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What is This?
The dual faces of service user participation: Implications for empowerment processes in interprofessional practice

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Abstract

• Summary: This article reports on an empirical research study exploring and describing variations in how front-line practitioners perceive service user participation (SUP), specifically in interprofessional practice. The settings comprised three Swedish health and social care organizations where the professionals worked in interprofessional teams: a program for chronic pain rehabilitation, a program for surgical treatment of obesity, and a short-term municipal home for older adults. The qualitative study design was informed by a phenomenographic approach and conducted as semi-structured individual interviews with 15 professionals representing nine professions, including social work.

• Findings: The main findings show seven qualitative variations in understanding of SUP: 1) inclusion in activities and social events, 2) obtaining guidance, 3) having self-determination and choice, 4) getting confirmation from and contact with professionals, 5) negotiating for adjustment, 6) personal responsibility through insight, and 7) circumstance surrounding SUP.

• Applications: The interprofessional dimensions discerned in the meaning attributed to SUP are mainly described in terms of amplified opportunities for participation. An interesting aspect of the findings is that in all the variations of perceptions of SUP, there are potentials to reverse to their opposites, that is, paradoxes that can be termed ‘the dual faces of service user participation’. These aspects stress the need for continuing reflection on practices among both front-line practitioners and managers in
empowering and paternalistic processes and on constantly improving organizational and policy conditions to facilitate SUP.

**Keywords**
Social work, consumer participation, empowerment, interdisciplinary, interprofessional, service user participation

**Introduction**

In recent years, teamwork and interprofessional work in various guises have become increasingly common features of health and social care practices. The provision of services is very often predicated on cooperation among representatives of multiple professions. Furthermore, such cooperation may extend to participation between the professionals and the service users. Service provision no longer targets delivery of pre-arranged services; instead, it recognizes the need for the active participation of an individual in the process of designing and executing various services. Hence, interprofessional work in health and social care services is ideally apprehended as co-created at the interface between the service user and the various professionals (D’Amour & Oandasan, 2005).

These changes entail not only novel organizational forms but also a novel view of professional roles and tasks. While professionals once could base their actions on professional authority that conferred power over the events of the service provision process, today, they often find it important to create collaborative relationships with service users to facilitate the development of co-operative power (Tew, 2006). The building and effectuation of these collaborative systems is predicated on the professionals’ capacity to encounter and communicate with the service users in their organization. This necessity places demands on the collaborative skills of the professionals (D’Amour & Oandasan, 2005; Engel, 1994) and may also bring about changes in the power relations between service users and professionals. The unequal relations in health and social care encounters may shift to an orientation based on partnership, with links to the concept of service user participation (SUP). Concurrently, the questions related to power in the encounter between service users and professionals become central.

The concept of SUP, as employed in this study, refers to service user involvement in everyday matters concerning various service activities (Swedish National Board of Health and Welfare, 2003). The concept of the SUP is closely linked to the notion of empowerment; a person can be empowered by enhancement of the person’s participation, or have the need of being empowered to be able to participate (Adams, 2008). According to Braye and Preston-Shoot (1995), an understanding of interprofessional collaboration is vital for the empowering of service users as well as the professionals. One related perspective used as a basis for the present study concerns the importance of the organizational context in which
encounters between service users and professionals take place. Jerry Tew, a contemporary scholar in social work, has pointed out this aspect in a literature review, noting the need to take into account the organization when it comes to how well the professionals can support service user participation:

...social workers’ abilities to deploy power in positive ways may be influenced by the culture and power relations of the organizations in which they work. (Tew, 2006, p. 48)

With this perspective, we rely on a framework with which professionals may be able to map out and work with issues of power and powerlessness in their everyday practice (Tew, 2006).

In this article, we focus on the front-line practitioners and their understanding of SUP in interprofessional practice. A number of studies have investigated attitudes towards SUP in various settings (e.g. Bryant, Saxton, Madden, Bath, & Robinson, 2008; Lee & Charm, 2002; McCann, Baird, Clark, & Lu, 2008). These studies are based on participant attitudes towards SUP, but few studies have, like this one, addressed the meanings attributed to the SUP concept specifically when placed in an interprofessional context. In particular, we are interested in the following questions. What beliefs do professionals who work interprofessionally have about SUP? What implications do the meanings attributed to SUP have for professional tasks and empowerment processes in interprofessional work?

As a consequence, the aim of this study was to explore and describe the variations in front-line practitioners’ conceptions about SUP, specifically in interprofessional practice.

**The study**

**Study design**

The study had a qualitative descriptive interview study design. In line with the research aim to explore professionals’ conceptions, the study design was informed by phenomenographic and interactive approaches.

Phenomenography is an empirical research approach directed towards experiential description. It derives from the premises that there are qualitative variations in people’s conceptions of the meaning they ascribe to phenomena in the world around them (Dahlgren & Fallsberg, 1991; Marton, 1981; Marton & Booth, 1997). In addition, the study was influenced by the interactive study approaches described by Svensson and Aagard Nielsen (2006) to achieve consistency between the study aim and the study design. The intention was to carry out research about participation together with the participants rather than on the participants, as described by Herr and Anderson (2005).

**The participants.** The study sample consisted of 15 professionals recruited from three clinical microsystems (Batalden, Nelson, Gardent, & Godfrey, 2007) in Swedish
health and social care organizations to obtain sufficient variation of conceptions within the scope of the study. Clinical microsystems are the places where the frontline practitioners as team members meet with the service users and their family (Batalden et al., 2007). The identified clinical microsystems were a program for chronic pain rehabilitation (team A), a program for surgical treatment of obesity (team B), and a short-term municipal home for older adults (team C). For individuals to attend these programs and the short-term home in the role of service users, they had to accept the program and also previously have gone through an assessment and approval process performed by professionals. The client groups at the three microsystems were dominated by women and had considerable individual variation of vulnerability and age variation. In the programs for chronic pain rehabilitation and obesity treatment the client groups were comparatively young with an average age of just over 40, while in the short-time municipal home most individuals were 80 years of age or more.

The three settings were characterized by relatively preset programmes structuring the daily routines. The service users participated in various activities together with multiple professionals at the settings during daytime. In the program for chronic pain rehabilitation, the service users returned home at nights, while persons attending the program for obesity treatment and at the short-time municipal home were in need of residential accommodation ranging from a couple of days to several weeks. Furthermore, service user control structures such as collective user-controlled service provision or direct payment systems were not present in these settings. In each clinical microsystem, the professionals worked in interprofessional teams. The presence of the service user at team meetings varied from the service user’s usually taking part in the team meetings to having only individual encounters with the multiple professionals.

Participant recruitment was conducted with a purposeful sampling strategy (Silverman, 2010). To obtain variations among participants, one person from each participating profession in each team was included. In four cases where the professional group consisted of more than one individual, a selection was made among those individuals based on random sampling or based on information about future team attendance. The potential respondents were approached by the first author by a visit to a team meeting or by a telephone call. Agreement to participate in the study was provided either in person or by telephone, or was administered by a contact person at the setting. All individuals approached agreed to participate in the study. The professional participants were as follows: one administrative assistant, one dietician, one nurse assistant, two occupational therapists, two phys-ical therapists, two physicians, two social workers, one psychologist, and three registered nurses. Twelve participants were women and three were men. Their ages varied between 27 and 61 years, and they had between two and 26 years of experience in their respective professions (mean 16, SD 7). The respondents had been members of the team for 1 to 18 years and worked with the team an average of 20 hours a week. All respondents described their team as having interprofessional or transprofessional characteristics, indicating relative closeness and integration.
among the members, according to a team type index developed by Thylefors, Persson, and Hellström (2005).

Data collection. The individual interviews were carried out in a conference room or equivalent premises at the service agency. The semi-structured interview form contained two main areas: the person’s conceptions of the phenomenon of SUP and more specifically of SUP in interprofessional practice. To reach the person’s unprocessed experiences (Marton & Booth, 1997), no explicit definition of the concept of SUP was provided, and the phenomenographic introductory question was, ‘What comes to mind when you think about service user participation?’ and then, ‘How do you conceive of service user participation when several different professions are involved?’ The participant was requested to give examples from her or his own experience, in line with Marton and Pang (1999), and probing questions were asked (see Appendix). The interviews were recorded on tape and transcribed verbatim. After the interviews, participants provided background data as well as their understanding of the team’s interprofessional approach according to a survey developed by Thylefors et al. (2005), aimed at deriving a description of the characteristics of the participants and of the team. All participants completed the survey. The returned questionnaires were compiled and processed using the computer program Excel, and basic calculations of frequency distributions (mean and variation) were made.

The analysis was done in three parts. The first involved defining the preliminary descriptive categories; the second was ordering these categories according to complexity and nature of variation regarding activity, proximity, and conscious interactivity, all aspects that, according to Meads and Ashcroft (2005), can be generally applied to collaboration. The final part was to perform joint reflection seminars based on these preliminary findings. The analysis of the interview data for the descriptive categories was directed towards the research aim using a phenomenographic analysis procedure performed in the steps described by Dahlgren and Fallsberg (1991) (see Box 1).

In the final part of the analysis, the preliminary findings were discussed and reflected on during interactive reflection seminars between the first author (S.K.), the original participants, and other colleagues in connection with the teams’ ordinary team meetings at each clinical microsystem. Four seminars in total were held.

Ethical considerations. The department managers at the institutions and a Swedish research ethics review board (Dnr 181-08) gave permission to carry out the study. Written informed consent was obtained from the participants, including information about their freedom to withdraw from the study at any time without any explanation whatsoever and assurances of confidentiality. The study was performed with due regard for participants’ well-being, privacy, and dignity and in accordance with the ethical code of the National Association of Social Workers (2008).
Findings

Seven qualitative variations of professionals’ conceptions of SUP were identified in this study. The variations are formulated as descriptive categories A–G:

A. Inclusion in activities and social events
B. Obtaining guidance
C. Having self-determination and choice
D. Getting confirmation from and contact with professionals
E. Negotiating for adjustment
F. Personal responsibility through insight
G. Circumstances surrounding SUP

Descriptive categories A, C, E, and G comprise a number of sub-categories. A total of 228 dialogue sequences expressing conceptions were identified in the 15
interviews (median 16, range 5–27). The descriptive categories were based on dialogue sequences from participants dispersed over all three clinical microsystems with the exception of descriptive category F, ‘Personal responsibility through insight’. This descriptive category did not contain any dialogue sequences from interviews with team members affiliated with the elder care facility.

The seven descriptive categories have a broad range. They encompass meanings attributed to SUP as actions with relatively small demands for proximity to professionals as service users’ inclusion in activities and social events (descriptive category A). They also include more complex conscious interactions between service users and professionals for personal responsibility through insight. The range reaches to encompass the time span after the encounters with the professionals in the clinical microsystem (descriptive category F). Table 1 shows the nature of variations with the range of complexity from descriptive categories A to F, with descriptive category G, ‘Circumstances surrounding SUP’, forming a broad-spectrum category depicted as a vertical block with connections to the other conceptions of SUP.

The descriptive categories are explained below and illustrated with dialogue sequences taken from interviews. The dialogue sequences have been translated from Swedish, which was the original language. Certain details have been adapted to the written text for the sake of readability. Professional designations have been omitted and personal names are replaced with code names to preserve confidentiality. To prevent identification of individual male participants, who were in the minority, all code names have a female connotation.

**Descriptive category A: Inclusion in activities and social events**

The conceptions of SUP as a phenomenon included in descriptive category A are characterized by the notion that service users are involved in their own lives and engaged in social interaction with other service users at the welfare institution. In this category, participation entails that the person is acknowledged as an active and social being and participation is set against passivity and withdrawal. The professionals’ task is to facilitate and encourage activity.

The variation within the descriptive category encompasses the sub-categories ‘service user participation in a general social setting’, ‘participation in social and rehabilitating events arranged by the professionals at the premises’, and ‘service user independence from professional assistance’. The sub-category that deals with SUP in a general social setting implies that SUP is attributed as an all-embracing presence in day-to-day events: ‘Participating, just being part of life, what is happening and going on’ (Carina, team C).

Participation in social and rehabilitating events arranged by the professionals at the premises means that service users spend time in common day rooms or physiotherapy together with fellow service users. Service user independence from professional assistance entails the understanding of service users’ participating in their own lives by buttoning their own buttons, making their beds, etc., and thus
Table 1. Variations and relationships between descriptive categories of conceptions of service user participation

<table>
<thead>
<tr>
<th>Descriptive categories</th>
<th>Nature of variation between descriptive categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inclusion in activities and social events</td>
<td>A. Relatively small demands for proximity in relations between service user and professionals</td>
</tr>
<tr>
<td>B. Obtaining guidance</td>
<td>B. Relationship with activity mainly from the part of the professionals</td>
</tr>
<tr>
<td>C. Having self-determination and choice</td>
<td>C. Relationship with activity mainly from the part of the service user</td>
</tr>
<tr>
<td>D. Getting confirmation from and contact with the professionals</td>
<td>D. Proximity and reciprocity in the contact interface</td>
</tr>
<tr>
<td>E. Negotiating for adjustments</td>
<td>E. Conscious interaction with negotiating relationship</td>
</tr>
<tr>
<td>F. Personal responsibility through insight</td>
<td>F. Complex conscious interactivity in the collaborative relationship; the individual as a part of her or his context</td>
</tr>
<tr>
<td>G.</td>
<td>G. Holistic, relativity of the whole of the concept</td>
</tr>
</tbody>
</table>
not needing help from the workers to manage routine everyday tasks. This aspect of participation was reported as possibly not being entirely welcome from a service user perspective:

In the ward, participation might be seen as making your own bed and dusting your bed-side table, but that type of participation might not be wanted, sort of. (Birgit, team B)

Unlike other descriptive categories in the outcome space, an interprofessional dimension of SUP is not apparent in descriptive category A.

Descriptive category B: Obtaining guidance

Conceptions of SUP ascribed to descriptive category B refer to service users being given guidance from the professionals and entail aspects of information provision directed from the professionals to the individual or groups of service users. The professionals’ task is to communicate expert knowledge in various ways. The guidance is described in the form of advice, support, and dialogue:

So maybe information isn’t the right word (…), there is much more to it than just ‘now, do it like this’; in other words, that isn’t what I mean to say, but it is more about starting a discussion. (Barbro, team B)

The interprofessional dimension of descriptive category B means that service users are, through the guidance given from multiple perspectives, afforded greater opportunity to understand and assimilate the message. Participation with regard to guidance is also reported as being connected to the professionals’ maintaining a mutually consistent line and giving service users similar advice. The interprofessional method gives service users access to multiple – but complementary – explanations that users can understand:

And when he comes to a [professional x], then he thinks, ‘ah, now I am at [the professional x] and then we train and we do this and that’, but there are many other things one must take into consideration …, and then perhaps [the professional y’s] intelligence is important …, and then you can extract knowledge from all the professions in the same way. (Ada, team A)

Descriptive category C: Self-determination and choice

The meaning attributed to SUP in descriptive category C is related to the service users’ personal volition, rights, and responsibility for self-determination. The professionals’ task is to facilitate this by providing the information upon which service users can base their various deliberations.
The variation within the descriptive category covers the sub-categories of ‘the right of service users to decline the offered service’, ‘obtaining information about rights and alternatives’, and the dimension of ‘choice’. The rights of service users to decline an offered service implies a view of service users as having, by virtue of their self-determination, the right to turn down activities and interventions at the premises or by other service providers:

Well, this has to do with self-determination. In other words, to be able to say no, to be allowed to say no, to have the right to say no when one doesn’t want to and also that one is allowed to do what one wants to do. (Carina, team C)

‘Obtaining information about rights and alternatives’ means that the professionals inform service users about their rights and the various alternatives available. The professionals present what the organization has to offer – a menu – and give advice. It is the service user’s responsibility to choose from the menu:

It’s not just deciding, but one needs to know what the alternatives are to choose from, to know one’s options and alternative choices, that one gets information about what one’s rights are. (Anette, team A)

‘Choice’ means service users select among several alternatives, which may involve anything from choosing what they want to wear that day to choosing among different service providers. Service users define a need or a problem, select the service in question, and then get help with their problem:

Well, they are participating, of course, in that they have in some way, you know, come here and gotten help with it. They have come here for a reason, you know, for all that, they have a problem they want help with. (Bertha, team B)

The interprofessional dimension of ‘Self-determination and choice’ includes aspects of the notion that service users are responsible for taking advantage of, choosing among, and selecting the professionals who are present in the clinical microsystem. The professionals are meant to inform users about the options available with respect to care and services provided by various professionals. For their part, involved service users are meant to take advantage of these opportunities. The following excerpts offer one example of the sub-category ‘obtaining information about rights and alternatives’.

It isn’t, of course, easy to participate if you don’t know (…) what you can participate in, if I (i.e., the interviewee) don’t tell them a little, this is what I can offer (…). So I (i.e., the service user) know what obligations as well as rights I have and what I can have and what it is thought another professional category could, in fact, do for me. (Birgit, team B)
**Descriptive category D: Confirmation and contact with professionals**

The meaning attributed to SUP in descriptive category D is opportunities for service users to meet at the same level as front-line practitioners and that service users open up to the professionals and make their needs understood. This understanding of SUP puts focus on contact and interaction between front-line workers and service users. The professionals’ task is to acknowledge the individual’s problems, clarify expectations, and give service users time to reflect on their concerns. The professionals confirm the service users and demonstrate their interest and respect:

> Basically, the responsibility lies with me as staff to create participation in that person I meet, to be able to meet that person so that she feels she is participating (…), to meet on the right level. (Anneli, team A)

*The interprofessional dimension* of SUP in descriptive category D contains aspects such as service users’ access to and communication with the various professionals present. The wider network of contacts makes it easier for service users to tell others what they need. The presence of several involved professionals improves prospects for participation because service users are not forced into poorly functioning ‘couplehood’ with only one person from one profession. The interprofessional dimension is further described as contact with multiple professional groups, getting to know the various persons and their fields and to see that they are working together on behalf of the individual service user:

> He knows exactly who we all are (…), it is an advantage for him that we are several who work with him and that he feels he is participating in it, I really think so (…), that is to say, it is both [professional x], it is [professional y], it is me, and it is [professional z], and he knows us all and he knows exactly what we all do and he, um, I don’t think he has any problem in making contact with any of us. (Barbro, team B)

**Descriptive category E: Negotiation for adjustment**

Part of the professionals’ conceptions of SUP in descriptive category E, ‘Negotiation for adjustment’, is that service users and the professionals express opinions that are subsequently negotiated in various ways. Goals for the service user’s stay at the service agency are jointly set and followed up. This way of understanding SUP puts the focus on the adjusting aspects. The professionals’ task is to match service users’ wishes and ideas with organizational frameworks.

The variation within this descriptive category encompasses the sub-categories ‘adjustment of the organization according to service user preferences’ and ‘user acceptance of and adjustment to organizational frameworks’. The variation that concerns adjustment of the organization to service user preferences refers to
consideration of the service user’s opinions when designing the service provided. In this context, service users state their preferences, express their opinions, and speak out. Study participants describe how the organization is adjusted in response to opinions expressed in evaluation surveys, but adjustment to the service user’s preferences or personality occurs mainly at the individual level:

Well, I think it is important that we adjust ourselves to them and how they want it. Then you talk to the relatives and then you get a reaction there, so then you can see if it corresponds somewhat and what they are like. (Cecilia, team C)

‘Service users’ acceptance of and adjustment to organizational frameworks’ means that the professionals relate the service user’s preferences to the organization’s frameworks, philosophy, and resources, as well as the professionals’ assessments of the service user’s capacity. One aim of the negotiations is to ensure that service users are not disappointed with the offered service. Service users are meant to be brought to understand and accept the professionals’ motives. In this way, service users are incorporated into the joint agreement and are thus involved:

For people are sensible, aren’t they, if they are part of a discussion and get proof (….) if you can support it, then I think that is also participation, that it might result in that they don’t get what they want but that there is a reason for it. (Anette, team A)

The interprofessional dimension in descriptive category E has to do with dialogue and agreements that include service users and the professional groups present in the clinical microsystem. Because the negotiations involve other parties in addition to the service user and a single front-line worker, agreements may be perceived as more sustainable. In the discussion, all participants contribute their personal perspectives, including the service user, which sets the stage for a potential equitable distribution of the expert role between the service user and the professionals:

It perhaps becomes clearer that it is not just one who is the expert with all the answers, but we all contribute with some aspect and then one can, as a patient, also have one’s own and that’s OK (….). I still think that it makes it easier, in comparison, than sitting with just one (professional) (….), then it becomes a clearer distribution of this expert role. (Alexandra, team A)

Descriptive category F: Personal responsibility through insight

The meaning attributed by the professionals to SUP in descriptive category F is that service users become motivated to take personal responsibility for their future lives after their time at the premises by means of information, conversations with the professionals, and joint decisions. In descriptive category F, the focus is on individual development of insight and change. Participation is
referred to as an educational mandate where the professionals facilitate learning and motivational situations in which service users assign responsibility to themselves. This understanding of participation is set against the situation in which service users assign responsibility to the professionals. Through the relationship with the professionals, service users reflect, learn, and develop insight and understanding.

Taking more responsibility for what happens afterwards, participation does that, doesn’t it, when you know (...). That is to say, one can then have very many reflections oneself that also may make one participate more and that one takes greater responsibility. As I said, I put that as equal, in other words, there is a dash between participation and increased responsibility, I think that goes hand in hand. (Barbro, team B)

*The interprofessional dimension* in descriptive category F concerns the professionals’ broader opportunities to reach individuals so that they can be motivated to change. Because the various professions have different areas of expertise and contribute with different theories and perspectives, service users gain greater opportunities to understand and arrive at insight into their situations and changes that ought to be made:

One has a greater chance to come to an insight, just because we have our specialties that we know and are good at and there she (i.e., the service user) can contribute with her own knowledge, can’t she, and that can help the penny to drop a little easier (...); in other words, we all contribute from different directions, perhaps at different times, and that makes that you, that is what insight is all about. That is to say, it must be allowed to take its time, and there is a little input from all different directions. (Barbro, team B)

**Descriptive category G: Circumstances surrounding service user participation**

In descriptive category G, SUP is understood as dependent upon several circumstances such as personal characteristics and institutional conditions. The focus in descriptive category G is on surrounding factors that influence and provide the conditions for SUP. Depending on the circumstances, the workers’ tasks are understood as being to determine the extent of SUP, accept the service user’s personality, or provide stimulus and preparation for participation.

The variation within the descriptive category G covers the sub-categories of ‘the service user’s individual circumstances’ and ‘institutional circumstances’. The first sub-category encompasses perceptions that the individuals in the service user group have unique personalities and accordingly ascribe varying levels of importance to participation. Service users may also have varying degrees of support from their social networks or cognitive impairments that impede participation:
Some very much want to, want to keep control of their life, ‘I want to decide’ or ‘I want to take part and participate’ and so on. Others just hand themselves over and think ‘do something’ (...), in other words there are as many variations as in the rainbow. (Camilla, team C)

‘Institutional circumstances’ means that participation is related to and constrained by institutional factors such as established procedures, time constraints, finite resources, and the belief that certain areas are unquestionable. The type of service, the service user’s problems, and the nature of the service user group impose varying demands on the service user’s involvement. SUP is believed to be an imperative in connection with certain types of problems, and problems can be solved only if service users take personal responsibility for their own situations. This is emphasized first and foremost in the interviews with team members involved in pain rehabilitation and obesity surgery. The length of time that service users spend at the premises is also regarded as a circumstance in which a lack of familiarity or insecurity with the situation can put service users into a subordinate position. On the other hand, the service users eventually get used to the routines and thus stop expressing their wishes. The power positions of front-line practitioners are such that service users do not express opinions even if invited to:

I don’t think that you as a patient always understand that it is possible, or feel emotionally that it is possible. Because you are in a position of power. It isn’t so easy even if we say ‘if something isn’t working out, tell us’. (Alexandra, team A)

The interprofessional dimension of the descriptive category ‘Circumstances’ is characterized by how the team meeting process is designed and whether service users are given the time and opportunity to be involved. The individual’s personality and sense of security provide varying conditions for inclusion in multiparty settings. The person’s motivation to change, occupational background, and experience talking in groups are circumstances that affect SUP in team situations where the service user is included. The professionals’ responsibility in these contexts is to engage in dialogue to prepare the person for the team meeting. The following dialogue sequence reflects the variation within the descriptive category. The dialogue sequence starts with institutional aspects, then individual aspects are described, ending with an institutional aspect:

The team maybe has a shortage of time and then it becomes a bit stressful and everyone preferably should have time to have their say (...). Sometimes you feel that you don’t really have the time that it takes, that a little time is needed to collect yourself and get going and the patient’s (...) role in the team is strongly linked to that person’s personality and maybe, as said, what support one has had to be active and to participate. (Antonia, team A)
Discussion

The present study has explored and described the variation of front-line practitioners’ conceptions of SUP within the context of Swedish interprofessional health and social care practice. According to Adams, Dominelli, and Payne (2005), the empowerment responsibility that rests on professionals includes processes such as giving people means to consider options, take choices, and reflect critically on their own experience. Actions that can be concluded are discernable as the professionals’ tasks in relation to the meanings that professionals ascribed to the phenomena of SUP in the present study.

One interesting aspect of the findings is, however, that the outcome space of perceptions of SUP as a whole can be interpreted as having dual potentials for empowering processes in practice. Thus, the findings provide a starting point for a discussion concerning various implications for both empowering and paternalistic processes in relation to SUP.

In all the variations of perceptions of SUP identified in the present analysis, there are potentials, more or less implicitly, that can reverse to their opposites, that is, paradoxes that can be considered as ‘the dual faces of service user participation’. Perceptions focusing on mutuality in the individual relationship, as in descriptive category D, ‘getting confirmation from and contact with professionals’, may tend to conceal a basic structural imbalance of power existing between professionals and service users in institutional settings (see Adams, 2008). The structural power dimension was elaborated by the participant Anneli as reported in the above-presented excerpt, in which she explicitly attributed the responsibility to the professional side: ‘...the responsibility lies with me as a staff to create participation’.

The risk of concealment of problems and unequal structures may concurrently be transferred to perceptions of SUP as ‘negotiations for adjustment’ (descriptive category E), if the matching processes between the individuals’ demands and the service’s resources mix with conceptions of equal power resources among the parties. By implying that both the service user and the professionals have resources for attainment of their respective goals, the responsibility of avoiding paternalism is thus placed entirely on the individual service user (see Karlsson, 2007; Murdach, 2008). Furthermore, symbolic and intermittent consultations of the service user by professionals can lead to a disempowering of the person (Adams, 2008). Arnstein (1969) has identified tokenism dimensions in her well-known continuum model of citizen participation in which tokenism, according to Beresford (1993), is participation used for delay, diversion, and marketing exercises.

The meaning attributed to SUP as ‘personal responsibility through insight’ (descriptive category F) is related to the development of the personal capacity of the service user and the service user’s ability to reflect critically on experience. Because empowerment processes, among other things, aim to ultimately achieve transformation of the service user situation (Adams et al., 2005), this objective may be interpreted as underlying the meaning attributed to SUP. These positions can be compared to that
of promoting coping with life and participation as a member of society, that is, a professional pedagogical endeavour described by Hämäläinen (2003).

Empowerment processes can, in spite of good intentions, nevertheless be considered as paternalistic when the professional as an expert manoeuvres the service user toward a goal that the professional considers the best and where empowerment processes are managed within predetermined frameworks (Rønning, 2007). The sub-category ‘Service user acceptance of and adjustment to organizational frameworks’ in the descriptive category involving negotiating (descriptive category E) contains a relatively apparent potential for professional exercise of paternalistic power interwoven as a part of conceptions of SUP. The participant Anette, in the above-reported extract, described the balancing act between meeting the service users’ requests for desired services and getting the service user to accept limitations in services by referring to the judiciousness of the service user: ‘For people are sensible, aren’t they, if they are part of a discussion’.

**Interprofessionality as increased opportunity for service user participation**

The findings indicate that interprofessional work is considered to provide the service user with increased opportunities to understand and assimilate information, choose among the variety of professions offering services, become familiar with various professionals, equalize the professionals’ expert role, provide more endurable agreements, and moreover give greater opportunities to gain insight for the person’s own development. Thus, the interprofessional dimensions discerned in the variations of the SUP’s perception are mainly described in terms of amplified opportunities for SUP.

The participation of the service user/patient is seldom explicitly stated in studies concerning interprofessional collaboration; however, empirical findings of decreased professional paternalism do exist (D’Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005), aspects of which correlate to that of conceptions of equalized expert roles between service users and professionals as described in this present study. Findings reported by Shaw (2008) and Willumsen and Severinsson (2005) show that service users appreciate involvement of specific expertise by different professional team members. Furthermore, the above-referenced studies also indicate that service users perceive it to be easier to make the professionals listen and discuss proper actions to take. These observations are thus in some respect in concordance with the findings of the present study associating interprofessional work with possibilities for SUP.

The perceptions of SUP as circumstances (descriptive category G) relate SUP to both individual and institutional conditions. Several other studies have positioned organizational circumstances as barriers for SUP, such as the lack of organizational responses reported by Carr (2007). In an interprofessional context, the lack of available funding for interventions aiming at involving the user in interprofessional treatment planning is reported as a barrier for SUP (Butow et al., 2007). However, Shaw, MacKinnon, McWilliam, and Sumsion (2004) conclude that
systemic barriers for participation are discernable only in the actual interactions between the service user and the professionals, which pose even greater challenges to managers at other levels of the organization in discerning and addressing such obstacles.

The earlier discussion concerning the ‘dual faces’ of SUP can further be transferred to the interprofessional context as well. For example, descriptive category E, ‘Negotiating for adjustment’, where agreements are perceived as more robust when made among several parties, can also be turned to a disadvantage. The opportunity for the service user to re-negotiate an agreement if she or he regrets the earlier decision can be apprehended as more difficult if several professional groups have been involved in the decision-making process compared with a situation involving only two parties. The individual may, as a consequence, lose self-determination and become disempowered, and the power balance is even more transferred to the advantage of the professionals.

**Implications for empowering processes in interprofessional work**

The findings of the present study address the need for front-line practitioners to recognize the increased diversity of various meanings attributed to SUP that may arise when persons from multiple professions are working together and meeting the same individual service user. An interview study with the corresponding research design as the present study, but conducted among service users affiliated with these three clinical microsystems (Kvarnström, Willumsen, Andersson-Gäre, & Hedberg, 2011), indicates similar variations in perceptions of SUP. The results from the study of service users show some overlaps but also gaps when they are related to professionals’ perceptions in the present study. One practical implication of the findings: in situations when members of an interprofessional team are to collaborate with a person whose perceptions of SUP differ to a great extent from that of the professionals, there is a requirement for reflection and sensitivity. Adjustments of their joint approach regarding the individual service user may be of uppermost importance.

Furthermore, the findings in this study indicate dilemmas in practice: how is it possible to achieve collaboration that facilitates opportunities for SUP and at the same time prevents the hazard of disempowering processes as discussed above? How can we develop a pattern of practice that gives support to the growth of co-operative power (Tew, 2006)? The need for communicative and pedagogical skills among professionals in the collaborative endeavour can be confirmed in this study along with a need for a consciousness of structural power relations in the institutional context. Participants in the present study express an awareness of institutional power relations; see, for example, the dialogue sequence by Alexandra in team A, that was reported above in descriptive category G, ‘**Circumstances for SUP**’. Lee and Charm (2002) suggest that SUP can be promoted by clarification of the service, the workers’ role, and the service user status, all aspects that may be transferred to collaboration in interprofessional clinical microsystems. In addition,
Alexander and Charles (2009) express the need for relational skills and advocate that transparent negotiations regarding the relationship provide resources for the service user, thus lessening the risks of exploitation. These processes also include constant transformation of both the setting for practice and the policy context (Adams et al., 2005), of which clinical microsystem levels as well as other levels of the welfare organization are part.

**Conclusion**

The contribution of this study is that it draws attention to the variety of conceptions of the phenomena of SUP that are possible in interprofessional settings. The study highlights the importance of acknowledging the variety of perceptions of SUP that are feasible when collaborating interprofessionally and, most important, when interacting with service users who in turn may perceive SUP quite differently. The significance of the described conceptions of SUP in an interprofessional context can be seen mainly as increased opportunities for SUP. Furthermore, when the variety of conceptions of the phenomena of SUP is taken into account, the findings stress the need for a communicative and pedagogic role for the professionals.

The study points out how each identified descriptive category (A–G) in the outcome space implies a pattern with dual faces of SUP: one paternalistic and one allowing for empowering processes within the clinical microsystems in health and social care organizations. These findings stress the need for continuing reflection on empowering and paternalistic processes among both front-line practitioners and managers and for constantly improving organizational and policy conditions to facilitate SUP. The knowledge of variations in the conceptions of SUP may hopefully be used to move toward the development of a framework for emancipatory practice (Tew, 2006) in the struggles for changes within health and social care services.

Finally, in the study results, there is comparatively little about how service users actively design and implement services, but more about whether they can take part in practical matters, for example, make their beds or ask for help. The sort of partnership that is highlighted in the service user literature (see e.g. Beresford, 1993) seems to involve much more co-production of services, working alongside the service user as allies and so on. Of course, professionals often may not achieve these goals, but at least some effort to push the work with SUP in that direction is desired. In this article, participation is about SUP in an everyday situation. However, a more thorough analysis of politics and power in this context would be useful in future research. With the results presented in this article we claim that the kind of participation described here may lead to the development of a kind of partnership, a co-production of services that some authors and workers are aiming for, although this is only the first step on a very long journey.
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References


**Appendix: Interview guide**

Introduction: Informed consent, aim, procedure, presentations, etc. First something about yourself, questions like, How long have you been a part of this team? What are your other experiences of teamwork, etc.?

1. *What comes to mind when you think about service user participation?*
   1.1 Can you give some examples from your own experience?
   1.2 How do you perceive the importance of service user participation?
   1.2.1 Do you perceive that there are any particularly important areas for the service user to participate in?

2. *Do you think that the service user may realize that there are several professional groups here? That you are working in a team? Why?*
   2.1 How do you conceive of service user participation when several different professions are involved?
   2.2 Can you give some examples from your own experience?

Closure: Do think that you had the opportunity to say what you wanted to say? Do you want to add something? What was your opinion of the interview? Agreements about feedback and verification, survey, and thanks, etc.