Implementing community mental health services in Sweden - organizational structure, inter-organizational cooperation and service delivery

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Introduction

The Swedish welfare state model is generally understood to display a set of common characteristics including generous social security benefits and high quality social, medical and rehabilitation services that cater for a variety of needs to practically the whole population. Income-related cash benefits and services would promote labour market participation and provide economic support enabling people to maintain about the same standard of living during periods when gainful employment was difficult or impossible. The fact that many needs of citizens rest with the welfare state distinguishes the Scandinavian countries from other countries where comparable needs are met by the market, the family or by means of co-operative arrangements (Anttonen and Sipilä 1996, Esping-Andersen 1990, Sainsbury 1994).
Such welfare regimes attach great importance to social and economic rights materialized into universal welfare services, that are broad in scope and that are intended to reduce inequalities. As has been pointed out by a number of scholars the Swedish model generalizes from social security benefits to welfare states and, hence, do not pay enough attention to health and social services (c.f. Carpenter 2000). In recent decades the Swedish model has in important aspects developed into a decentralised model, which implicate that decision-making in many social programs has been transferred from central to local levels in the organizational hierarchy. Local welfare agencies have been given more leeway in designing services and to develop modes of cooperation and networking with neighbouring organisations - and local level has also been given an increased economic responsibility for services that fall within the mandate of each agency. Drake (1999:36) who considers the Swedish model as the “maximum welfare state” contends that it constructs and maintains “a web of services aimed at the palliation and amelioration of individuals’ condition”.

Part of this picture is that welfare services are delivered by an array of agencies. The welfare system forms a landscape of different organizations, a labyrinth that is difficult to survey for clients and many times also for caseworkers. This landscape contains a lot of boundaries between organisations - boundaries that are constituted by legal, geographical, economic and other divisions. All in all, what we have is a highly “sectorized” system in which each authority can cope only with clients that fall within its purview - i.e., the client needs to fit in the boxes and compartments that are prerequisites of the organization. This picture is further complicated by the role that professionals play in health and welfare policies. Professionals within the field of community mental health services (CMHS) are the gate-keepers and arbiters to services because the outcome of services is to a large extent determined by the encounter between the patient (client) and the professionals (c.f Titmuss 1968, Bertilsson
Hence, the outcome of social policy reforms is contingent not only on cultural values and policy intentions. Implementation is also a function of organizational steering principles and professional ideologies - and as well work modes of the staff in each organizational field. Organizational processes, for sure, seem to be a missing link between ideas and practices in psychiatric services (Rosenheck 2001). Comprehensive local understanding of the needs in the community, coupled with a conviction that the method in question can deliver the anticipated solutions, can facilitate implementation in tandem with communication within personal informal networks (Greenhalgh et al. 2005).

In this paper we set out to discuss the implementation of the Swedish mental health reform of 1995 which signified an increased responsibility for the local municipalities to provide for social support and rehabilitation to persons with psychiatric disabilities. We focus on the organizational structure and social services provided by local welfare agencies. How were services organized and designed? What was the underlying rationale for service provisions and which were the dilemmas faced in order to support the target groups?

Norms and values guiding reforms in Swedish community mental health services

Up until the middle of the 1960s psychiatric care in Sweden was mainly hospital-based (Eriksson, 1989). The number of hospital beds per capita in state mental asylums was high in comparison with the situation in the rest of the Western world (Sjöström, 1992; Forsberg, 1994). In 1967 the responsibility for psychiatric care was decentralized from the state to the regional county health care organization. County councils were then expected to integrate the
organization of psychiatric and somatic health care within general hospitals and create psychiatric services in geographically defined catchment areas (Markström, 2003). Like many other countries turning away from institutional forms of care, Sweden began in the 1970s to move towards alternative forms for providing treatment for those experiencing mental illness.

It was not until the first half of the 1980s that mental hospitals began to be closed down. According to the then new Social Services Act of 1982 persons with mental problems would be given equal support in terms of housing, employment, vocational activities and psychiatric rehabilitation compared to other groups of disabled people (Prop. 1979/80:1). Such needs were in many places neglected and the actual definition of the target group covered in the legislation was unclear. This led to the establishment of a Psychiatry Commission in 1989 and a series of reports and recommendations which attempted to improve both medical and community psychiatry services (SOU 1992:73). The final report of the commission (SOU, 1992:73) firmly argued that people with severe mental health problems were to be regarded as disabled and hence entitled to social and disability services on the same terms as other disabled people. Another emphasis was the need for more inter-organizational cooperation between health and welfare agencies. Especially cooperation between the health care organisation and the social services, but also labour market authorities and social security administration needed to be more involved in the lives of mentally disabled people. User influence on the management and design of services was also urged for.

However, the reforms’ policy goals were rather vague. A number of ideological principles in phrasings like welfare, choice, normalization of the target groups’ living condition were described and paid tribute to in the preparatory work by the public commission and in the government’s proposition. One critical problem of the reform was the delineation and
definition of the target group. Who were the people addressed by the reform: a number of names and concepts were used: mentally ill people, people with long-term mental illness, people with mental disorders, psychiatrically disabled people etc. In the end the uncertainty and vagueness of the target group made it difficult to know how many persons that were affected by a new prospective legislation, which in turn made it difficult to anticipate the economic consequences. Such predicaments made the municipalities, the player on which the main economic burden would rest, very reluctant to accept the reform. When it was launched no substantial legislative changes were made in order to improve services and support. The existing social services law was seen as sufficient, except for some minor changes that were made. The preferred steering mechanism became the transfer of norms and economic directives. The government chose to invest in a time-limited economic contribution, with the aim of stimulating the development of community-based activities within social services in the municipalities. On the whole this led to the establishment of a huge number of projects in the municipalities – most of them initiated, operated and finalized by key enthusiasts and welfare entrepreneurs - in order to develop models of community-based care services. All in all, the whole planning process was propelled first and foremost by players at the nation state-level (policy shapers, state bureaucrats). Strong professional groups and the key providers – the psychiatric care organisation of the county councils and social services in the municipalities – were rather passive or reluctant in the planning phase. This created, in a second phase when implementation was to be carried out, a considerable leeway for the local players to take action and to design the mental health community services in their respective areas.

The Mental Health Care Reform of 1995 directed that the municipal social service system would develop new forms for providing residential, occupational and rehabilitation services
as well as improve inter-organizational co-operation. The county medical authority (specialized psychiatry) would limit itself to medical services and mobile psychiatric services to those in need of a round-the clock-treatment, while the tasks for the 290 Swedish municipalities were widened to encompass an array of services including residential facilities, work or activity, personal support etc. (Markström, Sandlund and Lindqvist 2004). Sweden organizes its municipal social services, including the needs-tested cash benefits under the Social Services Act of 1982. Such services must, according to the law, provide for a “reasonable level of living” and be given in relation to the local standard of living. As prescribed in the Social Services Act, the local social welfare authority must maintain an awareness of living conditions in the municipality for people with psychiatric disabilities. They are obliged to work cooperatively with the county-based medical care system as well as other public authorities (Socialstyrelsen 1998: 8) and to identify suitable methods with which to survey living conditions and participation in community life. It was legislated that municipalities must pay a fee for every day of hospital care for psychiatric patients that after three consecutive months were evaluated to be “sufficiently medically treated”. This would accelerate the discharge of long-stay hospital patients and provide economic incentives to develop new comprehensive services (Lindqvist 2000).

Beside the social service organisation in the municipalities, people with psychiatric disabilities additionally interact with a number of other welfare agencies, of which the public employment authority, the social security administration and the local health care centre (primary care) are the most significant. Local health care centres, which are supposed to be first-line helpers, for mentally ill people, seem to play a marginal role in the treatment of these people. The task of the public employment authorities (PEA) is to support unemployed people, or those who run the risk of becoming unemployed to participate in the labour market.
There are certain labour market programs that are especially targeted to people with work-related disabilities, like supported employment, subsidised employment, sheltered employment. In general it is required that the disabled person be “job ready” after having participated for a limited time-period in such programs. Persons with psychiatric disabilities are heavily underrepresented compared to other disabled persons that take part in such programs. The social security agencies are another key player involved in the lives of people with mental health problems. Long-term sickness and disability pensions (decided upon and administered by social security agencies) on the basis of psychiatric diagnoses is the second most frequent reason for allowing such benefits.

Disability services are also part of a social welfare landscape potentially useful for psychiatrically disabled persons. According to the Swedish Disability Reform of 1994 disabled people with “large and persistent difficulties to manage daily life” (including people with psychiatric disabilities) are entitle to additional services, of which personal assistance is the most known. The ten different services that were pointed out in the Law concerning Support and Services for Certain Groups of Disabled (LSS) and the Law Concerning Compensation for Assistance (LASS) are stated as precise social rights that the claimant can appeal in order to have the decision changed. Although persons with psychiatric disabilities are pointed out in legislation as a category eligible for such services, evidence tell that only a small fraction of psychiatrically disabled are allowed such services.

All in all, the Swedish community mental health reform was characterised by time-limited state subsidies to local agencies and by weak steering mechanisms in terms of distinct legislative measures. Strong commitment to transform norms and providing economic incentives at the local level was thought to act against such weaknesses. The shortcomings in
the county-based medical services system and the municipalities’ social services led to the appointment of a special national coordinator (in 2003) with the task to further investigate and to propose measures to improve conditions for persons with mental health problems. The conclusions made were that both specialised care and primary health care needed more resources if shortcomings in accessibility and quality of services were to improve. And social services in terms of housing, co-ordinated rehabilitation and meaningful leisure activities needed to be developed.

Implementing policies in a social welfare landscape of agencies

While policy statements of community-based services often have been phrased in normative and idealistic wordings, comparative studies have focused on problems related to implementation and practices such as trans-institutionalisation, inconsistencies in planning and inter-organizational co-operation and homelessness (c.f. Brown 1988, Goodwin 1997, Leff 1997). According to an ideal-type perception of implementation such processes may be successful to the extent that the specific policy goals are clear and based on proper theory about cause and effect. Local executive players must also be given legal measures to implement the program, which must be designed according to realistic expectations of the target groups’ behaviour. It is widely recognised that failure may occur when members of those organisations responsible for implementing public policies fail to comply with national policy directives (Van Meter and Van Horn 1975). Policy programs must also be given sufficient financial resources, be entrusted to committed organizations, skilled and motivated managers. One would expect difficulties to occur to the extent that policy programs counter-act each other (Mazmanian & Sabatier 1983).
A reasonable hypothesis is that the Swedish community mental health reform hardly met such preconditions as mentioned above because policy goals were open-ended and not very precise. The link between cause and effect was also unclear. The problem of translating research into practice certainly exists in mental health services and it is difficult to say what works for whom under what conditions (c.f. Lehman and Steinwachs 1998, Corrigan et al. 2001, Drake et al. 2008). A number of key policy programs seem not to be compatible with the needs of people with psychiatric disabilities: strong emphasis in labour market policies on the needs of employers, activation measures in social security and social assistance programs poorly adapted to the needs mentally ill people and health care politics prioritizing somatic care.

Given the fact that the Swedish welfare system is portrayed as a landscape of agencies with different mandates, target groups, rules and regulations different policy programs affect each other and might well be contradictory in certain aspects. It must be kept in mind that the Swedish welfare system is highly “sectorized”, i.e., several players and agencies act within the field of care and social services. It is within this organizational structure that persons with psychiatric problems encounter caseworkers in the helping system. Such contacts are especially arduous in case the client suffers from psychiatric disorder, social problems, poor social networks and unemployment simultaneously. Then many welfare agencies become involved, and the need for inter-organizational cooperation is large. Unless such cooperation takes place, the client tends to be endlessly circulated between agencies or to “fall between the cracks”. This is because each authority must cope only with categories of clients that clearly fall within its jurisdiction, which in turn mean that welfare workers also tend to specialize by attending to a limited number of client attributes perceived to be within their purview (Hasenfeld 1992, Lindqvist and Grape, 2000).
Hence, implementation must relate to a complex moral order of institutional values and aspirations on behalf of players within different organisational fields. Top-down steering and translation of national policy directives are difficult when local-level terrain is multi-faceted. Policy goals have to be reframed and reinterpreted. And implementation would idealistically require that locally situated agents translate national policy intentions. We agree with Martin Rein (1984, s. 40) in his statement that:

The terrain we need to cover is muddied. Social services are extremely difficult to define as a set of activities and tasks abstracted from their purposes. Specific activities are not merely neutral instruments of broad objectives: the activities themselves, and the way they are implemented, act to alter our intentions.

In order to identify the dilemmas and opportunities that occur in the field between policy intentions and reform outcomes, the relation between the organization and its surroundings are crucial. Welfare organizations are in many respects permeated (rather than created) by their surroundings, which provide them with certain structural traits and operational principles and determined modes of behaviour. But individual organisations must also adapt to a series of separate institutional sectors or orders with contradicting logics (Meyer 1994, Scott 1995). CMHS is in this respect an interesting field as it includes several organizations, among them the psychiatric care system, the social services and to some extent the authorities dealing with vocational rehabilitation (labour market authorities and social security agencies). According to, the logic of work life and public employment authorities, the client has to demonstrate his/her employability, if necessary by participating in various work-directed rehabilitation adventures. According to the logic of social services, applied by welfare bureaucracies, the situations-specific needs of the individual has to fit into the routines and procedures which are reconcilable with the legitimate mission of the authority. The third logic is that of psychiatric medicine, idealistically based on science, approved knowledge and evidence-based practices.
According to this the medical profession (psychiatrists) has the legitimate right to make important decisions about diagnoses, treatment and care interventions, something that others must comply with. Implementation must pay attention to such complex institutional orders when developing community mental health services.

Table 1. The institutional environment of community mental health services in Sweden.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Psychiatric care</th>
<th>Labour market authorities</th>
<th>Social security agency</th>
<th>Social services</th>
</tr>
</thead>
</table>

Translating policy intentions to local practices
The data that this paper is based on are written documents in terms of policy programs, action plans and evaluations from ten municipalities. A strategic sample was drawn which gave us ten municipalities of different character and size. We have 2 big towns 2 middle-size towns, 2 small towns, 2 sparsely populated areas (small municipalities) and 2 urban town districts. The number of inhabitants in these locations range from 7,000 to 120,000 people. Half of these locations had earlier had a mental hospital within the region, and six of them now have a psychiatric hospital clinic within short distance.

Table 2. Municipalities included in the study.

<table>
<thead>
<tr>
<th>Location</th>
<th>Geographic area</th>
<th>Inhabitants</th>
<th>Mental hospital earlier in the region</th>
<th>Access to psychiatric clinic</th>
<th>Level of ambition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Big town 1</td>
<td>North</td>
<td>100,000</td>
<td>Yes</td>
<td>Yes</td>
<td>Middle</td>
</tr>
<tr>
<td>Big town 2</td>
<td>South</td>
<td>120,000</td>
<td>Yes</td>
<td>Yes</td>
<td>High</td>
</tr>
<tr>
<td>Middle town 1</td>
<td>North</td>
<td>40,000</td>
<td>Yes</td>
<td>Yes</td>
<td>Middle</td>
</tr>
<tr>
<td>Middle town 2</td>
<td>South</td>
<td>30,000</td>
<td>Yes</td>
<td>Yes</td>
<td>High</td>
</tr>
<tr>
<td>Small town 1</td>
<td>North</td>
<td>8,000</td>
<td>No</td>
<td>No</td>
<td>Low</td>
</tr>
<tr>
<td>Small town 2</td>
<td>South</td>
<td>7,000</td>
<td>No</td>
<td>No</td>
<td>Low</td>
</tr>
<tr>
<td>Sparsely populated area 1</td>
<td>Mid Sweden</td>
<td>13,000</td>
<td>No</td>
<td>Yes</td>
<td>Middle</td>
</tr>
<tr>
<td>Sparsely populated area 2</td>
<td>North</td>
<td>13,000</td>
<td>No</td>
<td>Yes</td>
<td>Middle</td>
</tr>
<tr>
<td>Urban district 1</td>
<td>Mid Sweden</td>
<td>60,000</td>
<td>Yes</td>
<td>Yes</td>
<td>High</td>
</tr>
<tr>
<td>Urban district 2</td>
<td>South</td>
<td>12,000</td>
<td>No</td>
<td>No</td>
<td>Low</td>
</tr>
</tbody>
</table>

Secondary data were collected and interviews were conducted on each location with local politicians (chairmen of the boards of social services), managers in social service departments, middle-managers, caseworkers, representatives from psychiatric care organization and representatives from user-organizations. All in all, 93 persons were
interviewed. The study can be situated within the methodological tradition of case studies (Yin 2002). More precisely, we have conducted a multiple case study since we selected 10 municipalities. We rely on different sources of evidence and we also benefit from prior conceptual development within the field of welfare sociology, implementation and community mental health research.

Policies and ambitions

Implementing the reform became a different kind of enterprise in the municipalities. In locations with former mental hospitals the process started earlier than in other municipalities. Housing facilities were established to take care of patients when hospitals closed down. In such municipalities specific psychiatric services co-ordinators (*psykiatrisamordnare*), with extensive authorities, were appointed. They usually had an earlier work-history in the field of psychiatric care and they were now expected to be “local engines” or street-level policy entrepreneurs that got things accomplished (c.f. Petchey et al. 2008). In four of our municipalities such coordinators have, later on, become permanent caseworkers or middle managers. Data from our locations do not mirror any unified national practices in terms of level of ambitions and implementation strategies. To make it very simple, one could categorise ambitions and strategies in terms of *low status locations* and *high-profile locations*. In the former, which encompass five locations, support to the target group was not given priority; the target group’s needs were “squeezed” between the severely disabled entitled to support from LSS and the huge resource-demanding care for the elderly. Part of the problem seemed to be that the psychiatrically disabled was considered a weak group, with no strong advocates that could pressurize politicians and mobilize public support. The fact that *Small town 2* had “hidden” almost all members of the target group in private residential homes
outside the municipality indicates that the target group was assigned low status. Small municipalities in our sample seemed to have more difficulties than other locations to make the target group visible and to arrange support measures; scant resources had to be spent on other purposes.

High-profile locations on the contrary had strong advocates for the target group and caseworkers and managers with expert knowledge in the field. The field was prioritized and community mental health services were organized in separate units or departments. Services to the psychiatrically disabled were seen as a specific mission in their own right, and ought to be developed on its own premises. This was evident in Big town 2, Middle town 2 and Urban district 1. A common trait of high-profile locations is that they made efforts to develop common or at least co-ordinated goals and action plans with the county-based psychiatric care organization.

One interpretation of the fact that such differences exist is related to the absence of precise national policy directives. There were no external forces, except for rather vague and non-compelling statements in the social services law (*socialtjänstlagen*) that could enforce municipalities to develop high quality community mental health services. The field was left open for local traditions and conventional ideas and cognitive perspectives on behalf of caseworkers, managers and professionals. High profile locations indicated distinct ambitions to establish a new “mental health service culture” anchored in the normative ideals of the policy reform.

It was difficult to get hold of the policy content at the local level. Often general goal-descriptions were formulated in terms of “co-ordinated social and/or psychiatric
rehabilitation, meaningful occupational activities and leisure, strengthening the individual’s abilities to lead an independent life etc”. Information was rarely given how to operationalize such goals (Middletown 2). Only on one location (Big town 2) was it possible to see, in local policy programmes and action plans, how specific support measures were linked to general policy formulations.

One controversial issue seen from a local-level perspective was the role of government and central state authorities. In order to stimulate local players to take action and develop support measures subsidies and “stimulation grants” were given to those municipalities who applied and presented interesting and realistic developmental plans. Such grants were time-limited and destined to specific purposes prioritized by municipalities or county councils. Such “state-interventions” were appreciated by small municipalities with poor finances, but criticized by big municipalities that already had elaborated plans how to develop the field. Such interventions by means of “ear-marked” grants were seen, by the bigger municipalities, as an infringement of the principle of municipal autonomy. They also made developments a bit “shaky” since subsidies are temporary and must be finalized in due course.

On the nation-state level beds in psychiatric wards has decreased dramatically during the last decades. In 1967 Sweden had about 4.0 beds for every inhabitants, in 2006 the corresponding figure was 0.5 ( NOMESCO 2006). In parallel places in group residences have increased. In the late 1980s there was ca 100 such places; in the beginning of 2002 there was ca 8.000 places distributed among 850 group residences in the municipalities. On average 10 persons per unit, but in some cases as much as 25 persons were living in the same unit. (Socialstyrelsen 2003). Developments indicate that support also more and more is given in the users’ own dwellings, in terms of a diverse every-day support. 80 percent of all municipalities
had such support in the early 2000s (Socialstyrelsen & Länsstyrelserna 2005). Ordinary dwellings integrated in normal housing areas are also offered; in many municipalities supplemented by tailor-made out-reach support from a support team based in the same area (SOU 2006:100). Part of the picture is also the fact that private group residences have increased.

Persons with psychiatric disabilities are sadly neglected in terms of labour market participation: only one third of those who say they have such an impairment has an employment (AMS & SCB 2007: 107). The target group also have little access to labour market measures (compared to other groups of disabled people) - this is indicated by the fact that only 16 percent of people in sheltered employment has a psychiatric disability (Arbetsförmedlingen 2008). Occupational support in terms of drop-in centres is available in almost all municipalities. Structured activities oriented towards workplace introduction and vocational training is less frequent; this kind of support is arranged in slightly more than half of the municipalities. Evidence tells that users stay in such activities too long and that systematic methods in order to pass these persons on to regular jobs are missing. Individual placement support, designed according to place-then-train-principles, is even more uncommon.

Another ambition of the 1995 reform was to establish Case Management (personligt ombud) for psychiatrically disabled persons. National funding was offered to finance ten pilot projects in different parts of the country. Evaluations indicate positive effects in terms of a reduction of hospital days and high client satisfaction. This justified an expansion of case management programs (Björkman 2000, Socialstyrelsen 2004) and since the early 2000s, government subsidies were provided to all Swedish municipalities that established such programs. In 2006
there were about 300 active case managers whilst some 80 percent of all Swedish municipalities offered such services to people with severe mental illnesses. Although national policy ambitions encouraged municipalities to establish case management, such teams must nevertheless work independently vis-à-vis the regular social service organisations and other public authorities. The client was supposed to manage his/her case manager. The tasks of the case manager are normally to assist and represent the client in many different situations, not least in connection with his or her contact with authorities (Socialstyrelsen 2002, 2003).

Organizing community mental health services

Organizational design will certainly have an impact on service delivery. Municipalities in the sample did not reveal a clear pattern concerning the organization of support measures. Community mental health services sometimes were placed under individual and family services department (IFO), or under disability services department - or they form a special administrative unit of its own. Also part of the picture is the fact that half of the municipalities had changed the organizational structure since the reform was launched. In some cases the so-called psychiatric care coordinators were still “in the game”, but not in a role as welfare entrepreneurs. They were now integrated in administrative decision-making or management work or employed as regular caseworkers (Middle town 2, Sparsely populated area 1).

Experiences of organizing services to psychiatrically disabled people in small municipalities tell that it was difficult to develop specialized support measures. Support needed to be integrated in the sense that caseworkers must deal with broad target groups and support tended as well to be generally designed to suit broad groups of clients (Sparsely populated area1, Sparsely populated area 2). Psychiatrically disabled people run the risk to become
losers even if small resources were “pooled” and utilized in cooperative work modes. Experiences in middle-size municipalities build on specialization and a distinct conception of who belongs to the target group. Services were organized in special units, often on a long-term basis and designed along with established traditions, focussing the “historic” target group of psychotic persons. As time goes by this tended to cause problems as “new” groups enter the stage and claimed services, i.e., young people with neuropsychiatric problems, people with drug and alcohol problems combined with psychiatric illness, personality disorders. Since there are weak traditions of supporting such groups tensions appeared within the social service organizations (Urban district 1). These people needed help, but they often ended up in a no-mans land in the social welfare landscape. On one location a special work-team (grey zone group) was established with the mission to catch all clients that ran the risk to fall between the cracks because they would not fit into the boxes of welfare agencies. Big municipalities, on the contrary, organized services (including needs assessment and formal decisions on social rights) in separate independent units or in special units under IFO (Big town 1, Big town 2). Experiences in the big cities indicated that specialized services in separate units made services less vulnerable. If all the vital functions were arranged within the same unit this would make an omnipotent service organization that would stand firm to departments of care for the elderly and disability departments when competing for scarce resources. However, also such service organizations would have difficulties in coping with the “new” groups since their multi-faceted problems stretches over the borders of all social service units. The question of such target groups’ “domicile” caused tensions between subdivisions; and protectionism (dealing with the “historic” group) was seen as the easy way out.

Cooperation between psychiatric care organization and social services
Contacts and cooperation between psychiatric care organization and social services were well established in all locations. On the contrary, intra-organizational cooperation between subdivisions in the social service organization was more troublesome. Paradoxically, cognitive perspectives of social psychiatric units and mainstream social services (for instance IFO) differed significantly which caused difficulties to cooperate and indicated that community mental health issues were not an established part of social services. Personal relations and face-to-face contacts between caseworkers were seen as important preconditions for cooperation. In small municipalities three out of four had not a psychiatric clinic on location. Although psychiatric care services (except for mobile teams) were remote, relations were seen as constructive (Sparsely populated area 1, Sparsely populated area 2). Problems of cooperation were, experienced when in-patient psychiatric care was involved.

In middle-size municipality areas psychiatric clinics were usually available. Contacts had been established since long and networks were built. Cooperation was established concerning action plans and care conferences. A challenge for social services was to provide specialized caseworkers that would cooperate on an equal professional basis as the psychiatric care organization (Middle town 1, Middle town 2).

It is a good thing that they (social services) specialize, that they have qualified staff working with psychiatrically disabled people specifically. We know them personally and we respect the knowledge they have accumulated (Representative, psychiatric care organization, Middle town 2).

Clear organizational structures and coordinated activities characterized the big cities. The degree of specialization was higher and there were cases of far-reaching functional integration between organizations in the CMHS-field. Coordinated training courses and development projects were relevant examples. Basic preconditions for such developments were stable.
organizations on behalf of each party - and that accountability and decision-making procedures were compatible in the two organizations. Frequent reorganizing was sometimes seen as a detriment. “They seem to be fully occupied reorganizing all the time”, says a representative from the psychiatric care organization when thinking of his colleagues in social service department. Although high specialization on both sides facilitated cooperation concerning specific target groups, like patients with psychoses, cooperation for other groups was difficult to arrange.

For us cooperation only concern psychoses patients. In that case our respective organizations are compatible. However, when dealing with patients with neuropsychiatric conditions, they come under the purview of another division of the social service organization, i.e., the disability unit, in that case our organizations are incompatible. And if clients belong to IFO, then it’s the same dilemma (Manager, psychiatric care organization, Big city 2).

All in all, we found little organized cooperation between CMHS-units and other organizations like primary health care centres, public employment offices and social security agencies. If coordinated work teams were established they were not very active. And the other two players were hardly on the track; public employment offices were only involved when subsidised employment was on the agenda, and social security when disability pensions were at issue. More so, than taking actively part in vocational rehabilitation planning.

Differing practices concerning organizational design and lack of organizational stability may be caused by the fact that “social psychiatry” not yet is a distinct and well-established part of social services. The organizational environment (state-authorities, neighbouring welfare agencies, the federation of municipalities, professional bodies etc) have not provided normative guidelines enough or clear recommendations. Differing practices also indicate that
weak or poor interaction between municipalities cause problems to disseminate practices and work modes.

Provision of social support measures

Basic social support measures like group residences and meeting points, were established on most locations in the years after the launch of the reform, i.e., in the late 1990s. Only one of our locations was a late-comer in this respect. Some years later a “second wave” of development started. Flexible arrangements of supported housing meant that fewer persons needed to live in group residences and care institutions. Such developments are not paralleled within the field of occupational activities; most of the locations continued to run their traditional occupational services. However some new services were developed, for instance work teams dealing with persons having a combination of psychiatric disorder and alcohol/drug abuse, mellanvårdsformer, and coordinated support measures run by municipalities and county councils.

Table 2. Provision of social support measures in ten municipalities.

<table>
<thead>
<tr>
<th>Location</th>
<th>Group residences</th>
<th>Housing support</th>
<th>Occupational activities</th>
<th>Supported employment</th>
<th>Coordinated support measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bid town 1</td>
<td>Yes</td>
<td>Specialized*</td>
<td>Yes, diverse</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Big town 2</td>
<td>Yes</td>
<td>Specialized **</td>
<td>Yes, diverse</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Middle town 1</td>
<td>Yes</td>
<td>Specialized</td>
<td>Yes, if there is room</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Middle town 2</td>
<td>Yes</td>
<td>Integrated</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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* For psychiatrically disabled persons  
** Coordinated with support for elderly people

Group residences were established in almost all municipalities. Also both of the two municipalities in sparsely populated areas had developed such facilities, while one of the two small municipalities had a combined residence for intellectually disabled and psychiatrically disabled persons. Urban district 1 had only one group residence but purchased places from neighbouring urban areas. Big town 2 had 11 group residences with less than ten persons living in each unit. On this location a number of patients had earlier been on caring institutions, but since a couple of years almost all patients “were taken home”. Big town 1 had half the number of group residences and the number of places was significantly higher - in same cases about 20 persons per unit.

The overall impression is that such group residences were designed for a “historic” group of earlier long-term in-hospital patients. To cope with the needs of this group in times when mental hospitals closed down was one of the starting points of the reform. Such residences have plenty of staff, round-the-clock support, little privacy, a special area for the staff and show similarity with care institutions. Such institutions were thought to be a necessary support, but difficult to change. On some locations our informants thought that the municipality was stuck in old-fashioned support structures with big huge buildings and too much staff, since young people declined such support. Afterwards, such strategies to discharge patients from mental hospitals were regretted:
We took over entire hospital wards and moved them out in the community. These patients had lived their lives in the wards and all of a sudden they were placed in a group residence in the community. This was a dilemma. Another design would have been better, because now it is hard to make radical changes in that structure (Manager, social service department, Big town 1).

Such group residences are at issue; they are being questioned and they are no longer the first hand choice as a “basic support measure”. This is illustrated by efforts in Big town 2 that placement in group residences ought to be avoided to the benefit of a normalized living and support given in the persons own dwelling. Supported housing has, on our locations, developed into a variety of support measures; traditional home help for psychiatrically disabled people have in many municipalities developed into a more diversified pedagogical support, sometimes including elements of cognitive behavioural therapy, given by social workers or social pedagogues. However, such specialized services may not be possible to develop in small municipalities who rather need to have work teams that support both elderly and psychiatrically disabled for the purpose of using scarce resources efficiently. In one of the small municipalities (Small town 1) housing support was given by two social workers:

We do almost everything. It depends on who is the user, and if problems are urgent. People call and ask when you can come. Then you go there and make a judgement call in order to find out if the person needs urgent psychiatric care, or some other medical treatment or needs detoxification. The visit may trigger off a lot of additional support! We live in a little municipality and we must have a broad approach; you may have to cope with cases of alcohol or drug abuse, child or women abuse … or to give practical help in terms of cleaning, transport or to take the person to the hospital for treatment. It is a lot of therapeutic talk. If somebody has lost her/his husband or wife we link that person to a firm of undertakers (Social workers in housing support).

This kind of support is sometimes generalized to broad categories of target groups and it is also integrated in a package of support measures. In some municipalities teams for housing support developed a broader scope; support was not only related to the persons housing but also to motivating the person in his or her daily activities and social contacts. Pedagogical
work modes and cognitive therapy oriented approaches were developed in some municipalities. Housing support developed as the users’ needs and preferences changed. In most of the teams the traditional target group consisted of persons with psychoses, but this group was more and more being replaced by younger persons with other difficulties, i.e., less need for care and daily activities. Participation in the community (leisure, friends, activities) in many cases replaced the dwelling as the main life arena. Traditional housing support to elderly clients was described like this:

We are more like home helpers. It’s washing, buying food and the like. A lot of cleaning and to check that the user has money. Some get twenty crowns per day, some get three times per week. Some users get cigarettes once a week, while other get five cigarettes at a time. They can’t manage it! (Housing supporter).

In one of the Middle towns a “shelter residence” (crises centre) was established and in Big town 2 a joint transitional care institution run by the municipality and the county council started to facilitate the discharge of long-stay patients from psychiatric hospital wards. This institution was also meant to be a short term residential setting as an alternative to hospitalization, i.e., to be used in both directions.

Social relations and activities
Beside group residences so called drop-in centres (or in activation centres) was the basic supply for support to psychiatrically disabled people. Such centres originate from occupational therapy provided for in the old mental hospitals. All of our municipalities had drop-in centres aimed for socializing and various permissive activities. Often such centres were located close to group residences. Despite the fact that such support was seen as a bit “behind” staff cared very much for the users:
I know that some of them come here every day, and they don’t I call them to check if everything is okey. It happens that we go together to see the doctor or we go to the psychiatric clinic .. or just go to buy clothes or something …such things are easy for me but not for everyone (Direct care staff, Sparsely populated area 2).

However, activities have become broader in scope, and new forms of occupational arrangements have been established. In half of the communities such activity centres were organized by user-organizations, but subsidized by the municipalities. Study circles and catering were usual activities. In some locations Big town 1 and Middle town 1 municipal centres were transformed to a co-operatives run by the staff. Centres with more structured activities, including job training and vocational rehabilitation were put in place in a majority of the municipalities. Often the sale of second-hand products, gardening, repair work etc was organized in a manner that differentiated between target groups. In big towns and urban districts such developments were more salient; activities were more differentiated and more adapted to the work capacity of the users (Urban district 1, Middle town 1). The aim was to motivate the user to get sheltered employment or a subsidised employment. Except for one municipality, Big town 1, who had established a vocational rehabilitation centre for psychiatrically disabled people, there were very few examples of activities that were systematically designed as to develop the users’ work capacity in order to compete for regular jobs available in the local labour market. According to conventional practices the life quality, security and self-confidence of psychiatrically disabled was best promoted if they had an occupational career within their own “disability culture”, instead of being fully integrated in the unknown and dangerous community. As a consequence these people still found themselves locked in in an “asylum” outside the regular labour market. This is further illustrated by the fact that activation centres for long-term sick people or people on social
assistance were rarely open for psychiatically disabled people. The “work line” did not
encompass these people; it did not reach beyond sheltered employment. Also we did not find
much trace of Individual placement and support (IPS) in our municipalities.

Even if we upgrade ambitions and increase staff in order to prepare the users for gainful
employment, our partners, the public employment office and the social security agency,
“run business as usual”. We don’t get any help from them! Our vocational guidance
officers may have arranged a training position for a person; the person has gradually
increased his/her work time and there is an agreement that subsidised employment is the
perfect step to take. But managers in charge of such measures within the employment
office say “no”! (Manager, CMHS-department, Big town).

Obviously there is competition between different groups of occupationallly disabled for labour
market measures; in such competition psychiatically disabled persons end up as losers.

Case management

Beside group residences, housing support and daily activities case management (personligt
ombud) was available on most of the locations. The idea of case management was that such
managers should have an autonomous role vis-à-vis regular social service organizations and
they must work by direction of the user. Such managers …

However, this measure, strongly supported by user organizations, but not by the
municipalities, was launched (and subsidised, but not fully financed) by the state. Some
municipalities (Bid town 1, Urban district 1, Sparsely populated area 1) grumbled that the
state inflicted an additional measure upon them -a measure that they did not want to have and
that was not needed. While other saw such support as a supplement to (or a substitute for )
regular service (Sparsely populated area 2, Middle town 1 and 2). Although cherished by the
users, informants in the municipalities tell that such support was not very much used. All in
all, support structures may be described as “home-made”; few references to international role models and evidence-based research were made except for case management that was recommended by the state. Support measures were first and foremost designed for target groups of middle-aged people with a long earlier care history of psychosis. It was evident that the municipalities now were facing dilemmas of redesigning support structures to meet a younger generation of users with other needs and aspirations. Young people declined conventional support like group residences and drop-in centres. Old assessment criteria needed to be changed in order to make young peoples needs fit into the boxes of CMHS-agencies.

We see a new generation two don’t want to live in group residences. They are younger and they have other problems; they don’t have the same care needs. They are less stigmatized, not so heavily medicated, but more vulnerable and exposed. They have a richer and more mobile life, and at the same time a more dangerous life. A lot of drugs, violence and assault - and they get less health care (Middle manager, Sparsely populated area 1).

We have built support measures for the “chronicians”, there were no other groups. Now we have a totally different group to support. They are younger, born in the 1970s and 80s. The mix drugs and many times the have self-destructive behaviour and cut themselves. Many of them are lost and have never been directed. Therefore, they risk to end up in pitfalls (Development specialist, Big town 1).

The domain of CMHS seem to expand, but in stead of competing for domain claims professionals and organizations seem to escape groups with neuropsychiatric problems – at least they were not included in the CMHS’ target groups. In order to avoid that these people
“fall between the cracks” grey-zone teams were established in two of the municipalities with the task to allot these persons to the right sub-division and caseworker. In general social work with psychiatrically disabled people are low-status work; university education is rarely required and recurrent further education is rarely offered. However, in the bigger municipalities with specialized services competence development programs were launched. Also the pattern of user-influence was diverse. Such influence is contingent upon whether user organizations exist in the area. Small municipalities faced difficulties because local user organizations did not exist or were inactive. In middle-size towns relations were established, but often bound to one or two specific representatives. In the big towns user-influence was formalised and users were taking part in various fora for decision-making.

Conclusions

CMHS are an important part of social services in the Swedish welfare model. Especially so, if we take seriously ideals that services and support be vehicles to full social citizenship and reasonable living conditions. Hallmarks of such a model were also that benefits and services be broad in scope, aimed to reduce inequalities and implemented in a generous manner. Evidence put forward in this paper tells that the government gave very much credence to normative steering and temporary subsidies in order to develop CMHS to psychiatrically disabled people. In order to develop new support arrangements emphasis was put on norms like “the right to normal living conditions, independence, user-influence” etc. Evidently, this was insufficient in order to (radically) improve services to the target group. Difficulties in implementing the Swedish mental health reform can be traced back to vague policy goals, lack of precise statements in social welfare legislation concerning support measures, including the failure to delineate the target group. In the aftermath of the reform negative criticism was
voiced in the public debate; after being discharged from hospitals and psychiatric wards patients were said to be abandoned or left in the hands of local social service agencies that lacked the necessary knowledge and resources to cater for the target group. However, it would be unjust to label the reform a failure. In terms of housing the municipalities have developed different forms of residential and group homes. Still work and meaningful occupational activities are one of the most urgent problems to come to grips with. Case management was developed in a number of municipalities; very much cherished by the users. However, services in general to the target group were organized in a variety of ways. This indicates that the organizational level is crucial in order to grasp how policy programs are materialized in services at the local level. To deliver tailor-made support to vulnerable target groups requires inter-organizational cooperation. Given the fact that the welfare landscape incorporates a number of organizations with different mandates, regulations and staff with different competence, it is not an easy mission to make them work for the same aims. In addition, the CMHS-field seem not to be very attractive for (new) professional groups who want to carve out an knowledge field of their own; in stead of occupational groups with competing domain claims the field seem to entail work tasks that nobody want to cope with.

To understand how processes of policy implementation are dealt with in human service organisations, the capacity of the professionals working in direct contact with the users must be recognised. Welfare professionals interpret policies and assess the needs of the clients. They materialize public policies in ways that are not always in line with policy directives. Rather, it is not infrequent that they tend to devise their own working modes and procedures when dealing with the situational needs of clients. The fact that key workers have a good deal of discretion and that managers often have difficulties in controlling the hands-on work of such key workers meant that there were quite a large space for a variety of support measures
to develop. It seems like the Swedish model in the field of CMHS has to make an effort to catch up with policy ideals, but also to live up to the universal welfare regime model I social science research.

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