

Individual plan in rehabilitation processes: a tool for flexible collaboration?

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(Received 5 September 2011; accepted 29 February 2012)

This article explores how different collaborative strategies between clients and service providers mediate with the quality of individual plan processes in Norway. The main question concerns how clients and service providers interact and perform their roles during their collaboration. An inter-professional group of six health and social researchers collected the data, which consisted of in-depth interviews with 13 clients and 13 service providers. Three interactional discourses emerged from the data: collaboration led by the client, collaboration led by interaction, and restrictive interaction. A complex relationship between the three interactional discourses challenges the service providers' role behaviour in practice. The service provider must accept each client as a unique individual and develop a role performance that takes into account the individual's desired level of participation. This requirement complicates the client–service provider collaboration.

Keywords: collaboration; rehabilitation; individual plan process

Introduction

The Directorate of Health in Norway sets forth the client's right to have an individual plan drawn up to enhance the client's participation throughout the rehabilitation process (Thommesen 2004; Thommesen, Normann and Sandvin 2003). The legislation even gives the client the legal right to a degree of participation (Health and Care Department 2004; Kjellevold 2005). The right to participate, as enshrined in the individual plan, facilitates collaboration between the client, public services, and different service providers.

That this interaction is an important part of the rehabilitation process has been emphasized by many authors in the discussion of social work. Lawrence Shulman (2008) claims that an empirically based theory of social work practice must focus on the client's interaction with others. He emphasizes: 'instead of the client being the object of analysis, concentration is on the way in which the client and the client's important systems are interacting' (Shulman 2008). The author uses the term 'symbiotic assumption' to describe the mutual dependence between the individuals

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and systems that matter to them. This mutual dependence can be blocked by a number of obstacles. According to Shulman (2008), social workers are needed as mediators between the client and those social systems' representatives. He further stresses that at the core of such a theory is a model in which the social worker's skills may create a positive relationship with the client and thereby influence positively the outcome of the rehabilitation process. The same interaction between the client and the service provider should form the basis for collaboration using the 'individual plan'. Strengthening this interaction will ensure that the client's needs for assistance are met. Therefore, an individual plan entails an individually adapted and coordinated description of the solutions and services required by each client. In delivering individual services in health care, empowering the client to be a real participant in this collaboration is a challenge.

The term 'client-centred practice' concerns the partnership and collaboration between the client and the therapist, working together to achieve the client's goals (Sumsion 2006). Partnership, in this sense, includes the overarching theme of client power, with the important underpinning themes of listening and communicating, choice, and hope (Berg, Sarvimäki and Hedelin 2010; Johansson, Katajisto and Salanter 2010; Piper 2010; Sumsion and Law 2006). Although considerable research has been devoted to client centeredness, it is obvious that less attention has been paid to how service providers interact in collaboration with clients. As Townsend and Polatajko (2007) argue, the skill required to collaborate with clients involves a way of working with them that allows them to make changes, as opposed to making changes for them. How to empower clients in health care can be defined differently, depending of the kind of partnership discussed. As stated in the Norwegian health-care policy, an individual plan should contain an outline of the person's objectives, his or her resources, and the services required, and should stress that clients have the right to participate throughout the planning process.

Constance Fischer and Stanley Brodsky (1978) launched their ideas about participation in human services by saying: 'If a citizen is to make optimal use of the human service professions, he must be enfranchised to participate actively both in the gathering and evaluation of information, and then in subsequent decision making and reckoning'. More recent studies (Karlsson 2007; Leung 2008) argue that clients have a right to be involved in the service planning. Leung (2008) addressed the service provider's challenge to be accountable to clients. Karlsson (2007) revealed the dilemma of self-determination as part of practising client participation. Therefore, professionals must collaborate with their clients to develop top-quality human services; this requirement for collaboration challenges the idea that professionals are experts and clients are the objects of their intervention.

Gomm (1993) discusses different ways of understanding power in client-worker relationships, using the strength in empowerment processes as a basis for client participation. Gomm argues that the interaction may be oppressive or disabling on the one hand, and caring on the other. Furthermore, he argues for a brokerage relationship. Falardeau and Durand (2002) also discuss therapists' and clients' respective powers in a therapeutic relationship. They describe two kinds of client-centred practice, one led by the client, and the other led by the interaction. Gomm's and Falardeau and Durand's understandings both may be helpful in describing the quality of relationships.

According to Beresford (2002), the dilemmas faced in the delivery of services to individuals may be caused by the structural barriers and different cultures involved in the collaboration strategies.

The main questions addressed in this article are related to how clients and service providers interact and perform their roles during their collaboration and to how the quality of this interaction interferes with the individual plan processes in Norway.

Method and design

This study explores the collaboration between clients and the public services in Norway, using a critical discursive approach. In this article, we focus on the relationship between clients and service providers. An inter-professional group of six health and social researchers collected the data, which consist of in-depth interviews of clients and service providers. The interviews each lasted for 1.5 hours and were tape-recorded. They were performed in the clients' homes ($n = 6$) or workplaces ($n = 1$), in health or social institutions ($n = 4$), or at the researcher's office ($n = 2$).

Participants and procedures

Thirteen clients, six women and seven men, were interviewed. They were aged between 20 and 72 years. All needed long-term health and social services. To explore the complexity of delivering individual services and of developing a variety of interaction strategies, we selected clients who had different kinds of problems requiring an individual plan, such as stroke, Parkinson's disease, cerebral palsy, tetraplegia, encephalitis, burnout syndrome, bipolar condition, anxiety, and progressive eye disease. One client, who suffered a stroke, had problems expressing himself caused by aphasia. To supplement his information, he wanted his wife to be interviewed. Therefore, data from both interviews are used in this case.

The clients were recruited by leaders within the health and social services in two Norwegian counties. The inclusion criteria were two: that they be over 18 years old and eligible for an individual plan for their rehabilitation process. The individual plan process was voluntary for all clients. Those with severe cognitive problems were excluded. Clients dealt with their life situation differently; for some, the adjustment process was gradual and prolonged. It was also influenced by the clients' hopes and the confrontation with the reality of the rehabilitation process. Because clients had different resources and problems, their rehabilitation programs varied.

The professionals included in the study were selected by the clients and participated in the planning process. All clients were asked to select one of their service providers to be interviewed and all consented (Table 1). The service providers represented four professions: social work (4), occupational therapy (3), physiotherapy (2), and nursing (4). Twelve service providers were co-ordinators of the clients' individual plan process. One of them did not have a co-ordinator role. Her role was day-centre leader (Table 1).

Data analysis

The analysis was performed using a discourse analytical process (Berger and Luckmann 1966; Burman and Parker 1993; Burr 1998; Parker 1998; Shotter 1993) to understand how different interactional qualities allowed clients to collaborate in

Table 1. Descriptive information of holders of the Individual Plan and their service providers.

| Participants | Gender | Age | Diagnosis | Role of service providers | Service providers' profession |
|--------------|--------|-----|-------------------------|---------------------------|-------------------------------|
| 1 | Male | 49 | Stroke | Co-ordinator | Occupational therapist |
| 2 | Male | 72 | Parkinson, Stroke | Day-centre leader | Auxiliary nurse |
| 3 | Male | 20 | CP | Co-ordinator | Occupational therapist |
| 4 | Female | 37 | Tetraplegia | Co-ordinator | Occupational therapist |
| 5 | Male | 72 | Tetraplegia | Co-ordinator | Physiotherapist |
| 6 | Female | 48 | Encephalitis | Co-ordinator | Social worker |
| 7 | Female | 33 | Burned out syndrome | Co-ordinator | Social worker |
| 8 | Male | 47 | Bipolar condition | Co-ordinator | Nurse |
| 9 | Female | 48 | Bipolar condition | Co-ordinator | Physiotherapist |
| 10 | Female | 31 | Bipolar condition | Co-ordinator | Nurse |
| 11 | Female | 24 | Anxiety/heart disease | Co-ordinator | Nurse |
| 12 | Male | 22 | Progressive eye disease | Co-ordinator | Social worker |
| 13 | Male | 47 | Progressive eye disease | Co-ordinator | Social pedagogue |

the individual plan process in practice. Transcripts from in-depth interviews were the texts analysed. A discourse analytical process allowed researchers to move beyond the intentions underlying the delivery of the health and social services, and to identify how the interaction's qualities influenced, in practice.

The data were analysed according to Parker's analytical process (1999), which consists of a number of analytical steps. The first step in the analysis consisted of reading the text to grasp its overall meaning. Next, the interaction qualities in the text were categorized systematically to highlight the different collaborative processes involved in delivering individual services. We also looked for variations and conflicts in the method used to collaborate with clients. Variations in the qualities of the interactions were categorized into three interactional discourses: collaboration led by the client, collaboration led by interaction and restrictive interaction. This categorization was inspired by Falardeau and Durand (2002) and Gomm (1993).

Ethical considerations

The Norwegian Social Science Data Service and the Regional Medical Ethical Committee approved the study. The appropriate health or social institution approved the recruitment process. All informants decided the level of information that they wanted to share with us.

Results

Data analysis revealed how the relationships between clients and service providers play an important role in the tension and dynamics toward establishing individual

rehabilitation plans. When establishing or changing a particular relationship, certain interactional dynamics occur. As mentioned, three interactional discourses emerged from our data: collaboration led by the client, collaboration led by interaction and restrictive interaction.

Collaboration led by the client

In this level of collaboration the client's autonomy is strong and the client has most of the power in the process (Falardeau and Durand 2002).

Our data show that clients' wishes vary concerning what kind of influence they want service providers to have in the planning process. Clients are given the opportunity to test a co-ordinator for a period, and in some cases, clients can choose whomever they wish to co-ordinate the process. The same democratic procedure was used to select the other members of the individual plan process. As one client said, 'The co-ordinator has clearly expressed that it is up to me to decide the members of my planning group, and whenever I like, I can bring their participation to a close and suggest others join in'.

Clients can also choose how they want the planning group to work, by meetings or by informal contacts. Meeting with many professionals in the planning group made one client feel vulnerable and weak; although the large group of experts could help her to recognize the shortcomings in her life, she felt uncomfortable when they were discussed in such a large group. Another client did not want her planning team members to meet each other; she could not bear to think that the difficulties of her life were discussed in a gathering of experts? 'It was hard enough to read a draft of the written plan in which my situation was summarized'. She felt oppressed to see how much assistance she needed. Her lack of self-confidence made it impossible to arrange such meetings for the time being. She preferred the co-ordination of services to be made by telephone and e-mails.

Some clients preferred that the plan not include all the planned activities: 'It depends also about my own development further on. Partial plans are made between me and the different service providers through an oral dialogue. Those plans are my own property only'.

The plan allows each planning group member to develop a sense of personal responsibility. When group participants' responsibilities are written on paper, group members are essentially forced to carry out the planned service. Planning group members also form a network responsible for the client. For instance, one client, who seemed to be satisfied with the planning process, said, 'It is many persons with resources who are a part of my plan – who I can call on the telephone when something goes wrong – who know what I need. I feel very safe with this individual plan'. She also said, 'I think it is very important that those who participate in my individual plan have something to contribute'. This client reported that participants in the planning process worked closely together and that she did not worry about the power differences. One of the co-ordinators emphasized this by saying, 'In my opinion, we should be more open-minded, and all of us have to be involved in the whole plan, be open-minded and try to understand the client's situation'.

Our data analysis revealed that client-led collaboration was related to the planning group's formation and to the selection of those who would constitute it. Four clients expressed that it was important for them to manage their individual plan

process. Just one service provider, who was a co-ordinator, mentioned the importance of the clients' leading role in the planning process.

Collaboration led by the interaction

In this level of co-operation the clients and service providers are satisfied with the quality of their interaction because they meet each other with respect, share the power of influence, and acknowledge each other's competence (Falardeau and Durand 2002).

When applying for services, clients might be very optimistic about the duration of their conditions. One man, who was partly paralysed after a stroke and had difficulty walking, expected to take a walking tour in the forest within a week of the interview, and he even planned to participate some days after the walking tour in an orienteering competition. Orienteering and outdoor life had been important interests for him, and he rejected the loss of these hobbies. Although his condition could require a permanent reduction or change in his quality of life, he hoped and expected that his condition would be temporary. However, his service provider, who was both the client's co-ordinator and his occupational therapist, had a lot of experience with people with the same condition. She knew that the client must either be incredibly patient and accept that the rehabilitation process takes time, or come to terms with lifelong physical changes. When this occupational therapist was asked about the duration of the rehabilitation process, she answered: 'I reckon it will take at least a couple of years from now, maybe even more'. This was in great contrast to the client's idea that he needed just some weeks of exercises. This attitude represents a conflict between the client's hopes and reality. However, the therapist chose not to confront the client with her experience at the beginning of the process. In collaboration with the client, she allowed him time to accept the situation.

Another option for the professional is to wait for the results of the rehabilitation process itself. A man with Parkinson's disease who had had a stroke, which reduced his abilities even more, underwent physiotherapy at a rehabilitation centre, and the day-centre leader stated: 'His illness has changed in waves. And all of us who have been working painstakingly with him, we have often thought that now it is time for him to move to a nursing home, but then you see improvements'. The client and the service provider seem to negotiate between hope and reality, and surprises can be experienced by both. These results show that collaborative and sensitive service providers, who realize the need for their expertise, do not use their knowledge as power to challenge what they might consider to be their clients' unrealistic hopes. The service provider's role seemed to be flexible to accommodate the uniqueness of each collaborative process.

Some service providers interpreted their role as similar to that of a broker (Gomm 1993). One woman had severe physical dysfunction after a car accident and started her individual plan in specialist hospitals. After the rehabilitation process in hospital, she had to acquire a new apartment with easy access because she was dependent on a wheelchair. She also needed to adjust her daily activities in the apartment according to her daily functioning. The new apartment was not in the district where she had previously lived, and she did not know the local service providers. Thirteen professionals were engaged to assist her. The co-ordinator described the challenge of organizing all of them to meet the client's needs. She stated: 'This woman had lot of resources, both cognitive and mental, and knew exactly what she needed from the

service providers, although it was a huge problem to communicate with them all'. The access to all those services had to be negotiated, and the co-ordinator's role as broker was useful.

Analysis of some of our data shows a mixture of collaboration qualities; that is, the service provider's role performance influences the client's role performance. In addition, the content of the client's role varies. Decisions can be influenced to varying degrees. Sometimes clients are merely asked to give their opinions, but sometimes they seem to be accorded the right to determine the kinds of services they need.

The service provider's role seems to be a mixture of comforting, supporting, and organizing the clients and advocating their needs. Some clients focused on the task of helping to structure their daily lives and thereby both to avoid a chaotic lifestyle and to minimize the need for support. Whereas the co-ordinator had experienced similar circumstances in her professional practice, the client might be a novice as a disabled person. A woman with a bipolar condition required assistance in managing her daily chores and stated, 'Because I'm such a scatterbrain, that's why I need this structure'. It was only after her recent diagnosis that she understood why her life had constantly been so disorganized. The diagnosis had helped her to understand her limitations and prospects. Therefore, she sometimes needed a caring co-ordinator, and at other times she needed an enabling and strengthening one; so, the provider's role was negotiated upon each occasion.

Interaction between the client and the written document

As a written document, the individual plan is a concrete outcome of the collaboration between the client and the service provider. It seems to be an important tool in the planning process, and can thus be seen as a special variety of collaboration led by the interaction.

The plan is intended to clarify what should be done, by whom, and when. Our results show that the plan's function goes beyond these intended goals. One client stated, 'As I said, to have ideas written on paper, so that you have something in black and white, is important'. To have a plan for a period in their lives shows the individuals their own importance. The plan is a tool with which they can address the issues in their lives seriously. It also means that their efforts to change have been put into a system of contracts between them and different service providers. One client suggested that the plan has a very concrete function in 'partitioning my concerns, dealing with my complex problems by breaking them down into their component parts and addressing them one at a time as necessary'. Another client said, 'The plan can also function as some kind of whip'. She felt obliged to do the laundry once a week because her individual plan specified in writing that she do so. However, the plan can also contribute to the development of the client's thinking, as asserted by one client: 'When you make an outline of your objectives, you start thinking processes; when you express ideas aloud, you start a process in your brain...'. Another client said, 'The written version of a person's thoughts mirrors the level of thinking at that moment, and you will be able to agree or disagree with it and then develop your thoughts further'. For others, working with a plan creates an arena for dialogue between all the participants, as was expressed thus: 'The plan is a superior tool. The main ingredients are the decisions of different services. The plan makes it possible to follow up on those decisions'.

The negotiating roles in the collaboration led by the interaction seemed to be more common than the collaboration led by clients. Six clients and five service providers emphasized that the influence of the interaction was an important part of the planning process.

Restrictive interactions

Some relationships in the practices we have analysed might be called 'restrictive' (Gomm 1993) and could limit the collaboration between the helper and the client. An individual plan is meant to be a tool to facilitate co-operation between the client and the public services, and between the different service providers. However, some planning was not fully defined as co-operative processes involving the client, but instead defined service providers' own tasks and gave an overview of their actions. Other service providers were not willing to take part and be accountable within the team.

The collaboration between services that relate to late youth and services that relate to adults was challenging for some of the clients in this study, especially when the client was moving from school to the labour market. One of the service providers who worked in community-based services said: 'We have the responsibility to follow-up our clients from school to work. When one of my clients had finished school, he was about to look for a job, a task that the educational assistant at his school had done nothing about'. She explained that she contacted the Norwegian Labour and Welfare Organization (NAV hereafter). 'Because this client wanted to combine school and work experience, we had a problem', she confessed. No co-operative structure existed between the NAV and the educational assistance system; therefore, she had to arrange meetings between those organizations to initiate the individual plan process.

One adult client reported this problem: 'You are not always met with respect or trust, especially from the NAV system. I have had a lot of problems with them. They promise a lot, but they do not keep their promises. I am getting more and more disappointed by the whole system'.

Limiting practices might sometimes be caused by the professionals' lack of knowledge or empathy. One service provider said: 'I feel that some colleagues are very restrictive. One of my clients has a rather invisible kind of handicap. Because of this, she feels that service providers consider her to have more resources than she really has'.

Problems regarding the co-operation between different services and doctors were also reported. One co-ordinator said, 'Doctors have their own opinions, and we have to maximize the benefit for the client, who is the owner of the plan. Our professions and training differ, and we have different experiences'. These comments can be understood as referring to the dogma that medicine is the dominant science, superior to the more holistic approach of other professionals, and that doctors are the owners of this knowledge. Another co-ordinator said: 'Sometimes specialists do not have time to come to meetings. It is a challenge to collaborate with these specialists who do not take part in the whole process'.

One couple expressed that the head of social services in the community did not understand their situation: 'She seemed to be most engaged with what was best for the system'. The wife meant that the service provider did not think of her husband's situation when she planned his stay in a respite care unit, and said: 'I wish he could

be together with someone with common interests, someone who can inspire him a bit. This is also, what my husband asked for . . . but I feel they just have a list of persons'. The wife explained that she had the impression that, for the service provider, her husband was worth nothing and that he had no potential for rehabilitation. She also expressed that they needed some predictability in their life to plan for holidays, visits from children and grandchildren, and so on. Even here, they felt that the head of the social services did not co-operate: 'When we complained about the need for predictability, no conclusion was drawn. That made us sorry because it was agreed that they should leave a message, so that we could plan our activities'.

The process may be even more disabling if clients become resigned and lose confidence in their own opinions. When one client, a woman suffering from a bipolar condition, was asked about her participation in setting goals in planning her rehabilitation process, she replied that she did not know much about it. During the meetings, she had problems focusing and following the topics on the agenda, and complained of headaches. Her medical condition limited her ability to participate, and her lack of participation made her even more insecure.

Our data show that three clients expressed lack of interaction in the individual plan process. However, one of them emphasised that it had to do with her incapacity to interact. Four service providers, who were all co-ordinators, complained about restrictive interaction in the planning process. Two emphasised that it had to do with the welfare system, and the other two expressed that it was caused by restrictive professionals.

Discussion

The results of our study have revealed that varieties of collaboration strategies are generated between clients and professionals. Three interactional discourses – collaboration led by the client, collaboration led by interaction and restrictive interaction – were explored in terms of delivering individual services during rehabilitation. Also explored were combinations of the collaboration strategies. Such combinations imply role adjustments in client-helper relationships. Such role adjustments have been reported by other researchers (Helgøy, Ravenberg, and Solvang 2003; Vik, Nygård, and Lilja 2009). Some of the strategies empower the clients, whereas others restrict them. Finding empowering collaboration strategies and avoiding restrictive ones are challenges encountered constantly in delivering individual services during rehabilitation.

Fischer and Brodsky's ideas (1978) about user participation seem to be similar to the Norwegian legislation's premises concerning the individual plan. They and the legislation argue that professionals can no longer plan services for people paternalistically. Instead, they must collaborate with clients, always giving them the opportunity to influence the planning of their rehabilitation. According to Gomm (1993), the quality of the collaborative empowering process varies according to the client's needs and capacities.

Dialectic between client-led and interaction-led collaboration

That the plan and the planning should be the client's own property is the ideal underlying the individual plan processes. We have revealed tensions concerning the

service provider's adaptation to the client's capacity, that is, concerning the provider's ability either to accept limitations or to enable clients to use their strength and participate in the planning process. Often, this tension seems to result in a flexible adjustment of the quality of interaction. Moreover, we have experienced a variety of ways in which these adjustments are implemented. As argued by Leung (2008), it is a challenge for service providers to be accountable to clients. In contrast, Gomm (1993) discusses how service providers can act as carers and brokers.

The demarcation between interactions led by clients and interaction led by service providers is unclear in our data. It is more like a continuum, with client-led interactions on one side and interactions led by the professional on the other. Some clients seem to prefer that their service-providers alternate between different roles. For this reason, the service provider must collaborate with the client to select the role appropriate to the circumstances. The need for such collaboration can be seen as a dilemma that arises from the ideal of a full client partnership. Some professionals in this study seemed to combine the caring and empowering processes successfully in their interactions with their clients.

Meetings involving all participants may not be conducive to achieving a collaborative interaction. The study found that some clients, because of problems concentrating, could not follow discussions and fully participate in such meetings. Clients hesitated to discuss their difficulties in life in front of all those experts – another argument against such meetings. As argued by Wright et al. (2006), we must be aware of and acknowledge the power disparity between the professionals and their clients. The professionals generally have more power, resources, and capacities than their clients do. According to Karlsson (2007), some clients may even find it difficult to raise their voice in planning processes.

Clients are different

Beresford (2002) reminds us that clients differ, and if professionals expect the same effort and capacity from their clients as from their colleagues, they can be disappointed. Professionals must adjust their expectations to each client's level of functioning. Clients represent various social divisions and hierarchies. For the individual plan process to succeed, each client must be seen as unique. It is important to understand the client's present and future circumstances. Hence, when stroke victims dream of regaining their full strength and function, the dream may be necessary at the beginning of their rehabilitation so that they can accept their situation. The sense of loss differs between people, and the priorities given to problems must be negotiated with each individual.

How the protagonists perform and define their roles vis-à-vis one another is a major challenge in delivering individual services. If the change in the client's health status is the result of an accident or stroke, the change may have been sudden. The need to make sudden role adjustments in several arenas of life can challenge a person's flexibility. To sort out all the role changes that might be necessary is an important issue in the co-operation between clients and service providers. These role changes may involve whether clients will be out of work, their role in family life as a spouse and parent, or their being more dependent in practical matters. Clients might be ambivalent about needing assistance. For example, recognizing that they need assistance forces them to confront their dependence on others. Hence, they simultaneously resist that recognition. Independence is an ideal for most people in

Western societies (Chow 1987). The client's ambivalence might have consequences for the plan's content. Paralysis after a stroke may highlight a person's vulnerability, and it creates needs for many kinds of assistance in daily life. Analysis of our data reveals that some clients go from managing their own lives to being dependent on others, and that they see the latter as less admirable. Although many people assert that all humans have the same value, someone who has lost independence through illness might doubt this equality.

Establishing partnerships between clients and service providers is held to be a basic ideal for individual plan processes (Thommesen 2004; Thommesen et al. 2003). However, the results of our research have shown that both the collaboration strategies of the service providers and the clients' interest in participating in the collaboration process will vary. Empowering processes are necessary to make participation meaningful for the client (Shulman 2008) but Gomm (1993) suggests that this need varies. Sometimes clients are satisfied with professional assistance despite not having participated in decisions about relevant services. Respect towards the clients can be shown not only by accepting their autonomy but also by holding their limited capabilities in high esteem (Falardeau and Durand 2002; Sim 1998).

Cultural and structural barriers

As explored in this study, cultural and structural barriers seem to appear at both the individual and the system levels.

Within the medical tradition, the classic role of the professional is to be an expert who collects information, analyses it, makes a diagnosis, and selects a suitable therapy or services. This role is incompatible with the idea of client participation (Karlsson 2007; Shulman 2008; Townsend and Polatajko 2007). The professional must have collaborative skills to be client centred. However, the data shows that service providers like doctors and some specialists might tend to favour paternalistic strategies over collaborative and empowering ones.

The idea of collaboration accords different competencies equal value. However, according to our results, some professionals and some agencies act as if they reject the challenge of collaboration. Therefore, they do not listen to clients, and they do not take the need for participation seriously. The legislation allows the client to influence the composition of the planning group, but the regulations do not clearly define the extent of the client's power (Health 2006).

Structural barriers seem to appear on both the individual and the system levels. Each client's choice of co-ordinator is important for the collaboration, and therefore, clients should be accorded their full right to choose. This idea of the client's self-determination is challenged by some service providers because it presupposes an unrealistic level of information. Fisher's idea of 'informed participation' (Fisher and Brodsky 1978) supports this consideration. The division of work within the service might also restrain the client's right to choose a co-ordinator.

On the system level, an excessive focus on the efficiency and delivery of an individual plan as a product, rather than a focus on a collaborative process, may be a reason for imbalance. The professionals included in the planning process, representing different services or agencies, may be challenged by demands for efficiency and results. Such demands might cause both clients and professionals to focus more on efficiency than on collaboration.

Finally, we have revealed that it is challenging to develop good collaborative practices between different institutional settings, such as specialist hospitals and community-based services. The individual delivery of services lays claim to another practice discourse than the one that is common in hospitals, where professionals are seen as experts. A social-cultural discourse challenges this idea of professionals as experts and clients as the objects of their intervention. This discourse focuses on the collaboration between clients and service providers.

Methodological reflections

Concerning this study's validity, some limitations and strengths exist. The interviewers' subjectivity may have biased the results (Kvale and Brinkmann 2009). Conversely, this subjectivity may have highlighted specific aspects of the interaction processes and helped us to identify different discourses related to the collaboration process. The results cannot be generalized because too few cases were included in the study. However, in accordance with Kvale and Brinkmann (2009), although the results cannot be generalized, they are nevertheless valuable conceptually because they contribute to the heterogeneity of knowledge.

The clients were selected because their circumstances met the inclusion criteria and because they had long-term and complicated problems requiring an individual plan. In these respects, the clients were ideal for exploring the complexity of delivering individual services and of developing a variety of interaction strategies. On the other hand, the variety of the clients may have been too broad, which could have complicated in-depth analyses.

The six researchers who participated in the study have different professional backgrounds, which may have influenced their interviewing styles. However, an interview guide was developed collaboratively in the group, and the interview process was discussed after the interviews were completed. Furthermore, the discursive approach used in the analysis, in which reflectivity was one of the most distinctive features, attempted to make explicit the processes through which the data and analyses were produced (Sim 1998). Part of this reflectivity was to show how the different interviewing styles had some effect on the results, which enhances the credibility of the analyses.

The clients selected the professionals included in this study. This approach might have been subject to bias, as the clients' motives for their respective choices might be unclear. On the other hand, because the study concerns client-centeredness, it seems obvious that the clients were in the best position to select a service provider to be interviewed about collaboration.

Although the individual plan is a Norwegian concept, our findings arguably have relevance concerning similar client-centred practices in other countries.

Conclusions

Three interactional discourses – collaboration led by clients, collaboration led by interaction, and restrictive interactions – were explored in relation to delivering individualized services in rehabilitation. The quality of the collaboration between the service providers and clients differs according to what they each experience during the process. However, the most common interactional discourse was the collaboration led by interaction, where the plan process functions as a tool for flexible collaboration.

This article highlights a dilemma related to the ideal of full client partnership, as well as the challenges within the individual plan processes. Hence, each client is a unique person who requires a different type of partnership with service providers. Furthermore, cultural and structural barriers influence the outcome of the planning process. Cultural barriers are related to how the service provider's role behaviour forms different kinds of collaborative strategies in practice. Structural barriers are related to different institutional frameworks and these influence with the individual plan processes.

These findings affect collaborative strategies related to individual plan processes in practice, in addition to the health legislation related to this subject. Further research is required concerning how professionals form relationships and collaborate with their clients and whether this affects the delivery of an individual plan. Furthermore, research is needed concerning how professional culture and structural barriers influence the individual plan process, both in different practices and between different institutions.

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