

Variable and Vague Implementation: A Qualitative Study on Municipalities' Use of the National Guide for Services for Individuals with Intellectual Disabilities in Norway



RESEARCH

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ABSTRACT

The national guide 'Good Health and Care Services for Persons with Intellectual Disabilities' was launched in 2021, the first of its kind in Norway. This study aimed to explore municipalities' awareness, understanding, and use of this guide. Focus group interviews were conducted with unit managers, first-line managers, and frontline employees. A total of 39 people from 13 municipalities participated. Findings indicate weak and unsystematic implementation, with varying levels of awareness, typically higher at managerial levels. While participants across service levels acknowledged the relevance of the guide, few had established structured approaches for applying it. The involvement of people with intellectual disabilities and their families was limited. These findings suggest the need for clearer national follow-up and regular supervision of implementation.

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In Scandinavia and Europe, the past three decades have been characterised by extensive reforms in disability policy, including measures directed at individuals with intellectual disabilities (Grung et al. 2020; Halvorsen et al. 2017a; Halvorsen et al. 2017b). In Norway, services for persons with intellectual disabilities have likewise undergone significant changes. Research by Tøssebro (2016) demonstrated that deinstitutionalisation reform in Norway resulted in significant improvements in housing conditions and physical environments for individuals with intellectual disabilities. Most individuals moved from large institutions to smaller group homes, gaining private rooms and more autonomy. However, the reform had a limited impact on broader aspects of quality of life, such as social participation, employment, and inclusion. According to Tøssebro and Gustavsson (2025), many municipalities continue to prioritise service efficiency over individual choice, and housing quality and affordability remain pressing issues. These developments suggest that the reform's ideological goals—normalisation, inclusion, and self-determination—are still not fully realised. Instead, structural and organisational priorities often take precedence, limiting the transformative potential of national policies and reinforcing the marginalisation of people with intellectual disabilities.

Individuals with intellectual disabilities represent the third-highest expenditure group within the health sector, following dementia and fall-related injuries (Kinge et al. 2023). Demographic trends, particularly the ageing population, pose significant challenges for municipalities in recruiting and retaining personnel and create major prioritisation dilemmas (Hellesø et al. 2024). A national survey examining the competence of employees in health and care services for individuals with intellectual disabilities revealed that 33.2% lack formal education in health and social care (Ellingsen, Isaksen and Lungwitz 2020).

The Convention on the Rights of Persons with Disabilities (CRPD) outlines principles to safeguard the rights of persons with disabilities. Norway ratified the CRPD in 2013, but it is still not incorporated into national law (November 2025). The Convention affirms equal rights for individuals with intellectual disabilities and calls on society to uphold these rights (UN 2006). The UN Special Rapporteur has criticised Norway for its inadequate disability policies, disparities in health services across municipalities, and for not adopting a human rights-based approach to disability, questioning whether people with intellectual disabilities enjoy equal rights (UN 2020). National guidelines in Norway consolidate existing regulations, outlining laws and recommendations for sound practice. Though not legally binding, they provide a normative framework for assessing service quality and legal compliance and may be used in governmental supervision (Norwegian Directorate of Health 2019). The guide 'Good Health and Care Services for People with Intellectual Disabilities' was launched to address significant shortcomings in services for this population (Norwegian Board of Health Supervision 2017; Chalachanová, Fjetland and Gjermestad 2023; Witsø and Hauger 2020; Gjermestad et al. 2017; Official Norwegian Reports 2016, 17).

A 2016 nationwide supervision revealed significant deficiencies in leadership, staff competence, service delivery, individualised care, self-determination, decision-making support, and health follow-up, including medication management (Norwegian Board of Health Supervision 2017). Evidence also shows limited user participation and unlawful coercion (Gjermestad et al. 2017; The Equality and Anti-Discrimination Ombud 2019). These findings highlighted the need for a structured, knowledge-based approach to improve service quality and ensure equitable access across municipalities. In this sense, the guide can be seen as a response to persistent health inequalities affecting people with intellectual disabilities, aiming to reduce disparities in service provision and promote more consistent, rights-based care across the country.

The guide reflects Norway's CRPD obligations, emphasising self-determination, inclusion, and respect for individual preferences (UN 2006). Developed with input from users, families, professionals, and organisations, it promotes person-centred, ethically sound services and supports municipalities in delivering equitable, knowledge-based care. It offers practical recommendations across seven areas: collaboration and competence; person-centred services; life stages; habilitation and daily support; health follow-up; family collaboration; and documentation (Norwegian Directorate of Health 2021). To aid implementation, the directorate organised webinars, conferences, and funding opportunities and published tools for local evaluation. Two centres of expertise, the National Competence Centre on Intellectual

Disabilities (NAKU) and the Centre for Development of Institutional and Home Care Services (USHT), were tasked with supporting municipalities, such as using a quality improvement model, ensuring broad anchoring, identifying areas for improvement, assessing competence needs, and developing a plan for competence development. In addition, the directorate mandated the involvement of all relevant stakeholders and the initiation or support of networks for employees (Norwegian Directorate of Health 2021).

Implementing national guidelines in municipal health and care services is challenging, yet little research exists on how they are understood and applied locally in Norway (Gransjøen 2022). To our knowledge, no prior studies have examined municipalities' relationship to the guide 'Good Health and Care Services for People with Intellectual Disabilities', despite its aim to reduce health inequalities and promote rights-based services. This study addresses this gap by exploring how municipal managers and frontline staff understand and use the guide.

The research questions are: What knowledge and understanding do managers and employees in direct service have of the national guide? What signs of implementation can be observed in the services, and how can these be interpreted?

THEORETICAL BACKGROUND

The analytical perspective of this study is grounded in a theoretical framework that draws on implementation theory and disability and human rights perspectives.

IMPLEMENTATION THEORETICAL PERSPECTIVES

Several research-based implementation frameworks are applicable across diverse health and care settings (Barnden et al. 2023; Nilsen 2015). This study draws on key principles from Fixsen et al.'s (2005) framework, initially designed for specialist health services but adaptable to complex, dynamic organisations in other sectors (Fixsen et al. 2005; Nilsen 2015). Implementation is a structured quality improvement process that progresses through phases such as exploration, preparation, execution, and sustainability. The framework highlights three core components: intervention content, implementation support, and ongoing evaluation. Its concept of 'implementation drivers' encompasses workforce competence, organisational infrastructure, and effective leadership. Successful implementation depends on flexible integration into routine practice and active engagement from key individuals, ideally organised as an implementation team. Organisational readiness for change is considered essential for achieving long-term success. Capacity refers to the knowledge, skills, and actions needed for change and is seen as an organisational condition or culture (Fixsen et al. 2005). Effective implementation requires political directives to align with practice and reflect real organisational needs (Nilsen 2015). Managers play a central role by providing support, training, and resources that are vital to sustaining engagement among all stakeholders (Bertram et al. 2011; Aarons et al. 2015; Engell et al. 2023). Incorporating staff expertise and service users' experiences is also critical (Rycroft-Malone 2004). To strengthen engagement, stakeholders should be involved early in planning for introduction, change, and implementation (Steinskog 2024). Learning networks are highlighted as an effective approach to promote successful implementation (de la Perrelle et al. 2020).

Gransjøen (2022) distinguishes between active, complex methods and passive, simple methods for implementing national guidelines. Active methods include competence-building measures such as staff, end-users, and relatives training, as well as developing educational materials, using quality monitoring systems, ensuring guideline accessibility, and providing leadership support (McKay and Nigro 2016; Spoon et al. 2020). Combining active methods is most likely to achieve real practice change. Passive methods, such as distributing guidelines digitally or in print, are most common but least effective (Miilunpalo et al. 2001).

Barriers to implementation may include a lack of motivation within the organisation, limited resources (Sandström et al. 2015), insufficient training, and unclear mandates and responsibilities (Bergmark et al. 2021). Other barriers include time constraints, the presence of numerous or unclear guidelines in the field, the perception that the evidence base is not relevant to practice, and the lack of systems for providing feedback on implementation efforts (Evenstad,

Larsen and Gravingen 2020). Facilitators include leadership support for implementation and leaders adhering to the recommendations (Clement et al. 2016). Furthermore, the guidelines should be accessible and easy to comprehend (Gransjøen et al. 2020). Another critical factor is that the target group agrees with the recommendations, that sufficient time is available for their implementation, and that the guideline can be adapted to user preferences and local conditions (Clement et al. 2016). Municipalities that achieved a certain degree of success in their implementation efforts often had key individuals who actively monitored developments within the relevant knowledge domain (Bergmark et al. 2021).

DISABILITY AND HUMAN RIGHTS PERSPECTIVES

This study draws on selected theoretical frameworks from disability research to inform the understanding of disability in relation to public service provision. The deficit-based model conceptualises disability primarily as an individual impairment often linked to medical diagnosis and treatment, which may contribute to exclusion and underprioritisation in policy and practice (Shakespeare 2013). In contrast, the social model highlights how disability arises from societal barriers, such as inaccessible systems and discriminatory attitudes, rather than from impairments alone (Adam and Koutsoklenis 2023).

The human rights model further emphasises that persons with disabilities are rightsholders entitled to dignity, autonomy, and equal access to services (Waddington and Priestley 2021). The citizenship model complements this by framing disabled individuals as active members of society, whose participation should be supported through inclusive public structures (Shakespeare 2013). These frameworks do not form the basis for a comprehensive theoretical analysis in this study, but they provide valuable insights into understanding the implementation of the national guide. If disability is primarily framed as an individual issue rather than as a shared social responsibility, efforts to implement systemic measures, such as national guidelines, may be deprioritised or inconsistently followed. The models help situate implementation not only as a technical or administrative task but as part of a broader value system that reflects how disability is conceptualised within public services.

METHODOLOGY

The context of this study is the provision of health and care services for people with intellectual disabilities in Norway. The study employs a qualitative design, examining the perspectives of managers at two hierarchical levels within municipal services—unit managers (Level 1) and first-line managers (Level 2)—and employees directly involved in frontline service delivery (Level 3). Unit managers occupy a middle management position between the Director of Health Services and frontline managers.

The study was reviewed by SIKT (The Norwegian Agency for Shared Services in Education and Research) and deemed to comply with their guidelines for the processing of personal data and data protection legislation (reference number 801422).

PARTICIPANTS AND RECRUITMENT

Participants were recruited through NAKU, the project group's established network of municipal employees, and the USHTs. Based on these contacts, invitations to participate in the study were sent to managers in the health and care services of 28 municipalities, of which 13 agreed to take part. The sample reflects variation in municipal size (based on population) and geographical distribution, with participating municipalities ranging from approximately 2,000 to 75,000 inhabitants.

Participants received an email invitation accompanied by an information sheet and consent form. The information sheet specified that participation required a minimum of three representatives from each municipality: one unit manager (Level 1), one first-line manager (Level 2), and at least one frontline employee (Level 3). The final sample consisted of 39 participants, comprising 35 women and four men. Ten municipalities contributed informants at all three levels, while three municipalities participated with informants at two levels. In two municipalities, frontline employees were not represented, whereas in two others, two frontline

employees were included. One municipality participated without a first-line manager, and one included an additional unit manager. More details in [Table 1](#) Overview of the number of women and men by level.

LEVEL	FEMALE	MEN	TOTAL
Unit managers (Level 1)	12	2	14
First-line managers (Level 2)	11	1	12
Frontline employees (Level 3)	12	1	13
Total	35	4	39

Table 1 Overview of the number of women and men by level.

Most participants held a bachelor’s degree in health and/or social care. Among them, 21 were social educators, three were social workers, three were child welfare workers, and three were nurses. Additionally, one informant was an occupational therapist, two had a background in education, and one held a qualification in health management. Two participants had vocational-level health education, while three did not report any formal educational background. Furthermore, two first-line managers and eight unit managers reported additional training in leadership and management.

Data collection took place between November 20, 2023, and January 2, 2024. Informed consent was obtained from all participants, and they were assured of their right to withdraw at any time. Audio recordings were transcribed and anonymised, with all identifying details removed or altered. Data were stored on encrypted, password-protected servers accessible only to the research team. The study complies with national data protection regulations and ethical standards as approved by the National Committee for Medical and Health Research Ethics.

DATA COLLECTION

We selected focus group discussions as our method because they encourage dynamic exchanges and shared reflections that mirror the participants’ lived experiences. This approach offers valuable insights into the group’s social realities (McLafferty 2004; Vaughn, Schumm and Sinagub 1996). Eight digital focus group discussions were conducted, comprising two groups of Level 1 participants, three groups of Level 2 participants, and three groups of Level 3 participants. Each group consisted of between four and seven participants, except for one Level 3 group, which included only two participants. Microsoft Teams was used as the digital platform for all sessions.

The authors of the article were divided into three teams, each comprising two researchers, with each team responsible for conducting interviews at one of the three levels. To ensure the data addressed the research question, three semi-structured interview guides—one for each level—were developed. These guides were based on thematic questions and follow-up prompts. The interview guides included questions regarding participants’ familiarity with the national guide. Participants were asked how the guide had been disseminated within the municipality, whether it had led to any changes (and if so, what kind), whether the municipalities had identified areas requiring improvement, and any challenges encountered in implementing the guide.

Semantex AS transcribed all focus group discussions. The complete dataset comprises 168 pages.

ANALYSIS

The reflexive thematic analysis method, as described by Braun and Clarke (2022), was employed to analyse the qualitative data in six phases. Reflexivity was considered an integral and ongoing part of the analytical process. This was supported through continuous dialogue, critical reflection, and collaborative interpretation among the authors.

Phase one, *familiarising yourself with the dataset*, was undertaken during and after each focus group discussion, as well as through reading the transcripts. All authors recorded their immediate reflections during the reading process, and these notes were maintained and

developed throughout all phases. Both the notes and the dataset were discussed collaboratively by the authors in digital meetings.

The second phase, *coding*, was conducted primarily on a sentence-by-sentence basis, in some cases paragraph-by-paragraph. Coding was performed semantically, yielding 1,137 codes. Examples of codes include 'Our services lose out in the competition for resources', 'Other tasks affect the work with the guide', and 'Find the guide useful'. In the third phase, *generating initial themes*, the codes were reviewed and grouped. New themes were created or integrated into existing ones. This process resulted in 17 distinct themes, including 'Professional focus dependent on the guide', 'The role of leadership', 'Dissemination of the guide', and 'Use of the guide'.

In phase four, *developing and reviewing themes*, the initial themes and their associated codes were systematically reviewed. Themes that conveyed similar narratives and appeared conceptually related were merged. During this phase, the number of themes was reduced from 17 to three overarching themes. Examples of themes that were merged include 'Professional focus', 'Use of the guide', and 'Key personnel'. These were incorporated into the final theme, titled *Varying familiarity with the national guide*. During the analysis process, authors 1, 3, 4, and 6 were responsible for phases two, three, and four.

In phases five and six, the processes of *refining, defining, and naming themes, as well as writing up the entire dataset*, were systematically revisited. Following Braun and Clarke's (2022) description of reflexivity, this was a dynamic, iterative process involving continuous movement between the phases of analysis and engagement with the dataset. During this process, the names and content of the main themes were collaboratively discussed and refined. All authors contributed to these phases by providing input and acting as discussion partners in the final interpretation and presentation of the findings. From the analysis process, we identified the following three main themes: a) Varying familiarity with the national guide, b) Positive attitude towards the guide and c) Few traces of systematic implementation.

FINDINGS

a) VARYING FAMILIARITY WITH THE NATIONAL GUIDE

A key finding in our analysis concerns the varying degrees of familiarity with the national guide among different groups of informants. This variation is essential for understanding the extent to which the guide has been disseminated and internalised across organisational levels. While all unit managers and eleven out of twelve first-line managers were aware of the guide, some employees were either unfamiliar with it or uncertain whether they had encountered it. Informants who were aware of the guide had learned about its launch through various channels, including information from governmental bodies such as the Norwegian Directorate of Health and NAKU, communication within the organisation, websites of governmental bodies, collaboration with USHT and other organisations, and social media. Across all groups, some informants also reported becoming familiar with the guide's content through inspections carried out by the county governors. This was particularly evident in cases where external factors, such as inspections, prompted increased engagement with the guide. As one unit manager stated, 'I must admit that I, probably like many others, didn't read it properly until there was an inspection of the service. I haven't asked the others how familiar they are, but in places where inspections have taken place, the managers have educated themselves on the topic'.

The quote suggests that inspections prompted managers in the respective municipality to become more familiar with its content. Unit managers expressed greater familiarity with and understanding of the guide than first-line managers, who in turn reported greater familiarity than employees. Nevertheless, exceptions were found. Some managers had limited knowledge, whereas a few employees were highly familiar with the guide. One such employee attributes their familiarity to participation in a professional network—a CRPD network—aimed at enhancing knowledge and understanding of the CRPD. The employee stated, 'I suppose I have an advantage through my participation in this network because we go through the guides chapter by chapter and have both in-person and digital meetings. So, I've received a proper introduction and now feel that I'm very familiar with it'.

Several employees reported professional responsibilities, including legislation on coercion, training and internal education, medication management, key worker roles, and collaboration with relatives. Tasks described in the guide were often part of routine service delivery, reflecting a professional focus even when work was independent of the guide. As one employee noted, 'I can't really say that I associate it with the guide in our context, but the themes in the guide are discussed, even though I do not directly associate them with the guide'.

Examples included promoting self-determination, health follow-up, and family collaboration. The guide mentions positive behaviour support (PBS) as one framework for good practice. Two first-line managers and one employee stated they prioritised PBS over the guide, applying PBS-related approaches without direct reference to it. One unit manager noted that PBS was the municipality's chosen method for strengthening professional practice, with the guide serving as a value-based foundation.

b) POSITIVE ATTITUDE TOWARDS THE GUIDE

Despite varying levels of familiarity, informants expressed a positive attitude towards the existence of a guide intended to provide direction and contribute to quality assurance in services for people with intellectual disabilities. They described the guide as a helpful tool, a reference resource, a management instrument, and a professional framework. One first-line manager stated:

When I had the opportunity to review it, I found it to be an excellent tool for ensuring the quality of the work we do with people with intellectual disabilities and their families. A life is a life, and, of course, there are many phases; this guide addresses everything from the very beginning to the end. It's a very good management document for quality assurance in our work.

This quote illustrates how the guide is perceived as a valuable tool for ensuring the quality of services for people with intellectual disabilities. The first-line manager emphasises the guide's comprehensive coverage of different life stages and its function as a management document. This positive attitude, despite limited familiarity with the content, suggests a willingness to engage with the guide to improve service provision.

At the frontline employee level, it was also noted that the guide could serve as a valuable resource in supporting individuals with intellectual disabilities. As one employee stated, 'I went in and had a look today, before the meeting, where you can click through the different sections and so on, and I can see that it's a useful tool. Now that I know more about it, I genuinely want to use it at work and share it with others'.

Other informants across all three levels stated that the focus of our study prompted them to become more familiar with the guide's content in preparation for the interview. Another aspect of the guide's perceived usefulness as a tool and resource concerned its design. A unit manager emphasised the importance of guides being easy to read and understand, as this increases the likelihood of their active use in practice. Similarly, a first-line manager noted that the guide's structure, with its distinct chapters, had enabled her service to use it as a reference tool when addressing specific issues.

Many participants found it particularly valuable to have a guide specifically tailored to services for this user group. At all levels, concerns were raised about the high costs associated with these services, and there was a shared fear that elderly care might be prioritised over services for people with intellectual disabilities. Although the guide was regarded as a useful tool for strengthening these services, it was emphasised that a guide alone is not sufficient. As one employee put it, 'It's a concern I have for our target group, which we know is not necessarily a high priority—they are unfortunately often pushed aside. That's why we need clear voices, people who care, people who are engaged, research reports, and a great deal of commitment'.

This quote highlights a concern that people with intellectual disabilities are being deprioritised within municipal services. The informant emphasised the need for strong engagement from both professionals and society to ensure that this target group receives the necessary attention and support.

Only a few informants expressed criticism of the guide. One unit manager shared experiences in which standardisation, requirements, and directives—particularly those related to diet and nutrition—had led to ethical dilemmas in service provision. The emphasis on strict adherence to the guide had, in some cases, led staff to ‘pressure’ users to comply with its directives. The manager expressed concern that such requirements could compromise professional judgement in practice, while also emphasising the importance of individual adaptations and the responsible use of professional discretion.

c) FEW TRACES OF SYSTEMATIC IMPLEMENTATION

While informants generally viewed the guide as a valuable tool for structuring services for individuals with intellectual disabilities, they also described and encountered several challenges related to its implementation. These included issues with disseminating and communicating the guide, uncertainty about its scope, limited resources, and insufficient anchoring at the municipal level.

Informants across organisational levels emphasised the importance of disseminating information about the guide within their organisations. This was achieved through various communication channels, including email, newsletters, digital quality improvement tools, meetings and printing the guide for display in staff rooms. Employees were encouraged to read the guide, which was made available on several platforms. However, it ultimately remained each staff member’s responsibility to act on this encouragement. As one employee explained, ‘We go through it when we have spare moments—at least we try. So, we take some e-learning. Yes. But there’s no dedicated time set aside for it, and there’s no list of what should be prioritised or completed. There just isn’t’.

Both unit and first-line managers were unsure whether staff had received information about the guide. Many lacked systems to ensure its prioritisation and understanding. Launched during the COVID-19 pandemic, the guide encountered significant implementation challenges, including time constraints, staff shortages, and recruitment difficulties. Professional development was often deprioritised, and the lack of supportive resources compounded the challenge. First-line managers were expected to invest significant effort themselves but lacked clear implementation guidelines, prompting extensive internal discussions. Moreover, they were unaware that others within the organisation did not request or expect this effort. Low managerial density and large organisational units further complicated efforts, as managers had to balance external expectations, financial constraints, and competing priorities. One first-line manager stated:

I could have spent an entire year working full-time on implementation tasks. If I do not actively engage with the process and keep it alive, nothing progresses. At the same time, I have both personnel and professional responsibilities, including rota planning. As a result, this guide becomes work that must be completed in time that effectively does not exist, making it difficult to prioritise.

Informants from various levels emphasised the importance of anchoring the guide at the municipal leadership level and integrating it into municipal plans to ensure its effective implementation. This was frequently identified as a challenge, either due to a lack of information or knowledge or because the work had only just begun. The analysis reveals differences between municipalities in how this anchoring was approached. Some informants stated that their municipality had barely initiated the process, while others described efforts to address the issue. As one first-line manager explained:

We began nearly a year and a half ago when we were instructed to establish a working group comprising professionals from all residential units and managers. It was a strong group with decision-making authority, including a unit manager. We then began working through the material.

First-line managers prioritised the guide in quality improvement, particularly within leadership teams. Some had municipal support and sought political endorsement. Both management levels planned to introduce the guide to employees, though some prioritised managerial familiarity over broad staff knowledge due to time constraints. Informants described various

implementation strategies and showed varying awareness of online resources, some of which they found useful. A few used tools from the Norwegian Directorate of Health to structure efforts. Despite available support, daily operational demands made prioritisation difficult. Still, the analysis indicates that some of the participating municipalities had begun developing systems and structures to support the introduction and anchoring of the guide, for example, by organising regular professional development days and informational materials on topics such as nutrition, health, and dental care. Mapping of local services based on the guide, developing digital tools for easier access and adjusting staff rotas to allow more individually tailored services.

Informants' accounts and experiences of establishing structured and professionally grounded practices anchored in the guide suggest that systematic efforts were most evident at the unit management level and among first-line managers. One unit manager stated that the guide had catalysed change within the municipality. Meanwhile, a first-line manager described the structured work with the guide as follows:

When we plan the rota for the coming year, we have scheduled meeting points every third week, during which we will go through the guide chapter by chapter—either on professional development days or in shorter, dedicated sessions. In parallel, we are also developing routines in settings where established procedures are currently lacking.

These experiences underscore the importance of regular, planned meeting points for review and discussion, as they enable staff to better understand and apply the guide's content. The informant believed this contributed to a more holistic and structured approach to service delivery, potentially leading to improved quality and greater consistency in services for individuals with intellectual disabilities. The informants were also inspired by each other's accounts of how they have worked, or could work, on anchoring the guide. One employee said:

Yes, I actually think the same as [informant] – that using the guide more actively, bringing it more into everyday situations like staff meetings and things like that, is important. That you raise specific themes, like you said as well, [another informant], that you break it down. That sounded very clever.

Findings show varying familiarity with the guide, though it is widely seen as a valuable tool for improving services. There is broad agreement on the need for better integration into daily practice. Informants noted the motivational value of sharing experiences, suggesting more active use in staff meetings. Tailoring implementation to staff capacity was emphasised, and dedicated arenas, like professional networks were viewed as key for exchanging ideas and strengthening implementation.

DISCUSSION

The study examined awareness, understanding, and application of the national guide 'Good Health and Care Services for People with Intellectual Disabilities' among frontline employees and managers in Norwegian municipalities. Three years on, awareness varies: most managers know the guide, while several employees had scarcely heard of it, and some first encountered it through this study. Informants familiar with the guide received information through various channels. Although familiarity is not an end in itself, we argue that systematic use can support appropriate, recommended services.

This study, like Bergmark et al. (2021), shows that municipalities with key personnel who stay updated are better positioned for successful implementation. Implementation is complex, involving multiple phases and components (Fixsen et al. 2005), and national guidelines can be challenging to apply (Gransjøen 2022). Broad involvement of staff, service users, and stakeholders is needed to foster support (Rycroft-Malone 2004). Although staff were included, people with intellectual disabilities were not. Their exclusion from planning and guidelines in Norway has been criticised by the UN Special Rapporteur (UN 2020).

BARRIERS TO IMPLEMENTATION

A lack of motivation to utilise guidelines may stem from multiple guidelines within a single domain or from disagreement with the recommendations (Sandström et al. 2015). The guide ‘Good Health and Care Services for People with Intellectual Disabilities’ represents the first comprehensive framework within this field. Despite varying levels of familiarity with its content, informants expressed a positive attitude towards the guide and anticipated that it would contribute to improved service provision. Nevertheless, they encountered several barriers, including challenges with dissemination, uncertainty about the information’s reach, insufficient resources, and a lack of anchoring at the municipal level. Informants reported limited knowledge of where to access professional support promptly, consistent with findings by Clement et al. (2016), who identified time constraints, limited resources, and inadequate systems as key barriers. Managers disseminated the guide both digitally and in print, encouraging staff to read it during spare moments. These represent examples of passive, weak, and simplistic implementation strategies, which, although commonly employed, are generally ineffective (Miilunpalo, Toropainen and Moisio 2001).

More active and complex strategies were also observed, such as training and competence development, which are essential for ensuring the necessary skills (McKay & Nigro 2016; Spoon et al. 2020). Examples include courses, professional development days, supervision, and annual plans and competence frameworks. Effective implementation must be tailored to the specific context and environment, considering local resources, culture, and needs (Nilsen 2015). This was evident in our findings, where training focused on selected themes from the guide, such as self-determination, nutrition, and health. Some managers believed that not all staff needed to be familiar with the guide if high-quality services were delivered. This may be interpreted as a form of contextual adaptation (Nilsen 2015). In this context, PBS is briefly mentioned in the guide. However, only one participant (the unit manager) highlighted it as implemented in their municipality. This implementation was not explicitly linked to the guide, suggesting that while PBS shares underlying principles with the guide, such as person-centred and proactive support, their integration in practice remains unclear. This highlights a need for further research on how these frameworks intersect and whether the guide actively promotes or aligns with PBS principles.

Only a few informants had assessed their services and competence needs in preparation for implementation. One informant linked the municipality’s participation in a CRPD network to a strong familiarity with the guide—an example of a learning network that facilitates implementation (de la Perrelle et al. 2020). Participation in the CRPD network may also be seen as an indicator of the organisation’s capacity for change, highlighting the importance of knowledge, skills, and action in driving both change and implementation (Fixsen et al. 2005). While employees expressed a generally positive attitude towards the guide and anticipated that it would improve service quality, our findings also point to certain limitations in its practical utility—particularly regarding dissemination and perceived relevance among frontline staff. This contrast suggests that the guide serves as a robust normative framework, but its impact may be constrained by local context and competing professional logics.

WEAK CENTRAL GOVERNANCE OF THE IMPLEMENTATION PROCESS

Despite isolated examples of active, complex methods for implementing the guide, there was little evidence of systematic planning, anchoring, or evaluation—elements essential for effective implementation (Fixsen et al. 2005). This lack may stem from weak anchoring at the first-line management level, where managers balanced operational demands with expectations in the guide. Several informants stressed the need for public funding to support implementation. Unclear mandates and responsibilities remain significant barriers (Bergmark et al. 2021). Informants also called for stronger leadership commitment, crucial for providing support, training, and resources (Bertram et al. 2011), which in turn sustains stakeholder engagement (Aarons et al. 2015; Engell et al. 2023).

For implementation processes to be effective, political directives must align with practice and reflect organisations’ needs (Nilsen 2015). In Norway, people with intellectual disabilities have, over time, experienced violations of fundamental human rights (Chalachanová, Fjetland and Gjermestad 2023; Witsø and Hauger 2020; Gjermestad et al. 2017; Official Norwegian Reports

2016:17; Norwegian Board of Health Supervision 2017), limited self-determination, and insufficient support in decision-making (Guddingsmo 2020; Linde 2022; Skarstad 2018). They face weak legal safeguards (Official Norwegian Reports 2016:17; Norwegian Board of Health Supervision 2024), limited participation in their services (Gjermestad et al. 2017; The Equality and Anti-Discrimination Ombud 2019), and serious deficiencies in service provision (Norwegian Board of Health Supervision 2017). The UN Special Rapporteur (2020) questioned whether their rights are upheld on an equal basis with those of others. This context formed the basis for the Norwegian Directorate of Health's national guide, which aims to improve health and care services for people with intellectual disabilities (The Norwegian Directorate of Health 2021).

IMPLICATIONS FOR SERVICE USERS

Informants expressed concern that people with intellectual disabilities are deprioritised in municipal services and called for stronger engagement from professionals and society. Despite known challenges, we found little evidence of systematic implementation of the national guide. Instead, fragmented efforts indicate weak commitment to national directives, and implementation appears at an early stage.

This lack of prioritisation is not merely a practical or administrative issue; it reflects deeper societal assumptions about disability. When services fail to include people with intellectual disabilities in a structured and consistent way, it may signal a persistent reliance on deficit-based thinking, where disability is viewed as an individual limitation rather than a shared social responsibility (Shakespeare 2013). Such perspectives risk reinforcing exclusion and inequality, particularly in access to health and care services.

Alternative conceptual frameworks highlight how societal barriers, rather than individual impairments, shape disability. The social model of disability, for example, shifts the focus to the structural conditions that restrict participation (Adam and Koutsoklenis 2023). At the same time, a human rights approach emphasises the entitlement of disabled individuals to dignity, autonomy, and equal access. These perspectives challenge the passive positioning of disabled people within service systems and call for structural accountability. The citizenship model further underscores the importance of recognising disabled individuals as active members of society, whose full participation should be supported—not hindered—by public services (Shakespeare 2013). Seen through these lenses, the inconsistent implementation of the guide may reflect not only resource constraints but also a lack of ideological commitment to inclusion and rights. Addressing these challenges requires more than technical improvements; it demands a shift in how disability is understood and valued within public systems.

LIMITATION

Although the study includes a diverse range of municipalities in terms of size, geographical distribution, and levels of management, it is, as a qualitative study, not statistically representative. Nevertheless, the findings provide valuable insights into how municipalities understand, engage with, and apply the national guide. The study's focus on the guide may have increased participants' awareness of its content, as some may have prepared for the focus group discussions in advance. At the same time, several informants reported limited familiarity with the guide. The inclusion of both unit and first-line managers, each with varying responsibilities, may have influenced responses, as participants might have presented their practices more favourably. A key limitation is the absence of perspectives from people with intellectual disabilities. While this study focused on managers and frontline staff, service users' voices are essential for understanding the guide's impact. Although outside this study's scope, future research should include individuals with intellectual disabilities. An Easy-to-Read (ETR) version of the guide exists, which may improve accessibility. Future studies should examine users' awareness of the guide, their perceptions of its implementation, and any changes in service quality since its 2021 launch.

CONCLUSION

The national guide aims to reduce social health disparities by ensuring access to necessary health and care services. Despite its well-intentioned goals, our study suggests that a lack

of systematisation and anchoring has characterised its implementation. The involvement of people with intellectual disabilities or their families appears limited in the municipalities in our sample, and there was considerable variation in awareness and use of the guide among employees and managers. Familiarity tended to increase at higher hierarchical levels, and managers reported that the demands of other management tasks often took precedence over efforts to implement the guide's recommendations.

These findings reflect how structural and institutional barriers continue to shape the lived experiences of people with intellectual disabilities. Rather than viewing disability as an individual or medical issue, a lack of implementation reveals how social and organisational systems reproduce exclusion and inequality. When municipalities fail to prioritise this area and national authorities have few follow-up methods to support them, it undermines the autonomy and citizenship of people with intellectual disabilities. It reinforces ableist assumptions embedded in service structures. The study highlights the need for more substantial political and managerial commitment at the municipal level. Greater prioritisation in this service area is required, including more explicit national directives for implementation and regular national supervision. Inadequate implementation of the guide may contribute to the persistence of social inequalities in health, and access to healthcare services may increase the risk that the rights to health and self-determination for people with intellectual disabilities are not upheld. To reduce the social inequalities experienced by this group, the guide must be implemented more systematically and effectively, in line with its overarching intention.

DATA ACCESSIBILITY STATEMENT

In the anonymous main document no identifying information related to the authors and/or their institutions, funders, approval committees, etc, that might compromise anonymity are available.

ETHICS AND CONSENT

The study was reviewed by SIKT (The Norwegian Agency for Shared Services in Education and Research) and deemed to be in compliance with their guidelines for the processing of personal data and data protection legislation (reference number 801422). Written informed consent was obtained.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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