ORIGINAL RESEARCH

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

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

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

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

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

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

Introduction

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

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

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

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

Service Integration

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

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

The Concept of Collective Competence

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

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

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

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

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

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

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

Materials and Methods

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

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

Table 1 The Municipalities from Which the Participants Were Recruited

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

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

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

Table 2 Focus Group Interviews

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

Table 3 Individual Telephone Interviews

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

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

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

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

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

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

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

Analysis

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

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

Table 4 Analysis Structure

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

(*Continued*)

Table 4 (Continued).

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

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

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

Results

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

Knowledge About Individual Life Situations and Organization and System

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

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

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

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

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

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

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

Investigation Competence

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

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

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

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

Person-Centred Collaboration Competence

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

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

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

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

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

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

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

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

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

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

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

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

Facilitating Competence

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

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

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

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

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

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

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

Discussion

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

To Make Sense of Events in the Workplace

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

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

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

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

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

To Develop and Access a Collective Knowledge Base

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

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

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

To Maintain a Sense of Interdependency

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

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

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

To Legitimate Extra-Professional Involvement

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

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

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

Conclusion

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

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

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

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Disclosure

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