that a united stakeholder perspective could be achieved through constructive collaboration processes over time [210].

Previous research has identified the development of a logic for partnership in integrated care by taking the perspective of institutional logics [96]. There are similarities between the results reported on in this thesis and the findings of the other studied integrated care services. For example, they identified processes consistent with the partnership concept, used the integrated care concept in practice recommendations, proposed practice guidelines, recommended information-sharing forums, and argued for collaborative relationships and fostering of networks [96]. These findings are consistent with our interpretation of our results.

#### **5.4 SERVICE USER CENTEREDNESS**

At a structural level, the service user centeredness is manifested in the equal importance given to the service users' existential, medical, psychological, and social well-being in the formal agreements. Service user centeredness was expressed in various ways. One way was the participation of service user associations in the steering committee meetings that gave them real influence at the highest decision-making level. In the literature on co-production, this cooperation in the steering committee is referred to as "multi-stakeholder governance". Such governance systems imply that the organisation's decision-making bodies include the formal representation of different stakeholders who have a voice and a vote as contrasted with "multi-stakeholder dialogue" in which stakeholders have informal representation and a voice but not always a vote [211].

Achieving shared power is a challenging task. A study on user involvement in the planning and delivery of adult mental health services in England revealed the complexity of such work. The managers in the case retained responsibility and accountability for decision-making by only using consultations (i.e. multi-stakeholder dialogue) rather than partnerships (i.e. multi-stakeholder governance) [212].

In co-production, the service user's experience and knowledge are at the forefront of good public service design and delivery [213]. In the studies of the current thesis, this positioning was evidenced by the holistic view of the service users who were participants at the centre of their care planning and support. Moreover, all new service users could meet a professional from both the county and the municipality to ensure that their needs were taken into account as the coherent care and support were planned. From CAS theory, patient-centered care is the fundamental philosophy that supports and guides desirable behaviours in complex systems [100].

A review of the implementation and evaluation of person-centered care found that in reality people are not closely involved in their own care [214]. Yet, based on our results, it seems the



studied integrated services did shift their institutional logics towards person-centered care. The services moved away from the traditional models of organisational and professional-centered care by integrating and practicing the idea of holistic health and social care.

In the research on co-production, person-centeredness is about allocating some power to service users by viewing both service users and professionals as experts. In this perspective, each group has special knowledge and skills [215]. Three factors are emphasised as essential in person-centered care: patient narratives (e.g. the patients interpretation of his/her symptoms, illness and impact on life), shared decision-making (e.g. common evaluation of all aspects of options of treatments that are suitable in accordance to the patients' health issues, values, beliefs, preferences and lifestyle) , and documentation (e.g. documenting patients participation in decision-making of care and treatment [214]). These factors derive from the partnership concept in which the interaction and trust between a care provider and a service user are the key components [216]. One way to manage dominant control by providers over decision-making is to involve service users [212] and to build partnerships in decision-making that are based on trust [217]. Trust is essential. However, building trust is a long-term process that requires open interaction and continued commitment [218]. Service-user involvement in all care stages has been found to be vital to the success of person-centered mental health service innovation [219].

In this research the organisational and clinical decision-making process was largely decentralised to the professionals and co-leaders at the centres. This decentralization enabled a more service user-centered approach. Within CAS, the identification of organisational knowledge centres leads to greater creativity and improved communications, an act referred to as “Drop seeds of emergence” [37]. Following CAS, leaders encourage people to be innovative and to evaluate their innovations [37].

To follow the evolution of changing needs of service users, the Camberwell Assessment of Need (CAN) data and user questionnaires were used. In the research, patient feedback was found to reinforce the value of the personal approach as well as to improve patient outcomes and to increase the overall satisfaction with the care provided [220]. Similarly, patient reported feedback was identified as usable data for the evaluation of the quality of care delivery and for the efforts to improve patient-provider relationships [221].

The literature suggests that establishing patient/relative panels is a way to create arenas for building partnerships with patients [222]. An evaluation of patient-centeredness of integrated care programs found that people with multi-morbidities were involved in various ways in the

decision-making. However, various barriers were reported, including the service users' and the professionals' insufficient knowledge and inadequate skills [223]. In our findings, the learning forums for service users, professionals, and leaders were useful for arranging common training opportunities and for enabling communication and relationship-building at the co-located services. Sharing information about everyday work and relating this knowledge to the improvement of clinical practices are ideas found in the research of organisational learning that contributes to a deeper understanding of the clinical system and its interdependencies [224]. The same research found that leaders and professionals became increasingly aware of how different elements had to interact to enhance performance and how their own efforts could contribute to that enhancement. Our findings are consistent with this research.

## **5.5 METHODOLOGICAL CONSIDERATIONS**

At this point, it seems necessary to reflect upon the influence of the researcher's role in the creative process of qualitative research with respect to the entire research process from design, to data collection, to analysis, to results, to conclusions. Qualitative research is invaluable in exploring complex systems such as integrated care and the actors' experiences and impressions in such systems. That is the reason the qualitative approach was chosen for this research. However, critics of qualitative research charge it lacks scientific rigour [225]. They explain that qualitative research should have stronger theoretical awareness and greater theoretical commitment [226].

Some qualitative researchers address the quality of their work using the terms "validity" and "reliability", which are more often used in quantitative research [227]. The claim is that these terms are also applicable in qualitative research even if they are used in a slightly differently way in order to achieve the special aims of qualitative research [228]. Lincoln and Guba [229] use the term "trustworthiness" in their commentary on qualitative research.

Trustworthiness refers to the evaluation of the research by establishing its credibility, transferability, dependability, and confirmability. Trustworthiness is a dimension of perceived methodological rigour [230]. These concepts are discussed in the context of the term "reflexivity" and "sample size" in relation to the three studies of this thesis.

Furthermore, strengths and limitations of the methods used in this thesis are also discussed.

*Credibility* is addressed as internal validity in the positivist paradigm [231]. In the current studies, some members of the research team were familiar with the case because the studies in this thesis build upon earlier studies at the research center. Through previous cooperation, a

trusting relationship had begun. In addition, previous knowledge of the organisation contributed to a greater understanding of its complexity, but on the other hand, pre-knowledge may also have influenced the interpretation of the results.

In qualitative inquiry, the researchers' background, experiences, perspectives, pre-understandings, skills, and presentation are especially important when interviews are conducted with research subjects. How the research was funded and how access to the studied case was gained are also important. These data are significant because human perception is highly selective and dependent on interests, cultures, value systems, and personal biases [230]. Therefore, self-appraisal, also referred to as reflexivity, is central in qualitative research. Reflexive researchers examine themselves and recognize the relevance of their own "situatedness" in the research setting, including the possible effects their presence may have on the trustworthiness of the findings. Thus, reflexivity calls into question the independence of researchers and the objectivity of the knowledge they acquire [232].

In this thesis an attempt was made to take reflexivity into account with a brief introduction of me, the thesis author, my academic and clinical experience, and my pre-understanding of the studied subject. All these factors were addressed during the actual research for the three studies. For instance, the interviews were carefully prepared for prior to data collection. From my work as a counselor, I had extensive experience in one-to-one meetings. However, there are major differences between the practice of psychosocial counseling and the conduct of research interviews. Thus, careful preparation was necessary.

In the analysis of all three studies, I was aware of possible biases because of my and my co-authors' pre-conceptions about the data. To prevent distortions from such biases and to increase awareness of our pre-conceptions and interpretations, peer debriefing was used in all studies and respondent validation (i.e. member checking) was used in study I. The findings were discussed in various contexts where various disciplines came together to test and evaluate our interpretations. Moreover, the findings were reported and discussed with practitioners and with researchers at scientific conferences.

In addition, the three studies used analyst triangulation. The involvement of several researchers in multiple ways of understanding the data led to a deeper understanding of the data. Other triangulation methods can be used such as method, theory, and source [164]. These methods were applied in the thesis as a whole in order to manage the limitations of the individual methods. Triangulation of sources gave us the opportunity to include different

perspectives of the studied phenomenon – organisation/management and service user – which enriched the data as a whole.

*Transferability* is addressed as external validity with generalisability in the positivist paradigm [231]. We tried to provide a comprehensive description of the research with enough details to permit evaluation of the applicability of our conclusions to other contexts. For instance, this applied to all case and method descriptions. The major criticism of the case study method is also its strength: in-depth knowledge acquired in a real-life context that enables rich descriptions but, at the same time, makes generalisations difficult [233]. However, in qualitative research, generalisation to populations is not always sought. Rather, the primary goal is to obtain an insight into relevant and important aspects of the studied phenomenon.

The research in this thesis was systematically conducted over a time period – from 2014 to 2017. The cross-sectional research design resulted in a snapshot of the integrated services as described by the operational managers and service user association representatives. In contrast, although Study II was also cross-sectional, the characteristics of its data differed from the data in Study I and Study III. This difference meant it was possible to present a comprehensive description of the evolution of the integrated services from the steering committee's perspective. These groups were judged best suited as sources of insights into the relevant and important aspects of the integrated health and social care services. To ensure sincerity from the participants, only volunteers were interviewed. They were also told about the researchers' independent role in relation to the integrated services so that they could speak openly.

A question that typically arises in research, and particularly in qualitative research, is the following: How should the researcher determine the sample size (i.e. saturation point), also referred to as conceptual depth [234]. In Study III, the target group as a whole was very diverse because it was important to include a variety of service user representatives so as to be representative of all subgroups. However, because it was difficult to obtain participants, the group interviews for this research had fewer participants than desired. Nevertheless, the participants had characteristics that were highly relevant for the study's aim.

*Dependability* is addressed as reliability in the positivist paradigm [231]. Qualitative research is conducted in reality, which is not a static environment. This situation may create replication problems if the research is repeated, even if in the same context and with the same methods and participants. However, if a research process is described in detail, other

researchers may repeat the work, even though their results might differ. One way to show that research findings are consistent and that the research can be repeated is to provide in-depth methodological descriptions (as each of our studies strived for). In addition, the audit trail technique was used in all the steps taken in each study to enable other researchers to replicate the research.

*Confirmability* is addressed as objectivity in the positivist paradigm [231]. This concept refers to the degree of neutrality (i.e. the research results are not influenced by researcher bias). Confirmability can be increased by reflexivity, which we applied by regular researcher group discussions. In reports of our results for Study I and Study III, we used respondent quotations to ensure that their experiences and perceptions were reported rather than the researchers' opinions and interpretation. On the other hand, the qualitative researcher will inevitably interpret the respondent descriptions to some extent. The researcher should, therefore, be careful not to stray far from the actual respondent statements.

The limitations and their potential effects are described in each study and in the thesis as a whole as a way to increase the research confirmability. Next, I briefly summarize these research limitations as well as some of the research strengths.

The major strength of this research is its subject matter: a unique case in which the long-lasting integration of health and social care is explored longitudinally, from different perspectives. This study of the evolvement of integrated health and social care services from the organisational, managerial, and service user perspective offered unusual insights into the ongoing changes in these services. The case also resulted in new knowledge, greater understanding, and specific suggestions on the organisation and management of person-centered, coherent, and sustainable health and social care integration.

The chosen theoretical perspectives and methodological approaches were sensitive to the inter-organisational level of analysis. However, there are surely other theoretical perspectives and methodological approaches that could complement them by providing other perspectives.

The DSF was chosen as the theoretical framework for our study primarily because of its usefulness for the study of change processes in complex organisations and its dynamic approach towards sustainability implying that change is an ongoing, constantly refined, process and not an isolated phenomenon. Also, the model highlights the importance of adapting the intervention to the characteristics of the context as well as the importance of continuous learning. This does not exclude the fact that the use of the model had to be repeatedly reconsidered, developed and refined to better suit our purposes. The openness of

the framework contributes to its usefulness in different contexts and with different types of data - both qualitative and quantitative – and at the same time it provides no distinct instructions as to what data should be collected.

The lack of some perspectives and details may be a limitation of this research. The complexity of the case forced us to simplify and to present only what was relevant based on the aims of the different studies. More information emerged in the data collection than was featured in the articles. The thesis might, for example, have been strengthened if interviews had been conducted with professionals in the integrated services, politicians, and civil servants.

## **5.6 ETHICAL CONSIDERATIONS**

An ethical application was submitted that explained the study design of the three studies in detail (ref no. 2014/612-31/5). Because the main data sources for these studies were derived from face-to-face interviews, telephone interviews, and documents, the ethical considerations discussed here focus on the qualitative data collection process.

The use of interviews to collect data presupposes a trustful and respectful relationship between researcher and respondent. For this research, it was clear the researchers had a responsibility (as well as an opportunity) to create an optimal atmosphere in which the respondents felt comfortable. The respondents were informed of the research purpose (a research interview, not a therapeutic/clinical conversation) and of the role of the researchers. With this advance information, the respondents could prepare for the interviews. They could also contact the researchers if they had questions.

The respondents were guaranteed anonymity in the dissemination or other use of any research findings. They could terminate their interview at any time without explanation. Their written consent was obtained to the terms of the interview.

Each interview was considered a potential intervention for the respondents because the questions could cause stress, anxiety, or discomfort. The more sensitive the topic, the more vigilant a researcher should be. Interviews on sensitive topics may also require a certain readiness to provide subsequent support and assistance. The interviews conducted in this thesis do not address any obvious sensitive workplace topics. However, in workplace research, there is always a risk that people (managers and staff) feel obligated to participate as a consequence of the organisation's involvement. Therefore, we emphasised that participation

was voluntary and that anonymity was ensured by coding of the data and by avoiding the presentation of results that could be linked to identifiable individuals.

For the respondents' convenience, the managers and the service user association representatives were given the freedom to select interview locations. The interviews in Study I were conducted at the managers' workplaces by two researchers, one interviewer and one observer. Three interviews in Study III were conducted at municipal facilities; one interview was conducted at a university. Each interview for this study was conducted by a single researcher, assisted by a non-participant observer who took notes.

The interviews began with a presentation of the researchers' role and an explanation of the division of tasks during the interview. The interview purpose was repeated. The interview parameters related to participant confidentiality and interview termination were re-explained. This interview framing was intended to create a trusting atmosphere in which the respondents could speak freely about their perception and experiences. A codebook was prepared after the interviews that separated the information about the respondents from the interview data. The audio files, the transcribed interviews, and the analyses were stored securely.

The potential benefit of this research was deemed higher than the risk that the respondents could experience negative feelings from their participation in the interviews.

## 6 CONCLUSION

*“Integrating care is an incessantly building  
of bridges and braking of barriers.”  
Charlotte Klinga*

This thesis highlights the importance of early focus on sustainability and belief in the benefits of cohesive services for the achievement of dynamic long-term health and social care integration. In addition, prerequisites for cross-sectoral cooperation on structural and functional levels seem to be of great importance for the integrated services when it comes to continuous adjustments to changing needs and requirements. For example, the findings reported in this thesis show that the decision-makers resisted the potential rewards often associated with setting and achieving short-term goals. Instead, they focused on long-term goals. They understood the necessity of taking a broad perspective and of trusting that cohesive health and social care could produce shared solutions.

Moreover, the ability to translate and implement the institutional idea of partnership into practice seems to be of importance. The findings show that this foundation, based in a belief in a shared mission and common values for the integrated services, supported the continuous development of structures and processes. For instance, the joint steering committee, the co-location of health and social care facilities, interprofessional teams and the co-leadership clearly reflected a holistic approach that recognized the importance of fostering relationships and the benefit of shared responsibility for the services.

Other factors of importance for the achievement of long-term integration of cross-sectoral services involve engagement in quality improvement and stakeholder involvement. The findings in this thesis show that continuous evaluation of the interventions provided valuable feedback for the continual adaptation and improvement of services. The involvement of and negotiation with relevant stakeholders enabled managers to make more informed decisions, which contributed to ensuring a better fit between the interventions and the local context. For instance, challenges related to cross-sectoral cooperation were continually examined, and strategies to address those issues were commonly developed and agreed upon. These strategies were developed by monitoring the local, regional, and national context and by adopting management’s willingness to involve related stakeholders with an interest in the services. As a result, the steering committee members received continuous input that allowed them to tailor the services to the service users’ needs.



Overall, these findings suggest that the emergence and long-lasting integration of health and social care services were based in the capacity to manage differences and changes by relying on the concepts of partnership, person-centeredness, and continuous learning.

## **6.1 IMPLICATIONS FOR PRACTICE**

First, these findings may have practical relevance for managers and professionals in other integrated services, in particular those working in mental health and social care, as well as for professionals in associated welfare services who also deal with service users with complex needs. For instance, these findings may offer practical guidance in how to structure and manage daily operations aimed at long-term cooperation.

Second, these findings may be valuable for managers and professionals who are considering the possibility of joint working through integration of services. The findings underline the importance of involving all relevant stakeholders, of focusing on sustainability as soon as the integration is in place, and of monitoring and refining provided services.

Third, these findings may be of value for policy makers engaged in the planning and development of welfare service reforms. In particular, the findings underline the importance of the holistic approach and long-term strategic thinking when reforms in policy and structure are under consideration.

## **6.2 IMPLICATIONS FOR RESEARCH**

Numerous welfare and care improvement projects focus more on modifications of existing approaches than on extensive and comprehensive systemic changes. Currently, few efforts have been made to systematically examine the impact of various changes on an entire system with simultaneous attention paid to the organisation, its management, and its service users. Longitudinal studies covering the whole care continuum are needed [235].

The three studies of this thesis provided an opportunity to investigate how a cross-sectoral integration of health and social care was able to achieve organisational sustainability. The findings increase our understanding of this integration of services by taking a longitudinal, system-wide, holistic approach to integrated health and social care. The three studies also contribute methodologically by showing how empirical studies of integrated and sustained health and social care systems can provide new knowledge in the field of integrated care.

### 6.3 FUTURE PERSPECTIVES

The research reported on in this thesis concerns health and social care for people with complex needs in general and with mental illness in particular. However, this research may have implications for a wider range of welfare services. Here are some reflections based on the knowledge I have acquired during my research education.

What is the future of integrated services? I would argue that we are witnessing the movement away from the contemporary health and social care structure, with its profession-centeredness perspective, to a more person-centered, integrated service structure. I would also argue for an upcoming shift in focus from the now dominant hospital-based care to a more primary-based care and home-based care, in certain areas. Both movements require inter-linked and aligned services that span service borders, organisations, and sectors. Such progressive movements take time, effort, and, not least, motivation to conceive of and implement change. This is a radical idea that challenges the strongly anchored conception of contemporary welfare services. Nevertheless, even slow progress is still progress. Stagnation is no longer a possibility; perhaps it never has been.

Some questions still remain. One of the trickiest questions, as I see it, is whether integrated care can achieve the quadruple aim (enhancing patient experience, improving population health, reducing costs, and improving the work life of clinicians and staff) to which it aspires? A related question, currently under investigation, is whether service integration initiatives are sustainable?

One way to tackle the first question may be to create innovative integration solutions for services and to conduct research on the processes, outputs, and outcomes, preferably in collaborations between practitioners and researchers. One way to tackle the second question may be to invest strategically in long-term services and in research.

To continue this research, it would be interesting to follow-up on the integrated services reported on in this thesis. In such research, it would be interesting to monitor the changes that have occurred after our data collection ended. Moreover, I believe it would be valuable to hear the perspectives of professionals, politicians, and civil servants on these integrated services.

## 7 EPILOGUE

After the data collection for this thesis had been completed, several changes occurred that redrew the map of the current integrated health and social care services. For instance, one of the two project managers retired, which was followed by a period of staff turnover. The general psychiatric rehabilitation unit was divided into a social psychiatric rehabilitation unit (managed by the municipality) and a neuropsychiatric unit (managed by the county). In the same manner, the cross-sectoral psychiatric addiction team was divided into a psychiatric addiction unit and a social psychiatric addiction team.

In addition to several divisions, mergers also occurred. The three geographically dispersed centres were merged into one centre and the steering committee merged with the local cooperation group, as is required for the municipalities in Stockholm County in accordance with a regional cooperation agreement between the county council and the municipalities. The actors from the two principal organisations who were members of the steering committee now participate in the local cooperation group.

Because the data collection period for this thesis did not capture the abovementioned changes, these are not discussed in the thesis. The changes that occurred indicate that the health and social care services have structurally moved away from each other, while cooperation continues foremost on functional level. The question arises whether the integrated care services can really be defined as *sustainable* as suggested in this thesis. However, complementary data collection and analysis would be necessary to fully understand the changes that actually have taken place and the consequences of these changes, from different stakeholders' perspectives. As described in the introduction to this thesis, health care is complex and integrated care in particular fulfills the criteria of a *complex adaptive system*. Changes that occur in an integrated care organization are not linear in nature and there is no clear cut off between integrated versus non-integrated care. Rather, as a researcher one may need to adjust to the fact that an organization evolves through different levels of integration.

The importance of pre-determining how to conceptualise sustainability before starting to study complex organisations became clearer to me as a result of the experience I gained during these studies. Although retrospective longitudinal studies of empirical cases are well suited to gain knowledge on how to succeed with long-lasting integration, new questions arise. The phenomenon we are studying is in itself influenced by change. Hence, in the context of this thesis, when can we consider an organisation to have achieved sustainability?

And how can we identify the breaking point of services no longer being sustainable when they are constantly adapting to ever changing needs? I will leave these philosophical questions unanswered. Perhaps, it is as Weick and Quinn [204] argue “*change never starts because it never stops*” (p. 381), or as the Greek philosopher Heraclitus of Ephesus (c. 535 – 475 BC) expressed it, “*the only constant is change*”.

## 8 SWEDISH SUMMARY – SVENSK SAMMANFATTNING

**BAKGRUND:** Det svenska vård- och omsorgssystemet är världsledande på många områden. Ett område som däremot sticker ut som bristfälligt är samordningen mellan vård och social omsorg. Denna brist drabbar särskilt personer med komplexa behov då vård- och omsorgsinsatser från olika organisationer och huvudmän ofta förekommer. En av dessa grupper är personer med psykisk sjukdom/ohälsa. Fragmenteringen i vård- och omsorgssystemet leder till brister i samverkan på flera nivåer: mellan sektorer och verksamheter och mellan professioner samt i samordningen av insatser. I vetenskapliga studier har integrering av verksamheter föreslagits som ett sätt, ett medel att nå bättre sammanhållen vård och social omsorg. På nationell nivå finns många exempel på styrning mot en mer sammanhållen vård- och social omsorg. Därutöver finns det även idag många exempel på innovativa lokala samverkansinitiativ men trots detta har ingen genomgripande förändring skett mot en mer sammanhållen vård och social omsorg på övergripande systemnivå. Att nå varaktig organisationsförändring i de lokala samverkansinitiativen har visat sig vara svårt. Många av dessa har runnit ut i sanden. Därför är det av stort värde att studera och lära av exempel på varaktig integrering av vård och social omsorg.

**SYFTE:** Denna avhandling syftar till att utforska den organisatoriska dynamiken i en varaktig integrering av vård och social omsorg.

**METOD:** Avhandlingen baseras på tre studier och den övergripande designen är kvalitativ longitudinell fallstudiedesign. Samma fall utforskades i de tre studierna utifrån ett organisatoriskt (studie I och II) och utifrån ett patient- och brukarperspektiv (studie III).

Det *empiriska fallet* är en sektorsövergripande samverkansform mellan vård och social omsorg riktad till personer med allvarlig psykisk sjukdom/ohälsa eller psykisk funktionsnedsättning. Sedan psykiatrireformen 1995 bedrivs verksamheten utifrån en samarbetsmodell med ett delat huvudmannaskap och sammanhållen vård och stöd som utgångspunkt.

*I studie I* undersöks det verksamhetsnära parledarskapet och data insamlades genom parintervjuer. Resultaten analyserades med kvalitativ innehållsanalys med efterföljande respondentvalidering.

*I studie II* undersöks styrningen av samverkansformen genom dokumentanalys av styrgruppens styrmötesprotokoll för perioden 1995 till 2015. Tematisk analys användes

tillsammans med det teoretiska ramverket Dynamic Sustainability Framework i resultatbearbetningen.

*I studie III* undersöks hur samverkansformen uppfattas av patienter och brukare genom fokusgruppsintervjuer med representanter från intresseorganisationerna. Resultaten analyserades med hjälp av Framework method.

**RESULTAT:** Sammantaget identifierades fyra empiriskt och teoretiskt grundade teman som viktiga för åstadkommandet av varaktig sektorsövergripande integrering mellan vård- och social omsorg.

*Gemensam struktur och pågående förfining:* Strukturella förändringar i form av gemensam styrgrupp, samlokalisering och gemensamt uppdrag, vision och gemensamma värderingar ledde till goda funktionella konsekvenser för t.ex. parledarna att utöva sitt ledarskap tillsammans. Likaså underlättades det interprofessionella teamarbetet och det samlade stödet till patienter och brukare. Två personer i chefsbefattning med rollen att driva utvecklingen i verksamheten lyftes fram som särskilt viktiga för att långsiktigt överbrygga olikheter och hinder i syfte att skapa hållbar sektorsövergripande samverkan.

*Kontinuerligt lärande:* Ovanstående strukturella förändringar gav möjligheter för lärande, formellt genom gemensamma forum och strategiska satsningar på utbildning och utbyte av erfarenheter och kunskap men också på ett praktiskt plan genom delade lokaler och fikarum som möjliggjorde informella samtal och kunskapsutbyte i arbetsvardagen.

*Samverkan som vägledande princip:* Båda huvudmännens lika värde fastställdes genom formella överenskommelser, likaså den integrerade verksamhetens fundament, nämligen att allt arbete baseras på samverkan, på alla nivåer, mellan patient/brukare och vård-/omsorgspersonal, samt mellan professionerna och verksamheterna. I praktiken framkom detta bl.a. genom att alla beslut som berörde den gemensamma verksamheten grundades på konsensus mellan parterna.

*Personcentrering:* Ett sätt på vilket personcentrering och ett holistiskt förhållningssätt utövades i praktiken var att låta alla nya patienter/brukare få träffa representanter från både kommun och landsting. På strukturell nivå fastställdes även patientens/brukarens rätt till aktivt deltagande i all planering och genomförande av insatser. Vidare fanns en strävan att låta verksamhetens utveckling följa patienternas/brukarnas förändrade behov genom individuella uppföljningar, brukarråd på enheterna/gårdarna och representation i styrgruppen.

**SLUTSATSER:** Resultatet av denna avhandling tyder på att den integrerade verksamheten var långsiktigt orienterad redan från början. Resultaten indikerar att förmågan att motstå sådana belöningar som kortsiktiga mål kan ge och istället fokusera långsiktigt bottnade i en förmåga att se helheten och i en tro på sammanhållen vård och social omsorg som i sin tur kan ha motiverat sökandet efter gemensamma lösningar. Dessutom visade resultaten att grunden i ett gemensamt uppdrag, gemensam vision tillika värderingar vägledde den kontinuerliga utvecklingen av gemensamma strukturer och processer. Exempelvis visar den gemensamma styrgruppen, samlokaliseringen och det delade ledarskapet på en tydlig vilja till helhetssyn och samlat ansvar för insatserna inom verksamheten.

De utmaningar som verksamheten fortlöpande ställdes inför undersöktes kontinuerligt och strategier för att hantera dessa utvecklades gemensamt av huvudmännen. Resultaten visar att detta skedde genom monitorering av den lokala, regionala och nationella kontexten men framförallt genom inkludering av för verksamheten viktiga aktörer i styrgruppen. Detta möjliggjorde både kontinuerlig anpassning av verksamhetens innehåll till patienternas/brukarnas reella behov och bättre samverkan med aktörer i andra välfärdsorganisationer utanför den egna verksamheten.

Sammantaget pekar avhandlingens resultat på att framväxten av den hållbara integreringen av vård och social omsorg grundar sig på en lyckad uppbyggnad av en kapacitet att hantera olikheter och ständiga förändringar genom partnerskap, personcentrering och kontinuerligt lärande.

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