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THE ROLE OF PERSONLIGT OMBUD IN SUPPORTING THE RECOVERY PROCESS FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

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ABSTRACT

The overall aim was to explore the experiences and knowledge of Personligt Ombud (PO) (a Swedish version of Case Management) and how they relate to the client's recovery as well as their own role of supporting clients in the recovery process. The thesis consists of four original papers **(I-IV)**, and both quantitative and qualitative methods were used. Paper **I** showed that there were differences in knowledge and attitude toward recovery between three personnel groups: psychiatric outpatient services (POPS), the supported housing team (SHT) and the PO service, where the POs showed greater knowledge about recovery than both POPS and SHT. The results also indicated that university education and training in recovery was positive related to knowledge and attitudes towards recovery. Findings from papers **II - IV** showed that the clients' choices permeated all of the work that the POs and clients did together. The strategies used by the POs put the client in an active changing process, where he/she became involved in every aspect of the process. The work of the PO included discussions and collaboration with clients. The relationship with the client was the foundation of the work, and it was important to build a working alliance, which also involved a personal dimension. The findings also showed that POs experienced their role as unbounded, where they didn't have to consider any organizational frames, and POs solely represent the client. However, the free role was also connected with responsibilities concerning their work, and POs had to be able to work independently. The role as POs also enables to get a holistic view to both the client as well as to the welfare system. However, the freestanding role demanded legitimacy, and the POs had to work for this. It was important for the PO service to develop good platforms for cooperation with other actors in the society. In conclusion, it is interesting and leads to the question of whether POs and personnel in POPS can relate to two different kinds of recovery: personal vs. clinical. It may be important to consider the need for university education and training in recovery developing recovery-oriented practices. Findings showed that the PO service has developed a method in accordance to the NBHW guidelines, which in many cases, may benefit the clients' recovery process; however, there were aspects the PO service needed to develop. They seemed to use a problem-oriented approach, and they need to change this and look at the clients' strengths, both individual and environmental, and use them in order to support the client to reach goals in life. In Strengths Model Case Management, the Strengths assessment exists, that may be useful. The POs' service also needs to strengthen their organization and possibly develop support among colleagues.

Keywords: case management, psychiatric disabilities, recovery, rehabilitation

SAMMANFATTNING – ABSTRACT IN SWEDISH

Personligt Ombuds (PO) roll och stöd i återhämtningsprocessen för människor med psykiska funktionshinder

Det övergripande syftet var att undersöka Personligt Ombuds (PO) (en svensk variant av Case Management) erfarenheter och kunskap om återhämtning och hur de använder sig av detta samt deras roll i klientens återhämtningsprocess. Avhandlingen består av fyra originalarbeten **(I - IV),** där både kvantitativa och kvalitativa metoder användes. Paper **I** visade att det fanns skillnader i kunskap om återhämtning mellan tre personalgrupper: personal inom psykiatrisk öppenvård, boendestöd och PO verksamheter där det visade sig att POs hade mer kunskap om återhämtning än personal både inom psykiatrisk öppenvård samt boendestödet. Resultatet visade även att universitetsutbildning samt fortbildning i återhämtning hade positiv inverkan på kunskap om återhämtning. Resultaten från paper **II - IV** visade att klientens val genomsyrade allt arbete som PO och klienten gjorde tillsammans. De strategier som PO använde satte klienten i en aktiv förändringsprocess, där han/hon blev involverad i varje del av processen. Det var viktigt för PO att diskutera och samarbeta med klienterna. I klientarbetet var relationen med klienten en grundbult, där det var viktigt att bygga en allians med varje klient, som även innehöll en personlig dimension. Resultatet visade även att PO upplevde sig obundna i sin roll där de inte behövde anpassa sitt arbete utifrån organisatoriska ramar och tillhörighet, viket bidrog till att PO upplevde att de enbart representerade klienten. Men den fria rollen innebar även att ta ansvar i sitt arbete då PO måste kunna arbeta självständigt. Rollen som PO möjliggör att skapa en helhetssyn på både klienten samt välfärdssystemet. Den fristående rollen krävde legitimitet där PO där det är betydelsefullt att utveckla goda plattformar för samarbete med andra aktörer i samhället. Sammanfattningsvis är det intressant att reflektera om olika yrkesgrupper relaterar till två olika definitioner av återhämtning: personlig vs klinisk återhämtning. I utvecklingen av en återhämtningsinriktad praktik kan det vara betydelsefullt att beakta behovet av personal som är utbildade på universitetsnivå samt fortbildning i återhämtning. Resultaten visade att PO har utvecklat en metod utifrån Socialstyrelsens riktlinjer, vilket i många fall möjligtvis kan gynna klientens återhämtningsprocess, men det finns delar i PO verksamheten som behöver utvecklas. De verkade använda ett problemorienterat förhållningssätt och de bör utveckla verksamheten till att identifiera klienten styrkor, både individuella och miljömässiga och använda dessa för att stödja klienten att nå mål i livet. I Strength Model Case Management finns ett instrument där man tillsammans med klienten inventerar styrkor. Dessa kan bli

användbara i processen. PO verksamheten bör även stärka organisationen och eventuellt utveckla stöd bland kollegor.

Nyckelord: case management, psykiska funktionshinder, rehabilitering, återhämtning,

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LIST OF PAPERS

This thesis is mainly based on the following four papers, herein referred to by their Roman numerals:

Paper I Klockmo, C., Marnetoft, S. U., Nordenmark, M., & Dalin, R. (2012). Knowledge and attitude regarding recovery among mental health practitioners in Sweden. *International Journal of Rehabilitation Research, 35*(1), 62-68.

Paper II Klockmo, C., Marnetoft, S.-U., & Nordenmark, M. (2012). Moving toward a recovery-oriented approach in the Swedish mental health system—An interview study of Personligt Ombud in Sweden. *Vulnerable Groups and Inclusion, 3*, 1-16 http://dx.doi.org/10.3402/vgi.v3403i3400.18879.

Paper III Klockmo, C., Marnetoft, S-U., Selander, J., & Nordenmark, M. Important components to create personal working alliances with clients in the mental health sector to support the recovery process. (in press), *International Journal of Rehabilitation Research.*

Paper IV Klockmo, C., Marnetoft, S-U., Selander, J., & Nordenmark, M. A client-centered freestanding case management model in the Swedish mental health system focusing on supporting the client. (submitted)

Om jag vill föra en människa mot ett bestämt mål
måste jag först finna honom där och börja just där.
Den som inte kan det lurar sig själv när hon tror att hon kan hjälpa andra.
För att hjälpa någon måste jag visserligen förstå mer än vad han gör,
men först och främst måste jag förstå det han förstår.
Om jag inte kan det, så hjälper det inte att jag kan och vet mycket mer.
Vill jag ändå visa hur mycket jag kan, så beror det på att jag är fåfäng och högmodig och egentligen vill bli beundrad av den andre istället för att hjälpa honom.
All äkta hjälpsamhet börjar med ödmjukhet inför den jag vill hjälpa och därför måste jag förstå,
At detta med att hjälpa inte är att vilja härska utan att vilja tjäna
Kan jag inte detta så kan jag heller inte hjälpa någon.

Sören Kirkegaard

FOREWORD

The focus of this thesis is on people with psychiatric disabilities and recovery. My interest in this research field grew out of my clinical work experience. My first job after completing my bachelor degree in Rehabilitation Science was to support people with psychiatric disabilities in vocational rehabilitation (supported employment). The year was 2001, only six years after the Swedish Mental Health Reform, and it was interesting to follow the development of new services. During the next few years, the possibility of recovery entered Sweden, which presented a new way of viewing the clients. For me, new to the practical field and newly graduated, I recognized many of the ideas in this new rehabilitation (recovery field). I gathered many of the theories from education, but at the practical level, I learned how to use these theories and developed strategies to support clients forward in their life.

In connection with the Swedish Mental Health Reform in 1995, a Swedish version of case management (CM) called Personligt Ombud (PO) was piloted in ten municipalities. The evaluations of the service showed positive results, and the Swedish government decided in May 2000 to distribute grants to municipalities that wanted to build up services with PO. Three municipalities in my area (Sundsvall, Timrå and Härnösand) decided to apply for grants, and in January 2002, five POs were hired, and I was fortunate to be one of them. The only thing we knew when we arrived the first day was that this was a new kind of service, and we had an office, a leased car and a telephone. We were expected to build the content of the service ourselves according to the National Board of Health and Welfare (NBHW) guidelines (Socialstyrelsen, 2000). This was truly building a service from scratch, and the first few weeks we dealt with practical matters, such as furnishing our offices, acquiring the necessary materials such as computers, mobile telephones, etc. The first months were also filled with discussions about how we should build our service based on the guidelines from the NBHW. The guidelines emphasised that PO was a new kind of service, and that we had to put all of our old professional roles and methods aside. The PO service was expected to have a freestanding role in relation to other services, and a lack of association with other services was important. POs were to stand by the client's side and have his/her best interest in mind. The guidelines also emphasised that POs should ensure coordination of client services, without taking over other services' coordination responsibilities.

This was extremely inspiring and interesting, and I learned a great deal. The guidelines seemed clear and obvious, but it was not easy to determine HOW to perform this and incorporate it into practical work. However, the main ideas were always in focus, i.e., clients' choice—the client directs the process.

In 2007 I was working on a master's degree in Rehabilitation Science, and during this period the possibility of becoming a doctoral student popped up. My field of interest was clear—my work as a PO was very inspiring, and I found it interesting to investigate how POs act in contact with clients as well as their experiences of having this new role.

INTRODUCTION

Since the 1990s, mental health problems have increased in Sweden. The National Public Health Survey from 2012 indicated that 20 percent of the women and 14 percent of the men experienced mental health problems (Socialstyrelsen, 2013b). In 2012 the psychiatric diagnosis was the most common reason for being sick-listed and absent from the labor market (Sveriges kommuner och landsting, 2012). Statistics from the Social Insurance Agency from 2012 showed that 41 percent of the women and 30 percent of the men were sick-listed due to a psychiatric diagnosis. Of those who were granted sickness compensation (disability pension) during the year, 40 percent for both women and men, were related to a psychiatric diagnosis. Of those receiving activity compensation (time limited sickness compensation for those 20-29 years old), approximately 85 percent of both women and men related to a psychiatric diagnosis (Försäkringskassan, 2013). A recent report from the National Board of Health and Welfare (NBHW) also showed that there were an increasing number of young people with some kind of contact with psychiatric in- and/or outpatient care, and/or used psychopharmacologic medication. Many of them were diagnosed with depressions, anxiety disorders and drug addiction, and among women personality disorders had increased (Socialstyrelsen, 2013c).

The working life is an important arena for us. It offers social contacts, daily routine and the opportunity to do something of value and importance. Our occupation plays an essential role and is, indeed, part of how we view ourselves and our personal identity. A longitudinal study by Melchior et al. (2010) showed that people who were absent from work due to a psychiatric diagnosis were at greater risk for committing suicide, increased mortality from cardiovascular diseases and smoking-related cancer. To have employment is important in facilitating social

inclusion in the society. Therefore, more efforts need to be made to increase the possibilities of employment (Regeringens skrivelse 2009/10:166, 2010).

Political goals and investments

The political work follows the guidelines given in the UNs 22 standard rules. The foundation of the Swedish handicap politics is based upon strengthening each person's self-determination, influence, and integrity and facilitating participation in society and equality (FunkAutredningen, 2012). Follow ups on the disability political goals identified that there is a need to improve the situation of people with psychiatric disabilities. The goals were categorized into three main areas: healthcare, everyday life and individual choice (Regeringskansliet, 2009). The latest follow up showed that the goal regarding employment was not reached and there was a need to continue this work between the years 2011- 2016. For example, many people with disabilities have not found employment, and, therefore, the government has found it important to put more effort into increasing the possibilities of work (Regeringens skrivelse 2009/10:166, 2010). The political efforts place a special focus on concrete and long-lasting improvements for people with psychiatric diagnosis. The Ministry of Health and Social Affairs has developed an action plan (PRIO) on how to improve the situation and contribute to the recovery process for people with psychiatric disabilities. According to the plan, the focus is on improving awareness of psychiatric disabilities and increasing knowledge of treating somatic illnesses, improvements in compulsory care, improved possibilities of entering the labor market, development of sheltered work, and fostering strategies for cooperation among different authorities (Regeringskansliet, 2012).

During the 2000s, the recovery perspective has become an important aspect of the services that support people with psychiatric disabilities. Rosenberg (2009) showed in his thesis that the needs of those with psychiatric disabilities have changed over the years, and today they have different needs. This means that personnel in services are now facing new challenges. There is a need to develop the services according to the person's needs and to be more recovery-oriented.

BACKGROUND

The Swedish Welfare System

Historically, the Swedish tradition has been to take care of each other, where, for example, "county rules" from the thirteenth century obligated children to support their parents when they got old. When Sweden was a Catholic country, the Catholic church was the first to organize support for the poor, old and ill. Every farmer in the village had to offer support by providing grain. During the reformation, when Sweden became Lutheran, the attitudes toward the poor and the ill changed, and work and being able to earn one's own living became morally important (Holgersson, 1997). In the late 1800's and early 1900's, voluntary health insurance and accident insurance was developed. It was only those who had employment that had access to this. At this time, an unemployment benefit was developed; it put large demands on the unemployed who had to accept difficult tasks, which meant heavy work. This period also marked the beginning of a state retirement pension. The ideological basis for social politics was based on the fact that the state would support the citizens who were willing to take responsibility for their lives, where the others did not have access to insurance. In 1928, the Social Democratic Party introduced the ideology of building a state welfare system, in which the society was obligated to provide security and safety for its citizens. In 1932 they won the parliamentary election, which meant that they started implementing the social politic reforms with the ambition of building a welfare state in order to combat poverty and create financial security for citizens (Åmark, 2005). The general politics made the welfare accessible to all citizens, which meant that all people in the same situation had rights regardless if they had contributed financially or not (Holgersson, 1997). Still today, Sweden has a general welfare system where each service has its own organization with different responsible areas. They are administered at different levels in the Swedish society (state, county and municipal) and governed under different organizational frames, legislations and budgets.

The Public Health Services

The Public Health Services are administered at a county level and governed by the Health and Medical Services Act (SFS, 1982:763). The Public Health Services provide primary care, specialist health care (both inpatient and outpatient care) and emergency services. They offer therapy and treatment and, according to the law, the care and support are supposed to be built upon scientific methods and well-founded experience with respect to the consumer's self-determination and integrity.

The Social Services

The Social Services are administered at the municipal level and run by The Social Services Act (SFS, 2001:453). The municipality is ultimately responsible for its citizens. The Social Services provide financial assistance, supported housing teams (elderly and disabled), alcohol and drug treatment, family placement, etc. According to the law, the services have to be performed in a way that strengthens the individual to live an independent life in the society.

The Public Employment Service

The Public Employment Service is administered at the state level and is governed by the regulation with instructions for the Public Employment Service (SFS, 2007:1030). They actively work to improve the participation at the labor market by matching the unemployed with employers. A high priority is given to those who are far from the labor market. In the long term, this contributes to a stable, high employment rate. The Public Employment Service also has specialized units to support people with disabilities in the labor market. They can provide services such as supported work experience with a supervisor, sheltered employment with a public sector employer, and wage subsided employment. In addition, they make work-related social investigations.

The Social Insurance Agency

The Social Insurance Agency is also administered at the state level and is governed by the Social Security Code, (SFS, 2010:110), which includes seven areas: family benefits, sickness benefits and benefits related to occupational injuries, special benefits regarding disabilities, elderly benefits, benefits to the surviving relatives and housing allowances. The Social Insurance Agency provides financial security to citizens. They make decisions concerning the right to sickness benefits. The role of the case worker is to map rehabilitation needs, make rehabilitation plans, assure that the client gets needed services, and maintain contact with the employer or the Public Employment Services and the client to coordinate this work. The Social Insurance Agency also makes assessments of work capacity in the rehabilitation chain, which serves as a basis for decisions concerning sickness or activity compensation.

The rehabilitation chain

A person is entitled to sickness benefits if a doctor's certificate declares that the working ability in ordinary work is reduced to one-quarter, one-half, three-quarters or fully. During the first 90 days the working capacity is assessed in ordinary work; from day 91 to 180, the working capacity is assessed to any work available from the employer, and after the 181st day the person is only entitled to sickness benefits if he/she is unable to perform any kind of work in the ordinary labor market. Exceptions to this rule occur if the person is assessed to return to work before day 365. In that case the work assessment is performed in relation to work available from the employer. However, the work capacity for the unemployed is assessed in the ordinary labor market from the first day (Försäkringskassan, 2012).

From life in a mental hospital to a life in the society

During the seventeenth century, institutions were developed where people with divergent behavior (mental illness, alcohol abuse, homosexuality, etc.) were placed. They were sorted out to live in their own societies to protect them from the society and from themselves (Holgersson, 1997). During the nineteenth century, a large central mental hospital was built, where people from all parts of Sweden were placed. These mental hospitals were often located at some distance from the cities in order to protect the society from the people. The hospital became its own closed society; it was the place where the patients slept, ate and performed activities. The social contacts consisted of other patients and personnel. Often staff residences were also located in the mental hospital area. It was a life that was separated from the rest of the world. In 1967 the public health care at the county level took over the responsibility for the mental hospitals, but it took several years before the public health care services replaced the separated mental hospitals and the patients were placed in psychiatric clinics at the "somatic hospitals" where they received the same care and status as other patients (Ottosson, 2003).

The deinstitutionalize process and the Swedish Mental Health Reform

In the 1940s and 1950s, psychiatric care in the United States (US) and the United Kingdom (UK) went through changes, and the process of closing mental hospitals started. However, it took until the 1960s before this process started in Sweden. The first Swedish mental hospital did not close until 1987 (Ottosson, 2003; Regeringens skrivelse 2008/09:185, 2009). The political and ideological motives behind the deinstitutionalize process varied. The 1960s was a period where queries regarding every person's equal rights and value came into focus, contributing to a change of perspective. For the first time it was recognized that disabled people must be given the same rights to take part in society as other citizens. Keywords of the times

involved strengthening individual rights, self-determination and possibilities to live a life in the society (Regeringens skrivelse 2008/09:185, 2009). The public opinion of disability changed from viewing the problem as one that lies within the person to one that is part of the environment and how it was shaped. These discussions had an impact of the beginning of the deinstitutionalization process (Regeringens proposition 1999/2000:79, 2000). There were also other events that contributed to the beginning of the deinstitutionalize process, for example, the development of neuroleptics, which were introduced in the 1950s. This created a revolution and contributed to the treatment of mental health care. Another contribution came from two scientists, Erving Goffman and Michel Foucault, who wrote about the negative effects of being institutionalized. They raised the question of whether it was the environment that caused symptoms or if it was the illness itself. Another question concerned whether or not the institutions function was about social control (Ottosson, 2003).

When closing down mental health hospitals, the idea was to develop community-based support and to replace inpatient care with out-patient care; each neighborhood had its own psychiatric outpatient care service. Unfortunately, these psychiatric outpatient services did not provide the same level of care. In addition, the cooperation with the social services and primary care were poorly developed. This had occurred earlier in both the US and the UK in their deinstitutionalizing process. Unfortunately, community-based support did not develop at the same rate that the hospitals were closing, and many patients became trapped and left alone without support in the society (Ottosson, 2003). In the late 1980s it was observed that persons with psychiatric disabilities had poor living conditions and for this reason, a psychiatric investigation was undertaken (Knutsson & Pettersson, 1992). Their mission was to propose actions to improve the living conditions for people with psychiatric disabilities and increase their possibilities of participating in society.

The psychiatric investigation (Psykiatriutredningen, 1992), noticed that people with psychiatric disabilities had the worst living conditions of all disability groups and that the welfare system did not work for this target group. It also showed that those with psychiatric disabilities rarely sought care/support for themselves and their knowledge of their civil rights was lacking. Another problem was that different kinds of services were controlled by varying organizations and administered at different levels in society. This could be difficult for a person to grasp. The psychiatric investigation also determined that some positive changes had been made. Treatments were more grounded in knowledge and they were more goal-oriented. However, people were discharged from inpatient care without

any support in everyday life, and this often resulted in their ending up in inpatient care again. Another problem that was found was that Social Services, the Social Insurance Agency, and the Public Employment Service lacked competence on the target groups' needs. For example, 30 percent lived on early retirement benefits. They would have had a greater ability to work if the rehabilitation had been better planned and adjusted to individual needs (Psykiatriutredningen, 1992).

The overall aim of the Swedish Mental Health Reform was to improve the lives of people with psychiatric disabilities and to create opportunities for this group to get involved in the life of the community in the same way as other citizens with the same rights and responsibilities. The investigation, had many good suggestions for change that involved the Public Employment Service and the Social Insurance Agency, which would take a more prominent role in, for example, vocational rehabilitation (Psykiatriutredningen, 1992). Unfortunately, the Swedish Mental Health Reform ended up focusing on the responsibilities of the local governments where there was a clear division in which municipalities (social services) would be responsible for housing, employment and rehabilitation and which health care services (psychiatry) would be responsible for the medical treatment efforts. It became an economic reform which was a division of liability between the municipality and county in which the Public Employment Service and Social Insurance Agency did not have a central role.

Follow ups on the Mental Health Reform

A follow up on the Mental Health Reform was published in 1999 (Socialstyrelsen, 1999), showing that it had some positive effects. The municipalities had become more aware of the needs of people with psychiatric disabilities. For example, the municipalities developed community-based support, such as supported housing services, sheltered work and daily activities (centres). The line between responsibilities of the municipalities and the Health Care services was clear (Socialstyrelsen, 1999). However, the NBHW indicated that there were shortcomings concerning collaborations among different actors. Even though the municipalities had developed daily activities, sheltered work and vocational rehabilitation, there was a need to develop these further. The NBHW also emphasized the need to develop services that promoted the possibility of increasing participation and influence in the society for those with psychiatric disabilities (Socialstyrelsen, 1999).

The National Psychiatry Committee 2003-2006

In 2003 a series of tragic events occurred. Anna Lind, the Minister for Foreign Affairs, was attacked and killed at a shopping mall in Stockholm, and a series of violent actions received attention. For example, in Old Town in Stockholm a man was run over by a car and another man was attacked with an iron pipe. It was revealed that the offenders had sought psychiatric care, but they had not received access to care. The shortcomings in mental health care were highlighted as a result of these events, and the government decided to create a commission known as the National Psychiatry Committee. Their task was to review and improve the quality of care and support given to people with psychiatric disabilities according to Dir. 2003: 133 (Regeringens skrivelse 2008/09:185, 2009).

The final report, indicated that there were still shortcomings concerning collaboration and coordination among different authorities. They also pointed to the need for developing treatment and rehabilitation methods and developing psychiatric health care and social services that used evidence-based interventions to a greater extent. It was further indicated that practitioners in the mental health field needed to increase their skills involving the use of new methods. Another identified problem was that there was lack of resources in health and social care and a shortage of opportunities for rehabilitation (Nationell psykiatrisamordning, 2006a). The report also found that many people with psychiatric disabilities were still, despite the intentions of the Mental Health Reforms, living an excluded life in the society. They did not participate in the same way as other citizens. People with psychiatric disabilities still had worse living conditions than the general population; they were less able to cope with rolling or sudden expenses. They did not actively participate in recreational or cultural activities, and they rarely had contacts other than with professionals. People with psychiatric disabilities also had the lowest proportion of work in the labor market, compared with other disability groups. Vocational rehabilitation was not functioning satisfactorily; the working line had been lost and most daily activities outside the labor market were recreational. It was necessary to promote social inclusion in order to gain entrance into the labor market (Nationell psykiatrisamordning, 2006a). The NBHW report "Still Unequal" showed that there were still shortcomings, including the fact that people with psychiatric disabilities still had the lowest proportion of employed, and they maintained a poor economic situation even within all disability groups (Socialstyrelsen, 2010a).

Development of evidence-based practices

In 2008 the NBHW was commissioned by the government to develop evidence-based interventions and national guidelines for psychosocial interventions in health care and social services for people with schizophrenia or schizophrenia-like diagnoses. The end product was "national guidelines for psychosocial interventions for schizophrenia or schizophrenia-like state in 2011: support for governance and management" (Socialstyrelsen, 2011a). The purpose of the guidelines was to create conditions that would increase the function of working, living and relationships, reduce symptoms, improve quality of life and create opportunities for participation in society (Socialstyrelsen, 2011a). The guidelines stated that case management was a good service for people who had the need for coordinated services, particularly those with complex needs and extensive contacts. It was also deemed as an important service for those who frequently interrupted their contacts and were at risk for homelessness and/or substance abuse. The NBHW recommended two models that offered some scientific support: the ACT model and the resource model (Strengths Model Case Management, PO) (Socialstyrelsen, 2011a).

The National Psychiatry Committee found that personnel were lacking competence, and felt that it was important to increase their knowledge of psychiatric disabilities. It was found that personnel also needed to pay attention to physical illnesses, another essential part of the care needed so that patients had better experiences with inpatient care. A focus was also placed on increasing the daily activities of those with psychiatric disabilities in daily activities, improving sheltered work or employment situations, and improving coordination between authorities (Regeringskansliet, 2012).

Perspectives of disability

The viewpoint of disability has changed over the decades with different focuses and perspectives of the definition of a disability. The medical model was derived from the medical development during the twentieth century. It focuses on the bodily functions and indicates that a disability exists when the person has impairments caused by a disease. The solution is in clinical and rehabilitative approaches where the purpose is to minimize the negative effects of the disability. Rehabilitative services consist of experts who judge the obstacles and the needed services to overcome them. The main task from a medical perspective has been to diagnose the physical or intellectual deviation and prescribe an appropriate treatment (Socialstyrelsen, 2003a).

The social perspective, on the contrary, views disability as different circumstances in the living situation that affect the person and become an obstacle for integration in the society. The problems do not lie within the person; instead, the person is viewed in his/her circumstances in life and which aspects of the social environment affect the limitations. Society has to adjust the environment so the person can function (Socialstyrelsen, 2003a).

Today the bio- psycho-social model is often used in describing disabilities. It means that biological, psychological and social factors interplay in the descriptions of a disability. The WHO has developed a model for understanding health and disabilities, the International Classification of Functioning, Disability and Health (ICF). It serves as a theoretical model as well as a system that classifies a person's health qualities within his/her personal and environmental context (Socialstyrelsen, 2003a). The model views the person's state of health from bodily function and structure, activity and participation and contextual factors (environmental and personal factors) (WHO, 2011).

Definition of psychiatric disability

The National Psychiatry Committee developed a definition of psychiatric disability:

> A person has a psychiatric disability if he or she has considerable difficulty in performing activities in important areas of life, and these limitations have been or can be expected to persist for an extended period of time. The difficulties will be a consequence of psychiatric disorder (Nationell psykiatrisamordning, 2006b p. 6).

Psychiatric disorders, according to this definition, include psychosis, personality disorders, serious affective syndrome, neuropsychiatric disabilities (not intellectual disorders) comorbidity between substance abuse and mental disorders (dual diagnosis). Other diagnoses included in the definition of psychiatric disability are long lasting stress syndrome such as post-traumatic stress syndrome (PTSD) and burnout syndrome, but also including enduring psychiatric conditions that result from severe epilepsy and post-traumatic brain injury.

These disorders have to impact one's living situation and restrict the person's participation in important areas in life, such as residential, studies, work, social relationships and recreational activities. This also includes behavior that may impact the person's participation in society, such as taking care of personal

hygiene, maintaining one's home and/or disruptive behavior. This state has to last or be predicted to last for one year.

The definition indicates that the "target group," i.e., people with psychiatric disabilities, are a heterogeneous group with different ages and different ethnicities. Some are homeless, and some have difficulties which are connected to both physical and psychiatric problems. These people also have different goals and different needs (Farkas & Anthony, 2010). Experiencing psychiatric disabilities and not getting sufficient support may have a negative impact on the person's life, because of the risk of being excluded in the society. Therefore, there is an urgent need to develop services that support social inclusion (Regeringskansliet, 2012).

Personligt Ombud (PO): A Swedish version of Case Management (CM)

CM was developed in the US as a result of the problems that were raised when the large mental hospitals were closed (Malm, 2002). Although different models of CM exist, the brokerage model is the oldest. From the 1970s to the end of the century several models were developed, such as the Assertive Community Treatment (ACT), the Rehabilitation Model and the Strengths Model of Case Management. The various CM models use different strategies in their work with individuals; some are described as more intense (fewer than 20 clients), and others less intensive models (more than 20 clients) (Dieterich, Irving, Park, & Marshall, 2010). However, they have the same goal: to be a link between treatment services and the client, to coordinate these services and to make assessments of the client's health and needs (Ivezic, Muzinic, & Filipac, 2010). Many of the existing models such as the Rehabilitation Model, Assertive Community Treatment (ACT) and the Strengths Model, emphasize the importance of being recovery-oriented (Farkas & Anthony, 2010; Rapp & Goscha, 2012; Salyers & Tsemberis, 2007), and supportive (Marnetoft & Selander, 2000; Selander & Marnetoft, 2005).

The PO service

One of the main suggestions in the psychiatric investigation, (Psykiatriutredningen, 1992), was in regard to a development of case management (CM), which had shown positive results in the US and the UK. This was one of the reasons why the Swedish government decided to develop a Swedish version of CM, Personligt Ombud (PO), in connection with the Swedish Mental Health Reform in 1995. The benefits of a CM strategy were, according to the investigation (Psykiatriutredningen, 1991), that a CM coordinates the needed services and seeks out those who do not seek care, support and services by themselves. Another

function of CM was to act as an "ombudsman," both at a system level and at the individual level. The CM should ensure that the person receives an individual plan that covers all areas of need, medically, socially and professionally, which would offer efficiency of resource use. Other tasks of a CM include providing personal support, which is non-professional in nature. The advantages are that a CM creates continuity and reduces the number of professionals involved in the care, support and service.

The government thought that a CM function would benefit people with psychiatric disabilities (Regeringens proposition 1993/94:218, 1994), and the PO service was first tested in ten pilot projects from 1995 to 1998. A study and an evaluation of the ten pilot projects showed positive results. Björkmans (2000) study showed the same results as the NBHW's evaluation from 1999 (Socialstyrelsen, 1999), i.e., the PO's clients had a reduced need for services and inpatient care, and they were more satisfied with the support they had received than those clients who did not have a PO. It also showed that the PO's work was often about counselling, and that most of the work took place in the client's environment (Bjorkman & Hansson, 2000). The promising results led the Swedish government to decide in May of 2000 to provide government funding to municipalities that were interested in developing a PO service. The NBHW was commissioned to develop, monitor and evaluate the PO service (Socialstyrelsen, 2011b).

According to the NBHW's definition, the target group for PO services must:

- Be 18 years or older
- Have significant and substantial difficulties in carrying out activities in important areas of life and these restrictions have been or may be likely to continue for some time. The difficulties would be a consequence of (severe) psychiatric diagnose
- Have complex and extensive care needs for support services and rehabilitation and employment and require prolonged contact with social services, primary care and/or specialist psychiatric services (not only in diagnosis) and other authorities.

There would also be an opportunity for people with psychiatric disabilities who are in private activity to have contact with a PO, when there is addiction, homelessness or risk of developing severe disability (Socialstyrelsen, 2011b).

A report from THE NBHW regarding the PO service situation during 2012 showed that there were 311 POs in Sweden that were organized into 107 services. Approximately 35,000 – 40,000 clients had contact with the PO service between the years 2000 - 2012 and the NBHW calculated that approximately 6,000 clients had contact with the PO service annually (Socialstyrelsen, 2013a).

The mission from the Swedish government and the freestanding role

The PO service has two missions: first to work with individuals, and second to identify shortcomings in the welfare system and to report them in order to accomplish changes for the whole target group. The government gave the municipalities the primary responsibility for the service, but the PO service has a freestanding position where municipalities shall not organize the PO service within their social services. This means that even if the municipality has the responsibility, the PO service shall be separated from and organized outside of the municipalities' social services. There is also an option for the municipalities to outsource the PO service to an entrepreneur while still maintaining the responsibility. The PO service still receives funding from the Swedish government and there is an option for the municipalities to unite and seek government funding jointly (Socialstyrelsen, 2011b).

The PO service is administered through a management group with representatives from the municipality, the psychiatric unit in the health care facility, the primary care giver, the Social Insurance Agency, the Public Employment Services and the user organizations. The management group is an integral function of the PO service. One of the missions the management group has is to lead and manage the service, defining the target group and establishing priorities for the target group based on local needs. Another mission of the management group is to handling the shortcomings that POs report in their respective organization (Socialstyrelsen, 2011b).

The PO system is a cost free support to the client, and their main mission is to support clients to map needs and provide information about different services and to represent and advocate on behalf of the client. In addition, POs are responsible for ensuring that clients receive services to which they are entitled, such as care, support, and rehabilitation. Another essential part is to ensure that various services are coordinated (Socialstyrelsen, 2002a, 2002b, 2003b, 2011b). A few years ago, the NBHW also underlined the importance of the POs supporting the client to reach his/her own goals by finding services that promote the recovery process (Socialstyrelsen, 2008). An important tenet of the PO service is that they work from the individual's perspective; the work is built upon the individual's own choices

and nothing should be done without the individual's consent. It is important that POs work toward long lasting solutions and have patience. They should be flexible and able to adapt the work based on the client's state of health. It is important to create a working model of methodology and tools for stability at work (Socialstyrelsen, 2002a, 2002b, 2003b, 2011b). According to the NBHW (Socialstyrelsen, 2011b), the relationship with clients plays a central role in the POs' work, where one essential part in the role as PO is to inspire hope. The NBHW also emphasizes the importance of clients trusting their POs and being someone with whom they can talk. However, POs should not take on the role of either a therapist or a friend. It is important that the PO strike a balance between being private and professional (Socialstyrelsen, 2002b, 2003b, 2008, 2009, 2011b).

To manage these tasks, POs were given a freestanding position in order to be able to negotiate and advocate for their clients' rights and to work according to their wishes without having to take into account authorities and the service economy (Socialstyrelsen, 2008, 2011b). The NBHW emphasizes that the PO service differs from other services, for example by the freestanding position in the Swedish welfare system (Socialstyrelsen, 2011b), and the fact that the PO does not belong to any authority and cannot make any decisions in the capacity of an authority. PO has neither medical responsibility nor responsibility for treatment (Socialstyrelsen, 2008).

Studies and evaluations of the PO service

Bjorkman, Hansson, & Sandlund (2002) and Berggren & Gunnarsson (2010) recognize the POs' principles as being, to a certain extent, similar to the Strengths Model of CM developed by (Rapp & Goscha, 2012). The PO service is described as the resource model (Strengths Model of Case Management) in the National guidelines the NBHW presented for psychosocial interventions in health care and social services for people with schizophrenia or schizophrenia-like state (Socialstyrelsen, 2011a). The NBHW addresses in the guidelines that the PO service has shown positive effects in terms of the clients having a reduced need for care. A disadvantage with the PO system is the lack of Swedish scientific evidence regarding the effects of the service (Socialstyrelsen, 2011a).

The NBHW evaluations of the PO service showed that PO work is guided by the clients' needs (Socialstyrelsen, 2004, 2005c). The work is flexible, which makes it possible to fill in gaps and act in the gray zones (Socialstyrelsen, 2005c). Results of the evaluations showed that POs used the same methods, which were so similar that they without any problem could change workplaces with another PO (Socialstyrelsen, 2004). Another evaluation showed that the PO had different

opinions and views of the mission than the NBHW (Socialstyrelsen, 2005a). The PO service did not use any kind of documentation in the work with clients and had no administration at all (Socialstyrelsen, 2005a, 2005c). The management group plays an essential role in POs' work where it is necessary to cooperate, especially in the reports regarding shortcomings in the welfare system (Socialstyrelsen, 2010b). Unfortunately, the evaluation showed that the management groups were not active parts in POs' work (Socialstyrelsen, 2005c). A study of the PO service by Järkestig Berggren (2006) showed it was difficult to find dissatisfied clients; however, some critics was concerned that the clients did not have the sense that the PO worked for them. In some meetings the PO was silent; some clients interpreted this as a lack of legal competence and some felt that the PO did not have the necessary time (Socialstyrelsen, 2005b). Other critical voices concerned disagreements of the client's abilities, where the client thought the PO underestimated his/her abilities. There were also critical voices from professionals, who sometimes felt their competence was questioned by the PO. They did not understand that the PO's actions were to mediate the clients' wishes. The professional acted from the perspective of what he/she thought was the best for the client, while POs represented the client. However, overall, the clients were very satisfied with the support from the POs, and they wanted to have this support for a long time (Järkestig Berggren, 2006).

One problem is that there are different descriptions of the PO service. However, the NBHW emphasises that there is a need to change the organization around PO and believes that there is a need to expand these services (based on recommendations). POs receive training in the resource model and get tutoring (Socialstyrelsen, 2011a).

A RECOVERY PERSPECTIVE

Longitudinal research from the 1970s showed that it is possible for people with psychiatric disabilities to recover, but it took a long time for the practice field to adopt this knowledge (Farkas, 2007). Today, it is a well-known fact that people with psychiatric disabilities can recover and make major improvements in their lives (Davidson, Mezzina, Rowe, & Thompson, 2010), and many countries like New Zealand, Australia the UK and the US, use recovery as a guiding principle for mental health practitioners (Ramon, Healy, & Renouf, 2007).

Sweden has a long tradition of working for integration and normalization of disabled persons, which emphasizes the importance of developing user involvement in care and support services for people with psychiatric disabilities. Despite this, the recovery perspective has not yet gained a foothold. During the past years the policy documents that regulate health care and other services to those with psychiatric disabilities have emphasised the use a recovery perspective in providing support (Bogarve, Ershammar, & Rosenberg, 2012).

Different perspectives of recovery

There are different meanings of the term "recovery." Clinical recovery is an objective measurement made by professionals, and recovery is defined as returning to normal. The rehabilitative services focus on a decrease in the level of symptoms, and recovery is defined when the client has a full time or part time job, and lives an independent life without any support. Professionals also define when the person is recovered. The other perspective refers to personal recovery, which defines recovery as a lifelong, ongoing process. It is a subjective process focusing on the person's aspirations of reaching personal life goals. From this perspective, recovery does not mean that all the symptoms will disappear and no longer affect one's life (Turton et al., 2011). Rather, the attention is placed on increased well-being, despite the fact that symptoms will still occur occasionally (Slade, 2010) Recovery refers to a new sense of self and to the creation of a life despite and beyond the limits of the disability (Perkins & Slade, 2012). In this perspective, recovery represents a paradigm shift where the focus moves from working on the rehabilitation of people, where the aim is to improve the person's capabilities in some areas, to recovery, where the person is seen in a holistic perspective based on his entire life (Borg & Davidson, 2008; Farkas, Gagne, Anthony, & Chamberlin, 2005; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Topor, 2001).

What are the people recovering from?

One usual consequence of psychiatric disability is the loss of valued social roles, such as employment, memberships in associations and being a parent. Many experience poverty and live in poor residential areas (Anthony, 1993; Borg et al., 2005; Davidson et al., 2005), and it is usually the feeling of being a "second class citizen" arises (Deegan, 1996). Research has shown it can be more difficult to recover from the negative consequences of the psychiatric disability than the symptoms linked to this disease itself (Anthony, 1993).

The recovery process is often described as a complex process that involves many different areas of life (Jacobson & Greenley, 2001b; Topor, 2001). It is an internal process which involves a change of identity and attitudes toward oneself, but there is also a need to start to reflect about how things are experienced, both in the past as well as in the present and change one's viewpoints. It also involves increased self-confidence (Jacobson & Greenley, 2001b). Another essential component of recovery is taking an active part in one's life, for example by making active choices, using services in an active way, and to doing something active with one's life (Ralph, 2000). Recovery is also an external process, which concerns creating meaningful valued social roles such as employment, a respectable home, social participation, a sense of self, well-being and reduced discrimination (Anthony, Rogers, & Farkas, 2003). The challenge for the welfare system and the professionals working in the systems is that each person's recovery process is unique; every journey must be based on each individual's wants and needs (Jacobson & Greenley, 2001a). A well known definition of recovery is the following one from Anthony (1993):

> Recovery is a deeply personal, unique process of changing one´s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one´s life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Recovery orientation in practical work

Over the years several models emphasizing the importance of facilitating the recovery process have been developed. These include models such as the rehabilitation model, individual placement and support (IPS), Assertive Community Treatment Team (ACT) and the Strengths Model Case management. The different models have different focuses and use varying techniques in their support, but they aim to function in a similar way. The ACT model is based on a multi-disciplinary team where there is a psychiatrist, nurse, specialist in addiction problems and a specialist in rehabilitation. For continuity it is preferable if the same staff are seen repeatedly over time. One goal is to support the client to be able to live a life in the community. The rehabilitation model focuses on supporting the clients to get the needed services in order to reach their goals and to receive support to increase function in selected roles. The model has a clear focus on role performance. It is important to work together with the client to support skill development and to find effective support in the individual's environment. By building and developing skills and using the support that is available in the surrounding area, the clients become more competent and stronger in succeeding in the roles they have chosen (Anthony & Lindqvist, 2007). In the Strengths model, the focus is on finding strengths and resources within the client, but also in the environment. The model emphasizes a positive belief in the client's capacity to make significant changes in his or her life situation, and the case manager's mission is to support and facilitate this change. The case manager assists the client in gaining access to needed resources. The resources that health care provides are important, but these are only part of the resources that the client may need. The natural resources in the community are also important, such as organizations, agencies, associations and neighbors. These are seen as an oasis of resources and not as an obstacle to the client (Rapp & Goscha, 2012). Using the strengths perspective and supporting the client to find purpose in life is important ingredients in recovery-oriented services (Borg, Karlsson, Tondora, & Davidson, 2009; Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009; Davidson et al., 2007; Deegan, 2005; Farkas et al., 2005; Onken et al., 2007; Rapp & Goscha, 2012; Slade, 2009b; Topor, Borg, Di Girolamo, & Davidson, 2011).

All models use a structure for mapping, planning, implementing and evaluating the client's process. In the rehabilitation model, the first step is to set a rehabilitation diagnosis by assessing the client's readiness for change, thus setting overall rehabilitation goals and assessing abilities of function and available resources. Assessing readiness is not about studying the client's capacity to perform, but rather, it is used to assess whether this is the right time, or whether to wait to make a change until later. The client may not be interested in this at the

moment, but it can also be about self-confidence, and one might have to focus on this instead. Together with the client, the different personal requirements and various options are explored. The next step is to make a clear plan which clarifies who is responsible for what, and at what time plans have to be started or completed. The client and the professional sign the rehabilitation plan which shows that there is an agreement (Anthony & Lindqvist, 2007). In the Strengths Model case management the focus is on four types of strengths: 1.) personal qualities and characteristics, which are experienced as meaningful for the person, 2.) talents and skills, which focus on competencies that the person experiences, such as playing guitar or being a good writer or photographer, 3.) the environmental strengths, such as family, friends and places where the person feels safe, and 4.) the areas of interests and aspirations, such as enjoyment of football or dance. The Strengths Assessment used in the Strengths model is divided into seven life domains: home and daily living, assets and financial insurance, employment/education/specialized knowledge, supportive relationships, wellness/health, leisure/recreational and spirituality/culture. The areas to investigate are the current strengths, the person's own desires and aspirations, and resources in the past personal, social and environmental experiences. The authors of the book emphasize that the assessment is done together with the person and the importance of using the person's language in the assessment. It is also important that the assessment is specific and detailed. The assessment is used during the process and should be constantly updated with new information. It should not be used as an interviewing tool (Rapp & Goscha, 2012).

Professionals can play a significant role in the client's recovery process, which depends on how the professionals act and the attitude they have toward the client. All the previously mentioned models emphasize the importance of a trusting relationship between the professional and the client, and it is often mentioned as characterized by a strong partnership (Farkas & Anthony, 2010). The helpful relationship differs from the non-helpful relationship, which is often described as a distance between the client and the professional, where the professionals make assessments and judgments of the client's situation based on the narrative and tells the client how he/she will solve the problem. The professional views himself as an expert (Slade, 2009b). The helpful relationship, on the contrary, is described as reciprocal where the professional shows that he/she cares about the client (Denhov & Topor, 2011; Gilburt, Rose, & Slade, 2008). The professionals need to change the focus, from making the individual agreeable to treatment to providing hope in order to achieve goals in life based on personal dreams (Davidson et al., 2007). Another important aspect for professionals in recovery-oriented services is to have a holistic view of the client's entire life situation and not to focus only on the

disease. It concerns seeing the client in various contexts such as how he/she works in various roles as a parent, student, etc. (Farkas et al., 2005), and find the purpose in life (Davidson et al., 2007; Deegan, 2005; Onken et al., 2007).

One essential part in recovery-oriented services is to be person-oriented. Each client should be viewed as a person with a holistic view of the living situation, the focus, the work and the environment. The support is also developed here; the importance of involving the client in the process with an emphasis on the client's own choice. Another important cornerstone in the recovery process concerns hope (Anthony & Lindqvist, 2007; Davidson et al., 2007; Deegan, Rapp, Holter, & Riefer, 2008; Farkas, 2007; Onken et al., 2007; Rapp & Goscha, 2012; Topor, 2001).

Hope and the professionals' contributions

Patricia Deegan has written and published many scientific papers about her own experiences in the recovery process. She wrote about the sense of carelessness, a sense that nothing matters, which grows from the feeling of not being in control of one's life. She relays how it seems that every effort that is made in order to accomplish change, such as following treatment plans and medication does not work. Deegan further states that this feeling can be enhanced by professionals, who determine the conditions of the housing, with whom the home will be shared, the rules, and the way in which the money is spent. The sense of hopelessness arises after struggling and still the doors will not open into the community. In order not to feel despair, it is better to be helpless rather than hopeless (Deegan, 1996). Research has shown that a usual strategy of avoiding the feeling of failure is to withdraw social contacts and to show apathy. Professionals may interpret this state as degeneration and start to engage the person in various activities, increase medication doses or replace medication. This can be an obstacle to the recovery process. Professionals may also consider this hopelessness as a symptom of a mental illness with a poor prognosis, and do not expect that the person will change. The professionals may assess the person as lazy, unmotivated and poorly-functioning (Topor, 2001).

The awakening

After a walk on the bottom, the person may finally come to a turning point, which could be described as an awakening and a hope of the opportunity to live a different life, where it is possible to regain control and become independent (Jacobson & Greenley, 2001b; Topor, 2001). An essential part for the person, who gets to this turning point, is to have other people involved, people who are emotionally committed. It is common that the first stage of a change is made for someone else's sake, a child, a parent, an animal or a professional contact.

This longing to be something more than just living with psychiatric disabilities, is a source of hope of a better future (Topor, 2001).

Research of peoples' experiences of going through a recovery process describes it like riding the roller coaster of life, and the most important part in this process was to have someone to trust and to stay and follow this process for a long time, through both the good and the bad periods ("being there overtime") (Anthony, 1993; Davidson & Roe, 2007; Mezzina et al., 2006). One essential part for professionals is to communicate hope in this process (Davidson et al., 2007; Deegan, 1996; Jacobson & Greenley, 2001b; Onken et al., 2007; Rapp & Goscha, 2006; Topor, 2001). It has also been shown that professionals at times may have to convey and carry hope; a trusting relationship between the person and the professional is necessary for this. It is a relationship that is founded on caring and compassion where the professional supports the person's growth, dreams and goals (Rapp & Goscha, 2012).

To build financial security

To financially live on the margin is stressful, which often leads to feeling of hopelessness where it is difficult to put forth any effort into something; surviving from one day to another is the only thing that matters. Not having enough money can often lead to the individual not having the opportunity to put their effort into something other than merely surviving. It is important for professionals to keep this in mind if they are to support the individual's recovery process. It can be very useful to get some "extra money" to live on, which means you do not need to worry about the bills being paid. If the individual is constantly thinking about his or her economic situation, no progress will be made in the process, because the individual will have hands full just getting along financially (Mezzina et al., 2006). Most people experience stress of living under a limited budget with few opportunities for debauchery (Mattsson, Topor, Cullberg, & Forsell, 2008). It is important that individuals have the finances to be able to live in safe and reasonable housing. In addition it is important for them to have access to health care, transportation and facilities for communications (e.g., telephone). It is important to "move" people toward recovery. Poverty and lack of basic resources undermines the sense of security and deters people in their recovery process (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

The person as director of the process

One essential part of supporting a recovery process concerns personal choice and self-determination; to support the person to find and work toward his or her own personal goals. Professionals have to relinquish the role of expert and let each individual direct the process (Anthony, 2003, 2004; Rapp & Goscha, 2012). But self-determination and the ability to make choices does not mean to only enumerate various requests and act according to them. It is important to let the client have the opportunity to reflect and discuss the various choices available and the consequences of each (Farkas & Anthony, 2010).

In order to make well-grounded choices, another necessary concern involves the client who has the ability to influence his or her own recovery process. Researchers talk about "shared decision-making," which means there are two experts in the relationship. The client is the expert on themselves and the professional is an expert in his profession (Anthony, 2010; Borg & Kristiansen, 2004; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Deegan, 2007; Deegan et al., 2008; Mancini, Hardiman, & Lawson, 2005; Rapp & Goscha, 2012; Slade, 2009b). The professionals should set up a “smorgasbord” of choices for the clients to choose from. However, there is a need for humility, for it can be difficult to make one’s own choices and decisions about the future simultaneously. Clients may not be used to this, as other professionals often dictate the best choice. Therefore, it may be useful to gradually teach the individual to make choices, to choose activities and processes that contribute positively to well-being. It also provides a sense of control.

Based on a fear of failure, professionals can hold back the person’s recovery process by not allowing the person to make his or her own choices (Mancini et al., 2005). People must be allowed to fail and learn from their mistakes (Davidson & Roe, 2007). In a trusting relationship the person dares to take risks and dares to fail. It is easier if there is someone to lean on and to support and pep up the recovery process. Failure is part of the growing process (Rapp & Goscha, 2012).

> Recovery does not mean cure. Rather recovery is an attitude, a stance, and a way of approaching the day's challenges. It is not a perfectly linear journey. There are times of rapid gains and disappointing relapses. There are times of just living, just staying quiet, resting and regrouping. Each person's journey is unique. Each person must find what works for them. This means that we must have the opportunity to try and to fail and to try again. In order to support the recovery process mental health professionals must not rob us of the opportunity to fail. Professionals must embrace the concept of the dignity of risk and the right to failure if they are to be supportive of us. (Deegan, 1996, p. 96-97).

To give responsibility

Involving the client in the process increases the likelihood that he/she will become active and take responsibility. One essential part in the involvement is to engage the person in every piece of the work, where nothing is done behind the client's back (Rapp & Goscha, 2012). Research has also shown the importance of allowing the person to choose the way in which the goals will be achieved and in which order things should be done (Onken et al., 2007). For professionals, it is important to participate in the person's process to guide, to be supportive and to be involved (Davidson & Roe, 2007).

It is also important to support the person in taking responsibility for his/her own health and to find the personal strategies for achieving a balance in life, as well as to develop strategies to manage the symptoms that might occur occasionally (Davidson et al., 2009; Deegan, 2005, 2007; Slade, 2010). One essential part is to prepare the person to become an active participant in life and not just let "things happen" (Deegan, 2005; Onken et al., 2007; Ridgway, 2001). One part of this is to find pharmacology that fits in accordance to life as a whole, but also to find non-pharmacological strategies such as singing in a choir, taking care of animals, being a parent, or being active in a recreational association (Deegan, 2005, 2007). This involves using the health care and medications in a more active way (Deegan, 1996; Schön, 2009). From a recovery perspective, there is a significant difference between voluntarily "putting themselves" in inpatient care during a difficult period than an involuntary stay in inpatient care. This distinction is not often mentioned in evidence-based practice studies (Anthony et al., 2003).

Facilitating a life in society

One essential part is to support the client to change his/her view of him/herself from an identity as psychiatric disable to an identity that is meaningful and prosperous. Even though the symptoms of the psychiatric diagnose can recur, it is important to assist the person to ensure that the disease is not the "whole personality," but only a part of the individual (Mancini et al., 2005). A great part of the research of recovery emphasizes the need to work to develop social networks. Social networks are found in different social arenas such as the workplace or in school, but they can also be developed through membership in an association, and of course contact with family and friends (Piat, Sabetti, Fleury, Boyer, & Lesage, 2011; Slade, Adams, & O'Hagan, 2012). Recovery occurs in a social context, where it is important to create a life under "normal" circumstances (Mezzina et al., 2006). People with psychiatric disabilities are not a homogeneous group, which means that each individual has different dreams, aspirations and goals in life, and are supposed to be given the same chance to live a fulfilling, meaningful life in society as other citizens (Farkas & Anthony, 2010). Practitioners can encourage the person to find a supportive social environment and support the person to improve or develop valued social roles by finding an activity that gives meaning, such as being a parent, a student or an employee, or a member in an association in order to support social inclusion (Anthony, 1993, 2003; Craig, 2008; Davidson et al., 2010; Deegan, 2005; Farkas, 2007; Mezzina et al., 2006; Slade, 2009a; Topor et al., 2011).

In social environments individuals are given the opportunity to meet others who can be supportive and provide hope (Mancini et al., 2005; Schon, Denhov, & Topor, 2009; Topor, 2001). For many persons with psychiatric disabilities the step into the labor market can be important, as it helps the person enter into the community, where one can be respected and cease to be financially dependent on welfare benefits. It also opens up a natural way for rewarding relationships based on mutuality and shared responsibility (McGurk, Mueser, DeRosa, & Wolfe, 2009). Being out in the workplace increases the chances for personal development. It creates opportunities to learn a trade and become good at it, to feel needed and appreciated. Work also provides structure to the day: you get up, go to work, come home and you are ready to get into bed at night. It provides stability in life, something that is especially important in the recovery process (Dunn, Wewiorski, & Rogers, 2008).

Social relationships also fulfill a function, as it may be important to recognize that all people struggling with problems in life; this makes your expectations more sensible (Topor, 2001). It is important to distinguish between the difficulties of life and the symptoms the client is experiencing. Those who have a large social

network are happy, have more hope and are more oriented toward goals and success in their recovery process (Corrigan & Phelan, 2004).

Empowerment

From a recovery perspective, empowerment plays a central role and many of the strategies are used in recovery-oriented services, where one essential part is to increase the sense of empowerment. There are aspects that give the person the power to make personal choices, to get information from available resources and provide options that actually present a choice; not just a single option that requires a yes or no response. It involves making important decisions concerning one's own life, to see things from other perspectives and to revalue the person and his/her own abilities. It is also important to get the sense of being a part of a group, understand the rights, to learn what others value as important, to view others with capabilities, to keep changing and growing as a person, and to increase the positive view of the self (Chamberlin, 1997). Empowerment means, as in recovery, to have the personal power to have an impact on one's own life, instead of just being a receiver of support. The emphasis of empowerment lies in the resources and abilities instead of the deficits. Dimensions of empowerment are related to self-esteem, self-determination and the ability to act (Bogarve et al., 2012). In a literature review empowerment in recovery-oriented services was found to include giving personal responsibility, getting control over life and focusing on strengths (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

Part of recovery is to achieve a sense of empowerment, which means that the clients feel that they have the strength to make their own choices and have control in life, to no longer see themselves as helpless, to have the courage to dare to take risks and to leave the safe and to meet challenges. There is a feeling that develops within the person, but there are also external factors that are crucial (Jacobson & Greenley, 2001b). It is not enough to have individual strength; welfare systems must also encourage and allow the individual to grow and to create conditions for different options (Jacobson & Greenley, 2001b; Ralph, 2000).

MOTIVE FOR THE STUDY

People with psychiatric disabilities are not a homogeneous group, and there needs have changed since the Mental Health Reform was enacted in 1995. This means that services in the welfare system are facing new challenges; people with psychiatric disabilities are not only found in psychiatric care. At the same time, the use of recovery principles is becoming more important in supporting people with psychiatric disabilities. The concept of recovery is used as a guiding principle in many Western countries, and mental health services in Sweden are moving toward recovery orientation. For example, the NBHW recently published new guidelines regarding support to individuals diagnosed with schizophrenia (Socialstyrelsen, 2011a).

The PO service was developed in connection to the Mental Health Reform with a mission to, together with the client, identify needs of care/support, rehabilitation, and support the client to reach his or her own goals by finding services that promote the recovery process. The service was given a freestanding position to be able to negotiate and support he client to get needed services. The NBHW is very clear on the point that POs are not supposed to provide their own services that can be found elsewhere (Socialstyrelsen, 2008). Despite this, a study of Markström, Lindqvist, & Sandlund (2009) showed that POs in rural areas provide own support. Another study of the PO service has shown that clients are satisfied with the POs' support, where the relationship was described as a "professional friendship" with whom the client felt free to share experiences of life (Berggren & Gunnarsson, 2010). Research has also shown that POs act as negotiators and in this way support the client's change and development of empowerment (Berggren, Blomberg, & Petersson, 2010). The PO service has not been viewed from a recovery perspective, which would be interesting. The study of Järkestig Berggren (2010) indicated that POs may play an important role in the clients' recovery process. She also concludes it is important to define the PO service and then it is possible to evaluate the effects. The concept of recovery has moved from being a vision to principles to a method (Bogarve et al., 2012). The guidelines written by the NBHW for the PO services are recovery-oriented, but no one has explored in what way the POs use these guidelines in their practical work. POs also have an unusual role in the welfare system, and it is interesting to find out more about their experiences from this role.

AIM OF THE STUDY

The overall aim was to explore the experiences and knowledge of POs and how they relate to the client's recovery, as well as their own role of supporting clients in the recovery process.

Paper I — The aim of the study was to investigate the extent of knowledge and the attitudes regarding the concept of recovery among practitioners working in the Swedish mental health system, Personligt Ombud (PO), Supported Housing Team (SHT) and Psychiatric Out Patient Service (POPS). Do knowledge and attitudes regarding recovery vary among these different groups of practitioners?

Paper II — The aim of the study was to explore what supportive strategies POs use in their work with clients having PO support.

Paper III — The aim of the study was to investigate the components that POs found to be important in the relationship with clients.

Paper IV — The aim of the study was to investigate POs' experiences of working from a freestanding position when supporting clients.

METHODS

This thesis has a focus on recovery with a special focus on the PO service; both quantitative and qualitative methods were used. The PO service is interesting, because its principles in many cases resemble those in recovery-oriented practice. Therefore, it was interesting to investigate if POs knowledge and attitude toward recovery differs from other personnel groups, in this case Supported Housing Team (SHT) and the Psychiatric Outpatient Services (POPS). These two services also have the mission to support people toward change, but their guidelines are not as founded in recovery as POs. In three of the studies the focus is on POs and their practical work, and how POs perform, act and experience their practical work.

Table 1. Overview of the four studies

Design	Participants	Method for data collection	Method for data analysis
I Quantitative	Personnel in 512 -POPSs 220 - SHTs 245- POs Total 977 personnel Response rate: 311 – POPS (61%) 122- SHT (55%) 178 – POs (73%) Total: 611 personnel (63%)	Web based questionnaire Recovery Knowledge Inventory (RKI) June – August 2010	Multiple linear regression
II-III Qualitative	22 POs (6 men and 16 women)	Telephone interviewing Interview guide Interviews lasted between 45-90 minutes The interviews were recorded and transcribed into text. December 2010 – February 2011	Manifest Qualitative content analysis
IV Qualitative	22 POs (6 men and 16 women)	Telephone interviewing Interview guide Interviews lasted between 45-90 minutes The interviews were recorded and transcribed into text. December 2010 – February 2011	Latent Qualitative content analysis

Paper I

In the first study, a questionnaire was sent to three different groups of personnel, all of whom supported people with psychiatric disabilities to accomplish changes in life. However, their main missions differed. The POPS are responsible for treatment and medication, and the SHT who are organized within the Social Services in municipalities have a mission to provide social assistance, such as residential support. The third group consisted of POs, the Swedish version of CMs. The questionnaire was sent to prospective participants in June 2010, and the aim was to investigate the attitudes and the level of knowledge regarding recovery in the groups and to determine if there were differences among the three different groups of personnel.

Study population

In 2010, there were 322 POs in Sweden who were organized into 104 small services (Socialstyrelsen, 2010d). All of these services were asked to participate in the study. The POPS and SHT are larger services, and in order to ensure that different parts of Sweden were represented, and to achieve a reasonable size for each sub-sample, the SHTs were chosen by a stratification using Statistic Sweden (SCB) categorization of municipalities. Each municipality was placed in one of six strata, based on the population size. The POPS at county level were chosen in a similar way, with northern, central and southern parts of Sweden as strata. Municipalities and counties were then chosen randomly and 17 municipalities (with SHTs) and 7 counties (POPSs) were invited to participate. The head of services of 13 SHTs, 4 POPSs and 35 PO services approved of their personnel's participation in the study. The questionnaire was sent to 512 personnel in POPSs, 220 in SHTs and 245 POs, a total of 977 personnel.

The Recovery Knowledge Inventory (RKI)

The Recovery Knowledge Inventory (RKI) is a validated instrument developed by (Bedregal, O'Connell, & Davidson, 2006). It contains 20 items divided into four subscales: (A) roles and responsibilities (7 items), (B) non-linearity of the recovery process (6 items), (C) the roles of self- definition and peers in recovery (5 items), and (D) expectations regarding recovery (2 items). The response set is the same in all subscales, from strongly disagree (1) to strongly agree (5). To avoid respondents choosing socially desirable answers, the response sets were placed in different directions. The questionnaire included gender, age, educational level such as psychiatric aide/nursing assistant, university (bachelor degree), one year education (i.e. treatment assistant at high school level), further education such as registered nurse (district nurse or psychiatry nurse), psychotherapist step 1, registered psychotherapist step 2 and training in motivational interviewing (MI) and solution

focused interviewing, small training courses within occupation, relevant work experience and training in recovery.

The RKI was translated from English to Swedish and reviewed by a Swedish speaking expert in English. Then it was tested by personnel with experience from psychiatric health care and from rehabilitation work.

Statistical analysis

The results generated generic numbers ranging from 1 to 5, where higher scores represent a better understanding, according to (Bedregal et al., 2006). The result was normally distributed, and, therefore, a multiple linear regression was used. Since results from the multiple linear regressions are robust to departures from true normality in the response variables, it was assumed that the analysis itself gave correct results. The means from the four subscales were compared across the three main categories of personnel and to control and estimate confounding variables in the linear regression model, indicator variables were used. In order to reduce the model, non-significant indicators were removed from the equation one at a time. Then the levels of subscale means in different categories of personnel became more easily interpretable. Due to theoretical reasons, however, educational level, relevant work experience and training in recovery, were exempted from removal regardless of p-value.

Papers II - IV

To gain an understanding of how POs developed their methods in accordance with their principles, interviews were conducted with POs across Sweden. The interviews took place from December 2010 to February 2011. The interviews were rich; POs shared lots about their practical work experiences. During the analysis of the second paper, it was discovered that the interviews were telling much about the relationship, and therefore, the third paper was added, focusing on the relationship. The fourth paper focused on the experiences of their role as POs.

Study population

In the qualitative method it is important to obtain extensive descriptions and variations of these descriptions (Graneheim & Lundman, 2004; Sandelowski, 2000). One way to accomplish this is to use purposeful sampling (Patton, 2002). Therefore, the attempt was to get in touch with POs across Sweden, from cities, urban areas and rural areas. They differed from each other in age, educational background and work experience. The heads of 23 PO services were provided information about the study and a request for approval for participation. The

heads of 18 PO services approved their POs' participation in the study. Finally, 22 POs (6 men and 16 women) were interested in participating and were interviewed.

The interviews

An interview guide was developed and used during the interviews as an instrument to maintain structure. The goal was to work from an inductive perspective. The guide covered different themes, such as entrance to the PO service, examples of a typical case, ending contact and management group. The questions were held to "how" questions, e.g., "How do the clients get in touch with the service, and what happens next?" "How do you act then?" POs were also asked to reflect about difficulties and possibilities in their role. Follow-up questions were used: "Earlier you said something about – Could you develop that?" or "Can you give me an example of when you did it like that?"

Since POs were selected from different geographical parts of Sweden, the interviews were conducted by telephone. The interviews lasted between 45-90 minutes and were, with the permission of participants, recorded and transcribed verbatim into text. The transcribed interviews consisted of 417 pages written text.

Analysis

In all three papers (**II, III** and **IV**), qualitative content analysis was used. Qualitative content analysis is an analysis whose interpretation level is close to the original material, but can still clarify the content of the text (Elo & Kyngas, 2008; Graneheim & Lundman, 2004; Kvale, Brinkmann, & Torhell, 2009; Patton, 2002; Sandelowski, 2000). Even if the intention was to keep the analysis at a descriptive level, researchers always do something with their data, and, therefore, any analysis involves interpretation (Sandelowski, 2010; Sandelowski & Leeman, 2012).

The analyzing procedure followed the steps recommended by (Graneheim & Lundman, 2004). However, two different ways of carrying out the analysis were used. In paper **II** and **III**, the analysis was held on a manifest level because the aim was to describe how POs transformed the given principles into practical work. However, a main theme was found in paper **III**. Paper **IV** focused on experiences of the role of the PO, and the analysis was carried out at a latent level. The difference between manifest and latent level in qualitative content analysis lies in the interpretive level. Analysis at the manifest level concerns the visible and evident content, which means the analysis has a low degree of interpretation, and the categories answer the question of "what." The latent analysis, however, has a higher degree of interpretation and focuses on the underlying meaning and themes, the meaningful essence, and something that reoccurs through the material.

The material has to be read through several times and thought about, i.e., What is this about? (Morse, 2008).

The analyzing processes were performed in accordance to the model presented by (Graneheim & Lundman, 2004). The first step was to read the written interviews several times to get a sense of what the interviews were about, a sense of the whole. The next step was to divide the text into meaning units, which were shortened into condensed units, a shorter description that provided the central meaning. In papers **II** and **III**, codes were made from the condensed units, which were labeled closely to the content of the text. The codes were examined and compared to each other, and finally those codes that were considered as belonging were sorted into sub-categories. From the sub-categories, categories were created. From the categories, main categories and themes were identified.

Table 2. Example of the analysis process paper II and III

Meaning unit	**Condensed meaning unit**	**Code**	**Sub-category**	**Category**	**Main category/theme**
He was very clear about the kind of support he wanted. He wanted help in contact with this unit and he wanted an investigation.	He was very clear about the kind of support he needed. He wanted help in contact with this unit.	People know what they want from the PO.	To have a clear thought	Defining goals	PO as a facilitator of an active changing process
They cannot always formulate what kind of support they want. But when we got to know each other, you don´t want to rush. It is important to give the client time.	The client may not always know what kind of support they want. It is important to give the client the necessary time.	Clients do not know what they want.	To find goals together		

In paper **IV**, the analysis was held to a more interpretive character, and the steps in the analysis differ. However, the first step was to reread the interviews to get a sense of the message. Then, meaning units relevant to the aim were identified. The meaning units were condensed into shorter descriptions close to the text/data. The next step was to interpret the underlying meaning of the condensed version. The interpretations that were found to be repetitive were brought together into sub-

themes, which built themes. The analyzing process consisted of movement back and forth between the whole and the parts of the text. The analyzing process also consisted of asking such questions as: "What is this about?" and "How do the POs experience their roles?"

Table 3. Example of the analysis process paper IV

Meaning unit	**Condensed meaning unit** **Description close to the text**	**Condensed meaning unit Interpretation of the underlying meaning**	**Sub-theme**	**Theme**
But, of course, to not be obligated to do any documen-tation, and not being obligated to take part in planning groups and conferences, we are free to use our available time to decide.	Not being obligated to do documentation or take part in planning groups or conferences. We are free in using available time.	Being free in using the time and not being bound in organizational frames.	Being unbounded	Being free and directing one's own work
Well, you have to think all the time. Take a stand. Is this right? Where is my limit? What are the roles and the mission?	You always have to think and take a stand for where the limits are in the role and mission.	The need to take responsibility for the actions and what is and is not included in the role of the PO.	Being responsible for one's own work	
… It is that which gives me the possibility to listen to the client, and not have in mind that I have an organization I need to consider in the first place. It is from those premises I can listen to the clients' wishes.	I can listen to the client and not have the organization to consider. I can listen to the clients' wishes.	Not representing an organization, but the client.	Representing the client	

Ethical considerations

The ethical codes and guidelines were followed in accordance to the recommendations from CODEX and the publication of Vetenskapsrådet (2011) (Swedish Research Council). This involves informed consent, confidentiality and use requirements. Since the participants was asked to participate and answer questions regarding their work, the first step was to send a letter to the heads of the presumptive services with a request for approval for the employees to participle in the study. The letters covered the information in the study, the aims of the study, the procedures and the way in which the personnel would be contacted. Information was also provided on how the personnel could, without stating a reason, end the participation. Information on the analysis process was also included. It was explained that the materials would be kept in a locked cabinet and properly handled. After the approval of the heads was received, an e-mail was sent to the presumptive participants with information regarding the study. They were assured that participation was voluntary and were requested to participate in the study. The e-mail consisted of the same information sent to the head of the service.

In paper **I**, the web designed questionnaire, the first page consisted of an information letter. After reading it the presumptive participants could choose to move on and access the link leading to the questionnaire. The web program was programmed so that the reminder letter was sent automatically to those who had not answered the questionnaire. In papers **II, III** and **IV**, the POs who were interested in participating in an interview responded by e-mail, and they were contacted by telephone for further information about the study. They were given the opportunity to ask questions and to make an appointment. Before the interviews were conducted, there was an additional opportunity to ask questions. In the transcribed text, the interviews are named using Interview 1, Interview 2, etc. There was a code list, but interviews and the code list were kept separately. The material was placed in a locked cabinet for ten years in accordance to Mid Sweden University's policy (MIUN 2008/1550).

The Research Ethics Committee of Mid Sweden University approved the study on March 18, 2010.

RESULTS

Paper I

Knowledge of recovery

The aim of paper **I** was to investigate the extent of knowledge and attitudes regarding recovery among personnel in the mental health system (POPS, SHT and POs). The results of the study showed that personnel overall had a great deal of knowledge about roles and responsibilities and the role of self-definition and peers in recovery. The results also indicated a need to expand their knowledge of non-linearity of the recovery process and the possibility for everyone to actively participate in the recovery process. These were the subscales on which the personnel had scored the lowest. The results also showed differences in knowledge and attitude toward recovery among the different personnel groups.

The linear regression showed that there were significant differences between POs and the POPS where POs had scored higher on all four subscales when controlling for other variables in the regression model. POs also scored higher than the SHT across the four sub-scales, even if the differences were not significant on scales B and C.

The regression model also showed that personnel with a university education scored higher on all subscales, and the difference was significant from psychiatric aide/nursing assistant at three of the subscales (except for the role of self-definition and peers in recovery). The results also pointed to the fact that personnel with more work experience had greater knowledge. They scored higher in all scales, and the differences were significant in three of the sub scales (A, C and D*). Another interesting result was that personnel who had training in recovery scored significantly higher at two of the subscales (B and D*). These were the two sub-scales in which personnel scored the lowest.

Table 4. Linear regression of mean differences from respective reference categories

	A	B	C	D*
Level of reference categories**	4.01	3.12	4.11	3.28
Personnel category				
POs (ref)				
SHT	- 0.16 (p = 0.010)	-0.13 (p = 0.083)	-0.06 (p = 0.254)	- 0.50 (p = 0.000)
POPS	- 0.14 (p = 0.004)	-0.41 (p = 0.000)	-0.15 (p= 0.001)	- 0.47 (p = 0.000)
Educational level				
Psychiatric aide/nursing assistant (ref)				
University	0.17 (p = 0.000)	0.21 (p = 0.000)	0.02 (p = 0.611)	0.26 (p = 0.018)
One year education	0.24 (p = 0.030)	0.14 (p = 0.345)	0.14 (p = 0.177)	-0.08 (p = 0.742)
Relevant Work Experience				
More than 10 years (ref)				
Less than 10 years	-0.16(p = 0.001)	-0.13 (p= 0.035)	-0.11 (p = 0.010)	-0.25 (p=0.013)
Training in Recovery				
No (ref)				
Yes	0.10 (p = 0.104)	0.16 (p = 0.030)	0.02 (p = 0.675)	0.33 (p = 0.016)

A. Roles and Responsibilities
B. Non-linearity of the recovery process
C. Role of Self- definition and peers in recovery
D* Not everyone is capable of actively participating in the recovery process

** The mean of all reference categories

It was interesting to note that although POPS and POs had the highest proportion of university graduates and the greatest amount of work experience, categories that are higher on the scales, the POPS as a group has a lower average score and differed significantly from the POs regarding attitudes and knowledge toward recovery. However, SHT, which had the most psychiatric nurse/nursing assistants and where most personnel have less work experience, scored higher than the POPS. A possible explanation for the differences in attitude and knowledge may be found in differences in the organizations, missions and roles. Another interesting result was that training in recovery has a positive impact on knowledge regarding non-linearity of the recovery process and that everyone is capable of actively participating in the recovery process. These are the areas in which the results indicated that personnel needed to expand their knowledge. All of these factors may be important to consider when developing a recovery-oriented practice.

Paper II

Strategies used in working with clients

The aim of paper **II** was to explore the supportive strategies POs use in their work in order to support their client's recovery process. The findings from the analysis showed that POs were *facilitators of an active changing process*, where the ultimate foundation of the PO service was about client's choice and placing the client as the director of the work. The client has to be active in making personal choices; POs do not do things *to* or *for* the client, but *with* the client. Much of the work in the role of PO is about discussions. Another ingredient in POs' support was about strengthening the client, both internally by reflections and teaching the client the system and how to navigate it, and also externally by negotiating and connecting the client to necessary and available services. POs used several strategies, such as defining goals, acting to push the client forward, acting as mentors, strengthening the client and mobilizing external resources. One important goal was to move the client toward greater independence and to have him/her create and maintain contact with other supportive services.

Figure 1. Findings from the analysis, categories and main category, paper II

It was typical for clients to desire some kind of change when seeking PO support, and the willingness for change was the starting point. Therefore, it was important for POs to act immediately when the client was motivated for a change. However, they needed some kind of goals to work toward, and POs used several strategies for this. Some clients did not have any idea of what to do, just a wish that life would be different. Others, however, had clear goals and ambitions when they sought PO support. There were also PO services where the client needed to have a clear goal before PO contact began. Once the goal was set, POs tried to keep the process active, because it was important for the client to feel as if something had happened. For example, if the client was at risk of losing an apartment, the PO acted by making phone calls to the landlord and trying to establish payments plans. POs also gave the clients a ride to important meetings with authorities just to make sure they would take place.

Another important part of the active process was for the PO to act as a mentor and strengthen the client. POs explained the welfare system, how different laws and legislation worked and how case workers based their decisions. It was common for POs to prepare the client before meetings, where together they reviewed what the meeting was to be about and what issues the client wanted to raise. One part of

mentoring was to set up a "smorgasbord" of available options from which the client could choose. This strategy made it easier for the client to make well-grounded choices because he/she was aware of different consequences and could be prepared for them. Another essential part was to discuss the consequences of different choices and involve the client in the process. Some of the clients were struggling with negative feelings/emotions that adversely affected them. This was an obstacle to the changing process and POs tried to support the client to reflect about these things and what was needed to move forward. POs also supported the client externally by connecting clients with various external resources, which the client wanted, needed and were available; these were mostly formal resources, even if sometimes POs also contacted the informal resources. One part of the PO's work was concerned with negotiating, and they often had to balance the needs of the client against the authorities' frameworks to find beneficial solutions. In contact with other services or authorities, POs found it was important to communicate and demonstrate that they were on the client's side. Another essential part of the PO's work with clients was to create stability and bring structure to the process by making sure that agreements with authorities were maintained and accomplished.

Paper III

Important components in the relationship with clients

During the analysis of the second study, it became apparent there was something more that permeated the PO service. It concerned the relationship between POs and the client, which made it interesting to investigate this closer. Therefore, the aim of paper **III** was to investigate components that POs found important in the relationship with clients. The relationship was the key for being able to work together with the client, and if there were no relationship it would not benefit the client. Therefore POs put forth the effort to connect with the client with an understanding and non-judgmental attitude. Each relationship differed, and some relationships were deeper than others. However, the depth was not the most important aspect; instead, the findings showed that POs found that important components in the relationship centered around trust, a balance of power and the personal tone of the relationship. These findings were together reflected in a main theme: *the importance of creating a personal working alliance with each client.*

POs found it necessary to connect in some way with clients; it served as a platform for working together. To do different activities together was one way in which this was accomplished. POs had no formal power in the role, and this was one reason that the POs experienced themselves as non-threatening to the client, which benefited the relationship. The analysis showed that the foundation in the relationship was to create a working alliance where one essential part was about

trust. The client had to trust the PO, but the POs also wanted to trust the client as well. POs choose to trust their clients, even if they are aware that they could be misled, which seldomly happened. Another necessary part was to be honest and respectful toward each other. It was also essential that sensitivity be part of the working alliance. The client chose the aspects in life he/she wished to share with the PO, and it was important to move slowly and not be too straightforward. The analysis showed that POs tried to have the client in the center of the work in several ways, and strived to keep the client's best interest in mind. Another central part of the working alliance was that power was balanced. POs tried to work collaboratively by allowing the client be the expert on themselves, while the POs shared their knowledge. The client was given the power to decide where to meet and directed the process, and POs showed that they stood by the client's side in the choices made.

The findings from the analysis also showed that the relationship often had a personal tone, where the POs became a part of the clients' everyday life. They discussed everyday matters, and often POs obtained valuable information about the client's life, for example about difficulties, interests, children, family and friends. POs also disclosed some things about themselves; it was important to let the client get a picture of who the PO was as a person. However, the PO did not disclose as much information as the client, and they did not share the same things to each client. It depended on the client and what was deemed appropriate at the time. The relationship between the PO and client maintained a professional nature, and it was important for the PO to put some limits on the relationship, such as not calling after working hours. POs tried to be available to the client and often made phone calls between meetings, did not use telephone hours and tried to return calls every day. POs also tried to be available for the client in times of crisis. If there were no other solution, the PO could make him/herself available after working hours. POs were persistent and patient, and it was difficult for the clients to fall out of the PO service; both the client and the PO had to agree to ending the contact. If the client did not open the door or did not show up for an appointment, the PO kept seeking contact.

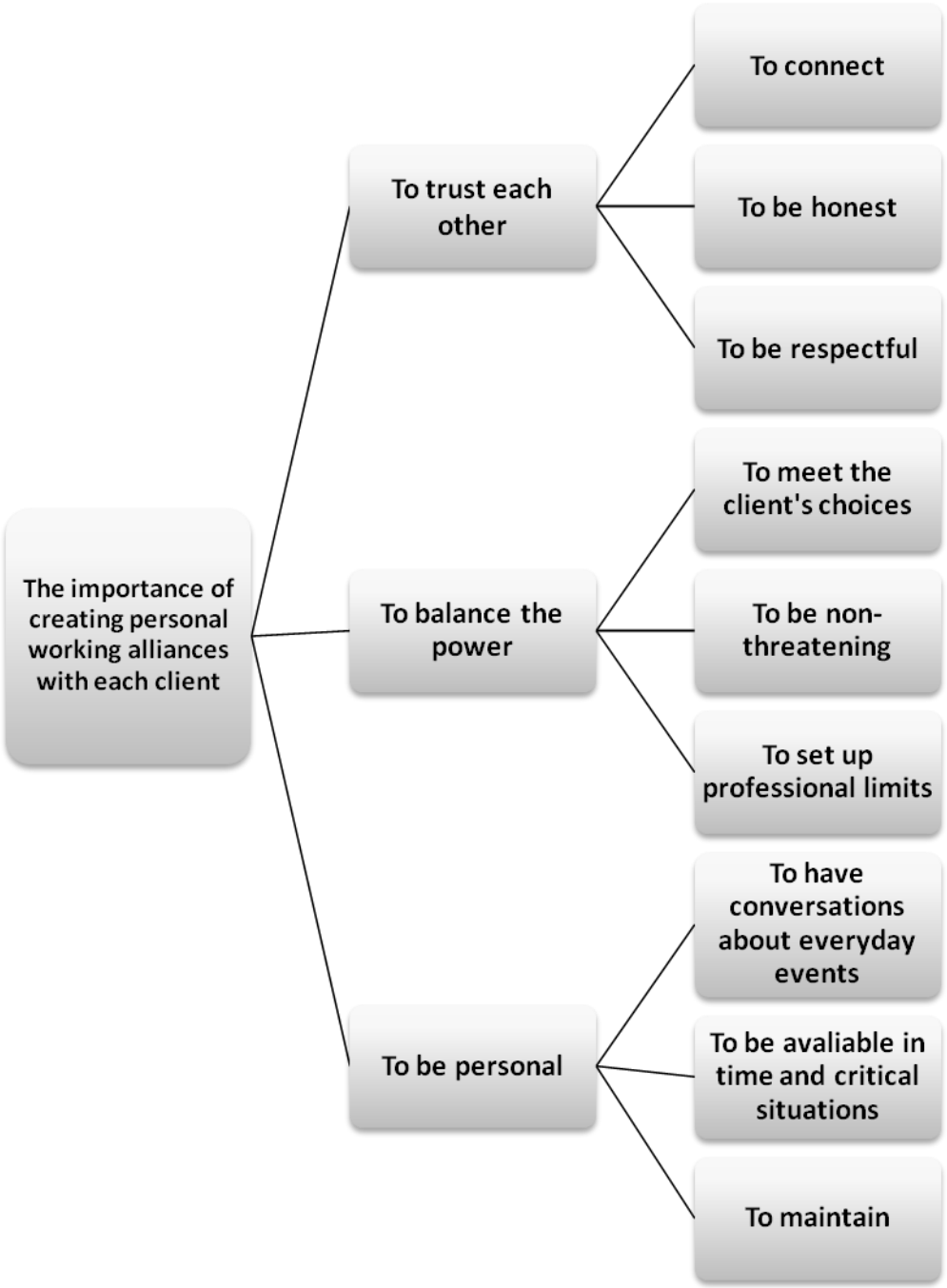

Figure 2. Findings from the analysis, categories and main theme, paper III

Paper IV

Experiences of supporting from a freestanding position

The PO service differs from other services in the Swedish welfare system as well as from other CM models. The aim of paper **IV** was to investigate POs' experiences of working from a freestanding position when supporting clients. The findings from the analysis were generated into four themes. POs found their role as being free and self-directed. The role also requires competence about the society, agencies and available services. However, POs also had a need for reflection and felt they had to work to gain legitimacy.

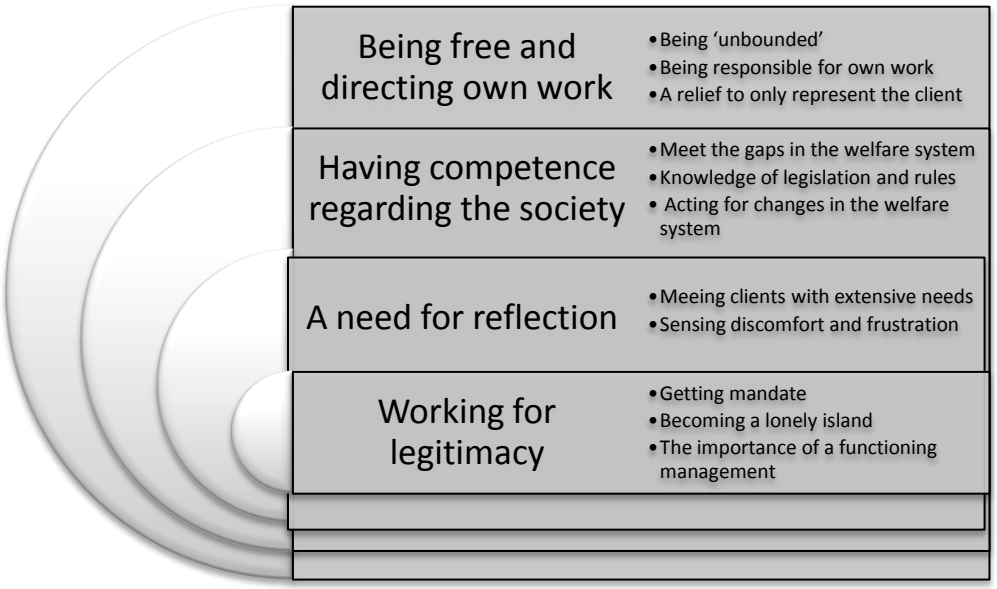

Figure 3. Findings from the analysis, themes and sub-themes, paper IV

POs experienced being unbounded which gave them lots of autonomy in their work together with each client. POs did not have to consider any organizational frames, for example POs were not obligated to any administration. POs were not required to maintain formal records, and there was no need for referrals to enter the service. The autonomy in the role made it possible for POs to take part in several areas in the client's life. This often led to POs getting a holistic view, based on the living situation of the client. The role of the PO was also connected to responsibilities, especially since many of the interviewed POs had no present leader, however there were some PO services that had a leader among the colleagues or an administrative leader. Having a non-present leader put demands in the role, POs experienced they needed to work independently, especially when

POs often made decisions concerning work. The findings showed that POs have the responsibility to accept or deny a client's wish for having contact with a PO. However, the analysis also showed that they had developed their own system where they met the client and then discussed the client's need for a PO at a meeting with PO colleagues. There were, however, no frameworks upon which to base the decisions. The decision was often based on the POs opinion of the client's needs, and the POs emphasized that the focus was *not* on the diagnosis. According to POs, they seldom denied clients who wanted to make contact with the service. The freestanding position also provided a signal to the client of who the POs were primarily representing and it was important for POs to mark this position, and often they were located separated from other authorities.

POs experienced that the client's needs and experienced problems had changed over the years, and today the clients are facing multidimensional problems, which involve health conditions, social conditions and financial conditions. A result of this was that several actors often got involved in the clients life. One essential part in the role as PO was the demand of a great deal of knowledge about the society and the welfare system. POs described they had the possibility to "surfing" in the system and the result of this was that POs developed knowledge about the system and where the client were likely to "fall between the stools", and find ways to avoid the pitfalls, but also be able to advocate on behalf of the client. POs got in touch with several actors in the society, the social services, health care services, the Public Employment Services, the Social Insurance Agency, banks, the police, landlords, etc. In the work together with the client, POs met several gaps in the welfare system, which could be an obstacle in the client's process, for example the frequently changing of personnel and application forms which were hard to understand and complete, medical forms which lacked of required information for applying for important financial benefits. Findings from the analysis also showed that POs experienced frustration in their role, where they felt there was a need to reflect about their work in order to be able to see things from other perspectives and to maintain professionalism. The frustrations were mostly raised from meeting with other authorities and sometimes it could lead to feelings of powerless. POs also expressed that there were clients who raised feelings of discomfort, which they needed to handle.

The freestanding position may also entail problems, for example there was a risk that the POs will become isolated and end up in the same negative position as the client; therefore it was important that POs to develop good platforms both with the management group as well as to other actors in the society. But POs worked for getting legitimacy where one important aspect was to obtain a mandate from the

managers at the authorities as well as the personnel. One part of the role of POs was to act for changes in the welfare system and it was important that the criticism that was delivered was well-grounded and based on fact. The management group was viewed as important, and POs found it necessary to have all authorities present as well as the user organisations. POs also found it important that the people in the management group needed to have mandates to make decisions concerning their own organizations, and that this would facilitate their work because it would make it easier to work with changes in the welfare system. Unfortunately, it was typically the management group that was lacking; representatives frequently changed and all important members were not involved in the management group. The findings also showed that there were some management groups that functioned well, but there were also non-functioning management groups who did not understand the mission of the PO. In these cases POs experienced their work as difficult, and there were disagreements of when for example end contacts with clients.

DISCUSSION

The overall aim the thesis was to explore the experiences and knowledge of POs and how they relate to the client's recovery, as well as their own role of supporting clients in the recovery process. As described previously, the PO service is interesting in many ways, because of the freestanding role; they have an unusual role in the Swedish welfare system, because they do not belong to any authority (Lindqvist, Markström, & Rosenberg, 2010). The result of paper **I** showed that POs had more knowledge and attitudes toward recovery than SHT and POPS. The findings of paper **II, III, IV** showed that POs had from the guidelines from NBHW, developed a method which often involved components which are emphasized as important in a recovery oriented practice. For example, POs put the client in the driver's seat and had developed strategies that facilitated the client's recovery process. However, the role of PO also involved various challenges.

Putting the client in the driver's seat

The guidelines of PO services emphasize the client's choice (Socialstyrelsen, 2002b), and the overall impression of the findings from the interviews was that the client is the main focus and the center of the PO's work; client's choices permeate all work POs and clients do together in various ways. The client sets goals, directs the process, and chooses subjects of conversations, the depth of relationship and locations for meetings. Even if the client owns the final decision, much of the PO's work includes discussions and collaboration with clients. It is in these discussions that they discuss consequences of different choices, goals and life as a whole **(II, III)**. This approach makes POs the co-driver and the client is put in the driver's seat. Allowing the client to make his/her own choices is one of the key ingredients in recovery-oriented services (Rapp & Goscha, 2012; Slade, 2009b).

The working alliance – acting as a team

The relationship between the PO and the client was characterized as a working alliance. To build a working alliance or develop a partnership with clients is often described as an essential part in recovery-oriented services (Farkas & Anthony, 2010; Rapp & Goscha, 2012; Slade, 2009b; Topor et al., 2011). Several aspects may contribute to this and one of them is that the client seeks the PO's support. Typically, they are looking for some kind of change in life, which may be a good platform from which to start work, because the client may have greater willingness and be more motivated to work for change. Findings from the paper **II** showed that there were differences in supporting defining goals. One way was that the client needed to have a clear mission when seeking PO support. There were also clients who had a clear wish and there were clients who just wanted a change and

did not know where to start. From a recovery perspective, it is important for POs to be aware of the fact that working with clients' choices does not mean that clients "order jobs." The discussions and collaborations play an essential role in supporting the client to make well grounded decisions (Farkas & Anthony, 2010).

Another essential part for the relationship may be that POs solely represent the client **(IV),** which may signal to the client whose side the PO chooses. The findings showed that trust was an essential part in the relationship between the PO and the client **(III)**, and the fact that POs only represent the client may contribute to trust in a positive way. Another central part of trust concerned the way in which the PO acted in contact with clients, such as being honest and respectful **(III)**. Another part of building the working alliance was that the relationship was equalized in that POs act in accordance with clients' choices and without any formal power **(III)**. However, POs do have some power because of their knowledge in the professional role, and the client asks for and needs this knowledge, but it is as equalized as a professional relationship can be. The working alliance was also characterized by collaboration, where both parts shared their experiences and knowledge in their ambition to move forward in the process **(II, III)**. Even if POs work in accordance with the client's choices, the findings from the interviews showed that the role as PO was to functioning as a sounding board, which involves discussion with the client about the different options and consequences of different choices **(II)**. POs set up a "smorgasbord" of different options from which the client can choose. But as Chamberlin (1997) emphasizes, there cannot be only one thing to choose from; there must be several options. To set up many different choices can, however, be difficult in some of the sparsely populated areas in Sweden where the selection of services is smaller (Socialstyrelsen, 2005c). However, this kind of collaborative work is often described as important in recovery-oriented services (Anthony, 2010; Borg & Kristiansen, 2004; Davidson et al., 2005; Deegan et al., 2008; Mancini et al., 2005; Rapp & Goscha, 2012; Slade, 2009b). This kind of collaboration resembles a lot of shared decision-making as described by (Anthony, 2010; Borg & Kristiansen, 2004; Drake & Deegan, 2009). POs engage the client in the relationship **(III)**, but also take an active part in the process **(II)** by using this collaborative strategy. One positive aspect of this was that the client got involved and engaged in the process, and since the client owns the final decision, the client somehow made active choices. Engagement has been shown as an essential part in recovery-oriented work with clients (Farkas & Anthony, 2010; Rapp & Goscha, 2012).

Meet the client on his/her playground

The NBHW guidelines emphasize that the PO should meet the clients in their environment (Socialstyrelsen, 2000, 2002b, 2011b) Findings from the study showed that POs used this principle by letting the client choose the place for a meeting, which could take place at the client's home, in a public place or at the PO's office **(III)**. This is similar to the Strengths Model of Case Management, which also emphasizes meetings in a public place (Rapp & Goscha, 2012). The findings also showed that organization around the PO service was experienced as facilitating the work when POs did not have an organizational frame to take into account. This led to POs feeling a sense of liberty in their role, and in turn, they could act freely in contact with each client **(IV).** The findings also showed that the role as PO also allowed them to become involved in several areas in the client's life **(II, III, IV),** which increased the possibility of viewing the client in a holistic way. The discussions did not always focus on work; the relationship also invited discussions of other matters in everyday life such as interests, children, family and friends, and sometimes they could find common interests. The client could ask the PO "simple" questions about everyday matters and get an answer. POs found it important to reveal neutral things about themselves to let he client get a picture of who the PO was as a person. However, an important aspect of the personal relationship is that the PO cannot lay his/her problems on the client's shoulders (Denhov & Topor, 2011; Rapp & Goscha, 2012). The personal, self-disclosure is an essential part of helping relationships in recovery-oriented services; it can support the client to open up a bit more, and many clients appreciate this (Borg & Kristiansen, 2004; Denhov & Topor, 2011; Rapp & Goscha, 2012; Schon et al., 2009), it is described in terms of "reorient professionalism" (Borg & Kristiansen, 2004; Topor, 2001), and POs seem to use this behavior in their work with clients. A study by Berggren & Gunnarsson (2010) showed clients were satisfied with the PO support/service, where one reason was that POs became like a "professional friend", and the clients experienced differences between the PO service and service from social services and psychiatric care.

Facilitating the client's process

According to the NBHW guidelines for the service, POs are not supposed to provide a duplicate of that which is offered in other services (Socialstyrelsen, 2011b). Often the PO service is described as simply mobilizing external resources, being a coordinator and supporting clients in contact with various authorities. However, findings from the papers **II** and **III** showed that PO support involved much more. The strategies POs use in their work with clients may strengthen the client and increase the sense of self-esteem.

Developing ground for increasing a sense of empowerment

An interesting finding from papers **II** and **III** is that POs, despite not taking over other actors' tasks, may impact the client in developing self-efficacy and a sense of increased empowerment, which can be useful in the changing process. A thesis by (Hillborg, 2010) showed that professional actions, such as finding strategies, giving practical support in building networks, and having an equal and trusting relationship with the professionals increased the sense of ability to act, which had a positive impact on the person's development of empowerment. From a recovery-oriented perspective, it is important to develop a sense of empowerment, and many of the POs' strategies may empower the client. By involving the client and working together, POs showed the client how the welfare system worked, how to navigate through it and what could be expected from it **(II)**. POs also showed the client several strategies that were needed before meetings with various authorities and prepared the client for the meetings **(II)**. Another strategy POs used was to support the client to start to reflect about him/herself, and the attitudes and the way the client viewed him/herself **(II)**. This may serve as a platform to move toward arenas in the society, such as becoming member in an association, taking a place in the labor market, getting an education, etc.

Activities to promote the changes

From a recovery perspective, several of the POs' strategies could be seen as a facilitator for their clients' recovery process. POs bring hope to the client by listening and acting according to the client's desires; client choices are respected. The findings showed that POs do not sit and wait for something to happen, but act immediately **(II)**. The findings also showed that POs sometimes acted in the gray zones **(II, III)** where other services cannot, because it is not their task. One example was that POs can ease the situation by, for example, giving a ride to the store, printing important papers, and transporting the client to different services and treatment – to make it happen! POs thought it was important for the client to reflect on how a problematic situation could be solved if it should recur. This kind of action is certainly not typical in other services, and POs felt questioned

sometimes by other personnel in different services. As Topor, Borg & Lindelöf, (2008) wrote, to break "professional rules" and performing tasks that normally is not included in services may contribute to a person's recovery process.

POs expressed that most of their clients were poor with low incomes and many had extensive debt **(IV)**. POs found it important to make the economic situation stable. There is a need to know when money arrives so you can make your payments and still have some money left. In this work it was important to negotiate payment plans with various organizations and landlords. Not having enough money and constantly living on the margin is very stressful, and a result of this can be that the person cannot put any effort into doing anything other than merely surviving. From a recovery perspective, it is important to create a stable ground to make it possible to make important changes in life (Mattsson et al., 2008; Mezzina et al., 2006). Poverty and lack of basic resources undermines one's sense of security and holds people back in their recovery process (Onken et al., 2002). However, when POs take care if the problem right away, it signals that something positive is happening, which may bring about hope that life could be better in the future. Hope is the foundation in recovery (Davidson et al., 2007; Deegan et al., 2008; Farkas, 2007; Onken et al., 2007; Topor, 2001), and one essential part for professionals in recovery-oriented services is to inspire hope. Professionals may have to carry hope during times that the client loses it.

Even if the client needs to have some kind of motivation when seeking the PO's support, sometimes the process gets stuck and it is impossible to move on. Research has shown the importance of using activities in order to support the client to find motivation again. One essential part in using activities is that that the activities are experienced as meaningful to the client, which means that each activity has to be adjusted to each client's specific choice (Ahrberg, Landstad, Bergroth, & Ekholm, 2010). The findings showed that POs used activities when things did not work out as planned, because it could affect the client in a negative way when he/she may think that the situation is pointless. Activities POs and clients used to do was things, such as drinking coffee, visiting places, going for a walk, etc.

The need for developing a strengths perspective

The findings showed that POs did not use any kind of formal tools in their work with clients; often the work was built on the clients' experiences **(II)**. This approach may lead to a problem-based view of the client, whereby POs solve problems in the client's life. From a recovery-oriented perspective, it is important to use a person's strengths, and there may be a need for POs to develop and use a tool to support the client to find strengths that may be useful in striving toward another life. Using the strengths perspective may also support the client to find social arenas investigate other possibilities. The findings also showed that POs did not focus as much on the personal social network, which could help to develop informal resources and ultimately build the formal network. However, they often talked about the importance of supporting the client's efforts to get involved in various activities, mostly daily activities and sheltered work. The POs experienced an age difference, in that younger people were more often striving to enter the labor market **(IV)**. POs also supported the client in finding recreational activities. Recovery involves two processes; it concerns a personal change, but also involves active participation in the society to be socially included (Tew et al., 2012). Social relationships with others and social environments have been shown to be a facilitator in social inclusion in society (Mezzina et al., 2006; Schon et al., 2009; Tew et al., 2012).

Challenges for the service system

The development of PO services grew from the discovery that people with psychiatric disabilities were not getting the needed services to live an independent life in society. Therefore, one main task for the PO is to mobilize resources and to advocate for their clients in an effort to make sure that they get the support to which they are entitled. To manage this, POs were given a freestanding position in the welfare system (Psykiatriutredningen, 1992; Regeringens proposition 1993/94:218, 1994), which should facilitate the PO service to negotiate and advocate for their clients' rights and to work according to their wishes without having to take into account the authorities economy (Socialstyrelsen, 2008). Today, the welfare system are facing new challenges, because of that people with psychiatric disabilities are not a homogeneous group, and their needs have changed since the Mental Health Reform was enacted in 1995.

The concept of recovery is used as a guiding principle for services in many Western countries, and mental health services in Sweden are moving toward recovery orientation. For example, the NBHW recently published new guidelines regarding support for individuals diagnosed with schizophrenia (Socialstyrelsen, 2011a). However, it is necessary to give the professionals the right tools to develop

their services according to the principles of recovery-oriented practice (Craig, 2008). In the development of a recovery-oriented practice, it is also important to pay attention to mission, policies, procedures, network and staffing (Farkas et al., 2005).

The welfare arena

The Swedish welfare system is often described as fragmented where each authority is specialized in one area, with different legislations and are administered at different levels with different missions. For example, the municipalities have the responsibility of social support, public health services for health care, Social Insurance Agency for financial benefits (insurance) and Public Employment Services for support to employment. Professionals working in these authorities can be described as "street level bureaucrats". In making decisions and providing services; they have to consider the organizations framework, where professionals may face dilemmas such as achieving balance between the client's needs and the organizational frameworks. The purpose of the frameworks is to treat all citizens equally, but at the same time, the professionals have to take into account the clients' wants and needs. Another identified potential difficulty is that the professionals redefine the client's problem, in order to fit the client into the framework of the organization (Hjörne, Juhila, & van Nijnatten, 2010; Johansson, 2007; Rosenberg, 2009). Studies of case workers in the public authorities have shown they feel limited in their role, when they experience the clients needs are wider than they are able to provide support for in accordance to their respective organization's rules and frameworks. They wanted to be able to do more for the client (Hillborg, Danermark, & Svensson, 2013; Thorstensson, Mathiasson, Arvidsson, Heide, & Petersson, 2008). Another identified problem is that cooperation among the authorities can be complicated and a literature review of (Andersson, Ahgren, Axelsson, Eriksson, & Axelsson, 2011) showed that one obstacle in collaboration among authorities involved in rehabilitation is the different field of responsibilities and different perspectives of the clients' problems, but also that services does not fit to each other and are provided at different levels. A consequence of this is that the client risk ending up between two different services (Lindqvist & Rosenberg, 2011). This was also something that POs experienced **(IV)** in their role of supporting the client by acting in the gray zones to bridge the gaps. Another way for the client to "fall between the stools" concerns the authorities' lack of knowledge of the other authorities' systems and how they connect to each other. For example, there may be personnel in the health care system who does not know the date for leaving the medical certificate at the Social Insurance Agency in order to obtain financial benefits. Following the client through the welfare system resulted in POs detecting and experiencing the same

difficulties the clients face when dealing with the welfare system **(IV);** it would be easy to fall out of the system if the client did not qualify for a service.

As described before, the different perspectives of viewing the client may be an obstacle for cooperation, and the result of paper **I** makes it interesting to reflect about if the three groups of personnel refer to two different definitions; clinical recovery or personal recovery. The results showed that POPS had less knowledge towards recovery compared to the SHTs and the POs, even though they had the most people with a university education, which was shown had a positive relation to knowledge to recovery. Therefore it was interesting to reflect about the different services mission and organization. The PO service is described as user-oriented (Berggren & Gunnarsson, 2010), and findings from papers **II** and **III** showed that POs use several recovery-oriented principles in their practical work. POPS provide treatment and care (Socialstyrelsen, 2010c), and are strictly oriented toward medical treatment. Studies have shown that personal in psychiatric care often uses a symptom-oriented approach (Lilja & Hellzen, 2008). The SHT, to the contrary, provide support to the individual in the tasks of everyday life, such as cleaning, laundering and shopping for food. Their focus is traditionally on the social aspects of a person's everyday life, which means that their actions are based on a social perspective. This may be an example that services have different cultures. They are designed in different ways and have different frameworks.

Surfing through a complex welfare system

The welfare landscape plays a central role in POs' work since a large part of POs' work was to mobilize external resources **(II)** and advocate **(IV)** for the services to which the client was entitled to. POs often supported the client to get contact with several actors in the field, Psychiatric Care, Social Services, Social Insurance Agency and Public Employment Office, which gave POs a wide holistic knowledge of the welfare system and how different rules and legislations and organizations worked **(IV)**. One PO expressed this as "surfing around in the system", and the freestanding position may play some role in this, because of that POs did not represented any organization and could easily move from one authority to another without being a threat. Knowledge about the welfare system was necessary, because it was easier to navigate with an awareness of what to negotiate for and knowledge of the limitations and how to go around some rules. It was also difficult for a case worker to withhold information from the client. POs were also aware of what different authorities want from the client and could prepare the client in what to expect **(II).** Stylianos & Kehyayan (2012) emphasized the need for freedom to be able to actually negotiate and advocate on behalf of the client, and findings from paper **IV** showed that the freestanding position played a central role; POs were

relieved to only represent the client, without needing to consider organizational rules. Here, knowledge of legislation and frameworks plays an important role to be able to advocate for the clients' rights. The interviews were conducted in connection to the introduction of the "rehabilitation chain", as POs experienced it difficult for to figure out how the new rules worked, since no one really knew. Personnel in the Public Employment Service had to handle those people who had previously been assessed as work disabled and the new rules required that they went through a program to test their workability. A study Stahl, Svensson, Petersson, & Ekberg, (2011) showed that personnel in the Public Employment Service were not ready to handle this, and they had to develop new methods. Other studies has also showed that case workers in different agencies experienced inadequacy where they had to follow regulations more strictly and time pressure and were unable to work with clients at a personal level (Hillborg, Danermark, & Svensson, 2013; Thorstensson, Mathiasson, Arvidsson, Heide, & Petersson, 2008). This lack of time and the tighter framework were confirmed as problems by the POs who found it more difficult to negotiate for individual solutions **(IV)**. This may also be one of the reasons that POs found it difficult to end a contact with a client with extensive needs; other personnel groups could not support the client in the same way as a PO.

Against this background, the welfare system faces challenges. If we are to move toward a recovery-oriented practice, there is a need to create common platforms and develop common tools in accordance with what has been found to have evidence to support people with psychiatric disabilities in their recovery process. The results **(I)** also showed that training in recovery can have a positive impact on knowledge and attitude regarding recovery. This concurs with other studies using the RKI that have also shown positive effects (Bedregal et al., 2006; Meehan & Glover). Moving toward a recovery-oriented practice involves a shift in value for practitioners (Slade, 2009a). It also involves a functional strategy, which involves several parts of the "system". It is not enough to train practitioners in recovery principles (Rapp, Goscha, & Carlson, 2010).

Challenges for the PO organization

The role of PO involved several challenges, and many of those are connected to the freestanding position. The study where POs experiences were examined **(IV)**, revealed the difficulties and advantages in the role, as well as aspects that the POs had to overcome and solve. The findings from paper **IV** showed that many of the PO services lacked external control. This may be a risk factor both from a working environment perspective as well as from a client perspective. Although the free role allowed for a wide frame, it can be difficult to set limits on what is and is not included in the role. Findings from paper **III** showed that the role of PO often involved becoming personal with clients, but who can control that the PO does not cross the limits and impact the client in a negative way? POs also meet people with extensive needs and they are expected to carry a lot of the client's burden **(IV)**. The POs need to have guidance and support from the outside to remain professional. It is not certain that a salaried boss is the best solution. Another solution is to develop "reflected teams" as used in the Strengths Model (Rapp & Goscha, 2012), where the collective group finds solution or opportunities for reflection among colleagues. A study by Järkestig Berggren (2006) showed that POs and personnel in other services may view the client from different perspectives. POs represented the client's perspective and other personnel often identified the clients' problems from the perspective of their profession. This is an essential part of representing the client; however, the study also pointed to difficulties for POs in keeping the client in contact with various authorities. It is easy to lose the view and instead take over the other professional view. This is also another aspect of the need for POs' reflections in regard to representing the client.

The freestanding position and the lack of administration and regulations may be a problem when making decision concerning of who will get a PO and not **(IV),** the person who is denied contact with the PO service cannot appeal against this decision, because there is no regulation regarding this. However, regulating the PO service may not be the best solution; the freestanding role involves many positive pieces for the client. One solution may be to use the management group, where the person can appeal and get a second opinion. This demands cooperation between the POs and the management group with an agreement of what the role as PO involves and not. The freestanding position may also involve problems in terms of a lack of legitimacy, where there is a risk that POs stand alone and end up in the same bad position as the clients. Despite the freestanding position, it is important for POs to develop good platforms for cooperation with other actors in the society. The management group plays an important role, because of the PO service mission to report shortcomings in order to make changes in the welfare system. Another important role for the management group is to function as door openers in their

mother organization. This would facilitate POs work, because it gives legitimacy. The freestanding position puts POs at risk to become a lonely island, which could ultimately undermine their work. Findings from paper **IV** showed management groups did not have all needed members represented. This is unfortunate, because today POs address more services than just the municipalities and health care. The reflections of the findings also indicate that the user organizations are not as involved as they were in the beginning. It is important not to forget to involve the user organizations in the management group; they may contribute valuable information to the authorities. In order to use the management group fully, it is important that the members has mandate to make decisions in their organization. This would, for example, ease the activity of making improvements in accordance with the reported shortcomings. The management group would also be useful for other purposes. Recently the NBHW published guidelines for services (Socialstyrelsen, 2011a), which in some way involve all public authorities. The management group of the PO service could also serve as a platform for discussions in developing the recommended services.

The findings also revealed that there were difficulties in cooperation between the POs and the management group. POs were not invited to meetings and did not feel as if their concerns had been heard or addressed. POs also experienced that the management group and the POs had two different ways of viewing the role. It is very important that the management group and POs work together. There may be a need to develop agreements of the role and goals within the service. It is also essential that the management group and POs develop agreements of the goals of the service, whether it is a service that solves problems (problem-based) or if the goal is to support the client to reach his/her dreams and ambitions. These two different approaches have two different timetables. It is problematic when the management group and the POs have different views of the position and its role. The management group may have the perception that POs only mobilize resources and coordinate activities. Findings from this study showed that the role of the PO involves more. Another risk is that PO will become too involved in the municipal organizations. For example, one PO expressed that the representative demanded and decided when it was time for POs to end their contact with the client; this was a demand to produce. Even if there are aspects the PO service needs to consider, it is important to keep the freestanding position without taking part in the rules of the authorities.

Methodological considerations

This thesis involves both quantitative and qualitative studies.

The quantitative study

In the quantitative study the aim was to investigate the level of knowledge and attitude towards recovery among three groups of personnel. Since POs are spread throughout Sweden and to measure differences it was important to have comparison groups that were from the same areas of Sweden. Therefore, a stratified sampling was used to choose participants from the SHTs and POPS. The results showed that there were numerous participants answering the questionnaire from big cities, rural area, etc. The response rate was satisfying: the overall response rate was 63%; 61% in POPS group, 55% in the SHT group and 73% in the PO group. The response rate among the groups was not markedly different, and there is no reason to believe that the non-response rate had any notable effect on the result.

The reliabilities in the original RKI for each scale were as follows: A (0.81), B (0.70), C (0.63) and D (0.47). After the translation into Swedish, the reliability coefficient (Cronbach's alpha) showed A (0.70), B (0.66), C (0.39) and D (0.13). The scale D (2 items) had almost no reliability, and, therefore, only one of the items is used in the analysis. This item, Question 5, stated: *"Not everyone is capable of actively participating in the recovery process."* This was used due to its relevance and ability to discriminate between groups of personnel.

The qualitative studies

The qualitative studies were conducted for the purpose of gaining a deeper understanding as to how POs perform their work. The focus was on their practical work, and qualitative content analysis was found to be a well-suited method to determine the purpose. The same interview material was used throughout all three studies. This was not the original plan, but in the beginning of the analysis, I discovered the richness in the interviews. Therefore, I chose to fully use the material. This is also important from an ethical point of view. The transcribed interview material consisted of 417 pages of text.

I have several years of work experience as a PO, and I had to use my pre-understanding of the PO services wisely. During the analysis, the interview material was read through several times, and I have reflected over the material and various ways of building components in the creation of categories and themes. Text material is often interpreted in different ways (Krippendorf, 2004), and I was

solely responsible for the analysis, but the findings were discussed with my supervisors in an effort to increase the credibility of the analysis. In qualitative methods it is important to reflect about credibility, conformability, subjectivity, and transferability aspects (Graneheim & Lundman, 2004). To strengthen the credibility, it is important to pay attention to the selection of informants. It is a positive factor if they are different, and the informants in the present qualitative studies were different in age, work experience, sex and employment locations in Sweden. Another essential part of increasing the credibility is to show examples of the analyzing process, so others can follow the researcher's interpretation.

The interviews were conducted by telephone, and I believe this was not a problem for the interviewed POs. The use of the telephone is a tool in their everyday work life, and I believe it felt natural for them to be interviewed using this method. However, there are both advantages and disadvantages to using the telephone in data collection. One advantage of telephone interviewing in collecting qualitative data is the ability to reach those in outlying geographic areas (Sturges & Hanrahan, 2004). Another advantage is that the person could be more forthcoming in his/her responses because an interview by telephone is more anonymous (Musselwhite, Cuff, McGregor, & King, 2007). Novick (2008) addresses some of the disadvantages of telephone interviews, such as reduced depth in the interviews. Additionally, there could be potential distractions from the surrounding environment over which interviewers have no control. Furthermore, the interviewer is not privy to visual cues. Novick (2008) concluded, however, that there is little evidence regarding shortcomings in telephone interviews in comparison to face-to-face interviews.

The interviews followed an interview guide covering specified areas, and all interviews began in the same way and followed the same structure. Similar follow-up questions were made, and all POs were asked to draw examples from their practical work.

CONCLUSIONS

The concept of recovery is used as a guiding principle in many Western countries, and mental health services in Sweden are moving toward recovery orientation. Paper **I** showed differences regarding knowledge and attitudes towards recovery among three personnel groups (POPS, SHT and PO) which leads to the question of whether the three personnel groups relate to two different kinds of recovery: personal vs. clinical. Paper **I** also showed that overall, personnel needed to update their knowledge about the non-linearity of the recovery process and that everyone is capable of actively participating in the recovery process. Another interesting result was that university education and training in recovery was positively related to knowledge and attitude towards recovery. The level of education was also shown to be an important aspect. However, POs scored higher in all scales compared to SHT and POPS, even though the POPS had the most personnel with a university education. This indicates that in the ambition to create recovery-oriented services, it is important to pay attention to the organizational regulations, legislation, organizational frames and the impact on the professional's ability to act in their work. A combination of these elements could facilitate the development of a recovery-oriented mental health system.

The guidelines for PO services are similar to principles used in recovery-oriented practice. However, today the character of the PO service is often described as simply mobilizing and coordinating external resources, but findings from this study showed that POs do much more, which is important to highlight. The PO service has developed a method in accordance to the NBHW guidelines, which in many cases, may benefit the clients' recovery process. Findings of the analysis **(II, III, IV)** from the interviews with POs showed that the client is the centerpiece in all POs work, and the client's choices permeate the entire process, from setting goals, directing the process, choosing the subjects of conversations, determining the depth of the relationship and suggesting the location for meetings. Building a working alliance was a necessary component of the system, which served as a platform in the work. Even if the client owns the final decision, the PO functioned as a personal support in making important choices, and including the client in the active process. An overall picture of POs work is that they work with both the client's internal process as well as with mobilizing and coordinating the external support.

The findings also showed that the freestanding position was a facilitator in the PO's role, and it made the PO the sole representative of the client. The free frames around the service also enable the POs to obtain a holistic view of the client's life as well as for the welfare system. Not belonging to an organization means that POs solely represent the client, which should be positive as part of POs role involves advocating for the clients rights. Another important aspect of advocating is knowledge about the welfare system, and PO has over time developed a good knowledge of how it works and what roads are possible to take to facilitate the client's process.

Although many methods used today by POs are in line with a recovery-oriented practice, there may be a need to develop the methods further. The interviewed POs often used a problem-oriented approach where the client's perceived problems and solutions of those were in focus. The PO service may need to change focus and pay attention to the client's strengths and support the clients to achieve goals in life. There is an instrument in the Strengths Model CM, the strengths assessment, which could be useful in the PO service, which focuses on dreams and aspirations with a focus on both internal and external resources and how they could be used in the move forward.

The freestanding position may also entail problems in terms of lack of legitimacy. There is the risk that the POs will stand alone and end up in the same negative position as the client. Despite the freestanding position, it is important for POs to develop good platforms for cooperation with other actors in the society. The PO service had low control, which may become a risk, both from a working environment perspective as well as from a client perspective. In many cases the non-existent control could mean that the client is put into risk situations. The almost non-existent control together with the free role may require a need for guidance and support from the outside to maintain professionalism. This support could come from a manager, but it could also be a result of "reflective teams" in which colleagues support each other in their role through practical guides and reflections.

IMPLICATIONS

- POs need supervision and opportunities to reflect in order to maintain professionalism in their roles. This can be accomplished with the help of an engaged boss or reflection teams. It is another way of making the work performance visible.
- The PO service should develop a strength-based perspective and develop tools focusing on the strengths. Such instruments already exist and they may be useful.
- There is a need for the PO and management group to strike an agreement of the goals, problems, and methods of the POs.
- It is important to pay attention to who will represent the organization in the management group.
- There is a need to work toward development in the management groups. Today services are supposed to develop recovery-oriented services, which require cooperation between different public actors and user organizations. The management group of the PO service could also include this task.
- It would be interesting to conduct research on the clients who have PO support in an effort to determine if or how they have developed a sense of self-efficacy or empowerment. This could be used in their recovery process.

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