

User involvement in interprofessional team meetings within services for substance use disorders

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Abstract

Background: People with substance use disorders (SUD) and concurrent mental health disorders often need prolonged, coordinated health and welfare services. Interprofessional team meetings are designed to tailor services to users' needs and should be based on interprofessional collaboration involving the user. **Aims:** To investigate service users' experiences with interprofessional team meetings and to identify potential barriers to successful user involvement. **Methods:** Semi-structured interviews with five male service users aged 27–36 years with concurrent substance use and psychiatric disorders, and observations of team meetings involving both users and relevant professionals. Users were interviewed shortly after commencing treatment and after the team meeting. A phenomenographical approach framed the data analysis. **Results:** Users described the interprofessional team meetings as less than useful, and perceived that lack of a targeted process and of information hindered their collaboration with professionals. Observations

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revealed that users were given a subordinate role in the meetings, which largely undermined their involvement. Three categories reflecting lack of information as a core obstacle to user involvement emerged from the data material: (i) unclear role responsibilities and unclear professional role functions, (ii) unclear practices regarding rules and routines, and (iii) absence of user knowledge. **Conclusions:** User involvement in team meetings may be improved by facilitating adequate information, clarifying role expectations, emphasising user knowledge, increasing professionals' awareness of the importance of collaboration, and by teaching skills that enhance user involvement.

Keywords

collaboration, interprofessional team meetings, phenomenographical approach, substance use disorder, user involvement

In current national health and welfare policy, coordinated services aim to improve the general quality of care, including the treatment of substance use disorders (SUD). The Norwegian government's guidelines for coordinated services emphasise the importance of good planning, information exchange and cooperation among professionals to promote choice-based services that are flexible, effectively targeted, and adequately adapted to the needs and wishes of service users (Norwegian Ministry of Health and Care Services, 2008). To meet those guidelines, practitioners in SUD services have established various models for collaboration, including some that use interprofessional team meetings as a way of organising cooperation across service levels and between users and professionals (Bjørkquist & Hansen, 2018). Although the guidelines do not require the use of interprofessional team meetings, such meetings are recommended by the Norwegian Directorate of Health and are therefore common practice (Norwegian Directorate of Health, 2012).

The term *interprofessional* may be viewed as synonymous with several other terms, including *multidisciplinary*, *interdisciplinary*, and *transdisciplinary* (Birkeland et al., 2017; Reeves et al., 2011). Some scholars have argued that the term *interprofessional*, particularly in relation to team meetings, implies a negotiated

agreement between professionals who value the expertise that different team members bring to patient care (Franklin et al., 2015). Reeves et al. (2011) have defined *interprofessional teamwork* as a type of work involving individuals from different professions who share a team identity and work closely together in an integrated, interdependent manner to solve problems and deliver services. In this article, the term "interprofessional team meetings" refers to a work process consisting of high levels of communication, mutual planning, and user involvement for long-term care delivery.

User involvement is an increasingly important strategy in health and social care policy and practice (Askheim et al., 2017). It builds upon the principle that people who use services are experts on their own treatment-related needs and on ways of improving the services. According to Rance and Treloar (2015), establishing a trusting, collaborative relationship between professionals and users is a prerequisite for successfully involving users in SUD treatment. Stemming from the model of empowerment, the concept of user involvement concerns mobilising marginalised individuals and user groups to apply their own capabilities and resources to solve their own problems as well as influence the services that they receive (Bonfils & Askheim, 2014). To promote user involvement, professionals need to strive to facilitate

collaborative relationships with users, especially if one recognises each user's life history and experiences as resources (Laitila et al., 2011).

Despite sharpened scholarly focus on user involvement in care services, few studies have focused on users' experiences with interprofessional team meetings in SUD services. To date, research has shown that service users with alcohol and drug use problems want to be involved in their own services (Schulte et al., 2007). It has been suggested that users of mental health and SUD services possess the most relevant expertise on their own service needs (Laitila et al., 2011). The importance of user involvement in SUD services has been further demonstrated by studies reporting an association between user involvement, treatment satisfaction, and treatment outcomes. For instance, one study reported that perceived patient participation in SUD treatment was associated with patient satisfaction and subsequent treatment outcomes (Brener et al., 2009). In line with this finding it has been suggested that opportunities for user involvement in SUD treatment, including interactions with staff, might have a positive influence on the therapeutic alliance and treatment outcome (Rance & Treloar, 2015).

Studies on user involvement in SUD treatment have identified factors that may prevent the successful involvement of users, including some professionals' stigmatising and stereotyping attitudes towards substance-dependent individuals (Luoma et al., 2007), lack of trust, lack of time (Patterson et al., 2009), and power imbalances between users and professionals due to their hierarchical relationship (Goodhew et al., 2019). In particular, it has been suggested that a general attitude may exist among professionals that service users with substance use problems lack both skills and interest in choosing interventions to meet their own needs (Bryant et al., 2008).

Because most research on interprofessional team meetings in social and health services has focused on collaboration between professionals, less is known about users' involvement in

those meetings. This article examines the usefulness of attending interprofessional team meetings from the service users' perspective and discusses how users with substance use problems can be involved in and influence such meetings. Two research questions guided our analysis:

1. What do service users with substance use problems experience in their involvement in interprofessional team meetings?
2. What are potential barriers to users' successful involvement in interprofessional team meetings?

Methods

Study setting

Our study was part of a larger qualitative follow-up study of 16 service users during and after discharge from an inpatient treatment unit for substance use disorders in central Norway. The Norwegian healthcare system consists of two governmental levels. The hospitals, managed by the specialist healthcare system, are responsible for inpatient and outpatient treatment, whereas the municipalities are responsible for providing primary healthcare and social services. The two service levels cover a variety of disciplines and are governed by different laws and regulations. The current data were based on team meetings including professionals and service users representative of both service levels.

Approval

The regional committee for medical and health research ethics approved the study. All participants provided their written consent prior to the interviews and observations, and all data were anonymised.

Informants and recruitment

A formal agreement was made with the unit's management that the patient coordinator would

continuously inform the first author about newly arrived inpatients over a six-month period in 2016. All newly admitted inpatients were informed about the study and invited to participate by the first author. Sixteen patients agreed to participate. To make the amount of data manageable, we only used data from the first five patients recruited to the study. With users' consent, we invited their professional contacts to participate. All informants received verbal information about the study and were invited to participate at an in-person meeting, via email, or over the phone. The informants received no money or gifts for participating in the study.

The informants were five men aged 27 to 36 years with comorbid substance use and psychiatric disorders. All informants had been introduced to illegal drugs during early adolescence and had developed substance use problems at around the age of 14 to 17 years. They had low levels of education and varying degrees of job experience. Two of them were homeless. None had prepared a personal plan for future goals or treatment measures. All informants received services from both specialists and primary services, except for one who was in prison and was thus receiving only primary services at the time of the interview.

The first author gained access to team meetings in various units and conducted participatory observations during those meetings. Owing to the geographical distance between the parties, three of the meetings were video conferences, whereas the remaining two meetings were conducted in person. The first author interviewed one of the informants three times after two separate meetings but observed only one of those meetings. Nevertheless, we have included both post-meeting interviews in the results. Two of the meetings were held in an early phase of treatment. One of the informants was no longer in treatment, and the observation of his meeting was performed while he was in prison. No one from the specialist health service attended that meeting, although representatives from the prison, the welfare service, and

the municipality were present. In the remaining team meetings, professionals from the specialist health service and several municipality units were present.

Data collection

An interview guide was developed with reference to literature on interprofessional team meetings and user involvement. This literature addresses the following major topics: the users' understanding of the purpose of the team meetings, the roles of the professionals during the team meetings, and the users' involvement and expectations for the meetings. Field notes taken during the meetings were subsequently reviewed in collaboration with the users. The field notes included memos on meeting structure, the positioning of roles and responsibilities, interaction in relation to the power balance, communication, and relationships between participants.

The first author conducted all interviews with the participating users immediately after the meetings. The interviews lasted 15–60 minutes. In the interviews, the first author endeavoured to establish a dialogue in which she was open to the informant's perceptions. The process by which a researcher seeks to display an unbiased attitude about the informant's experiences can be understood as *bracketing* (Creswell, 2013). However, researchers may not be able to fully abandon preconceptions and attitudes, thus data may be interpreted based on their knowledge of theory and life experiences. In phenomenographical studies, researchers focus on people's reflections about their experiences with and within the social world around them (Barnard et al., 1999; Creswell, 2013; Dahlgren & Fallsberg, 1991). In such research, ethnographic methods emphasise collective meanings. Therefore, in addition to semi-structured interviews, we used an ethnographic approach to study the process of and communicational dynamics in team meetings. Unarticulated knowledge and experiences were considered to be as important to us as

researchers as those verbalised by the informants (Barnard et al., 1999; Hilden & Middelfton, 2002).

Analysis

Transcripts from the audiotaped interviews and field notes were coded in NVivo. In the process of establishing categories to answer the research questions, we followed the steps of phenomenographical analysis described by Dahlgren and Fallsberg (1991). The goal of phenomenography is to identify the diversity of experiences related to the phenomenon being explored (Dahlgren & Fallsberg, 1991). The approach distinguishes between what can be observed as either a first-order or a second-order perspective. The first-order perspective is concerned with facts and directed at the phenomenon *as it is*. The second-order perspective seeks to *understand* a person's perceptions of the phenomenon. The second-order perspective is studied in phenomenography (Barnard et al., 1999). The process involves identification of similarities and differences in informants' statements, exploration of how the phenomenon occurs and has been perceived by the informants, and grouping of identified statements and perceptions into different descriptive categories. The categories that emerge from this process thus represent the collective experience of the informants with the phenomenon (Dahlgren & Fallsberg, 1991).

In our phenomenographical analysis, we first attempted to get an overview of the material. In the next round, statements that were significant to the aim of the study were selected. The topics that emerged from this round were the following: understanding of the purpose of the team meeting, understanding of roles, sharing information, users' knowledge, user involvement, rules and standardising, and users' expectations. The topics were thereafter classified into three major categories. As a last step, the data were conceptualised and discussed in accordance with descriptions found in relevant

literature on the intentions of interprofessional team meetings.

Results

The service users' experiences with attending interprofessional team meetings and observations made during such meetings formed the basis for this study. The analysis revealed that the informants perceived the purpose of the meeting in different ways, depending on their previous experiences. However, they all expected that the meetings would contribute to acceptable solutions for their future life situations.

Interestingly, although an unmet need for information was one of the users' main motives for attending the meetings, insufficient information made it difficult for them to have influence on their own health services. Within this core category, the following three main obstacles for user involvement were identified: (i) unclear role responsibilities and unclear professional role functions, (ii) unclear practices regarding rules and routines, and (iii) absence of user knowledge.

Unclear role responsibilities and unclear professional role functions

Despite the fact that the users and some of the professionals did not know each other, the meetings began with only a short presentation of the participants. Thus, little information was available about the service user's background and service needs, and what the individual professional could contribute to the meeting. Several of the service users interpreted the service providers' lack of insight into their case as lack of competence.

Arne wanted to get started with education, and to get some advice regarding this. He was not satisfied with the answers that were given:

None of the professionals [who attended the meetings] knew anything about my rights regarding education.

Simon shared Arne's experiences. In a post-meeting interview, Simon expressed somewhat ironically that if the service user does not have a good insight into their own case, the practitioners will not be able to provide any help:

They [professionals] have become better and better at helping me, because I am getting better and better at knowing what I am entitled to or not!

In line with the services users' experiences of professionals' unclear roles, competencies and responsibilities, the field notes from observations revealed that the services users were encouraged to figure out solutions on their own, without taking into account their capacity to do so.

We use Arne's case as an example: In his team meeting, the caseworker from The Norwegian Labour and Welfare Administration (NAV) encouraged Arne to tell about his background and his perceived current challenges. The caseworker wanted him to tell a little more about his drug profile. Arne responded by listing the drugs he has been using and proudly said it was exactly one month since he took drugs the last time. Never, since first taking drugs at age 14, had he abstained from drugs for that long. He reminded the team that he was now 28 years old, which meant he had been using drugs for 14 years. The caseworker encouraged Arne to find out on his own what rights he might have regarding education. However, as Arne pointed out, for persons with a long substance use career it can be difficult to get an overview of what services are available and how to contact them:

I hope that they [the professionals] understand that I have a drug problem (. . .) they said I had to figure it out myself, but where should I start looking for answers? I feel like a shuttlecock!

Adding to the uncertainty around the professionals' functions and responsibilities were answers like "not yet" and "wait and see". These answers often occurred as a response to questions asked by the service users, but were

often unaccompanied by further explanations. One of the service user informants, Simon, asked for outpatient treatment. He said in the meeting that he intended to meet the required conditions for work assessment allowance. The caseworker replied that Simon would "not yet" be given such an allowance because he had previously broken agreements related to his activity plan. Instead, he was informed by the caseworker that he would receive the minimal benefit. The caseworker encouraged Simon to stop thinking about the allowance. The phrase "not yet" can be regarded as a normative but arbitrary statement drawn from practices that are not related to legal provisions and definitions of formal roles. Simon was encouraged to contact the Labour and Welfare Administration for an explanation of the decision. In the meeting, we observed the following on how Simon responded to the temporary denial:

Simon shows frustration and says that then the path is short to selling drugs. That is quick cash and something he can fix in a short time. Basic cash benefit is not enough to live on, Simon claims. The caseworker replies that many have managed this before him. (Field notes)

Nevertheless, Simon seemed to understand that it is difficult to make decisions that require financial resources in the team meetings. He accepted that the professionals were not able to answer every question during the meetings and that final answers had to be given later. However, the following comment he made after the meeting indicated that he was disillusioned:

I get no help. They [the professionals] know very little. After all, it's always the people [the leaders] above them who decide.

According to the informants Victor and John, the tendency to get few answers, the lack of decision-making, and the lack of solutions to their problems at team meetings caused their cases to progress slowly, if at all. Victor's comment on this was as follows:

I feel very uncertain not knowing. I don't get a definite yes or no. It's hard to plan, when it's like this: "No, we'll see what happens!"

John was generally pessimistic about the outcomes of the meetings:

It [the meeting] was as expected: I didn't get any wiser, and not much came out of it other than that I should get a job as soon as possible.

Unclear practice regarding rules and routines

The user participants' utterances in the meetings exposed a dynamic that was predominantly rule-oriented and underpinned by justifications of the caseworkers' actions. For instance, we observed that users struggled to argue for their point of view against professional decisions, since the professionals referred to rules and conditions that were often unknown to the users. This made the practices appear unclear to the users.

As suggested by Simon in relation to the first category, the responsibility for making informed choices rested on the service user and his or her capacity to stay updated on the rules.

Another phenomenon addressed in the post-meeting interviews that may illustrate rule orientation, was service users' belief that the content of the meeting was predetermined or standardised. In the following excerpts both Simon and John suggested that the professionals conducted the meetings in a routinised way and let them progress in an "automatic" manner:

Simon: Yes, they [the professionals] probably read from a script.

John: The meetings are routines to the professionals!

Rules asserted by the professionals and the service users' own conceptions of what was best for them often ran counter to each other. In one observation, when Morten stated that he

would quit treatment before the scheduled time and apply for a job, the other team members strongly advised him to complete the treatment programme and to apply for an employment scheme after completion of treatment. After the meeting, Morten reflected:

There's no point in saying what I'm thinking; they only refer to a set of rules anyway.

By this comment Morten seemed to believe that if he did not follow the rules, he could be sanctioned for violating the terms of treatment. Implicitly, it seemed that he had been told that he could not choose "from the top shelf", but should accept measures that were already available to him. The representatives from the system did not show willingness to aim for individually tailored solutions, despite the fact that this is emphasised in the national guidelines for health services.

As was the case with information regarding professionals' mandates or competences, language barriers also seemed to exist regarding rules or requirements. In several observations we noted that welfare case workers used expressions such as "fulfil the terms" and "satisfy the conditions" without any further explanation or elaboration. This caused the service users to have problems with understanding the rationale behind the professionals' decisions or advice.

Absence of user knowledge

A lack of user experience-based knowledge was illustrated in the case of Morten, who wanted a "decent job" right away instead of following the advice from the professionals to complete the treatment programme and then apply for an employment scheme. His caseworker, as a rationale for that advice, argued that he had to be realistic and reminded him of his history with drug use, implying that "realism" was something that had nothing to do with service users' experience. Thus, professional knowledge became the dominant form of knowledge,

which prevented collaboration with users on setting and achieving goals. A comment from Victor in a post-meeting interview illustrated that service users may communicate strategically, because they fear the consequences of speaking up:

I don't express what I feel! (...) [because] a case-worker from welfare services said, "Those [service users] who are arrogant and rude go to the bottom of the pile!"

Contrary to what the user informants said that they hoped for prior to the meetings, namely to gain insight and knowledge to help their continued rehabilitation, the data from post-meeting interviews suggested that their expectations regarding the outcomes of the team meetings was significantly lowered after having seen how the meetings functioned. The service users experienced that the responsibility for comprehending crucial information rested upon themselves.

According to the findings, the service users also withheld information for several reasons. The many service providers that were present at the meeting could overwhelm them. At times up to five professionals from different units participated. To Morten, becoming the centre of attention elicited his personal shortcomings. He expressed his unease in the following way:

I don't like meetings that are about me.

According to information from the individual interviews, all user informants had specific, basic needs for security and belonging related to work, income, and in some cases housing assistance, which provided a certain quality of life and sense of safety. The users said that they aimed to receive sufficient help with finding solutions, yet they felt incompetent in defining and expressing their needs and did not know exactly what they could ask for. Arne put it this way:

I'm not a professional and don't know what I need help with.

To John, asking for help in the meeting was not an option:

No, I expect this [job, aftercare, economy etc.] to be addressed by them; they [professionals] have a checklist that they use at such meetings.

Victor, in contrast, felt more at ease with being proactive in the meeting, despite the lack of demand for his concerns:

Nobody asked or wondered, but I said how I felt, and they showed understanding for it – but zero solution orientation.

One of the follow-up questions in the post-meeting interview was about how the user's experiences were received and appreciated: "Did you experience that you were included to contribute with your experiences and user knowledge in the meeting?" Some of the answers disclosed relatively realistic expectations:

Arne: I felt I was being listened to. I did not expect everything to be arranged after one meeting.

Although all informants clearly stated that they wanted to be involved in their own case, *how* they could influence their case remained unclear. Morten drew attention to this issue in the interview by stating:

How to influence? I do not know how ... I do not have a clue about that.

It seemed that the service users had to be familiar with the professionals' language in order to express their needs or to get appropriate information. Morten stated the implications of this as follows:

They should use plain language that everyone knows. I have to look up words online that I don't understand.

It is a paradox that although the meetings were often presented as "the user's meetings", it

seemed that the users' competence were not very visible.

Discussion

The main aims of our study were to investigate service users' experiences with their involvement in interprofessional team meetings and to identify potential barriers to successful user involvement in those meetings. Although user involvement is understood as the core of recovery (Storm & Edwards, 2013), the current data indicated that users perceived the interprofessional team meetings to be less than useful, and that their involvement was largely undermined. Lack of information seemed to be a major challenge for the users' ability to participate in their own services. The empirical data from our study indicated that in particular, three different aspects related to lack of information constituted obstacles to user involvement, as discussed in the following sub-sections.

Unclear role responsibility

One major finding was that the users lacked knowledge about the professionals' roles and functions at the meetings, and that they were uncertain of what to expect from the services and support systems. This finding might indicate that the roles of the professionals and tasks of their services are either too similar or too vague. Consequently, the professional roles may become vague and the continuity in the teams may be weakened (Belling et al., 2011; McNeil et al., 2013; Mitchell et al., 2008).

It seemed that the caseworkers had not got to know the users before commencing the team meetings. This is in contrast to the recommendation of Rance and Treloar (2015), who emphasise the importance of user engagement and service user-staff relationships in service delivery and treatment outcomes. Moreover, it has been suggested that supportive professionals may contribute to reducing uneven power relations, thereby providing the users with a stronger negotiating position (Hansen, 2019).

Another main finding of the current study was that when the preconditions for a good communication climate were absent from team meetings, the use of sanctions and bureaucratic terminology increased. We observed that professionals became preoccupied with their own roles and professional limitations, and as a result they concluded meetings too quickly without ever including the users. This finding is consistent with the results of Hansen (2007) suggesting that professionals in teams were more concerned with setting limits for their own interventions than with contributing to comprehensive, coordinated service provision. Conflict between professionals may also heighten the risk that decisions and clinical approaches become based on professionals' moral attitudes instead of their professional discretion (Samet et al., 2001). The current finding, suggesting that service users perceived a lack of information and adequate answers from the meetings, could also be a consequence of their limited knowledge on professional mandate and the negative attitudes that users with SUD are frequently confronted with (Fischer & Neale, 2008).

The current data also suggested that the participants in the meetings had a poor understanding of their respective responsibilities, and that they did not attempt to clarify the role or responsibilities of the other team members. We observed how the users were expected to make many arrangements by themselves and to behave according to the rules. Although some professionals may have considered these requirements to be ways of facilitating user involvement, such a belief did not appear to be justified in the observed meeting context. In light of our findings, it makes sense to apply the concept of responsabilisation, which has become a dominant discourse in public health services in the last decade (Juhila et al., 2016). In the literature this discourse has been linked to neoliberalism, where the customer is viewed as responsible and rational and possessing the same authority as in the market model (Tritter, 2009; Trnka & Trundle, 2014). Moreover, the

individual is supposed to make choices that maximise his or her wellbeing and quality of life (Juhila et al., 2016). Such notions are at the core of the discourse of responsabilisation. Responsibilisation has some inherent paradoxes. On the one hand, individuals are expected to take responsibility for their lives. On the other hand, they have to adapt to the demands that services impose upon them and to threats hanging over them, including the loss of social benefits. That dynamic does not confer total freedom of choice, especially not for individuals whose life situations may mean that they are marginalised and dependent upon the help that they receive.

User involvement can thus be understood as a multi-tool grounded in the modern health discourse. The services need to be both cost-effective and targeted, and individual responsibility is demanded from the user (Johansen & Solbjør, 2012). From that standpoint, collaborative models of involvement have tended to legitimate existing provisions instead of challenging them (Rhodes & Nocon, 1998). By facilitating user involvement, and by giving the users responsibility for their own problems, service users become active co-producers of their own services and also share the responsibility for the results (Ekendahl et al., 2020; Johansen & Solbjør, 2012).

Absence of adequate information and answers

The informants stated that the meetings were organised in an automated, standardised way, and that they rarely received concrete answers. It seemed to them that their engagement in making significant decisions was ignored and that collaboration, if any, did not contribute to new knowledge. The users tended to lack adequate information about alternative measures that were available to them. Thus, to the extent that any decisions were made at the meetings, the users had little ability to have any influence on the decision-making process. This finding is in line with previous research suggesting that

when users lack information about the purpose of meetings or the functions of individual providers, their involvement is decreased (Horlait et al., 2018).

Some users in the current sample had no previous experience with interprofessional team meetings, thus did not know how to behave in these meetings. Managing multi-party situations, including meeting different professional groups and multi-party conversations, may require communication skills and adequate experience (Kvarnström et al., 2009). Professional codes and terminology can be difficult for users to understand and may give them a sense of alienation. For example, the participants in our study demonstrated different understandings of the term “satisfactory conditions”, and we observed that users in the meetings struggled to understand rules cited by the professionals. Laitila et al. (2011) have emphasised that users may need adequate, comprehensible information to become involved, and that the information should be repeated and provided in an understandable form. Terminology used by professionals without any explanation only increases the asymmetry and distance between parties (Ekeland, 2014). If the team lacks a patient orientation and instead allows rule-based practices to dominate, then those practices will not capture or be able to cope with variations in the users’ needs (Ekeland, 2014). If users are perceived only as cases by professionals, then their own knowledge becomes worthless, and they risk becoming or remaining passive users (Askheim et al., 2017).

Structural frameworks of user involvement

Our study revealed that although users wanted to influence their cases, they had difficulties in doing so. One reason may be that professionals and users have a different understanding and valuation of user involvement (Rise et al., 2013). Another factor that may counteract user involvement is that encouraging users to become proactive in their own treatment may be interpreted as an attempt from the welfare

service to partially escape responsibility for its outcomes (Johansen & Solbjør, 2012). Today's healthcare systems are complex, fragmented, and continuously operating under severe pressure, which are conditions that are suggested to counteract functional teams. For example, different organisational and systemic factors, such as legal frameworks, financing systems, political missions and information technologies, may hinder the establishment of common goals (San Martín-Rodríguez et al., 2005). Furthermore, diverse values, multiple interpretations of appropriate treatment, and overlapping or new roles in the team may create distance and fragmentation between the parties involved (San Martín-Rodríguez et al., 2005).

Barriers to introducing user involvement may include paternalistic approaches taken by staff (Laitila et al., 2011). There may also be lack of time and cultural understanding (Patterson et al., 2009). Autonomous professionals are required to empower users to act against oppressive practices, while in reality, non-autonomous professionals may face challenges and perhaps find it impossible to facilitate the self-empowerment of users (Larsen & Sagvaag, 2018).

In line with results reported in other studies (Liljegren, 2013; Sommerseth & Dysvik, 2008), all professionals in our study, including medical doctors, social workers and primary healthcare staff, held the same level of authority. Owing to the lack of evident team management, the teams were rather reluctant to make final decisions. A flat managerial structure may constrain discussion and the exchange of information, as well as prevent the implementation of new practices (Bulling & Berg, 2018). Moreover, some users may be unwilling or unmotivated to participate and instead rely upon professionals to make decisions for them (Fischer & Neale, 2008; Laitila et al., 2011).

Strengths and limitations

A particular strength of the study was the combination of interviews and participant

observations, which allowed a researcher to be present in the context that the users referred to during the interviews. The phenomenographic design included a pragmatic approach that captured the complexity of users' opinions as products of relational knowledge. The informants were given the opportunity to reflect on their thoughts and perceptions, and how they experienced their presence in the meeting context together with professional actors.

The study had some important limitations. We used a convenience sample procedure to gather data. However, as the purpose was not to generalise or evaluate but to gain deeper insight into the various dynamics that may hinder users' involvement in team meetings, we believe that the sample size was large enough for the aims of the study.

The first author was doing the research in an environment she was familiar with, as she has clinical experience from SUD treatment. This could, from one perspective, entail "going native". On the other hand, her acquaintance with the system, the user population and their jargon could also prevent misunderstandings and thus enhance communicative validity.

Conclusion

The current study suggests that service users may not receive the answers and information necessary to become fully involved in team meetings. If the team meeting fails to create a reflective culture, and if user-based knowledge is not considered, there may be no opportunity to create a common understanding of the task, and the work of the team may stagnate.

Initiatives to improve user involvement and raise awareness about collaboration skills in interprofessional team meetings may clarify expectations regarding the roles and functions of all members present at meetings, especially those of the professionals. Collaboration skills training should thus be part of professional development. Additionally, user involvement in interprofessional collaboration needs to be anchored at the managerial level, and should

be considered a high-priority task in service delivery. Above all, a view on collaboration not as a mere fact, but rather as a continuous, flexible process is needed.

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