“Individual plan” in a user-oriented and empowering perspective: A qualitative study of “individual plans” in Norwegian mental health services

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Abstract

The aim of this study is to describe what was emphasized as important in their Individual Plan-process by ten patients who were satisfied with their Individual Plan (IP), and also to explore how the process of development and use of the IP possibly can promote strengthened user participation. IP is both a process and a written master plan built on the user’s own goals, needs and resources. It assumes an appointed service provider is coordinating the services involved and is intended to ensure increased user involvement and better coordination when extended services are needed. The study is based on two semi-structured interviews of patients, two years apart, and one interview of their coordinators. The analyses were based on Systematic Text Condensation. The findings comprise what the interviewees considered important in the process of development and use of an IP; how the goals were formulated and reached, to take active part in the IP process, to build up enough competence and knowledge to cope with daily life, as well as experiencing good relations with respect and mutuality, especially with the coordinator. These topics are not considered to be specific to IP but can be understood as more general aspects of adequate treatment and care. In any case, a well-functioning IP process seems to be able to improve user participation and empowerment.

Keywords: “Individual plan”, qualitative study, mental health care, user-participation, empowerment.

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Introduction

The Individual Plan (IP) was introduced into Norwegian health legislation in 2001. The background was that several patient groups were not offered acceptable measures, in spite of great need for a diversity of services. The intention is to ensure that patients in need of extensive services participate in planning their own treatment and care, have a written master plan built on their own goals, needs and resources, and an appointed service provider (referred to as the coordinator) with responsibility for coordinating the services involved. This is to make sure the patients will receive an overall and individually adapted treatment (treatment in an extended sense). An IP is meant to be both a written plan and a process. As a written plan an IP lists the patients’ own goals, like getting a job and being able to take the bus without panicking; needs, like a stable income and a therapist; and an overview of service providers delivering planned services and when. It is intended as a process of developing an IP together with the patient, hereunder to formulate goals, make the service providers cooperate, search out the right measures and ensure that the IP becomes an organizing and user-oriented tool over time. An IP has to be used in a context, in interaction with the involved services, to fulfil the intention. A process of regular evaluation and reformulation is necessary to keep IPs a useful and updated tool. The patients are intended to have a central position in the development and use of IPs to ensure real influence on the process, and thereby improve user participation (Sosial- og helsedirektoratet, 2010). How this is to be done is not described.

As a statutory tool, the IP seems to be unique to Norway with legislation crossways laws regulating health (both mental and somatic health care), social services, child welfare and occupational services. Otherwise the IP is part of the international movement promoting an increased diversity of integrated care models. The purpose of integrated care, defined by the World Health Organisation WHO (World Health Organisation, 1986; World Health Organisation, 2005) is to improve services in relation to coordination, access, quality, user satisfaction and efficiency. Integrated care can be understood as the umbrella covering many models developed to compensate for a fragmented delivery of care (Åhgren, 2007; Leichsenring, 2004). Reducing fragmentation and improving continuity and coordination of care seems to be a common feature, but otherwise focus and content differ widely. Different, although comparable, models are termed as shared care (mostly in the UK), transmural care (mostly in the Netherlands), managed care (mostly in the United States), intermediate care, seamless care, disease management, care planning, continuous care and integrated care pathways. All these place the strongest emphasis on the organizational perspective, in the sense of working for a useful organization and coordination of services offered to different patient groups (Åhgren & Axelsson, 2011; Gröne & Garcia-Barbero, 2001; Kodner & Spreeuwenberg, 2002; Leichsenring, 2004; Ouwens et al., 2005). These models are used both within somatic and mental health care. Other models, such as different case management models, as well as the IP, are mostly used within mental health care and are focused around patients rather than the organization of services (Ziguras & Stuart, 2000; Zwarenstein, Reeves, Straus, Pinfold & Goldman, 2009). There is a Swedish individual care plan used in primary health care (Berger et al., 2009; Socialstyrelsen, 2005) and a Danish individual action plan mostly used within social services (Center for Evaluering Psykiatrien i Aarhus Amt, 2006; Kristensen, 2010), also focused around each patient. As in Norway, there is a lack of research on the Swedish and Danish plans and they seem not to be used as intended or to a satisfying extent. The user perspective, together with a use of
coordinators, seems to be most frequent in case management models, but also in the Scandinavian models mentioned here.

In 2005, Norway ratified the WHO Plan of Action (World Health Organisation, 2005) designed to improve quality of life and user involvement/participation for people with a mental health disorder. According to the WHO, lack of empowerment and poor advocacy is a hindrance to delivery of care, and points to international trends emphasizing strengthening the position of those in need of services. User involvement is a central aspect in the more global concept of empowerment (World Health Organisation, 1986), which is an increasing objective for state welfare policy (Askheim, 2003; Norges offentlige utredninger, 1998; Sosial- og helsedirektoratet, 2006). The goal is to prepare patients to be able to manage their own life in the direction of their own goals and needs (Norges offentlige utredninger, 1998). Promoting empowerment is not explicitly mentioned in connection with the IP in any white paper, guidelines or reports, but common goals and parallels in thinking seem evident.

Aim of the study and its background

The aim of the present study is to describe what 10 patients satisfied with their IP process emphasize as important; as well as to explore how the process of development and use of an IP possibly can promote a strengthened user participation. The findings will be further discussed within a frame of user participation and empowerment.

The present study is part of an extensive project studying what promoted or hampered the implementation and use of the IP by a given population of adolescents and young adults with mental health problems and their coordinators. In the overall project there were 24 IP processes, and in 10 cases the patients were satisfied and found the IP to be helpful. The other 14 processes were not evaluated as satisfactory by the user and the IP was not used according to the intention and regulation. Since an IP is meant to be both an organizing and user-oriented tool, in the sense of strengthening user participation, it is important to obtain knowledge about what the users and their coordinators experience to be helpful with IP; both the IP itself and in interaction with the involved services. This knowledge can prepare for a better use of the IP in mental health care in the future.

Methodology

To answer the main research questions about implementation and use of IPs, a qualitative approach with semi-structured in-depth interviews was chosen. The whole project is elaborated and understood as evaluation research where the intention is learning and/or change. According to Patton (2002), evaluation research concerns studying what promotes or hampers the appropriate function of a method or a tool, like studying what promotes and hampers the IP, on this occasion, in being implemented and used as intended.

Informants and recruitment process

Each of the 10 IP processes forming the basis of this study consisted of a patient and a coordinator or another person chosen by the patient to be interviewed. The IP processes were
considered by the patients to be helpful and by the author to have been used according to the intention and regulation.

All informants in the research project were recruited in the health region South East Norway, most of them close to the capital area for practical reasons. Twenty-one managers from 18 different clinics within mental health specialist care/secondary care were interviewed first. Except for four senior managers without patient contact, each was asked to recruit two patients with an IP, but they recruited from zero to four. The managers asked the patients first, but as some were not able to be interviewed due to their mental health status their relatives were interviewed instead. This gave a total of 24 IP processes in the project, where either the patient or a relative or both were interviewed. In this part of the study all 10 interviewees are patients. It was the patient who put the researcher in contact with their coordinator or another person they wanted to be interviewed, which gave a total of 11 coordinators and a therapist to be interviewed.

The patients were between 17 to 37 years old, seven from 18 to mid-20s. They all received help from mental health services and were suffering from long-term, complex mental health problems. They received a wide range of services, both in primary and secondary care, and had a wide range of diagnoses and/or problems like psychosis, severe depression and anxiety, self-harm, being suicidal, developmental disorders, personality disorders, traumas, drug abuse as well as social and family problems. A combination of different disorders and problems was common. They were all characterized by an extended need for individually adapted help. Adolescents and young adults experience many changes due to age (increasing age/development and therefore shift of needs) as well as fluctuations in symptoms. This group of patients is therefore considered to have a special potential for illustrating the challenges involved in the implementation and use of IP because of their situation, where flexibility is essential to meet their needs.

Table 1: Description of patients, coordinators and clinics

| Patient*  | Coordinator, or other helpers interviewed | Clinics recruited from                          |
|-----------|-------------------------------------------|-------------------------------------------------|
| MONICA – two interviews | Old and new coordinator, both in primary care | Children’s and adolescent outpatient clinic    |
| HENRY – one interview | Coordinator in secondary care, outpatient clinic | Adult outpatient clinic |
| HAROLD – two interviews | Coordinator in secondary care, institution | Adult inpatient clinic |
| CARINA – two interviews | Coordinator in primary care; Psychologist in secondary care | Children’s and adolescent outpatient clinic |
| OSCAR – two interviews | Coordinator in secondary care, institution | Adult inpatient clinic |
| JOHN – two interviews | Coordinator in secondary care, outpatient clinic | Adult inpatient clinic |
| BRIAN – two interviews | Coordinator in secondary care, institution | Adult inpatient clinic |
| ROSE – two interviews | Coordinator in secondary care, outpatient clinic | Adult inpatient clinic |
| MIKE – two interviews | Coordinator in secondary care, institution | Adult inpatient clinic |
| HELEN – two interviews | Coordinator in secondary care, institution | Adult inpatient clinic |

Note: *All names are fictive and names are not linked to age and diagnosis to protect privacy.
Interviews
The interviews were semi-structured and the patients were asked about their experiences with the IP, collaboration with service providers and organization of measures, as well as how the process of making an IP was initiated, how the plan was made, who made it, who was responsible for which measures, how the collaboration went, whether they were satisfied or dissatisfied with the plan, with collaboration and information, and how the IP was used over time. They were also asked about their relations with the coordinators. The coordinators (or other helpers interviewed) were asked about their experiences with the individual patient and each person’s IP process, as well as general thoughts and experiences with the use of IPs in their daily work. The interview topics were further developed during the interview process according to grounded theory (Charmaz, 2006). All interviews lasted between one and two hours, and the informants decided where the interview was to be held, which meant at home, at the clinic or at the researcher’s office.

Permission
All interviewees signed an informed consent form. The project was validated as a quality assurance project by the Regional Committee of Ethics of Health Region East. Norwegian Social Science Data Services and the Data Inspectorate gave the necessary permission. The material is anonymous and the names fictive. All interviews were taped and transcribed verbatim.

Analyses
The analyses were conducted, with a few adjustments done by the author, according to Malterud’s Systematic Text Condensation (in short a method of decondensation of text into meaningful units and then recoding these units into categories and further into new descriptions and concepts or themes) (Malterud, 2003). For this part of the research project all interviews of patients, relatives and coordinators were first consecutively read in a naïve way and the author made notes about topics illuminating what aspects were emphasized as important in the process of developing an IP and putting it into action. After this 10 cases were chosen where the patients evaluated the IP process as useful (were satisfied with the plan) and additionally the author considered the plan to be used according to the intention and regulation. The interviews were then analysed in turn, the topics mentioned were improved with identification and coding of meaningful units of text from the transcribed material. In this part of the analysis, the software program NVivo8 was applied. Then the coded text was developed into categories and sub-categories which were further revised into the main categories presented in this article: to formulate goals, to take active part in the process, to build up competence and knowledge, and a relational cooperation. Since an IP, both as a written plan and a process, interacts with the services and treatment measures involved, it was sometimes difficult for the informants to distinguish the IP from the treatment in general; and additionally, there might be an artificial discrepancy due to this interaction, but when possible the IP is kept separate. Some patients had better formulated, more interesting and more “solid” descriptions which give them more weight in the following presentation (Kvale, 1996).
Findings

There are 10 IP processes validated by the patients to be in satisfactory use; they found the plan helpful in some way, and at the same time the plan was in use more or less according to the intention and regulation at the time of one or both interviews. Six out of the 10 had a well-functioning IP at both interviews. All 10 patients were over 17 years old and were interviewed in person. They all had a collaboration group, not too big and with a high rate of personal continuity, with the involved service providers, the patient and sometimes a relative (not interviewed), meeting on a regular basis to secure the IP process and general treatment. Both developing an IP and putting it into action consist of topics like participation, knowledge and relations.

Formulating goals

Formulating goals and then putting these goals into action was considered essential to make a well-functioning IP. All 10 had been asked about their goals, wishes and needs by the coordinator who had written the plan. Only one, Monica, explicitly said she would have preferred to write the IP herself to make it even more her plan. Half the coordinators explicitly stated that their patients had clear and realistic goals. According to the analyses it appeared that all 10 were quite realistic. This made it more likely that they would reach their goals, which were of importance to all of them. Harold said: “An IP is supposed to show your goals and what is necessary to work on to reach them. . . . If not the IP is out of step with the purpose”. Just to have goals were emphasized by several. John said: “If you do not have any goals to reach for, you won’t move anywhere”. Both coordinators and patients emphasized the dialogue around the formulation of goals as an important part of the process, as well as the evaluation where they could adapt the goals to the actual situation. Two said their goals were a bit too ambitious at the beginning and had to be downgraded, while three had the opposite experience. They had changed due to their treatment. They mentioned that they were too ill to find an IP useful at first, like Monica: “My goals changed when I became less ill and realized I could cope”. John said: “At first some goals were suggested. Later I suggested them myself”. The coordinator talked about Harold and the process he had to go through to be prepared to collaborate with the service providers at all. This process was about trust, insight and feeling secure. Four patients mentioned a discrepancy between the goals put down in an IP compared to private dreams and wishes for the future which they did not want to include in the plan. Two of them were slightly paranoid so that could be the reason, but for the other two dreams about love, family and higher education seemed to be too private to be set out in a plan. Two patients said that their IP was a short overview of goals, measures and services, which they looked at from time to time. There had not been a real process, but a meeting where they had written all the information down. These two were satisfied with this way of using an IP as a kind of “reference book”. At the second interview Monica said: “Actually I was a bit stressed about having this plan. It was hard to decide what I wanted to do and what my needs were. It tied me up in a way. . . . but for those around me it was a great help”. Over time she had found the IP more useful for the system than for herself.
Taking an active part in the process

The 10 patients in focus experienced, most of the time, that their role was filled with influence, participation and balanced responsibility in the IP process. The concept of “participation” seemed to be somewhat stronger than “influence”, in the sense of having a more active role or position. Many informants used the word “control” – to be in control or lack of control when they responded to questions about how they participated in and looked at their own process. In several cases it was evident that participation had to be continuously adapted to the individual’s changing needs and development during the process. It seemed to be challenging for the services to be flexible enough. The needs of adolescents and young adults will often change and according to some of the coordinators they found it challenging to use IPs in a way that fitted with an often changing situation of being more or less self-reliant. A young man found it difficult to take an active part in the process all the time, but this was what he worked for. He stated: “Trying to take part in the collaboration meetings is important for me. Otherwise I do not think the intention of IP is fulfilled”. Helen had been very insecure and dependent on her helpers, but her coordinator pushed her a little at the beginning of their joint process. The coordinator said she wanted Helen to use her own words and express her needs and dreams in order to be in control of the situation. This seemed to be successful, since in the second interview Helen said: “I do feel I participate myself. Both because it’s nice, and yes, I do participate. I just have to dare to express myself. Even if I don’t get it all my way, it’s important to say what I think”. Helen now appeared like a secure woman who was able to speak for herself and be an active partner in organizing her IP process. She said: “I have been very active myself. I have been in control of what papers have been sent, what kind of information new service providers have received, and so on”.

Most of the 10 experienced a balanced level of responsibility. It appeared as though there was a kind of negotiation to reach this balance, with patients and service providers carrying on a dialogue about who was responsible for what and at what time. John was not a person who expressed himself very clearly. He talked about his responsibility in relation to the service providers: “I have to say things more openly myself, both what people do wrong and what I need, not what they think I am in need of”. John worked up his courage to speak out, and felt the coordinator and service providers had promoted that. Brian’s coordinator had clear thoughts about using the IP both as an overview of services and people involved, a planning tool and a way of letting Brian be heard. To give Brian a voice as well as making him responsible for his own life and treatment was a goal for the coordinator. He was also occupied with not taking too much responsibility, to prevent Brian from taking up a position of learned helplessness. This was something the coordinator was concerned could happen. At the same time he wanted to be supportive and positive. According to what Brian said, his coordinator achieved an appropriate balance. In the beginning Brian stated that he was not so interested in the IP or having any responsibility, either for the IP or the treatment, but this changed. The explicitness of the patients’ responsibilities differed, but all 10 had clear thoughts about responsibility. Mike said: “It is not written down, but I do have the responsibility. I feel that myself. It is me that has to take my medication, go to school, to therapy and so on. No one expects these things, or yes, they might do. They really wish me well, but they have not put too much responsibility on my shoulders”. While Brian said: “I am co-responsible . . . My name is put next to the coordinator, to the doctor and the therapist in the plan”. Helen had become a very
active and responsible user at the second interview, but she had her limit: “It is me that is in the lead. I was also offered to be the chairperson in the collaboration meetings, but I did not want that”. Responsibility was also about being able to tell what was too difficult to handle. Four patients described a feeling of too much responsibility at some time in the process. Mike described an IP process where he felt supported in doing things for himself. He knew he was in need of appointments every morning to get out of bed and start the day before he got depressed by his own thoughts, and together with his coordinator he had made plans to deal with it. Commitment was a topic for several of the patients and Harold said: “Taking part in the process and the meetings gives commitment. I don’t want to tell people at a meeting that I have not done my part”. He found this “push” necessary to move the process on.

The importance of knowledge and competence

The patients varied considerably regarding the content of this category, which was to make use of information and knowledge and build competence to handle their own daily living, and through this try to reach the goals put down in their IP. They used words like “knowledge” and “information”, which in this context covered facts about the patient’s own illness and needs, about prognoses, what treatments were possible, and how the health and social service systems functioned. These are all aspects of having competence to make reasonable choices for daily living. For Rose, one of the main goals in her IP was to get a job. In the second interview, she stated: “I went on a special course for people with mental health problems who had been out of work for a long time. It was very positive for me”. The course referred to facts about how to handle this specific situation of staying in a job with a mental disorder. She could use her new knowledge in a job, and in relation to colleagues. Helen mentioned her moving from long-term hospital care and into a flat, which was one of her goals, and her need for time for preparation and building of competence: “To live by myself in my own flat was very scary to think about. The others decided it first. Then I had to get accustomed to the thought and work out how to handle it. Now it feels fine to move. It has come step by step”. Helen needed knowledge about practical things like economy, shopping, cleaning, how to get help in a crisis, how to organize her daily life, and so forth. After all her questions had been worked through with her coordinator and the other service providers, and she got used to the thought of living by herself, she was ready to start a slow moving process. She had acquired sufficient competence to cope with the situation. Information and competence cover a wide span, from being a precondition for experiencing control, to promoting coping and feeling safe in the situation of being a patient. Talking about Oscar, the coordinator said: “I think that through working with the IP he might have thought more about his situation. He is more involved in his own life and he does ask more questions about how he wants things to be”. In the second interview, Oscar himself described the process of moving to a new flat and getting a new coordinator as part of this: “I have met her several times. We have walked in my new neighbourhood to get to know the place. This makes me feel safer”. Knowledge was also about having an overview, in the sense of using an IP to help organize the services involved. John said: “Without that IP the situation would have been more ‘messy’ with all those people involved. I would not have known who to call or . . . It is a good overview”.

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A relational perspective on the cooperation

The relational perspective was mentioned in connection with collaboration and communication between patients, coordinators and service providers, which is more indirectly connected to the IP process. All patients were occupied with the personal relationship and communication with their helpers. Respect, trust, mutuality, sympathy and to be liked were all mentioned often. How they felt liked and trusted were somehow a topic for all of them. Carina said: “If I feel I have a conflict with someone I somehow feel everything is ruined, as if things can’t be fixed again. I know those people who are in my collaboration group are good people, and we would be able to work it through”. Talking about his experience with the IP, Brian said: “IP is not so... clausrophobic... it is such a smart device, because you do collaborate. That is, well, for me it is reassuring to have all these people around, and they all know each other. It becomes a kind of family, which I aim at”. As one of the goals in his IP, Brian had moved from an institution to a flat with some friends. Some of these friends were using drugs, which had been a challenge, but Brian wanted to live there. His helpers had not tried to prevent him even though they did not applaud his choice all the time. The coordinator said he had to find his own way. They let him take control and make his own choices and worked together with him to find ways of coping with the situation without using drugs, and manage his studies, which were important goals to him. Brian felt respected and said he could talk openly with his helpers without feeling reproached. When Helen talked about her coordinator and the social workers at the staffed apartment where she lived, she talked about them almost as friends – as people who treated her “as an equal and as a person, not a patient” to use her own words. Helen continued: “I do feel they take me seriously. I can talk openly to them, about the future, or if I am insecure about something I trust them”. Other patients also mentioned these friendship-like relationships as meaningful, more often in connection with coordinators and social workers than in relation to psychologists and general practitioners (GPs) who seemed to have a more set role function. Monica expressed it clearly: “People are more important than the plan”. When the patients were asked about qualities the coordinator should posses, they talked about being good at communication, being calm and not stressed, and being kind, supportive, honest and respectful. A few mentioned being experienced, well-organized and effective.

Discussion

To sum up briefly what the patients with the most well-functioning IP processes described as important: they emphasized having their own goals, taking an active part in the process, building up competence and knowledge to meet their goals and to experience good relations with the service providers and especially the coordinator. Somehow it is self evident that these aspects are important, but a more thorough exploration of what the patients described gives a useful picture of what to take into consideration in planning an IP process as well as strengthening the user’s role. So far the IP is not put into action at a sufficient level in Norway (Bjerkan et al., 2011) and when used it is not always according to the regulation, as was seen in this main project with 14 IP processes out of 24 not in satisfactory use. This indicates a need for increased focus on how to make better use of the IP. In the part of the main study presented here, seven out of 10 patients were in inpatient treatment, which indicates that institutions
might have a more general impression of the patients' needs and take on more responsibility than outpatient clinics.

For some of the patients formulating goals was a process where they needed to be given some time to be able to change their goals in a more realistic direction. The service providers must be aware of this need for time. All 10 patients had reached some of their goals between the first and the second interview, and the goals and their IPs had been evaluated in that period. This indicates that the plan has to be actively in use. The impact of reaching goals is also known from therapy research (Duncan, 2010; Horvath & Bedi, 2002). After the experience of reaching goals users may increase their trust in the helpers, which again can improve the alliance. To make plans for the future can raise patients' consciousness about their own role, needs, dreams, resources and need for competence or knowledge in the process of reaching one's goals. This is a situation to be met with respectful dialogue. The dialogue between the patient and the service providers, especially the coordinator was emphasized as an important part of the IP processes by both patients and coordinators. It was also interesting to notice how two mentioned that private dreams or goals must not be included in the IP. An IP might be too official in a way. To take this knowledge into consideration means a coordinator should not be a distant person, but one who plays an active role in the process and knows the user quite well.

Several patients realized they were needed to learn new things and to build up competence to reach some of their goals. It is necessary to know about and cope with a lot of things to move to a flat, to get and hold on to a job, to become a student, to be able to pay for your leisure-time activities, to cook, etc. In order to cope with daily life, it is necessary to know facts, but also how to do things practically, in addition to forming an overview and knowing how the services involved are organized and function. The coordinators must map out what the users need to reach their goals as part of the IP process. Not only is the need for knowledge and competence experienced in relation to an IP, but the process of formulating and putting an IP into action can also make the needs visible and hopefully prepare for improvements as part of the process. Knowledge is an important part of user participation, especially as the patients formulate goals, and together with collaboration and good relations knowledge forms the basis of user participation (Michaelsen, Vatne, & Hollingen, 2011; Munro, Ross, & Reid, 2006; Sumson & Lencucha, 2007). All the way through an IP process, as well as in treatment in general, user participation is supposed to be a central theme in today's mental health care. In this study the patients did participate most of the time in their own process, but some needed trust, safety and knowledge as well as encouragement to participate. Others participate more naturally, but the service providers still have to prepare for participation. They have to ask the patients the right questions, maintain a constant dialogue, and listen respectfully as well as cooperate in a kind and mutual way, and sometimes “push” a little. It is above all the collaboration and interaction and not the written plan that can ensure a patient respect and mutuality and a balanced responsibility. When all these aspects do function, an IP process might even prepare for psychological growth. Patients such as Brian, Carina and Helen explicitly focused on the collaboration and importance of being appreciated and liked by their coordinators and other service providers. The feeling of being liked is good support for patients to experience both participation and psychological growth (Farber & Lane, 2002). The coordinator was the most, or one of the most valued persons, for the patients in focus in this study. This is also seen in other reports (Berge & Lorentsen, 2003; Thommesen, Normann & Sandvin, 2003). The coordinator's ability to build a good working alliance with relational bonds needs to be strengthened within
mental health care. This is something of a contrast to what was expressed by parents of children
with a disability in another study, where they wanted effective coordinators who knew the
system and the parent’s rights more than coordinators who were relational (Holck, 2004).
It confirms the importance of adjusting an IP both at the individual level and for different groups
of patients.

When patients and service providers work together to draw up an IP, it may provide many
occasions for active involvements and positive interaction. All 10 in this study participated
actively in the process and felt respected and supported. This kind of interactional and mutual
involvement can be considered a way of promoting empowerment. Empowerment ideology,
like user participation, is based on the assumption that knowledge and influence support the
ability to be in control and feel powerful in life. Lambert and Barley (2002) emphasized
the client’s resources also in the therapeutic process. This is a point stressed both in the
IP regulations and in an action report from the WHO referring to people with mental health
problems. To be able to use their own resources was mentioned as essential by several of the
patients interviewed. Empowerment ideology looks at human beings as proactive individuals.
This challenges the traditional role of helpers and represents the antithesis of paternalism
(Askheim & Starrin, 2008). Paternalism and the lack of opportunities for patients to be proactive
are known also from Norwegian health care, and were among the reasons for introducing the IP
and emphasizing user participation. Within this proactive perspective Rodwell (1996) mentioned
freedom “to make your own agenda” as promoting health. This might be valid for some of the
interviewees, for instance Helen and Brian, who were in many ways those most satisfied with
their IPs and their own role in the process. According to Freire (1970) knowledge, competencies
and self-efficacy is the way to freedom and power, both for individuals and for groups of
marginalized people. An important aspect of having better control of one’s life is to achieve
increased consciousness about one’s own situation and more knowledge about how to affect
the surroundings and develop personal skills (Andrews, 2003), which is important in the
“mastery of life”. According to this knowledge as mentioned, the process of working out an IP
has empowering potential. Wallerstein (1992) and Rissel (1994) found no specific research
documenting that an increase in a psychological state of empowerment leads to improvement
in health, while there is ample evidence that groups without power experience worse health.
Some of Wallerstein’s (1992) findings concern powerlessness or lack of control over destiny as a
broad-based risk factor for disease. This should be remembered in the IP process and in
organizing mental health care.

Implications for practical work with IP

Whether using an IP really is the best way of organizing services and supporting user
participation or not is hard to tell, but the intention is good and it seems to be useful for some
patients. It can appear that those patients who experienced the IP to be most useful did have
resources to participate, wanted help and were cooperative. In all events, it is important to
prepare for using an IP in a practical way, both for the user and service providers. Empowerment
ideology embodies a goal of building up independence and strength by active participation in
one’s own life and treatment. This is also what the IP and the Patient’s Rights Act assert. How to
find flexible and suitably adapted ways of involving the patient in the IP process is important
knowledge for future health planning. It is necessary to take time to formulate and adapt the goals, and to map the need for measures and services to be involved. A coordinator should do this job together with the patient, but needs time, support and knowledge about mental health to do it. This involves more than acting as a leader of the cooperation group, which is how primary health care often uses the coordinators. The coordinators working at inpatient clinics were both coordinators and social workers/contact persons, which gave them other tasks besides coordinating the involved services. They got to know the patient quite well and had a good overview which seemed to make them better coordinators. In mental health care there are, compared to somatic health care, some extra challenges for the service providers. Due to the complexity of their disorder some patients do not have a realistic picture of their goals and needs, they do not cooperate very well, or they struggle with cognitive difficulties. It calls for considerable time, expertise and flexibility to put an IP into action in a useful way, and maybe there should be a specific training for coordinators to support this kind of work.

Limitations of the study
The picture given in this study is not very precise, since it is difficult to determine exactly whether it is the IP, the involved persons, treatment measures or characteristics with the patient himself/herself that makes the patient satisfied. The study is descriptive and conclusions can hardly be drawn. The selection of informants have some limitations due to a process where managers were asked to get in touch with the interviewed patients, but they contributed with a range from zero to four informants each, and it is not known how the managers chose subjects for recruitment. The adult inpatient clinics differ, but they are more similar than if compared with children’s and adolescents’ in- and outpatient clinics, which gives a more homogenous material than meant to be. Only informants aged 17 years or older were included in this part of the study, which is a limitation due to the total material. A few informants had psychotic symptoms and/or cognitive problems at the time of the interview. This was a challenge since the risk of asking leading questions increases in such situations.

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NOTES
1 The concepts of “patient” and “user” are employed, both being used in the field.
2 Hereafter an IP process means both to make/develop and to use a plan.
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