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RESEARCH ARTICLE

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Tackling social inequalities in health: Assessing contexts for implementing integrated health access for people with severe mental illness

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Abstract

Social inequalities in health are a complex problem that often emerge at the interfaces between different sectors, such as health and social care, and the corresponding transitions between different provider organisations. Vulnerable people are typically in greater need of accessing different sectors of the health system and therefore often experience lack of coherence in their treatment pathway. We aimed to examine the contexts of health systems that influence initiatives concerned with integrated health access. We used the theory of Organizational Fields to study the contexts for implementing Flexible Assertive Community Treatment (FACT) in Central Denmark Region and three municipalities in the region. We collected 33 documents and conducted six qualitative interviews with professionals involved in FACT to understand the contexts of implementing integrated health access. We found that contexts for implementing FACT are highly complex, as they are divided between health and social care (horizontal complexity) and between national and the sub-national levels of the region and the municipalities (vertical complexity). This leads to conflicting demands on implementation. Local contexts of collaboration

may offer a lever to handle these demands, but these are likely to vary. Analysis of how complex health system contexts influence implementation is important to understand how changes might become sustainable and help to tackle social inequalities in health.

KEYWORDS
contexts, cross-sectoral collaboration, inequality in access to care, integrated care, mental health services, organisation of health care

Highlights

- Integrated care is important to address social inequalities in health, however some initiatives are difficult to implement and make sustainable due to varying contexts.
- The regional contexts were highly complex and provided conflicting demands on the implementation across health and social care.
- Understanding these contexts, however, enlightened the possibilities and limitations in implementation of integrated care initiatives.
- To provide sustainable initiatives on integrated care, contexts are important to understand and take account for.

1 | BACKGROUND

Social inequalities in health are a complex problem, defined as systematic, avoidable, and unfair differences in health outcomes among population groups.[1–4] Social inequalities in health often emerge at the interfaces between different sectors, such as health and social care, and the corresponding transitions between different provider organisations. Vulnerable people are those who lack personal, social, or material resources.[2,3] They face higher comorbidity[5–7] and typically have a higher risk of physical or mental illnesses. Therefore, this group is in greater need of accessing different sectors of the health system.[5,8] Nevertheless, vulnerable people often experience higher unmet needs and a lack of coherence when seeking healthcare, when compared to other groups of society.[6,9,10] Indeed, one of the main concerns related to the growing inequalities in health is the poor access to healthcare for vulnerable groups.[11,12]

Therefore, initiatives with a focus on creating integrated health access are potentially very powerful when it comes to addressing social inequalities of health. A prominent example of such an initiative is the Flexible Assertive Community Treatment (FACT).[13] FACT offers integrated health access to people with severe mental illness with the help of interprofessional teams from across health and social care services involving potentially both specialised care from hospital and mental health providers as well as primary care providers. In her discussion of different types of initiatives to address social inequalities in health, Whitehead[3] argues that initiatives like FACT are particularly powerful because they identify the 'critical causes of observed health inequalities'. These causes relate to exposure to health-damaging environments coupled with poorer access to essential goods, including health care.[3] Similarly, Braverman and Gruskin [14] identify health care as a social determinant of health. Importantly, the authors use the term broadly 'to refer not only to the receipt/utilisation of health services, but also to the allocation of health care resources, the financing of health care, and the quality of health care services'.[14] This highlights the importance of the system-level organisation of health care and how this distributes resources and designs

processes that make for more or less (un)equal health access. FACT targets both individuals and their environments. The main goal of this outreach approach is to sustain the commitment of people with severe mental illness to remain in treatment; and the nature and intensity of the support by the teams is scaled up or down according to the needs of the individual person with severe mental illness.[15,16] This is done to restructure the environment around people with severe mental illness, so that they enjoy more integrated health access.

However, the implementation of initiatives concerned with integrated health care is likely to be a highly complex, context-dependent, and social process.[17] Health access itself is a complex trajectory concerned with 'the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services, and to actually have a need for services fulfilled'.[18] Here, the health system is highly influential, as it determines principles and procedures for the approachability, acceptability, availability/accommodation, affordability, and appropriateness of health services[18] (similarly Cu et al.[19]). Implementing *integrated* health access adds further complexity as initiatives span different sectors of the health system, each with their own principles and procedures for health access. High specialization is a key principle of contemporary health systems but also makes health systems highly fragmented. Therefore, system-level contexts are key for understanding the implementation of integrated health access.[18,19] At the same time, health access is highly dependent on local contexts. This is because the trajectories of health access involve the interplay between supply and demand factors, notably between health systems and the specific abilities of individuals and populations to perceive, to seek, to reach, to pay, and to engage, in healthcare.[18] Thus, any initiative of integrated health access will necessarily have to be translated to and by local contexts. However, local contexts vary and may be a barrier to implementation in one setting, and a facilitator in the other.[20] This makes implementation an essentially social process, driven by different stakeholders representing provider, funder, professional, community, and user interests. The success of initiatives to strengthen integrated health access for vulnerable people, therefore requires a careful assessment of the contexts of healthcare organisation at different levels.[21]

Therefore, our research questions are as follows: What are the health system contexts that influence the implementation of initiatives concerned with integrated health access? How do health systems contexts influence the implementation of initiatives concerned with integrated health access?

We use the theory of Organisatizational Fields[22] to help answer these questions. This is because the theory focuses on the broader, systems-level environment and helps us to identify what multiple and specific contexts influence the implementation of integrated health access.[23] The theory also conceives context as a framework for action by organisational-level actors and this helps in understanding the specific ways in which context matters in processes of implementation. The theory suggests that the study of contexts needs to look at actors, institutional logics, and governance mechanisms. This allows for the identification of the complex contexts of implementing integrated health access and the interdependencies between them.[24]

We apply the theory of Organizational Fields to study the contexts for implementing FACT in Central Denmark Region and three municipalities in the region.[15,25]

2 | METHODS

2.1 | Analytical framework

The theory of Organizational Fields draws our attention to the environments in which health organisations, like public authorities, providers, community organisations, and professional bodies, function.[22,26] This is important as these environments shape how health organisations act, for example, when implementing integrated health access. Organizational fields such as health care are characterised by a distinct but separate set of actors, governance mechanisms, and institutional logics.[23,24,27] This complexity means, that each of these actors, governance mechanisms, and logics makes different and potentially conflicting demands on how to understand, organise and develop health care.[23,28,29]

Firstly, an organizational field typically has different individuals, groups of individuals, organizations and groups of organizations that make up the *actors* a field. This is important as actors have diverse roles and responsibilities in the field, depending on their resources. For example, in the health field there are often several public authorities with funding responsibilities at different levels, but with competing interests about what health services to prioritise. Secondly, an organizational field has distinct *governance mechanisms*, which are the arrangements that support regulation and control in the field. These mechanisms lay down the rules of the game for how the actors in the field interact with each other. Governance mechanisms draw on different principles of coordination, notably hierarchy, markets, and networks.[23] These are often layered onto each other; for example, in the health field, hierarchical decisions by public authorities may co-exist with joint agreements among providers and funders as well as competitive performance rankings. This makes competing demands on actors in the field and may have unintended consequences.[23] Thirdly, the interactions in an organizational field are underpinned by common cultural frameworks and systems of meaning. These *institutional logics* legitimise the specific roles of actors, and they also condition the practices of actors. For example, in the health field, medical professionalism offers a basis for diagnosis and treatment, while economic efficiency and population health underpin the provision of health services. The health field is typically characterised by co-existence of multiple and potentially contradicting logics.[29]

2.2 | Research setting

Studying FACT in Central Denmark Region is interesting, as the contexts for implementing integrated health access are highly complex.[20,21] Denmark has a tax-funded, publicly regulated but also decentralised health and social care system. At the national level, the Health Act and Social Care Act set out the overall framework for service provision. The delivery of specialised mental health services and hospital care is the responsibility of the regions, whereas municipalities are responsible for community mental health services and social care. These horizontal and vertical divisions matter because, in Central Denmark Region FACT has been implemented as part of a cross-sectoral collaboration between the Regional Centre for Specialist Mental Health Services and the Community-based Mental Health Services in the municipalities of Silkeborg, Skive and Viborg.[25] This cross-sectoral focus distinguishes FACT in Central Denmark Region from the implementation of FACT elsewhere.[15,16] The municipalities have many similarities in terms of geography and demography, and together with the region, they are also part of a mandated cluster of health care providers (*Midtklyngen*). Nevertheless, the municipalities enjoy high levels of autonomy over implementation.

The FACT model offers integrated health access based on interdisciplinary teams that aims to help people maintain their treatment.[13] Those who are included in FACT are people with severe mental illness, who experience chaotic life circumstances that includes substance abuse, severe mental illness, and social problems. Depending on the current situation of the users, they are either offered continuous supervision and monitoring (through a case manager) or intensive care treatment (through an interdisciplinary team). Users therefore receive regular check-ups by the case manager who, in cases of deteriorating health, deploys the rest of the team in an intensive team treatment. The team meet weekly at boardmeetings to discuss current challenges and treatment options for those receiving intensive treatment. The teams in *Midtklyngen* are implemented in parallel to regular treatment and the professionals therefore provide additional treatment to other users outside FACT. The teams typically consist of psychiatrists, specialist mental health nurses, community nurses, different social workers (addiction treatment, housing), and other relevant professionals.[13,30]

2.3 | Document analysis

We collected and analysed written documents to gain knowledge about contexts of implementing integrated health access at national, regional, and local levels. The collection of documents was an ongoing process, based on the

snowball method and with the purpose of reaching saturation.[31] Thereby, we could identify new documents of interest with the help of the references of included studies, until reaching a saturation point.[31] We selected a total of 33 documents based on three inclusion criteria: relevance for the topic (mental health, health access, cross-sector collaboration, implementation); representation of relevant field actors (either as authors or target audience of documents); and publication between 2007 (major health reform) and 2022 (end of project period). Taken together, this allowed us to capture the diverse field actors and how their interests and actions were situated in time and place.[31] Examples of documents are national legislation (Health Act and Social Care Act), regional Health Care Agreements, and municipal reports on community mental health services. The documents can be categorized as secondary literature; this included policy documents, administrative documents, and project documents, which are publicly available, for example, on websites.

The analysis of documents was a deductive process based on the theory of Organizational Fields. We analysed the documents with the help of Nvivo, where we organized the documents in literature displays, one for each level, and coded the text according to the analytical dimensions of our theory (*actors*, *governance mechanisms*, *institutional logics*). This offered concise overviews of the material and helped identify central themes and understand relationships between themes.[32] In the final part of the analysis, the literature displays helped identify important patterns that were relevant for understanding the contexts for implementing the FACT model. This was done by reviewing all literature displays and combining them in a table of themes for the different analytical dimensions of the theory of the Organizational Field.

2.4 | Semi-structured interviews

Based on the themes identified in the document analysis, we conducted semi-structured qualitative interviews with experts involved in the implementation of FACT in Central Denmark Region. This was to gain more detailed insights into how the contexts mattered.

We recruited a total of six experts, based on representation of different field actors and involvement in the implementation of the FACT model. The experts were all engaged with the development and adaptation of the model as part of their day-to-day work. This reflected responsibilities for meetings, recruitment of users, and coordination between the municipality and the region as well as more general management. The experts included one senior manager from each municipality, two members of FACT teams, and one manager from the region. We conducted the interviews online via Teams in March 2022; the interviews lasted between 45 and 50 min and were transcribed verbatim.

The interview guide was based on the main themes found in the document analysis: coherence, economy, governance, and technology. In the first step, we categorized and coded the interview material in an open manner.[33] We then divided the emerging codes into overall codes and more specific sub-codes. The rationale was to gain an overview to develop the final coding structure. We put together the codes from the open coding process in a coding list, which was the basis for the final analysis.

3 | RESULTS

Overall, this study finds that the contexts for implementing FACT are highly complex, as they are divided between health and social care (horizontal complexity) and between national and sub-national levels of the region and the municipalities (vertical complexity) (Table 1).[28] This leads to conflicting demands on implementation. Local contexts of collaboration may offer a lever to handle these demands, but this is likely to vary.

TABLE 1 Overview of contexts of implementation of FACT.

Vertical compexity across levels		Horizontal complexity across sectors	
		Health care	**Social care**
National Level		Actors	Actors
		Parliament, government, Danish Health Authority, Danish Regions	Parliament, government, National Board of Social Care, Local Government Denmark
		Governance mechanisms	Governance mechanisms
		Legislation (Health Act)	Legislation (Social Care Act)
		Institutional logic	Institutional logic
		Treatment (professionally defined, duty of treatment)	Person-centred care (tailored to individual needs, voluntary)
		Collaboration as operational strategy for service restructuring	Collaboration as operational strategy for service restructuring
Sub-national Level	Region	Actors	
		Regional Council, hospitals, specialised mental health services, health professionals	
		Governance mechanisms	
		Standards (specific treatment pathways)	
		Institutional logics	
		Treatment guarantee and responsibility	
		Collaboration as strategy to prevent admission to specialised services	
	Municipalities		Actors
			Municipal boards, municipalities, community mental health services, health/social care professionals
			Governance mechanisms
			Standards (broad, local quality standards)
			Institutional logics
			Voluntary support based on individual needs
			Collaboration as interprofessional working

3.1 | Horizontal complexity: Treatment versus person-centred care

The implementation of FACT spans across the health care system and the social care system, which leads to co-existing *governance mechanisms* in the form of two different pieces of legislation (Table 1). In turn, this multiplies the number of actors. For example, at the national level, each sector has its specialised agency (Danish Health Authority and National Board of Social Services) and umbrella interest organisations of providers (Danish Regions and Local Government Denmark). Similarly, the health and social care sectors fall under the auspices of different sub-national levels: health care is the responsibility of the regions, whereas the municipalities are responsible for social care. Horizontal complexity is further exacerbated as the actors and the legislation in the health care system

and the social care system respectively draw on two very different *institutional logics*: treatment and person-centred care (Table 1).

At the national level, legislation is the predominant governance mechanism; that is: the Health Act (*sundhedsloven*) and the Social Care Act (*serviceloven*). The Health Act states that *'(t)he aim of the healthcare system is to promote the health of the population and to prevent and treat illness, suffering and functional limitation for the individual'*.[34] This puts health professionals in the driver's seat in terms of defining how to deal with health. The emphasis is on treatment; indeed, the Health Act includes a section that stipulates a duty to treat in case of acute illness.[34] Importantly, there are corresponding sections in the legislation on professional licenses and on criminal offences committed by health care professionals. In contrast, the Social Care Act describes social care in much broader terms. The act stipulates that municipalities must offer, for example, assistance by social workers, long-term and temporary accommodation, services related to social life (for example, training in everyday activities, and socialising), as well as alcohol and drug treatment. These services must be *'organized on the basis of a concrete and individual assessment of the individual person's needs and prerequisites and in collaboration with the individual'*.[35] The Service Act demands that assistance must be tailored to the individual and that the resources and the needs of the individual are central for service delivery.

The differences between the institutional logics of treatment and person-centred care are also reflected at the sub-national level, where standards are the main governance mechanism. Following the institutional logic of treatment, Central Denmark Region has defined a care pathway for mental health. This is to ensure uniform diagnosis and effective treatment.[36] This contrasts with the standards in the municipalities. In line with logic person-centred care, the standards vary between municipalities. They are also less specific as they relate to a range of service areas in addition to mental health.

Treatment and person-centred care are the dominant institutional logics in the organisational field that makes up the context for implementing FACT. These logics unfold their influence as they form the basis for legislation and standards as governance mechanisms, which the actors directly involved in FACT must follow. This includes specialised actors like hospitals and specialised mental health services in the region, as well as the three municipalities and their community-based mental health services; and frontline actors like psychiatrists, mental health nurses, nurses, and social workers. As part of FACT, they work at the crossroads between the health care system and the social care system. For them, the conflicting demands on service delivery are hard to reconcile, as the following quotes illustrate:

> 'The Social Service Act is very much a law that stipulates that we must give the citizen the support that the citizen needs, in cooperation with the citizen. Whereas the Health Act is more… You are allowed to say; well, if it looks like it could harm the citizen (…) then we take over, and we can't do that in the Service Act. After all, we must always include the citizen. It requires a lot of translation work.'
>
> (Team member)

> 'We have treatment responsibility and treatment guarantees, and this sometimes makes life difficult for us. For example, the care pathways in the specialised mental health services in the region are at odds with FACT. According to the Social Care Act, FACT is a voluntary service offer.'
>
> (Municipal manager)

The two institutional logics construct the relationship between professionals and people with severe mental illness in different ways. In the social care system, a person's self-determination is paramount, whereas the duty of treatment in the health care system puts professionals in the driving seat and in specific circumstances even allows overruling the expressed needs of the individual person. Here, professionals as front-line actors have a prime role in navigating between the two logics and translating them in a way that is meaningful in the situation at hand.

The recent *Ten-Year Plan for Mental Health*[37] acknowledges the existence of conflicting institutional logics. The Danish Health Authority and the National Board of Social Services state *'that integration coherence is better supported at a structural level through better consistency between the Service Act and the Health Act'*.[37] However, the plan does not recommend changes to the legislation itself but instead offers earmarked funding for intersectoral initiatives, a named contact person, and data sharing.[37] One of the managers in the region suggests that the plan still can facilitate the implementation of FACT. The joint authorship of the plan at the national level sends a powerful signal to managers in the region and in the municipality to go the extra mile when it comes to supporting FACT.

3.2 | Vertical complexity: Different logics of collaboration

The vertical complexity stems from the fact that the health care system and the social care system in Denmark are characterised by considerable decentralisation. At the national level, as the *main governance mechanisms*, the Health Care Act and the Social Care Act respectively draw on framework legislation (Table 1). Thus, the respective ministries and boards as the regulating and specialised *actors* follow up with administrative guidance. In addition, the annual budget negotiations between the government and the regions/municipalities often further specify areas of priority and objectives for service development. Beyond that, the regions and especially the municipalities as the sub-central regulating actors enjoy considerable autonomy; they are independent and democratically elected public authorities, and the municipalities even levy their taxes. This makes for vertical complexity as the specialised actors in the region (specialised mental health services, hospitals) and the municipalities (community mental health services) enjoyed great autonomy when implementing FACT, while they were also subject to legislation and other pressures by national regulatory actors.

The vertical complexity was especially reflected in different and conflicting *institutional logics* related to collaboration at national and at sub-national regional and municipal levels. At all levels, there was an overall understanding that collaboration underpinned by an integrated care perspective should be central for the delivery of health care and social care services. For example, one of the central aims of the national 10-year-Mental-Health-Plan is to strengthen collaboration across the health care and the social care system. The same is true for the regions and a report on mental health identifies collaboration and integrated care as central for service improvements,[38] as well as for the corresponding report by Danish municipalities.[39]

However, a closer look reveals that there is great variation in the specific cultural and social meanings connected to collaboration at each level; this leads to three distinct logics of collaboration. At the national level, collaboration is based on meanings concerning the importance of formal structures. Collaboration becomes an operational strategy to restructure mental health services to secure more integrated services.[37] As such, collaboration must also fit into norms that mental health services should be cost-effective and employ evidence-based methods.[37,40] The programme *'National goals for the healthcare system' (Nationale mål for sundhedsvæsenet)* states that these goals must support "(…) that as much health as possible should be delivered within existing funding".[40] At the regional level, collaboration becomes connected to norms around the primacy of treatment and specialisation. For example, the report on mental health frames collaboration to prevent admissions to specialised mental health services.[37] Here, collaboration emerges as the prerequisite for the operation of standardised treatment pathways. This contrasts with the municipal level, where collaboration centres around individual persons and their community settings.[39] More specifically, collaboration is associated with norms of interprofessional working rooted in the everyday lives of people with mental illness, as a manager from one of the municipalities explains.

> 'Service delivery should be integrated, independent of who is involved. This [the sector] is irrelevant for the individual person. I am hoping that we will be moving closer to each other [in the FACT teams]

> (…) And that the people receiving services will notice that this [collaboration] is beneficial for their situation.'
>
> (Municipal manager)

Here, the perspective of the individual person and the improvements to his/her life situation become the defining set of meanings for collaboration. These values around collaboration in service delivery are consistent across the three municipalities, illustrating an overall culture that is shaped by governance mechanisms in the form of the Services Act. As the Social Services Act states, the one of the central aims of social care is to *"promote individual persons' opportunity to develop and manage themselves or to facilitate their daily lives and to improve their quality of life"*.[35]

The co-existence of these different and conflicting institutional logics of collaboration posed challenges for frontline actors in FACT, who were supposed to work across the health care system and the social care system. Following on from this, the professionals in the municipalities typically come from across different professional groups, whereas the professionals in the regions are mainly nurses. This has implications for previous experiences with interprofessional collaboration and the relative ability to adjust to the FACT teams, as a manager from one of the municipalities suggests.

> ' (…) they [regional employees] are all nurses, they have the same frame of reference and the same background. My employees, they are interdisciplinary. My employees are used to operating within the entire social care system and with a wide range of all possible collaboration partners.'
>
> (Municipal manager)

From the perspective of front-line actors, the implementation of FACT required developing a thorough understanding of these different approaches to collaboration, and how they were embedded in the health care system and the social care system respectively.

3.3 | Local contexts of implementation

There is another layer of the vertical complexity of the health care system and the social care system; the contexts for implementing the FACT model are also locally specific. Considering the autonomy of the region and the municipalities, they can shape the specific local contexts for implementation, illustrating the plasticity of local contexts (Table 2).[21] The specialised mental health services and the community mental health services can decide what health and social care professionals to include in the teams. The composition of front-line *actors* has implications for the roles and responsibilities of the team and the extent to which the interests in the team are competing. The two services also have a choice over where in the health care system and/or social care system they position the team. This can have implications for how closely the teams become associated with the specific *governance mechanisms* (legislation and standards) in the health care system and the social care system respectively. Finally, the specialised mental health services in the region and the community mental health services in the municipalities each bring their *institutional logics* of collaboration with them to the teams, formed as part of previous and ongoing experiences of working across sectors. For an overview of the local contexts for implementing FACT see Table 2 below.

In Skive municipality, the FACT team mainly consists of two professional groups: nurses from the regional mental health services and outreach support workers from community-based mental health services. Most of the frontline actors in the team are from community-based mental health services. The FACT team is also based in community mental health services, namely the Centre for Mental Health and Substance Abuse, which offers mental health and social care services as well as treatment (*Center for psykiatri og rusmiddel*).[41] The composition of the team potentially favours the frontline actors from community-based mental health services and the organisational

TABLE 2 Local contexts of implementation.

	Actors Composition of team	Governance mechanisms Organisational setting	Institutional logics Local cultures of collaboration
Skive	Region 3 nurses, 1 middle manager Municipality 9 outreach support workers, 1 social worker	*Municipality* Centre for Mental Health and Substance Abuse	Relational Strong communication and close teamwork Weak hierarchy
Silkeborg	Region 5 nurses, 2 doctors, 2 secretaries, 2 middle managers Municipality 4 outreach support workers, 3 substance abuse counsellors, 2 secretaries, 3 middle managers, 1 development officer	*Region/municipality* Integrated Mental Health Centre	Intersectoral Parity between region and municipality Inclusiveness in terms of different professional groups
Viborg	Region 8 nurses, 1 middle manager Municipality 4 outreach support workers, 1 middle manager	*Municipality* Centre for Substance Abuse, Centre for Welfare Services	Hierarchical Clinical leadership by region Dual professional approach

setting is rooted in the legal provisions related to social care. However, this seems to be counterbalanced by a local culture of collaboration that is highly 'relational'. The relations between different professionals are considered the driving force for collaboration. As a manager in Skive municipality explains, the focus is becoming a 'we' by investing time to find out what each party can bring to the collaboration. This rests on notions of fostering collaboration through strong communication as well as close teamwork and is premised on low hierarchy. This relational collaboration may emerge with the strong representation of outreach support workers in the FACT team, who mainly engage in principles of low hierarchy and holistic approaches.

In Silkeborg municipality, the FACT team includes a broader range of professional groups: doctors and secretaries in addition to nurses from the specialised mental health services in the region, and substance abuse counsellors, secretaries, and a development officer in addition to outreach support workers from community-based mental health services in Silkeborg municipality. In terms of numbers, there is also a greater balance between the frontline actors from the specialised and the community-based mental health services. Likewise, the organisational setting has a strong cross-sectoral orientation. The team is based at the Integrated Mental Health Centre (*Psykiatriens Hus*). The centre builds on a well-established collaboration with the specialised mental health services in the region.[42] The local culture of collaboration also has a distinct intersectoral focus. This rests on notions of parity between the specialised and the community-based mental health services as well as inclusiveness in terms of professional groups. The team has one coordinator each from the community-based and the specialised mental health services; and each team meeting includes additional professionals, who are not part of the team, but who are involved in supporting the person with severe mental illness. The team is further characterised by being highly

structured with for example, designated timeslots for including additional professionals in their weekly meetings and timeslots for discussing each of the FACT team-users.

In Viborg municipality, the FACT team mainly consists of two professional groups: nurses from the specialised mental health services and outreach support workers from the community based mental health services. Most of the frontline actors in the team are from the specialised mental health services, although the team has its base in the community based mental health services in Viborg municipality. The team spans across two different centres, the Centre for Substance Abuse (*Rusmiddelcenter Viborg)* and the Centre for Welfare Services (*Forsorgscenter Viborg)* targeting socially vulnerable adults.[43] The composition of the team potentially favours the frontline actors from the specialised mental health services, while the organisational setting is rooted in the legal provisions related to social care. However, the local culture of collaboration emerges as 'hierarchical' and is steeped in notions of clinical leadership and a dual professional approach. The middle manager from the specialised mental health services acts as the chair of the team. The Specialised Mental Health Services are co-located with the regional hospital in Viborg and emerge as the dominant actor. In the team, the nurses and the outreach support workers continue to work side-by-side and the team appears fragmented with little knowledge about each other's competencies and practices.

4 | DISCUSSION

The paper aimed to analyse the contexts for implementing integrated health access at different levels and how these contexts influence implementation with the help of the theory of Organizational Fields. The analysis was based on the implementation of an intersectoral FACT model for people with severe mental illness in three municipalities in Central Denmark Region.

The analysis shows that the contexts for implementing the FACT model are highly complex in three respects. Firstly, the contexts are characterised by horizontal complexity as they span two very different, overall institutional logics: the treatment logic and the person-centred care logic. These logics matter as they get enshrined governance mechanisms and lead to very different legislation and standards in the health care and the social care systems respectively; and as they shape the roles and responsibilities of actors. These institutional logics that guide professionals are however not pervasive, and when operating in multiple institutional spheres the professionals may obtain plural logics that breaks the borders of the health and social care systems.[44] Secondly, contexts are characterised by vertical complexity, as each level has its own, specific institutional logic of collaboration. At the national level, collaboration emerges as meaningful as an operational strategy to create structures for integrated care; whereas at the regional level, the meaning of collaboration is closely connected to avoiding hospital admissions; while at the municipal level, collaboration is meaningful as a way of working across different professions. Thirdly, contexts are complex as they are locally specific, as reflected in the different organisation of the three FACT teams. The frontline actors involved in the teams vary in terms of diversity and the relative balance between the region and the municipality. The organisational base of the teams is more of less closely connected to the governance mechanisms of the municipality and thus also previous experiences with intersectoral collaboration. Teams therefore exhibit highly diverse cultures of collaboration, ranging from relational and intersectoral to hierarchical.

The implications for implementing integrated health access as part of FACT are two-fold. Firstly, the horizontal and vertical complexity of contexts make for many, many different and potentially conflicting demands on implementation. This is problematic because the frontline actors in the FACT teams together with the specialised/community mental health services in the region/the municipality engage in implementation in the spaces in between the divisions between the health and the social care system as well as between the regional, and municipal levels. This makes agreement and consensus difficult, as many actors try to assert their own interests.[44] The frontline actors of the FACT teams thus all aligned with the overall goal that people with severe mental illness

should improve their life situations to the best of their own capabilities; but the frontline actors had different views on how to reach this goal. This led to disagreements on which type of treatment was appropriate in each situation. Therefore, organising such intersectoral and multidisciplinary teams might become fragile and needs extensive management and support to survive.[45] Secondly, the variations of local contexts potentially add another layer of complexity, but also show that contexts can be formed in different ways and are not fixed. Therefore, it is important to understand the plasticity of initiatives and the elasticity of contexts when implementing initiatives of integrated health access. The initiatives need to be translated to and by local contexts. Contexts thus emerge as highly adaptive social structures, which professionals can mould, for example, by changing standards or cultures, to ensure that specific components of the initiative work. By the same token, initiatives can be adapted to fit a particular context.[20] In their study, Trane and colleagues[46] describe the challenges of implementing FACT in rural areas and suggest adapting elements of the programme to a rural context, such as frequent collaboration between municipalities and adapting the planning of the FACT model to the local context. Therein lies the potential to create levers to navigate the conflicting demands on implementation. These levers appear to be strongest in Silkeborg, where the local context has a distinct intersectoral focus, and weakest in Viborg, where the local context is biased in favour of the region.

What are the implications for future research and practice? In terms of research, our study suggests that the contexts of health systems at different levels are very important for understanding the implementation of initiatives of integrated health access. We need to analyse contexts as processes, which involve actors, rules, and cultures (at different levels), and which are part and parcel of implementing integrated health access. This view of contexts is echoed by more recent contributions to the literature on implementation, which considers contexts as changeable and relational, shaping the mechanisms underpinning the implementation of health initiatives.[20,47] For example, Pfadenhauer and colleagues[48] describe context as complex constructs that exist in multi-level systems, which are constantly changing and interacting with each other and the broader environment. Similarly, in its updated version of the key elements of developing and evaluating complex interventions, the UK Medical Research Council[49] conceptualizes contexts from a systems perspective. The authors ask both, how interventions adapt to the systems in which they are implemented, and how interventions change the very systems in which they exist.

In terms of the practice of working towards more integrated health access, analysing the complex health system contexts and how they influence implementation is important, as this helps in understanding how changes might become sustainable[49,50] and indeed help to tackle social inequalities in health. This is because health systems contexts offer more structurally embedded knowledge on how and why initiatives of integrated health access work. Here, qualitative studies are particularly instrumental as they can offer insights into the dynamic interplay between health system contexts and processes of implementation.[51,52]

4.1 | Study limitations

Using the theory of Organizational Fields offered a frame to understand the complex contexts of health and social care organizations. This theory provides one perspective on contexts and other theories might have illustrated other elements in the analysis. For example, the theory of Organizational Fields has been criticized for focusing on the larger perspectives of fields and not as much on the social interactions and agency of actors as the other important elements in institutional theory.[53]

The participants further provided in-depth data on the topic, which gave the study strong information power. Although the study could also have expanded the empirical material to include users and health care professionals who were involved in the FACT teams, this was not feasible in the current study. The described challenges and adaptations of the FACT model in *Midtklyngen* might also be relevant for other FACT teams. This makes the article relevant for implementing similar innovations across health and social services.

5 | CONCLUSION

This study offers a systematic analysis of contexts for implementing integrated health access. The qualitative perspective provides more thorough insights into the relations between health systems contexts and the mechanisms of implementation. Such an overview of contextual limitations and opportunities can provide researchers, managers, and professionals with the knowledge on how to navigate and potentially optimise implementation of initiatives in complex systems. Based on the current study, it can be concluded that contexts for implementing integrated health access, such as FACT, are highly complex. The contexts are characterised by both horizontal and vertical complexity, which contributed to the conflicting demands that the professionals in the three FACT teams experienced. However, knowledge about the complexity of contexts can contribute to the sustainment of initiatives, as the complexity of contexts helps in understanding the possibilities and limitations of implementation. This may in turn address the growing social inequalities in health.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Research was carried out in accordance with the Helsinki Declaration. An ethical approval was waived by The Central Denmark Region Committees on Health Research Ethics (No.1-10-72-124-22) Participants gave signed informed consent for study activities.

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