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Conditions for implementing shared decision making (SDM) in coordinated individual care planning (CIP) in Sweden through the lens of normalization process theory: a prospective study

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ABSTRACT

This study explores staff perceptions of the organizational and behavioral conditions required to normalize SDM within CIP processes in Sweden. Three focus group interviews were conducted with mental health and social care staff in three sites. Data were analyzed qualitatively, using constructs from Normalization Process Theory. Largely, there was shared validation of SDM-CIP, indicating high *coherence*. Generally, commitment was expressed to strengthen the conditions for implementation (reflecting the construct *cognitive participation*), by challenging attitudes and establishing effective roles. Inadequate infrastructure limited conditions for *collective action* for realizing SDM-CIP. The findings highlight a need for cross-organizational staff training and supportive infrastructure.

KEYWORDS

Coordinated individual care planning (CIP); mental healthcare, social services; shared decision-making (SDM); workplace culture

Introduction

In the field of mental health care, people with complex needs, who rely on a range of services, often encounter significant difficulties when navigating mental health systems (Andersson et al., 2023; Baker et al., 2018).

In Sweden, the tax-funded health system provides universal care for all citizens, with responsibilities divided among the state, the regional authorities, and the municipalities (Ludvigsson et al., 2025). Mental health care is primarily delivered through two key actors: psychiatric care, provided by the regional health system, and social services, delivered by municipalities. Psychiatric care includes inpatient treatment, medical assessment, and medical treatment along with specialized interventions tailored to specific diagnoses or co-occurring substance abuse issues. In contrast, municipal social services

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provide social care and support, including financial assistance, housing support, and activity support (Andersson et al., 2023). This fragmentation within the system has been recognized as a factor contributing to individuals with mental illness not receiving personalized support due to a lack of collaboration among professionals and organizations (Baker et al., 2018; Bromark et al., 2022; Erlandsson et al., 2023), thus warranting urgent attention for improved integration and efficacy within the mental health-care continuum.

To address this challenge, coordinated individual care planning (CIP) has been introduced in Sweden as a strategy to enhance collaboration between key actors, with the aim of facilitating the coordination of care and support for individuals with complex mental health needs (Knutsson & Schön, 2020). This model is similar to care plan coordination practices seen in other countries like Norway (Björkquist et al., 2018) and the United Kingdom (Simpson et al., 2016). Since 2010, Swedish law has mandated the implementation of CIP for service users (hereafter abbreviated to SUs) necessitating support from both social services and psychiatric care. This model aims to promote user participation and address individual needs effectively (“SFS 1982:763. Social Services Act,”). A primary goal of CIP is to actively involve SUs in planning and decision-making processes. However, recent research on the processes of CIP has highlighted a lack of collaborative deliberation with SUs (Matscheck & Piuva, 2023; L. Nordström et al., 2023), and the utilization of shared decision-making (SDM) (Knutsson & Schön, 2020).

Previous research highlights several challenges in strengthening user participation in CIP, including staff’s lack of competence in CIP, lack of resources, different organizational cultures (Matscheck & Piuva, 2022a, 2022b) and ambiguities of responsibilities between service providers (Knutsson & Schön, 2020). Additionally, prior studies show that the CIP process is often reduced to a single meeting for which neither staff nor SUs are prepared, leading to low user participation and lack of staff collaboration in CIP processes (Knutsson & Schön, 2020; Matscheck & Piuva, 2022a). In response to these issues, a proposed strategy to increase user participation in CIPs is the incorporation of SDM into the care planning process (Andersson et al., 2023; Knutsson & Schön, 2020).

Over the past decades, attention has been directed toward exploring how SDM can be facilitated within mental health care. SDM is widely acknowledged as a crucial component of a person-centered care (Matthias et al., 2012) and an effective approach to enhance individuals’ participation in the planning and implementation of care and support interventions (Hamann et al., 2020; Marshall et al., 2021). SDM has emerged as a method to uphold the principles and adhere to legislation concerning user participation. It goes beyond ethical principles and involves concrete actions to elicit and validate the knowledge and experiences of SUs (Levin, 2015; Morant et al., 2016). In the field of mental health care, SDM is recognized as a model for increased participation that complements the recovery philosophy (Dahlqvist-Jönsson et al., 2015; Morant

et al., 2016). Key elements of SDM encompass the active participation of providers and SU throughout the decision-making process, including exchanging information, discussing options in alignment with SUs' values and preferences, and arriving at a decision on the best course of action (Charles et al., 1997).

While SDM initially found its roots in the medical and healthcare field, there is a growing global trend to incorporate SDM into the delivery of social services (Levin, 2015; Nykänen et al., 2022).

The SDM in CIP intervention

To support the broader national strategy in Sweden aimed at increasing SU participation in CIP, a research project was initiated to develop and implement an intervention that integrates SDM into the CIP process (Andersson et al., 2023; Knutsson & Schön, 2020). The resulting intervention, referred to as SDM-CIP, was developed through a co-creative process involving service users, professionals from both psychiatric care and social services, and researchers (Knutsson & Schön, 2020). The overarching goal was to enhance meaningful SU involvement in planning and coordination of care and support across organizational boundaries.

The SDM-CIP intervention is grounded in both national policy directives and practice-based knowledge. It builds on core SDM principles and aligns them with the structure and legal framework of existing CIP processes (Knutsson & Schön, 2020). Rather than replacing the CIP model, SDM-CIP reinforces it by operationalizing the levels of user participation mandated in practice.

The intervention follows a structured process that includes problem identification, information sharing, exploration of options, facilitation of shared decisions during CIP meetings, and the creation of actionable follow-up plans. A central component is a revised CIP form designed to embed SDM principles throughout the planning process. The form, an integrated tool, includes meeting notice, agenda-setting, documentation, and follow-up. It emphasizes through preparatory work with the service user, enabling them to influence both the content of the agenda and the selection of participants. Documentation is conducted collaboratively and in real-time on-screen during meetings, fostering transparency and shared ownership. A complementary follow-up form is also used to support continuity and accountability. [Figure 1](#) illustrates the key steps in the SDM-CIP process.

Importantly, SDM-CIP addresses common shortcomings in traditional CIP practice, such as low user involvement, unclear roles, and fragmented inter-organizational collaboration. The SDM-CIP intervention provides a structured way of cooperation among various agencies, enabling seamless access to information regarding available services, interventions, and their

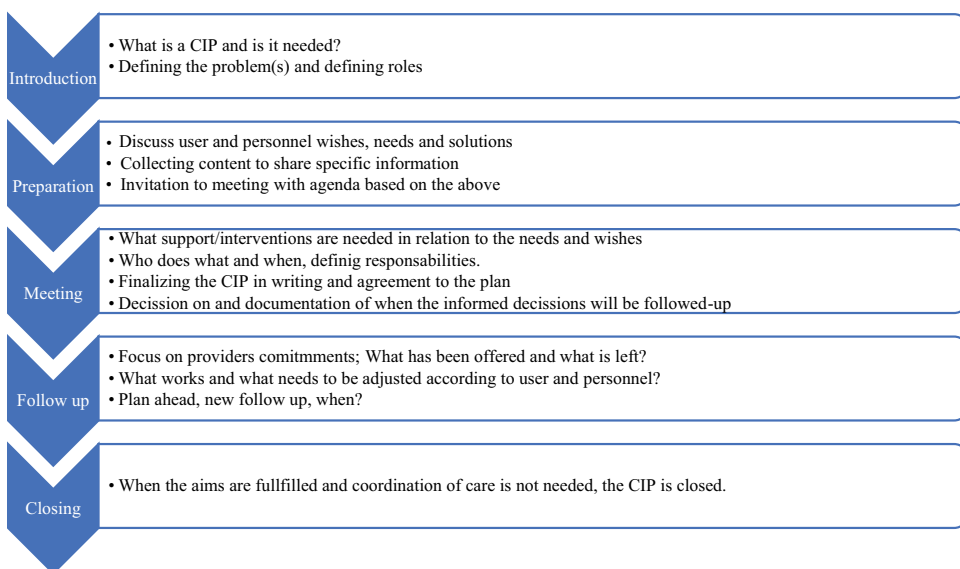


Figure 1. The logic of the co-designed process to promote SDM in CIP.

corresponding evidence base. Most importantly, SDM-CIP requires professionals to view SUs not merely as recipients of care, but as carriers of valuable knowledge and capable collaborative partners (Andersson et al., 2023; Jones et al., 2022; Knutsson & Schön, 2020).

As the SDM-CIP intervention is planned but has not yet been implemented, this study explores how staff currently describe and reflect on their CIP practices in relation to SDM principles. It also examines their perceptions of the organizational and behavioral conditions necessary to support the future integration and normalization of SDM within routine CIP processes.

Rationale and aim

While numerous international studies have addressed the implementation of SDM in mental health settings (Gurtner et al., 2021; Shepherd et al., 2014; Slade, 2017), research within the Swedish context has primarily focused on the broader conditions for user participation in CIP (Andersson et al., 2023; L. Nordström et al., 2023). However, there remains a need for research specifically examining the prerequisites for implementing SDM as a structured and sustained approach to user involvement in multi-agency care planning. To develop context-sensitive implementation strategies, previous studies underscore the importance of exploring the perspectives of staff actively involved in CIP (Andersson et al., 2023; Jones et al., 2021). Hence, this study investigates how staff describe their current CIP practices in relation to

SDM principles and explores their perceptions of the organizational and behavioral conditions required to effectively normalize SDM within routine CIP processes in Sweden.

Theoretical framework

In this study, the normalization process theory (NPT) (C. May & Finch, 2009), was used as a theoretical foundation for data analysis. NPT is specifically developed to explore various mechanisms of behavior and actions that are important in the implementation of complex interventions, making it particularly relevant for examining the conditions for integrating SDM in the CIP process. The NPT consists of four constructs: coherence, cognitive participation, collective action, and reflexive monitoring, which help to illuminate how new practices are understood, engaged with, enacted, and appraised by those involved. *Coherence* refers to the processes that individuals or the organization undergo to create an understanding and awareness when implementing a new routine, in this study, SDM in the CIP process. It focuses on how well the staff comprehend the new practice and how they compare it to the current way of working. *Cognitive participation* addresses how individuals engage in the new routines and what motivates them to perpetuate these changes. *Collective action* focuses on the practical work performed by individuals and the organization to establish the new way of working. This study delves into the conditions for staff to organize and structure their work processes in alignment of SDM-CIP. *Reflexive monitoring* relates to evaluation and is excluded from the current study as the onset of the implementation process is performed.

Although the NPT is typically applied to examine what people do and how they engage in the implementation of new practices, its relevance in this study lies in its ability to explore both current practices and the conditions that may shape future behavioral and organizational change. In the context of existing SIP practices, NPT provides a framework for understanding how staff conceptualize, engage with, and enact coordinated care planning across organizational boundaries (C. R. May et al., 2018).

Given the study's focus on the integration of SDM into the SIP process, NPT offers a useful framework for supporting the analysis of staff understandings, interpretations, knowledge, and motivation, conditions that influence how new practices are made meaningful and potentially adopted. In this regard, the framework is particularly suited to exploring mechanisms of action rather than observable actions; that is, the psychological, social, and contextual processes through which behavior change may occur, and the perceived conditions necessary for such change (Michie et al., 2021).

By applying NPT at this early, exploratory stage, the study seeks to advance our understanding of the complexity involved in integrating SDM into SIP. Using NPT as a theoretical lens enables the identification of both structural and

relational challenges, as well as facilitators, which may influence the implementation. These insights can inform the development of more targeted and contextually grounded implementation strategies within mental health and social care settings (C. R. May et al., 2018).

Methods

This study was conducted within the frame of the national research program “UserInvolve” (Markström et al., 2023) which aims to investigate and develop strategies for SU involvement in mental health and social care. The program focuses on SU involvement at the individual-, organizational- and system level, and is characterized by co-production processes involving researchers, welfare actors and SU organizations.

Setting and participants

Three regions in Sweden participated in the project. In each region, one psychiatric care unit (operated by the regional health authority) and one municipal mental health service unit were selected to serve as test environments for the development, implementation, and evaluation of the intervention SDM-CIP. These environments served as real-world settings for iterative learning, adaptation, and the development of implementation strategies aimed at supporting the future introduction of the intervention under routine conditions. These six units were involved throughout all preparatory phases of the research project, including stakeholder analysis, staff training, the preparation for the implementation of the intervention.

To facilitate recruitment, service managers assisted in identifying staff members for participation in focus group interviews. A purposive sampling strategy was employed (Creswell & Creswell, 2017) to ensure the inclusion of participants with relevant experience in CIP. In total, 18 participants were recruited across three focus group comprised 7–8 participants, as outlined in [Table 1](#). The focus groups were deliberately composed to encompass staff from both regional and municipal organizations with diverse work and educational experiences. This composition aimed to mirror the typical interprofessional nature of the CIP process. See [Table 1](#) for the characteristics of the included participants.

Data collection

Between October and November 2022, three focus group interviews (Kitzinger, 1994) were conducted and facilitated by KG, PA, and AG. Focus group interviews lasted approximately for two hours and were audio-recorded and transcribed verbatim. Informed consent was obtained orally and recorded,

Table 1. Staff characteristics ($N = 18$).

Characteristics	Subgroups	Number of individuals
Focus group 1		4
Gender	Female	3
	Male	1
Mental health service context	Region based psychiatric care services	0
	Community based social support services	4
Occupation	Care administrator	1
	Social service worker	2
	Housing supporter	1
Focus group 2		8
Gender	Female	7
	Male	1
Mental health- service context	Region based psychiatric care services	2
	Community based social support services	5
Occupation	Nurse	1
	Rehabilitation coordinator	1
	Occupational therapist	1
	Service developer	1
	Peer supporter	1
	Unit manager	3
Focus group 3		6
Gender	Female	6
	Male	0
Mental health- service context	Region based psychiatric care services	4
	Community based social support services	2
Occupation	Counselor	4
	Social service worker	2

and all participants were informed that they could withdraw their consent to participate at any time. Ethical approval was granted by the Ethical Committee in Stockholm (ref no. 2020-00584).

The discussions were initiated by introducing the CIP process integrated with the key components of SDM (Knutsson & Schön, 2020) by means a PowerPoint image of [Figure 1](#). We assumed that this stimuli material would spur in-depth discussions on the perceived value of SDM in CIP for their own professional practice and for the SUs, on how SDM-CIP differed from current practice and on factors in their contexts that could hinder or support implementation.

Data analysis

Data were analyzed using qualitative content analysis (Graneheim et al., 2017). An abductive approach was applied, incorporating both inductive and deductive methodology at different stages of analysis, as described by (Graneheim et al., 2017). Initially, the analysis was conducted inductively to stay close to the empirical material, while later stages incorporated a deductive application of theoretical constructs derived from NPT (C. May & Finch, 2009).

The analyses started by reviewing the data repeatedly to achieve a sense of the whole. Using an inductive approach, the first and last authors identified meaning units in the transcripts that were relevant for the study aim and

Table 2. Operationalizations of selected constructs and underlying components of NPT.

Coherence How do staff define and comprehend SDM enhanced CIP	Cognitive participation What inspires and hinders engagement and commitment of involved actors in SDM enhanced CIP	Collective action How will the work connected to SDM-CIP get done?
Differentiation: What distinguishes SDM-CIP from current CIP work and other meeting forms?	Legitimation: Do staff regard SDM-CIP as right and needed? If yes, how do they legitimize it?	Interactional Workability: Does SDM-CIP “fit” the general practice? What factors promote or hinder performing the tasks required?
Individual Specification: What are staffs’ understandings of their responsibilities in relation to SDM-CIP?	Activation: How is a community of practice built and sustained?	Skillset Workability: Do the actors to be involved in SDM-CIP practice have the right competencies and training?
Internalization: How do staff perceive the value of SDM-CIP for own their work		Contextual Integration: Are organizational support and resources sufficient for conducting SDM-CIP?

assigned them with codes. Following this initial analysis, the research group determined that NPT provided a suitable theoretical lens for further interpretation of the data, particularly in relation to understanding mechanisms that shape behavioral and organizational change in the context of implementing SDM within CIP. A preliminary analytical scheme was then developed, based on the NPT, focusing specifically on three of the NPT constructs: *coherence*, *cognitive participation*, *collective action*, along with a number of their underlying components. The choice of both core- and underlying dimensions considered relevant as predetermined analytical categories and subcategories was discussed in the research group, as were the initial operationalizations that would guide the next, deductive, step of the analysis.

The first and last authors independently sorted the inductively derived codes into the NPT constructs. The middle authors reviewed the preliminary categorization to provide analyst triangulation (Malterud, 2001). During this process, the analytical scheme underwent minor revisions until consensus was reached on a final version with which the analysis could proceed. No codes that did not fit into the analytical scheme were deemed relevant to include in the final analysis. See Table 2 for operationalizations in the form of guiding questions for analysis, of selected constructs and underlying components of Normalization Process Theory. The findings were continually discussed within the research team to refine and clarify emerging descriptive themes within the data, See Table 3.

Findings

The findings section is structured in accordance with the three descriptive themes that analytically have been derived from the data with guidance from the selected NPT constructs and underlying components as outlined in Table 3. The names of the underlying components are italicized and are

Table 3. Themes derived from normalization process theory constructs and selected underlying components.

NPT construct	Descriptive themes	Selected underlying NPT components
Coherence	<i>Shared and varied perceptions of SDM in CIP</i>	Differentiation Individual specification Internalization
Cognitive participation	<i>Cautions commitment to making it work</i>	Legitimation Activation
Collective action	<i>Challenging conditions and potential openings</i>	Interactional workability Skillset workability Contextual integration

discussed along with citations from participants that are specified with numbers of focus group interviews (FGI 1–3) and participants (P 1–8). The findings underscore the considerable cognitive and behavioral adjustments required from staff across various roles, managers, and policymakers, individually and collectively, to effectively normalize SDM within CIP processes in practical settings.

Coherence – shared and varied perceptions of SDM in CIP

The first construct of NPT - *coherence* - emerged as a prominent theme highlighting the sense making work required for successful implementation. It emphasized the importance for staff involved in CIP-processes to collectively make sense of key aspects: sharing the same understanding about the principles of person centeredness, distinguishing between SDM-CIP and their current CIP approaches, and determining the value and their willingness to integrate SDM-CIP in their work routines. Here, perceptions that relate to these sense-making elements are connected to selected components of *differentiation*, *individual specification* and *internalization* from the NPT-framework.

Regarding the underlying component of *differentiation*, varying perceptions of how an SDM-enhanced CIP (in the sense of improved) process would differ from the current CIP work were identified.

Participants frequently highlighted areas for improvement in current practice, often pinpointing aspects that require strengthening to achieve SDM-characterized CIP practice. In these descriptions, they often articulate the core components of SDM-enhanced CIP, illustrating some degree of comprehension of the new approach and their ability to differentiate it from current practice. For example, an important feature of SDM-CIP is its emphasis on being viewed as a process, to a greater extent than is usually the case, rather than a meeting. However, even though focus group participants expressed an understanding of CIP as a process, a general lack of process-oriented thinking among staff was evident in their descriptions of how CIP was performed without the thorough preparation and follow-up work that characterizes

SDM-CIP. In contrast to the features intended to be achieved by using the SDM-CIP form, participants described how the information provided in the invitations was often scarce, the purpose unclear, and the agenda not specified, which meant that those attending the meeting, both professionals and SU, had little control over what might come up during the meeting.

Even in cases where the exchange of information between professionals has been sufficient, a lack of anchoring with the SU was commonly observed. Sometimes CIP was initiated without the knowledge of the SU, which was described by a nurse as “a deviation” (FGI 2, P 1) and, as such, not compatible with an SDM enhanced CIP process.

Sometimes, some professionals were invited to CIP meetings without the SU’s knowledge so that the SU was “surprised by unfamiliar faces” (FGI 1, P 3). Many comments indicated that participants understood that CIP work, characterized by SDM, requires careful preparation, where the invitation specifying the invited participants and the agenda are designed in consultation with the SU, and how deviations from what has been agreed risk damaging the trustful relationships.

If the SU was not involved in the development of the agenda, the uncertainty of what will come up in the meeting created fear and uncertainty. In the following quote, a member of staff notes how this can be overcome; a description that is consistent with SDM in CIP:

It has to be clear to the user and to us what is going to be discussed at the meeting. Then it will not be quite as scary for the user, which they can sometimes feel if they don’t know. (FGI 1, P 3)

Furthermore, SUs were often compelled to make decisions about interventions without the opportunity, which would be granted by following the SDM in the CIP process, to be well informed or to reflect prior to the meeting. As one counselor puts it: “It’s more of a presentation of different things and then you get ‘what do you think about it?’”. (FGI 3, P 3)

According to the participants, a lack of process thinking leads to an over-emphasis on quick solutions and allocating responsibilities, without leaving room for reflection and deliberation, either by the SU or by the professionals. This problem is reflected in the following quote:

Usually everyone is very focused on getting to a solution instead of maybe stopping along the way . . . You can’t solve all problems and concerns in one sitting, but you have to do a follow-up CIP in a month or 3 months. (FGI 1, 1)

In terms of follow-up, which is a crucial component of the SDM-CIP process, several shortcomings were identified. A well-documented plan was often missing. And even when such a plan existed, staff rarely read the documentation from previous CIP meetings, so there was a lack of focus on following up on what previously had been discussed and decided. Instead, new issues kept

coming up, creating confusion for SUs and making it impossible to assess success and goal attainment. These experiences are reflected in the following quotes:

... then you just do it in a new way and don't take into account the goals that were set in the previous CIP... The user gets very confused because you start talking about something completely different. (FGI 2, P 6)

And how do you know that things have improved if you have nothing to compare with? (FGI 3, P 4)

A core value in the SDM enhanced CIP process is that the CIP should be seen as a tool for the SU rather than for the staff. Participants expressed an understanding that the professionals' focus should be on creating a safe and responsive dialogue environment for the SU. However, they described how the CIP was instead perceived and used as a tool for the staff, in order to bring other professionals to the table and "put pressure on each other" (FGI 1, P 4) to take responsibility for meeting the SU's needs:

Many people think that a CIP is a meeting with different authorities. Where the authorities say what they think. I think it is because they have not really understood the meaning of CIP. They haven't realized that it's the user's meeting. ... (FGI 3, P 5)

The findings indicated that professionals' understanding of their own roles and responsibilities in CIP processes varied widely. In the current analysis, the component of *individual specification* involves how staff define what they themselves need to know and do in order to achieve the principles of SDM-CIP.

While some expressed awareness that offering a CIP is mandatory when a need for coordination around a person is identified and that the SU has a statutory right to CIP, they also emphasized that many colleagues did not have this understanding. This variation in understanding meant that the fulfillment of SUs' rights was person-dependent. As reflected in the following quote:

When I see a need, I usually tell the user, "do you know that you have a right to a CIP." But I don't think it's generally known, so it is dependent on the individual caseworker. (FGI 1, P 2)

Similarly, it was noted that many professionals did not seem to consider the fact that they were obliged to attend when called to a CIP. Many wanted to change the meeting time or send someone other than the person who had been called, which often led to a decrease in the quality of the process.

Participants who understood the importance of CIP acknowledged the responsibility of staff to inform and motivate SUs about CIP. As noted by a rehabilitation coordinator: "We have to inform people that it exists. We have a huge responsibility" (FGI 2, P 6).

In the current analysis, the component of *internalization* involves how participants perceive the potential value of SDM-CIP for their own work. From descriptions of the lack of information sharing before CIP meetings, it was clear that participants recognized the value of an SDM-enhanced, carefully prepared CIP process, not only for the sake of the SUs but also for themselves. They expressed feelings of insecurity when going to meetings without knowing what would be discussed, who will be present and what their role will be in the meeting. The following quote by a unit manager highlights how staff can feel uncomfortable in front of each other *and* the SUs, and how the quality of CIP meetings is affected negatively.

I want to know what we should talk about? What will it lead to? Who will be involved? What are the roles of the people who will be in the meeting? I think you need those conditions when you go into something so that it feels a bit safe and you know why I should be there. (FGI 2, P 1)

Cognitive participation – cautious commitment to making it work

The construct of *cognitive participation* involves the relational work that staff may do to affect the engagement of various actors in SDM-CIP. In the findings, perspectives that relate to factors that inspire, support or hinder engagement are connected to selected components of *legitimation* and *activation* from the NPT-framework.

The *legitimation* component relates to whether participants believe that the intervention is right and necessary and includes statements reflecting both active support and those reflecting barriers to, or lack of buy-in for, working practices characterized by SDM-CIP.

When participants reflect on the value of well-functioning CIPs, they highlight the very core values that the SDM-enhanced CIP process aims to support revealing a conviction that such an approach is necessary to live up to the principles and legislation of CIP. They talk about person-centered aspects such as starting from the person's specific needs rather than focusing on interventions at too early a stage. They also talk about recovery-oriented principles, such as focusing on strengths and opportunities instead of focusing on deficits:

But it's this whole thing of trying to get hold of what it is that might be possible. Is it possible to go deeper into that?" (FGI 1, 3)

They discuss CIP from a rights perspective and argue that well-executed, clearly structured CIP processes are necessary to meet the requirements of equal, person-centered care. As a problem, they highlight how the integrity of SUs can be violated in CIP meetings if they do not carry out preparatory work *together* with them, something that is a core principle of SDM-CIP. As noted by a nurse:

This is something you should discuss with the patient beforehand. How much do you want to talk about? We check everything out together and clarify these things. You [the SU] may not want to tell them at all. It becomes offensive in a way [If topics not agreed upon are brought up]. It's very important. (FGI 2, P 1)

However, there were also perceptions that prevailed among staff that prevented a commitment to greater SU involvement in CIP. Participants spoke of the tendency of staff to think that “we know best” (FGI 2, P 1) and to want to assume a position of power. Participants observed that staff often relied more on documentation performed by other professionals than the SU's own statements.

A frequently discussed problem with CIP meetings, which contributed to low motivation for initiating CIPs, was that much of the focus of the professionals was on pointing the finger at each other when it came to responsibility for providing interventions, and how such conflict behavior led to the SU being “held hostage” (FGI 3, P 4), or “caught in between” (FGI 3, P 4). At the same time, concerns were expressed about “treading on each other's domains” (FGI 3, P 3). There was great sensitivity about experiencing, or giving the impression to other professionals, that “orders were being placed” (FGI 2, P 1), i.e. that one professional had decided in advance that another service provider's intervention was desirable.

In reflecting on the SDM-enhanced CIP process, which includes having pre-meetings with the SU to ensure that the SU is well informed about the interventions given by their own service as well as those of other services, participants expressed concern that this might be perceived as territorial invasion by professionals from other organizations. The full transparency inherent in SDM-CIP therefore hindered buy-in:

You are very careful about what you say to users. You don't want to step on anybody's toes. I don't want the social worker to come to the meeting and then have some kind of argument with the user because the user is asking for something they can't get from the council. (FGI 3, P 5)

In accordance, they were concerned that a SDM-CIP process, which invited greater SU influence, and ensuring that the SU was well informed and prepared before CIP-meetings, risked raising hopes in the SU which could not be met, or that plans proposed by the SU themselves might fail. This they feared could “kill the SU's motivation” (FGI 3, P 3) and required confidence in the SU's ability to “deal with such information” (FGI 3, P 4) without taking it as a promise. These concerns are expressed in the following quote, which also reflects a commitment to the sharing of decision-making power that is a requirement of SDM in CIP:

You have to dare! If you ask the question “What is most important to you? Then you have to be prepared to work on the things that the user thinks are most important. Then you can't have too much of your own ideas about what would be best. When you ask that question, you have to be able to deal with it. (FGI 3, P 3)

To protect SUs from disappointments and interorganizational tensions, many suggested holding pre-meetings among staff members before involving the SU. These meetings aim to clarify responsibilities and plan interventions beforehand, thus avoiding conflicts among professionals and unrealistic expectations from the SU. However, this approach reflects a lack of commitment to the SDM-CIP process, which assumes equal preparation by all parties and precludes staff from discussing the case without the SU present.

When identifying areas for improvement in their CIP practice, participants highlighted procedural changes largely depending on organizational factors and resource availability. Yet, they also proposed improvements based on past successes and suggested future actions within the sphere of influence of their work units. These actions centered on fostering relational aspects such as team building, collaboration, role distribution, knowledge exchange, and attitude shifts toward other professionals as well as to SUs.

As such, the component of *activation* focuses on how staff can support SDM-enhanced CIP practice, going forward, and how a community of practice, together with professionals in various roles as well as with SUs, can be built and sustained.

Many suggestions concerned putting more effort into the preparatory work, which, as previously noted, is a basic principle of SDM-CIP. Invitations need to be more explicit and there is a need to ensure that the right people are invited to meetings. Not least, it was suggested that there should be more focus on preparation together with the SU, where the SU can specify the key issues to be discussed and begin to reflect on their needs and wishes.

There was a demand for clearer structures for CIP to build a common practice across organizational boundaries.

Consistent with the SDM-CIP process, it was suggested to establish follow-up dates during meetings to ensure coherence. Participants sought clearer managerial guidance and local policies delineating responsibilities and procedures. They also emphasized the necessity of regular cross-organizational conferences to understand each other's activities, foster acquaintance, and build teams.

Many suggestions for improvement centered on a good division of roles in CIP meetings, avoiding "sitting on two chairs." It was emphasized how meetings with a designated leader and someone to take care of the documentation allowed other professionals to focus on the substantive issues. They also shared positive experiences of meeting leaders who had no personal interest in the issues, which created a relaxed and respectful climate of dialogue:

Then it becomes very uncharged. Because you have no part in the case yourself, but you distribute the word and make sure that the user gets to speak and that everyone gets space and room. And have confidence in that. . . . It worked very well and became very relaxed and respectful. (FGI 2, P 2)

In regards to the division of roles and which professionals should attend CIP meetings, good experiences were also highlighted in terms of ensuring that participants had decision-making powers so that things could be “solved at the table” (FGI 2, P 6). As was often the case, there was a shortage of people in these roles, and the service representatives who were present had to “take the issue further” promising to come back later, but which meant that many issues were left unresolved.

Regarding attitude adjustments, emphasis was placed on eliminating “territorial thinking” (FGI 3, P 7) among professionals, promoting unpretentiousness, and encouraging open dialog about interventions. Municipal staff often observed hierarchical organizational structures in the regions, with power imbalances hindering collaboration. Doctors were noted to hold significant legitimacy, sometimes irrespective of their familiarity with the SU’s problems, leading to detrimental “power games” that overlooked the SU’s needs. Conversely, in line with SDM-CIP principles, some acknowledged the importance of valuing the perspectives of frontline staff, such as carers and residential supporters, who despite their less prestigious roles in interprofessional teams, might be the ones who knows the SU best.

Moreover, it was emphasized that attention needs to be paid to their own attitudes toward SUs and to be more inclined to trust SUs’ ability to assess their needs and wants. As one participant noted:

Of course everyone has knowledge about themselves and what makes them feel good. But I think we have a lot of work to do! Dare to trust! It sounds completely crazy to have to state this. Trust people’s own judgement! (FGI 3, P 5)

Thus, a change in the relationship between staff and SUs, where staff trust and dare more, is suggested as an important factor in implementing SDM in CIP.

Collective action – challenging conditions and potential openings

The construct of *collective action* involves the operational work people can do to enact a set of practices. In the findings, this construct synthesizes perspectives relating to conditions for realizing the practice of SDM-CIP and are discussed as related to the underlying components of *interactional workability*, *skillset workability*, and *contextual integration*.

Conditions that affect whether SDM-CIP ‘fit’ the general practice determine the *interactional workability*. This component examines the supporting and hindering factors, within and between organizations, that influence the concrete actions of SDM-CIP, i.e. how SDM-CIP fits into current systems, processes, and workflows.

Many comments related to the fact that existing procedures and systems *did not* support the transparent exchange of information and decision-making and good preparatory work that characterize SDM-CIP. For example, different

organizations had different digital systems or varying access to correspondence and documentation:

Our system is called “cosmic link,” we have contact with the region. It can be a bit strange because not all the administrators have access. Only certain people have that access and then it can be a bit difficult when they call to a CIP. Then it’s more like care planning, but it’s really the same thing. And then it gets a bit strange sometimes when we don’t have the same system but you have to call or you have to look for a case worker. Also, a lot of people get involved when they don’t have to. (FGI 2, P 2)

The systems also did not allow for digital signatures for approval or decisions at the meeting itself. Signing was a cumbersome process, with documents having to be passed around to different participants before or after meetings. The fact that the processes were so “cumbersome” sometimes made them “reluctant to initiate CIP (FGI 2, P 3).

Participants from the municipal services observed how cultures differed between organizations, observing that regional staff were less inclined to engage in tasks vital for supporting effective CIP processes. While municipal staff demonstrated flexibility and willingness to personalize processes, such as providing transportation or conducting meetings in SUs’ homes, regional staff exhibited less commitment. It was remarked that they frequently neglected to respond to communications or attend meetings, sometimes “failing to show up altogether” (FGI 2, P 2).

As previously mentioned, CIP was typically initiated reactively during acute SU situations rather than being used preventively to avert crises. This was noted to be due to the complexity of CIP and the varying levels of professional commitment. These urgent calls often resulted in unavailable professionals, leading to representatives unacquainted to the SU or lacking decision-making authority being sent instead.

According to the SDM-CIP principles, pre-meetings are ideally held together with the SU, contrary to the strong preference of some participants for exclusively professional pre-meetings. This prompts inquiry into the feasibility of eliminating “staff-only” pre-meetings within existing frameworks. Nonetheless, some argued that user-absent pre-meetings were *not* needed with effective routines and structures in place, implying that SDM-CIP principles can be adhered to with supportive organizational conditions.

As two participants observed:

If there have been well-functioning, good CIP meetings, you don’t need to have a pre-meeting [without the user]. You just go. There is a good organization of the meeting and there is a clear invitation. It is clear what the meeting is about. Then, when I go there, I know what I can contribute based on my role. (FGI 2, P 8)

Some participants also described creative solutions to barriers to current practice, demonstrating a willingness to work in accordance with the principles of the SDM-CIP. For example, provided printed copies of

documentation to SUs were recommended, in order for the SU having access to the same documentation as the participating staff, without administrative delay.

The component of *skillset workability* relates to whether staff have the right skills and training to carry out SDM-CIP. It includes comments on confidence and skills, or lack thereof, among themselves and with other actors within and outside their own organizations. Many comments referred to a lack of knowledge about CIP, both among themselves and their colleagues. They described how the implementation of CIP processes was dependent on individual professionals' varying levels of knowledge, and how staff uncertainty about the process contributed to a general resistance to CIP. As one participant put it:

They get really scared, the care staff, when they have to go to this meeting, "oh my God," and they want to change shifts." The way it is now, unofficially, there are a few people who just do that every time. You can't have that. But I know there are others who say, "How do you do it? What should I do? Can I really call this person? Should I document this?" (FGI 2, P 6)

They expressed how the uncertainty of the staff led to uncertainty for the SU. They pointed to a lack of consensus and a desire for a common knowledge base across organizational boundaries. Some suggested joint cross-organizational training initiatives. High staff turnover contributed to varying levels of knowledge and suggestions were made for easily accessible training materials and regular courses.

It was clear that it was not just knowledge of the CIP process and how to chair meetings that was needed, but that there was a general need for better knowledge of the range of interventions available in their own organization and how the other commissioner was organized in the region where they were collaborating with CIP.

The final component involves conditions for *contextual integration*, examining whether organizational support and resources are sufficient for conducting SDM-CIP.

It was evident that many of the problems associated with CIP were due to a lack of resources in the municipalities and regions where the services were located. Budget constraints and lack of time to implement the CIP processes as carefully as desired was often expressed. Participants also described how a lack of regular staff and staff turnover made it impossible to provide the continuity needed for coherent, user-centered processes. As one participant expressed, "That's just the way this world is . . . If it happens to be stable, it's a happy coincidence" (FGI 2, P 6).

Moreover, participants discussed the advantages and disadvantages of conducting CIP activities in smaller municipalities. As an advantage, the proximity to other municipal organizations facilitated collaboration:

... the fact that we have the advantage of having close access to each other. I mean that both housing support workers, treatment staff and social workers in all different areas are under the same roof. (FGI 1, P 4)

The disadvantages highlighted were a more limited range of services and how it is more complicated for both SUs and staff to have meetings with regional organizations. Although it was emphasized that physical meetings were superior to digital ones, it was argued that the possibility of digital meetings would facilitate logistics and enable meetings that would otherwise not be held at all. However, no such systems were yet in place.

Discussion

Principal findings

This study examined how staff describe their current CIP practices in relation to SDM principles and explore their perceptions of the organizational and behavioral conditions required to effectively normalize SDM within routine CIP processes in Sweden. The principal finding through the lens of the NPT-construct coherence is that, despite divergent understandings and perceptions of how CIP is performed at present time, informants were able to differentiate SDM CIP from current practice. For instance, they recognized the value of careful preparations, of creating a safe and responsive dialog environment and understanding CIP as a process.

The principal finding through the lens of the NPT-construct *cognitive participation* is that staff have relational conditions that hinder engagement in SDM-SIP. However, participants were able to point out factors that could inspire and support the overcoming of such hindering conditions. For instance, territorial thinking and hierarchical relations within and between different organizations were suggested to be met with regular cross-organizational conferences, team building, and neutral meeting leaders. Even though there was concern about having to deal relationally with SUs' possible disappointments, the need to establish a more trusting approach toward SUs was underlined.

The principal finding through the lens of the NPT construct *collective action* is that even though conditions for enacting SDM-CIP are challenging, participants are able to point to different sets of practices for strengthening them. Ill-functioning digital systems, cultural differences between organizations and lack of regular staff could, to some extent, be overcome with awareness raising of available interventions. Joint cross-organizational training initiatives and easily accessible training materials and regular courses are examples of operational work that could be done to implement SDM-CIP.

Comparisons with previous work

In line with previous research on CIP (Matscheck & Piuva, 2022a), it was apparent that the SU was often not seen as the central person in the process needed to characterize SDM-enhanced CIP work. The present results clarify a varying understanding of the meaning of person-centered, recovery-oriented values such as autonomy and full participation. While these values were emphasized, there was an underlying concern that, by inviting participation and joint deliberation, unrealistic expectations were created in vulnerable individuals. A varying degree of confidence in SUs' abilities to define their own needs and to deal with disappointment was recognized. In harmony with previous studies on user participation (Grim, 2019; Mol, 2008), the analysis highlighted value conflicts between care logic and empowerment. This issue needs to be addressed to create conditions for real influence and SDM in the CIP process.

As also reflected in the previous research, inter-organizational collaboration was characterized by tensions that made person-centeredness and user involvement difficult Matscheck & Piuva, (2023). The CIP meetings were used as a tool for service providers to bring each other to the table, where the meeting was an opportunity to put pressure on each other to take responsibility for interventions. On the other hand, there was an anxiety about overstepping each other's territory, which prevented transparency in communication with SUs. Territorial thinking, which is linked to both structural and cultural conditions (Axelsson & Axelsson, 2009; E. Nordström et al., 2016), was in our study an obstacle to effective collaboration around the individual that needs to be challenged by person-centered thinking. A willingness to compromise and give up parts of one's organizational or professional territory in favor of better overall solutions can be crucial.

With regard to these problems related to values, understanding, and relationship, it was emphasized that staff in the units have a responsibility and some scope of discretion to be able to create better conditions for the implementation of CIPs characterized by SDM. For instance, they can challenge attitudes, establish effective roles, and develop local policies. This aligns with the previous findings (Knutsson & Schön, 2020; Matscheck & Piuva, 2022a), which also highlight a lack of process thinking in the CIP process. Many of the informants in our study perceived CIP as a meeting rather than a process, leading to insufficient focus on preparation and follow-up.

Moreover, in terms of systems and workflows, staff faced numerous barriers that hindered their ability to work according to the principles of SDM-CIP. These barriers were often beyond their control. Key findings were that infrastructure needs to be in place for intra-organizational collaboration and that resources in terms of time, staff and administration need to be directed toward supporting SDM-CIP. As demonstrated in a previous study investigating

manager perspectives on SDM-SIP (Andersson et al., 2023), there was a desire for cross-organizational training to build a common knowledge base. Previous literature points out how the kind of learning that is required in the transition toward a person-centered approach does not merely involve new technical approaches to delivery of care and support but ethical acknowledgment of the rights of the individual (Smith, 2016). The connection between reflective practice, person-centeredness, and practice development is underscored, highlighting the importance of deliberate reflection on practice in order for practitioners to deepen their understanding of their own beliefs, attitudes, values, and motives and become aware of the power that is embedded in their roles (Scholl et al., 2018; Smith, 2016). These findings underscore that the successful implementation of SDM-CIP is contingent not only on individual competencies but also on broader organizational readiness and ethical alignment. Embedding SDM within routine practice requires a shift in professional culture—one that supports critical reflection, acknowledges power dynamics, and embraces person-centered values as a normative foundation (Slade, 2017). Such transformation demands coordinated efforts at multiple levels of the system, including leadership engagement, policy support, and investment in long-term capacity building.

Methodological considerations

Using a stimuli material in focus group interviews always poses the risk that participants will adapt their answers to make them consonant with the presented material and with each other (Kitzinger, 1994). In recognizing this risk, we took care to pose probing questions that would open up to more fruitful discussions.

Combining deductive and inductive approaches in analyzing the data allowed for a theory-led analysis without needing to force data into a rigid theoretical framework (Tazzyman et al., 2017).

Nonetheless, the influence of the stimuli material cannot be entirely ruled out, as it may have subtly shaped participants' interpretations and constrained the emergence of divergent views. While efforts were made to encourage critical reflection and alternative perspectives, the group setting itself can reinforce normative agreement, potentially masking dissenting voices. Moreover, the dual use of deductive and inductive analysis, while methodologically robust, presents a risk of selective interpretation if not carefully balanced. These limitations highlight the need for reflexivity throughout the research process (Malterud, 2001), particularly when working with theoretically informed frameworks and group-based data collection methods. Employing analyst triangulation strengthened the credibility of the findings (Malterud, 2001).

Conclusions

Overall, the findings centered on concerns about making mistakes; about exposing users to liability and disappointment; and about overstepping boundaries in the absence of clear policies or sufficient know-how regarding CIP. These concerns reflect a broader uncertainty within professional roles when navigating complex, multi-organizational care contexts. Such uncertainty can create reluctance to fully engage in shared decision-making, particularly when the perceived risks of user autonomy are high. These findings underscore the importance of fostering a culture of inter-organizational learning, where staff feel supported in managing these challenges collectively rather than individually. Building this culture requires not only structural support – such as clear guidelines, joint training initiatives, and shared accountability frameworks – but also a fundamental shift in attitudes. Normalizing SDM in CIP practices entails moving beyond a protective stance toward users and instead cultivating a relational trust in service users' capacities to contribute meaningfully to their own care planning. This, in turn, calls for ethical and epistemic recognition of users as knowledgeable actors with legitimate authority over their own experiences and needs.

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Data availability statement

The data that support the findings of this study are available from the corresponding author [KG], upon reasonable request.

Ethical approval

The Ethical Committee in Stockholm approved the study (ref No. 2020–00584).

Use of generative AI tools

We have used Co-pilot, logged in through Karstad University, for slight language checks.

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