The deinstitutionalization process and mental health teams working with severely mentally ill persons in Sweden

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Abstract

During the last 50 years, mental health care has experienced important changes in many countries around the world. One of the principal characteristics of these changes has been the development of community-based care. These have had substantial implications from the point of view of human resources. Among other things, it have required for staff the development of a new set of competencies for work in community-based settings with other professions and with a new emphasis on recovery, rehabilitation and integration of mentally ill persons.

This study aims at reviewing this deinstitutionalization process from the point of view of professionals in the context of multidisciplinary mental health teams working with the most severely mentally ill people in Sweden.

It is a qualitative study based on literature review and interviews to professionals working in mental health teams in a specific region in the city of Gothenburg. The general framework for the analysis of results was based on the contribution that comes from Symbolic Interactionism, specifically the concepts of "teams" and "stigma" developed by the sociologist Erving Goffman.

The results have shown that the work within mental health teams is of great importance within the psychiatric organizations as well as for the intersectorial collaborations to achieve the aims of the mental health reform. It has lead to an advance in the methods used to work with the most severely mentally ill, between other things as a result of the inclusion of social professions within the field of mental health. The results also point out the complex transition Sweden has passed from the closure of big institutions until nowadays and that even if several changes and reforms has been done to improve the situation and integration of people with severe mental illness in the community it is still a big challenge for professional of mental health.

Keywords: Deinstitutionalization process; Mental health teams; severely mentally ill.

Contents

I- Introduction

Starting during the 1950's as an international movement against living conditions in psychiatric asylums in the USA and United Kingdom, in the last decades the process of deinstitutionalization of mental health treatments has taken place worldwide.

More recently, mental health care reforms have been implemented in different countries. The contents of the reforms vary between them but in general they imply the development of community care rather than hospital care (Arvidsson, 2005: 186).
In some cases, especially in Europe, these reforms are at the level of implementation since a long time ago, and some of them have been evaluated. In some others, such as Latin American' countries, it still exist the discussion about the closure or not of the big institutions. Even so, the tendency of mental health policies seems to be going in the same direction in different countries all over the world.

In countries where reforms of mental health services have been implemented, advanced models of community care have been developed, to a greater or lesser extent. These models varies in names and ways depending on the social, cultural and economic characteristics of the countries concerned, but the problems and challenges appear to be similar between countries seeking to provide care in the community rather than the institutions. The reforms include not only the closing of psychiatric hospitals but also the provision of alternative services with some common characteristics that Barbato (1998) describes in a report from the World Health Organization (WHO). These services are primarily targeted at the most disabled and seriously ill people and offered in well-defined catchments areas; services are based on needs assessment and provide individualized treatment aimed at empowering users and building on their assets and strengths; in general treatments try to combine medical, psychological and social aspects in accordance with the patient's individual needs and are based in evidence based methods; long-term hospitalization is avoided as far as possible (Barbato, 1998: 25).

In theory, the principal ideas in which, the deinstitutionalization movement is based are that people with severe mental illness should have the possibility to live their lives in society with the same fundamental rights as other citizens (Magnusson, 2003:352).
These ideas come from a concept developed during the 1980's in Sweden and other Scandinavian countries and it is the principle of normalization and empowerment, used as a philosophy for people being reintegrated into the community from hospital or residential care. This implied a participative approach based in the idea that people want and have a right to be involved in decisions and actions taken in relation to them (Payne, 1997:271).

> A different form of advocacy work grew up during the 1980's. It started as a process of increasing the capacity of people with mental illness and learning disabilities to manage their own lives. A movement grew up to give them assistance in achieving their civil rights within institutions, and in leaving institutions where they may have been held by compulsion. This movement started in Scandinavia, grew up in the United States and has moved to the United Kingdom. It has been particularly important in promoting the independence of people with all kind of disabilities. (Payne, 1997:270-271)

However, as Bjorkman (2000) argues, the deinstitutionalization movement refers also to a complex series of interrelated event and policy decisions; it is not only the criticism of inhuman conditions in overcrowded hospitals but also some political interests which guided all these reforms, such as to stop the rising expenses for the governments in keeping the mental hospitals ongoing. From the medical science there was also the introduction of new and promising kinds of psychopharmacological treatments and a growing knowledge about environmental conditions as directly influencing the treatment results. *"(…) that may be defined as the replacement of long-stay psychiatric hospitals with smaller, less isolated community-based service alternatives for the care of mentally ill individuals"*. (Bjorkman, 2000:3)

II- The study and the setting

- Background of the problem area -
In Sweden, as in other western countries, there was since the 1960's a strong emphasis on closing the larger mental hospitals. At that time alternative psychiatric treatments were rare and almost no ambulant care existed. Directions of mental health policies started to change aimed at reinforcing out-patient services, reducing hospitalization for the mentally ill and encouraging the enlargement of the professional composition of out-patient teams. Psychiatric nurses, psychologists and professionals from social services were included in those teams (Stefansson & Hansson, 2001:82).

> A multidisciplinary team responsible for each patient requiring a service, may facilitate more complete patient needs assessment and limitation of the number of staff involved in the case, thereby promoting the continuity of care. (Bjorkman, T.; 2000: 4)

Sectorized psychiatric care, both in- and out-patient care, within a delimited catchments area, was accomplished in the whole of Sweden between 1975 and 1985. At the end of this period, 135 psychiatric clinics had been established following the principles of the National Board of Health and Welfare (NBHW). An evaluation of this reform showed, that long-term mentally ill people, in a number of areas did not receive satisfactory treatment. Needs for medical treatments were mainly fulfilled, but other needs, such as social support, were not satisfied. The responsibility for interventions regarding these needs was, in conjunction with the Swedish Social Services Act of 1982, given to the social service agencies (Bjorkman, 2000:3-4).

The Social Service Act of 1982 implied that municipal social services should be given an increased responsibility in meeting the needs of acceptable housing and meaningful employment of the long-term mentally ill. However, in the late 1980s, the limits of responsibility for mental health care and social services were not obvious and in 1993, a parliament commission concluded that the efforts of social services were still largely inadequate (Arvidsson & Ericson, 2005:187).

Following this process, in 1995 a mental health care reform was introduced. The target group of the reform was persons with long-lasting mental illness that caused a disability to the degree that it influenced daily life. The reform implied reorganization at municipality level creating new social service field teams targeting these groups and providing them with domestic care and assistance in their daily life and the development of day-centres and other facilities for daytime activities. The law stated a number of specific forms of assistance that mentally disabled people could receive, including counselling and support, personal assistance, housing with special services, contact persons and companions (Arvidsson & Ericson, 2005:187-188).

> The responsibilities of social services were clarified through the reform. Social services are to make life outside institutions possible for the target group; psychiatric care organizations are to adapt their efforts and develop adequate treatment methods. Social services and psychiatric care organizations must support one another in their work with the target group. The involvement of the individual and families in the rehabilitation process is given particular

emphasis. The objective is social integration and the best life possible for the mentally ill, on equal terms with the rest of the population. (Stefansson & Hansson, 2001:83)

In 1999 the NBHW started an evaluation of the reform where they stated that it had improved living conditions for many seriously ill persons but there were still important shortcomings concerning daytime activities, mobile care teams and social service field teams (Arvidsson & Ericson, 2005:187).

The Swedish' psychiatric care reform was founded upon a new changed view of mental illness. This view set that a handicap can be ameliorated or even cease to exist, but may also be exacerbated, depending upon the support one receives or how the people in one's life act. So when it comes to treatments and rehabilitation the "*social, psychiatric and medical assistance must be seen as equally necessary components and interacting therapeutic agents*" (NBHW, 1999). That is also why the stress was put in the work in multidisciplinary teams.

The sectorisation of the psychiatric services constituted, between other things, a first step for the implementation of multidisciplinary teams. These services could have their base at a hospital, with a co-ordination with out patient clinics, mental health centers and day care units located in the community. Changes in these directions seemed to be the norm in most communities in Sweden (Bjorkman, 2000:3-4; Arvidsson & Ericson, 2005:188), including the city of Gothenburg where this study took place. In this context I can situate the creation of many of the units and teams visited during the study period and that constitutes the setting in which the study was conducted.

- Aims -
The purpose of the present study is to describe and analyse mental health teams within the context of the Mental Health care reform in Sweden. Furthermore, the purpose is to describe and understand the different roles and methods professionals involved in mental health teams apply for working with the most severely mentally ill people.

The importance of reflecting about this, for social workers as well as for other professionals involved in the areas of community care, is the challenge of develop new knowledge on how to improve services and practices in psychiatric community care.

The early implementation of the deinstitutionalization movement in Sweden makes it an interesting place to analyze the impact of these changes in the different professions involved in these new psychiatric teams and how in practice they try to achieve the goals of the mental health care reform, and what are the challenges they have to face in their everyday work.

- Research Questions -
Following these ideas, the research questions are:

- How is interaction within the mental health teams manifested and what is the role of the different professions involved?

- How do professionals see mental health reform and deinstitutionalization process nowadays?

- What are the principal implications and challenges when it comes to work with the most severely mentally ill group of people?

- The structure of the report -
In order to fulfill the aims and to answer the research questions I structured the paper in five sections. In the first section I will introduce a summary of the existing literature regarding this issue and with the focus in my specific research questions. In the second part I will try to deepen the understanding of the issue by developing the theoretical framework that will let me analyze the results. In the third section, the methods that were used are explained in detail. In the fourth section I analyze the results and relate them to previous research and theory. In the last section the research questions are answered, and I will also make final reflections, including suggestions for future research in the field.

III- Previous Research

In this chapter I will introduce a summary of the principal debates and issues discussed at the academic level about this area. Also I will sum up some concepts of previous research that will let us understand and analyze the questions at issue.

Previous research in the field is extensive from the international point of view. Most of researches come from United States and United Kingdom; this could be related to the earlier implementation of policies on community based approach in the field in these countries. In Sweden most of the earlier research is related to the medical field. However, in the last 10 years it is appearing to be of more and more interest from the social sciences.

The focuses of the studies vary but in most of the cases, at the international level, the concentrate on the discussion of advantages and disadvantages of working in the community setting, about different methods professionals apply and the implications of community base approaches in the everyday work.

For the Swedish research I found that most of them are qualitative studies which based their analysis in the grounded theory. In general they are trying to evaluate and analyze the impact of the Mental Health Reform and also advantages and disadvantages of new treatments when it comes to severely mentally ill people.

Research analyzing the work in mental health teams is rare at the international level and none has been done in Sweden. That was one part of the critical points and demands made by the NBHW during the evaluation made in 1999.

> There have been negligible efforts in the area from both the medical and social science research funds. Local research related to social operations and with interdisciplinary content needs to be strengthened. Knowledge generation within the field is made more difficult due to the lack of assistance such as documentation of experiences and controlled studies. (NBHW, 1999)

Because of the lack of research within this field in the Swedish context, I think it is very important to focus in multidisciplinary team work. To talk about professional working in mental health teams directly conducted me to search about the methods they use and I will present what is written so far about this issue and then, in the following chapters, I will compare this available knowledge with the everyday situations that professionals experience in the setting I study. In addition, as my focus is in professionals working with the most severely mental ill group of people, I will discuss some issues that, according to the available literature, become a challenge when it comes to work with this special group. I can say that the majority of the previous research coming from Sweden is in relation to this last issue.

Following the purposes of this section I will concentrate the attention in the development of new forms of team work in the mental health field, as well as the review of some of the

principal methods and challenges they have to face nowadays in the new context described in previous sections of this paper.

- Multidisciplinary team work -
During the deinstitutionalization process it has been substantial changes for mental health staff: reallocation from hospital to community-based service settings; the development of a new set of competencies for work in the community, a new emphasis on recovery and rehabilitation. Staff should be able to work in a variety of community, residential and inpatient settings; across agencies and across service levels; in multidisciplinary and multi-agency team's coordination of multiple professional and non-professional disciplines (WHO, 2005:3).

> Multidisciplinary teamworking is now widely accepted in mental health and the health care field more generally, as being the most effective way of using the different skills and experiences of professionals and others to improve the health status of individuals. Teamworking is therefore an expectation in the modernization of mental health care and is enshrined in guidance for new service models. (Newbigging, 2004:145)

As we can see, in this new context, teamwork is a basic competency, required for all categories of mental health workers. According to Newbigging (2004), a multidisciplinary team is usually conceived as a group of professionals working together in the same place to achieve the same aims (Newbigging, 2004:146). The same author establishes that the concepts of shared aims, interdependency and shared accountability for outcomes are central to the definition of multidisciplinary teams and these are the characteristics that let us distinguish teams from a group of people who are simply co-located (Newbigging, 2004:146).

Changing staff roles
No single profession has the expertise or the authority to undertake everything when it comes to mental health care. As Tilbury (2002) argues team work has not always been easy; according to different organizational structures and funding, varying degrees of operational autonomy, different approaches and priorities in many cases it have often led to rivalries, hierarchies, isolationism and disagreements between professions (Tilbury, 2002:60).

Therefore, as stated by Tilbury (2002) the development of multidisciplinary working has been central to the hope that there would be a fundamental shift from medical dominance to a more consensual and democratic style of working. A new importance is given to the contribution of the social assessment. Understanding the personal, social and material context in which the mental illness arose is today considered almost as crucial as the medical diagnosis, since it will profoundly shape the processes by which this person is assisted to the best possible recovery (Tilbury, 2002:73-74).

For Newbigging (2004) these changing of roles present important challenges for health workers. He identifies some aspects of teamwork that can be useful to describe the ways in which teams can differ. They are: the degree of integration among the members of the team; the extent to which a team collectively manages its resources in response to service

user needs as opposed to managing resources by professional discipline; membership; team processes including decision-making processes about who does what; management of the team. Each of these dimensions should be accounted for in the analysis of mental health team's development (Newbigging, 2004:146-147).

Newbigging (2004) also reflects about the benefits of team working: access to a wide range of skills across health and social care; a single point of access to these skills, avoiding unnecessary delays, duplication of effort and fragmentation of care; access to practical local information about services and contacts; coordination of care and cases allocated according to needs; direct and regular contact between those providing care, creating opportunities to share information, delegate work, develop joint initiatives and enhance decision making; a better use of resources and therefore the potential to be more cost effective (Newbigging, 2004:147).

There are therefore a number of things which teams need to do which will support the delivery of these outcomes and their ability to be innovative. These are: develop a shared vision and philosophy of care; interact regularly; regularly reflect on how the team is working and how well it is achieving its objectives (Newbigging, 2004:159).

- The methods -
Sweden Health care report (2001) establishes the different treatment forms that we can actually find in the Swedish health care system for mentally ill people.

In general treatments try to combine medical, psychological and social aspects in accordance with a patient's individual needs. Each of these methods or treatments for mentally ill are related to an area of professionalization and specialization, and we can relate each other with the different disciplines involved in the mental health care system. They are: mental health nurses, social workers, occupational therapists, psychologists and psychiatrists.

The most common treatment components are:
Psychotherapy: This implies **c**ounseling which is considered central to all psychiatric treatment; it may be used alone or in combination with other measures. Therapy forms used are cognitive psychotherapy, cognitive behavioral therapy, psychodynamic therapy, group psychotherapy, family therapy and network therapy. According to the NBHW, the psychotherapy as a treatment method has documented good effects in many psychiatric conditions (NBHW, 2001:186).
Psychosocial measures: Psychosocial measures aims at creating the best possible conditions in life situation of mentally ill persons. It is based on the idea that success in reducing the disability may lead in a better quality of life for them (NBHW, 2001:186).
Psycho-pedagogical and psycho-educational methods: This implies the support and teaching for mentally ill persons and their relatives, based on the idea that it is possible to facilitate and improve their daily lives by educating them to recognize early disease signals and how to cope with them (NBHW, 2001:186).
Somatic treatment: This includes primarily drugs, light therapy and electro-convulsive therapy (NBHW, 2001:186).

Physiotherapeutic and occupational-therapeutic treatment: The purpose of these treatments is to increase the patient's physical functional ability for returning to their activities if possible or to train them for new situations. It tries to improve and asset working ability, ability to live an independent life and handle social contexts, housekeeping training and work training (NBHW, 2001:186).

Nursing: This implies help during a shorter or a longer time given to people who cannot manage themselves in their daily lives. (NBHW, 2001:187).

Rehabilitation: The aim is improving and restoring the patient's functional ability. Rehabilitation for long-term-sick persons, such as psychotics, often involves major input to enable the patient to manage his or her daily life. It gives great advances both for the individual and for the community through the patient achieving greater independence and a better quality of life (NBHW, 2001:187).

Case Management: According to Bjorkman (2000) the main reason for the introduction of case management within the mental health services was to overcome service fragmentation and provide continuity of care to individuals and their carers (Bjorkman, 2000:10-11).

The basic functions of case management are: the assessment off clients needs; the development of service plan; the arrangement of service delivery; the monitoring and assessment of services; and the evaluation and follow-up (Bjorkman, 2000:12).

According to the NBHW, the evaluation of the case manager programs has showed the importance of making close and continual support available to the individuals, primarily to achieve continuity of assistance through being represented by someone who knows them in depth. A more formal representative with respect to the authorities and various care and assistance providers is another function of the case manager which has proved to be important (NBHW, 2001:187).

- Individuals with severe mental illness living in the community -
Different authors discuss the problems of stigmatization, chronicity and recovery and how can they become both obstacles and challenges when it comes to achieve the principal aims of the mental health reform.

The difficulties for social integration
One of the principal goals of the ideological motivation behind the transition from institutionalized to decentralized mental health care was the social integration, which is considered very important for improving mental health. However, reports suggest that efforts to socially integrate people who suffer from severe mental health illness have not been as successful as the expected (Granerud, & Severinsson, 2006:288).

The transition from big institutions to community based care was not an easy process and many things have occurred in the mean time. In the case of Sweden many violent episodes involving people in psychiatric care occurred during this process creating an intense debate in media and society about the effectiveness of the reform until today.

Despite this, several studies of the deinstitutionalization programs in different countries, including Sweden, have shown that these reforms have meant an improvement in the development of social skills and quality of life for people suffering of severe mental

illness (Hansson et al., 2002; Granerud, & Severinsson, 2006; Magnusson, Hogberg, Lutzen & Severinsson, 2004).

In one of these studies Hansson and colleagues (2002) concluded that people with schizophrenia with an independent housing situation showed a better quality of life in the living situation domain, which was associated with a more favorable perception of independence, influence, and privacy in the housing situation. The social network was also perceived as better by persons with independent housing irrespective of whether the person was living alone or not, or with family or not (Hansson et al., 2002:349).

In addition Granerud and Severinsson (2006) argue that individuals who suffer mental health problems struggle for social integration within the community. One explanation is the reported experience of living with shame and loneliness. That is why is of great importance that those working in community mental health care help to ensure that people suffering from mental health problems experience a sense of belonging in the community, thus enabling them to develop a network and achieve social integration. Mental health workers can directly promote social integration by supporting and helping through social skills training (Granerud & Severinsson, 2006:292-293).
But when it comes to professional intervention in these new settings, the same study showed the complexity of care provided in a patient's home (Granerud & Severinsson, 2006:292-293).

As these studies also stated there is a need of further research about how to change prevailing attitudes towards people suffering from mental health problems. Therefore, more knowledge is needed about the common societal attitudes of fear, ignorance and intolerance towards mentally ill people. Further investigation into how society could best meet the needs of mentally ill persons is essential to bring about their integration (Magnusson, Hogberg, Lutzen & Severinsson, 2004:26).

> (…) no service, even one offering the most updated treatments, will ever be effective in the absence of major efforts to challenge, through political action and public education, the stigma associated with mental disorders and psychiatric treatment. (Barbato, 1998:26)

Chronicity and Recovery
By "chronically mentally ill" or "severe mental illness" are defined those persons whose emotional or behavioral functioning is so impaired that it interferes with their capacity to live in the community without supportive treatment or services of a long-term duration (Topor, 2001:50).
Usually chronic illnesses have a long life span, extending over the patient's lifetime and can lead to severe impairments in psychosocial functioning including social relationships, work, leisure and recreation activities, and in the ability to care for oneself. They are most often present in schizophrenia-spectrum disorders but it could also be present in other disorders (Bjorkman, 2000:1).

The illness is thought to develop through a series of phases where a progressive deterioration of the individual's mental health occurred. New symptoms appear, earlier

symptoms become worse, even though there may be periods in which the patient could seems to be free from symptoms. In chronic illnesses a new episode is called a relapse. The implication is that the person has never really recovered, even if they no longer show the symptoms. The social and psychological consequences of chronicity tend to pervade all facets of daily life and makes deep inroads into the individual's self-identity (Topor, 2001:39).

Topor (2001), focusing on the recovery possibilities for people with the most severe mental illness, shows that even if Schizophrenia is a disorder associated with high levels of social burden and cost, as well as an incalculable amount of individual pain and suffering, there is evidence that the outcome of care can be as successful as it is in many other diseases if exists an effective care system.

The deinstitutionalization has resulted in a shift of focus from the disorder itself to the social consequences of the disorder, to the person's ability to live a normal life and the obstacles connected with this. In this context Topor argues that the handicap arises as a result of shortcomings in the community's support of persons with functional disabilities. So it is possible for a person to overcome a handicap. The illness and the functional disability are biological phenomena. The handicap arises when the disabilities related to these biological phenomena are improperly managed and the persons are given too little support (Topor, 2001:50-51).

> Such a perspective also calls into question the notion that mental problems are chronic; how such problems are expressed and how they develop depend on social interactions and not on an inherent "natural course" of the illness itself. But clearly has to do with the kind of life the patients are forced to live. (Topor, 2001:54)

In the next section I will try to show how some theoretical approaches can be applied to understand the questions at issue.

IV- Theoretical Framework

As a general framework for the analysis I will apply to the contributions that come from the **Symbolic Interactionism**.

The choice of this level of sociological interpretation has to do with the choice of the research questions. For this study I concentrate my attention in the interaction between groups and individuals in social relations within a specific area.

Symbolic Interactionism states that the meanings of social objects (persons and actions) are socially constructed (Blumer, 1969 and Mead, 1934, cited in Markowitz, 2005:130). This sociological perspective also stresses the idea that in the construction of identity through interpersonal relationships the perceptions of others are of great importance and in a way determines the identity formation.

> From this perspective, the meaning of behaviour is not inherent, but rather, through the use of language and symbols, it is subject to processes of interpretation and definition. Responses in social interaction are based on assigned meanings ("definitions of the situation"), which are drawn from shared cultural knowledge. (Markowitz, 2005:130)

In this perspective, all interaction between persons involves an exchange of symbols and the constant search for 'clues' about what type of behavior is appropriate in a specific context, and how to interpret what others do and mean (Giddens, 1997:565).

For the analysis of the data collected with the purposes of the present study I applied to the concepts developed by Goffman. His work is of great important as a theoretical approach for the problem at issue because he developed the concepts of teams and of stigma, which are directly related to the topic of my study and these concepts will help me understand and explain the results.

- The concept of "Team" -
Goffman developed a dramaturgical approach to social relations, using stage metaphors to illustrate the roles people play when interacting in various settings and conditions. For him many types of interaction are structured by scripts that outline which roles are available and what is generally supposed to occur (Calhoun, 2002).

Goffman sees social life as though played out by actors on a stage – or many stages, because how we act depends on the roles we a re playing at a particular time. Roles are socially defined expectations that a person in a given social position follows. People are sensitive on how they are seen by others, and use many forms of what he call 'impression management', sort of say it is how we try to be adapted to every social situation, to induce others to react to them in the ways they wish. Although we may sometimes do this in a calculated way, usually it is among the things we do without conscious attention (Giddens, 1997:79).

In this particular study I tried to see how professionals involved in mental health teams work and interact in the specific social situation of working with the most severe mentally ill persons.

In real life individuals negotiate among themselves to determine who will play which role and exactly how events will be conducted, and in this negotiation individuals must also convince others that their roles are important or genuine (Calhoun, 2002).

> A team, then, may be defined as a set of individuals whose intimate co-operation is required if a given projected definition of the situation is to be maintained. A team is a grouping, but it is a grouping not in relation to a social structure or social organization but rather in relation to an interaction or series of interactions in which the relevant definition of the situation is to be maintained. (Goffman, 1959:104)

Until now the concept of team can help us understand how professionals interact within the mental health teams but I also wanted to understand their concrete actions regarding the difficult task they have to face, that is the rehabilitation and integration of the most severe mentally ill people. For this purpose I will apply to the concept of stigma.

- The concept of "Stigma" -
Goffman (1963) defines it as visible or invisible social distinction that disqualifies individuals or social groups from full social acceptance. "*The term stigma, then, will be used to refer to an attribute that is deeply discrediting*". (Goffman, 1963:13)

Some social groups, such as professionals, have the power to set and impose definitions of what constitutes deviant behavior. Social actors at a power disadvantage (of lower social standing) are less able to resist application of deviant labels. Their behavior is thus more likely to be labeled as deviant. For Becker, a deviant is "one to whom the label has been successfully applied" (Becker, 1963:9, cited in Markowitz, 2005:30)
Because of the devaluated status of mental patient and the attendant stigmatization, rejection by other people, isolation from social networks and opportunities, and changes in the self concept are probable results (Goffman, 1961, cited in Markowitz, 2005:131).

> Mental illness is perhaps one of the most discrediting attributes. It is linked to an array of negative stereotypical traits (e.g. Dangerousness, weakness, incompetence), it is widely misunderstood by the general public, and is often inaccurately and negatively portrayed in the media. (Corrigan & Lundin, 2001; Wahl, 1995, cited in Markowitz, 2005:130)

My interest in the development of this concept of stigma is to analyze in which way the diagnosis and treatments are used nowadays by the professionals working in the mental health teams try to cope with this stigma and how this diagnosis can sometimes be a label for the patient and how the intervention of multidisciplinary teams can help to avoid this.

V- Methods

- **General conduction of the study** -
In order to answer the research questions of the present study and according to the aims I applied to a qualitative approach. That means I applied to several qualitative techniques in the different steps during the research process.

The choice of a qualitative approach is coherent with the formulation of the research questions and aims of the study. Qualitative approaches are characterized by the analysis of non numerical data that come from multiple sources of information including interviews, observations and existing documents of previous research about the problem at issue (Colman, 2006).

As Kvale (1996) states, the qualitative research interviews try to understand the world from the subjects' point of view, to understand their experiences, to uncover their lived world prior to scientific explanations.

- **Data collection** -
The qualitative techniques which I applied were qualitative interviews and observations.

Interviews: Ten interviews were conducted with staff working in 10 wards for in and out patient care from Health Services, as well as two Centers for Daily activities from Social Services. All the interviews were conducted in the workplace at a time convenient for interviewees, they were in English, and they were combined with the study visits, all interviews lasted approximately one hour each.

For the registration of data I applied to the notes. In some places the informants provided information in written papers, but this was not very usual because most of this information was in Swedish. During and at the end of each study visit and interviews field notes were taken carefully as well as general impressions and ideas (during the interview with the consent of the interviewee).

I applied to the semi-structured interview, so they were conducted according to an interview guide[1]. As Kvale (1996) argues from a technical point of view the qualitative research interview is semi structured because it's neither an open conversation nor a highly structured questionnaire. It is conducted according to an interview guide that focuses on certain themes and that may include suggested questions.

Regarding the selection of respondents, the sample was constructed to include professionals from some specific psychiatric teams from health care system and some from social services. The first contact was made through a contact person from my field place practice. All the visited units and the interviewed staff work in close cooperation with my trainee post and that was why interviewees were very accessible and open for cooperation. In the selection I tried to get at least one interview with each profession involved in mental health teams nowadays.

For this selection I applied to the qualitative sampling technique called Snowball sampling. It is used to obtain a sample when there is no adequate list to be used as a sampling frame. This method is usually used to obtain samples of numerically small groups. This technique involves the personal recommendation of a contact and can only

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[1] See appendix

be used when the target group is connected by a network with others who share the characteristics of interest (Gilbert, 2001:63).

> This is both strength and a potential weakness of the method. An advantage of snowball sampling is that it reveals a network of contacts which can itself be studied. A potential problem is that it only includes those within a connected network of individuals. (Gilbert, 2001:63)

<u>Observations</u>: During the study visits I had the opportunity to assist in team meetings and daily activities at the ward for persons with psychosis were I was doing my practice. In these instances I made observations and take notes about all these activities I had the opportunity to attend.

> This, together with an explicit analytic framework and aim of the study, enables researchers to focus their research inquiries. Observations and the writing up of notes under these headings, together with any relevant interview data, provide a rich insight into social relations, events and processes. (May, 1993:121)

- Ethical considerations -
The question at issue it is a very sensitive one. During my interviews and study visits I very much respected the environment where professionals work and I tried not to disturb it with my presence, and that the contact and relation with the professionals did not affect the work with mentally ill persons being attended at the wards. Even if it was very interesting for me to knew about the mentally ill persons' perspective, as an ethical decision they were out of the focus of attention for this specific study. From an ethical point of view a study involving persons with psychiatric diseases as informants require more attention on how to get real consent and to prevent harm during the interview situation. For the case of professionals I think they are in a different situation and have sufficient knowledge and comprehension of the elements of the subject matter involved to make a clear consent (Gilbert, 2001:49).
Before every study visit and interview I introduced myself and explained the double purpose of knowing the place in the context of my field place practice and also to collect data for my degree report that will be related to the same issue. All of them accepted to be interviewed and offered themselves for further instances of exchange of information. In that sense it was fulfilled the requirement of informed consent.
I will preserve the name of places and professionals in this report because of the requirement of confidentiality. For analysis purposes the interviews will be identified with a number.

- Generalizability, Validity and Reliability -
Verification of knowledge is commonly discussed in modern social sciences in relation to these concepts, which ones according to Kvale (1996) in some cases are treated as a "holy trinity" and in others simply omitting them for being considered as oppressive positivist concepts that can go against creativity and freedom within qualitative research (Kvale, 1996:229-231).

For the case of this study I did not follow any of the above mentioned perspectives. I think taking an account of the three issues during the whole research process allowed me to be aware of the advantages and limitations of the present study.

Understanding that validity refers to the degree to which the analysis is properly conceived to address the subject of study (Calhoun, 2002), I would say the theoretical perspective I chose to analysis my results, Symbolic interactionism and consistently the qualitative analysis, was coherent with my research questions that pretended to focus in the ways people behave in their natural context, for the case of this study the mental health teams. In that way validity of results are ensured.

Matters of reliability often have to do with informational problems that can emerge during the utilization of the selected technique and that can negatively influence the results (Calhoun, 2002). In the case of this study I carefully prepared an open interview guide trying to avoid, for example, leading questions to ensure that the interview situation contributes the more possible for the reliability of the study. Anyway and even if language was not a problem for the understanding with subjects during the interviews we have to recognize and be aware that neither the interviewees or the interviewer used their mother tongue and that could be a limitation sometimes for the expression of ideas.

Finally and in regards with generalizability I would say according to the size of the sample it is not possible to generalize the results but I think it is possible to achieve the analytical generalization that Kvale (1996) mention as the one that involves "*a reasoned judgment about the extent to which the findings from one study can be used as a guide to what might occur in another situation*" (Kvale, 1996:233). In that sense the results that emerged from this study can be useful for studies carried out in similar settings or within the same field.

- **Data analysis** -
Finally for the data analysis I applied to the qualitative analysis techniques expressed by Kvale (1996) at the seven stages of analysis in qualitative research interviews. Some of them are: Meaning condensation, meaning categorization, meaning interpretation (Kvale, 1996:204).
For the analysis I made a revision by reading thorough all interviews looking for common patterns and then I started to categorize and find themes. After putting all themes together I started the analysis mixing findings with my impressions and things I have already read in previous research.
Finally I made connections and put it all together in a different way after relating them to some theoretical concepts that let me explain and understand the findings described after. The theoretical framework helped me to understand the issue and keep the focus.

In the next section I will present the three main themes that emerged from the data analysis and I will try to handle it both with the theories and previous research, trying to highlight and support that with some excerpts from the interviews.

VI- Results and Analysis

In order to present and analyze the results of this study I organized them in the following themes:

- Team work inside and outside the workplace: roles and interaction
- Mental health reform and deinstitutionalization process: an overview
- Working with the most severely mentally ill group of persons: implications and challenges

- Team work inside and outside the workplace: roles and interaction -

The links of a chain
In the majority of places that had part in this study the teams were formed by social workers, occupational therapist, psychologists, physiatrists, nurses and in some cases physiotherapists and "caretakers" (non professional staff in charge of daily attention of impatiens at wards).

When talking about team work, interaction and cooperation between these professions any of the interviewees mentioned hierarchies between them, they mostly talk about good cooperation. I think this has to do with the new emphasis put in the team work and the inclusion of professions from social sciences field in the mental health's area.

Why is that? As stated in previous research chapter, within the field of psychiatry there was a historical predominance of medical treatments and very little attention was put to the social aspects of the mental illness or its social implications. Deinstitutionalization process contributes to change these traditional roles within the teams. And maybe that is why the perception of professionals has also change in this direction.

However in some cases it is still the view that too much attention is put in medical treatments, and that more attention should be set to social aspects of mental illness, both in rehabilitation but also in prevention. This is more visible when it comes to responsibilities for somatic treatments.

> *(…) the formal responsibility for the treatment it is still mostly in the doctors (…).* (Interview I)

What I could see and understand in the different interviews was that all professionals respect the opinions and decisions of psychiatrist, they know they can influence the prescriptions of medications because they are also skilled (and usually they have been working in the mental health field for several years) but they respect that "medication" is part of the work of the psychiatrist and it couldn't be done without their contributions, as rehabilitation, support and social integration are part of their work and couldn't be done without the support of somatic treatments[2].

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2 Medication it is an issue very criticized within the field of mental health. What I could knew about it according to the information collected during this study was that it usually have very hard secondary effects

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In that way, I consider that even interaction between professions is perceived by them as being performed in a sense of equality, still we have to consider the issue that the task of mental health workers should be done with great responsibility, life and health of people it is in charge of professionals so they should be very involved with the situations and have a qualified knowledge about it. For these reasons I think all professions and roles are important but some are fundamental.

When introducing the concepts of role from Goffman (1959), I said above that they were "socially defined expectations" followed by persons in a given social situation. For the case of mental health field even though it has always been mostly connected to medical practitioners, such as psychiatrist and nurses, social professions have a very important role nowadays when it comes to contribute to the diagnosis and treatment plan for mentally ill. According to Newbigging (2004) this has implied for social professions the need to be familiar with the way medicine thinks and works, and the language it uses if team work is to be effective; as a consequence I think it implied the change of the traditional defined expectations or roles for professions.

> The change from hospital- to community-based care and the new emphasis on multidisciplinary and intersectorial approaches inevitably mean changing roles for staff and a need to develop a good understanding and respect for the differing roles of the contributors to the multidisciplinary effort (Onyett 1999). (Newbigging, 2004:159)

More and more other professions or mental health workers are being considered as essential contributors in the mental health field. Some of the most important new roles I could perceive are contact persons and care takers which are the ones in more close contact with the persons. As some of the interviewees expressed:

> *(…) the role of the contact person it is very important in the whole process because he or she is the one that know best the patient.* (Interview VII)

I found that nurses, care takers and contact persons are very important new roles when it comes to everyday life of mentally ill, and their contributions are very important both in decision making about medications but also during social assessment for deciding the treatment plan.

> *(…) team work is one of the most important things we have and it really works. (…) all the information is important when it comes to decision making regarding medications.* (Interview VII)

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in the general health of mentally ill persons (part of the work of psychiatrist is trying to reduce this bad effects the more possible), but they are fundamental for the rehabilitation and integration of severely mentally ill, because one of its principal functions is to reduce the symptoms of schizophrenia or psychosis that produces the crisis (some of them are: hallucinations, unplugged from reality, paranoid and persecutory ideas). (Interviews I and VII)

I think the interaction within teams has shown that all professions are important; it is not possible to think how it could works without some of them, the process is like a chain and the different steps couldn't be done without all this human resources, so each professional is like the link of a chain.

This interrelation is what according to Goffman (1959) is a main characteristic if interaction between team members.

> It is apparent that individuals who are members of the same team will find themselves, by virtue of this fact, in an important relationship to one another. Two basic components of this relationship may be cited. (Goffman, 1959:82) Team-mates tend to be related to one another by bonds of reciprocal dependence and reciprocal familiarity. (Goffman, 1959:83)

Even though some professionals expressed that they work alone with patients, in all teams I had the opportunity to visit, they have the collective instances as very important aspects of team work. They have meetings every week where they discuss all together the different aspects of practices but also the working conditions.
Regularly reflect on how the team is working and how it is achieving its objectives has been identified by Newbigging (2004) as an important function in enabling members to understand and explore each other's roles and to develop the 'team culture' that will reinforce that "*reciprocal dependence and reciprocal familiarity*" that Goffman (1959) talks about and that I think is crucial to the positive collaboration, effectiveness and success of team work.

Many interviewees think that teams with few members are an advantage. Small places and few personnel make the better teamwork, because among other mentioned things they can "*know each other better*" (Interview II).

Intersectorial collaboration
As stated by the World Health Organization (2005), in addition to multidisciplinary approaches a very important aspect of mental health services should be the collaboration with other sectors and units, both from health and social services.

> People with mental disorders have multiple needs related to health, welfare, employment, criminal justice and education. Thus the promotion of mental health within a country straddles a broad range of sectors and stakeholders, and is not limited to the activities of a ministry of health. For these reasons, the mental health workforce should be developed intersectorally. It is important that countries establish a clearly designated body to coordinate the many sectors involved in the development of a mental health workforce. (WHO, 2005:4)

In the case of Sweden I found that interaction and integration, primarily between the programs of social services and psychiatric care organizations was highlighted by the NBHW during the evaluation of the reform as one thing to be improved to achieve the success of it. At that time they identified that collaboration was characterized by conflicting interests on both the structural and cultural planes. They also found significant regional variations (better in the smaller communities). According to the same evaluation,

the NBHW stated that the inadequacies for cooperation were often due to the lack of a common approach and a common knowledge base (NBHW, 1999).

When the interviewees in the present study were asked about this issue, they emphasized that cooperation is mostly good nowadays. In all the visited units professionals mention the importance of coordination and collaboration between teams and units from both health and social services. They have a lot of coordination in their daily work, but in some cases it can be difficult when social services have to make decisions regarding social benefits for the person for what they should strictly follow the rules stated by the law. For example in the case of disability pensions, places at group homes or places in specific rehabilitation programs the mentally ill person have to apply and usually they do it through a report made by social workers. Some social workers interviewed about this stated that it is difficult to get some of these benefits, in the case of group homes it is also a very slow process. Some of them think social services are strict because they have to follow strict rules and laws. Some others affirmed that sometimes it depends on the people, on the individuals in charge. The majority said that nowadays it was basically good relationship, but some mentioned that "*it depends a lot in the particular persons*" (Interview III).

As Goffman (1959) states when thinking about this issue it is easy to assume that the content of the presentation is just an extension of the character of the performer and to see the function of the performance personal terms. He argues that this is a limited view and can obscure important differences in the function of the performance for the interaction as a whole (Goffman, 1959:77). From the point of view of symbolic interactionism I think this is not a matter of personal characteristics but of predetermined roles and the expectation each professional and team has to fulfill, the aims they have to achieve and the rules they have to follow to get a good performance.

> When two teams present themselves to each other for purposes of interaction, the members of each team tend to maintain the line that they are what they claim to be, they tend to stay in character. Backstage familiarity is suppressed lest the interplay of poses collapse and all the participants find themselves on the same team; as it was, with no one left to play to. Each participant in the interaction ordinarily endeavours to know and keep his place, maintaining whatever balance of formality and informality has been established for the interaction, even to the point of extending this treatment to his own team-mates. At the same time, each team tends to suppress its candid view of itself and of the other team, projecting a conception of self and a conception of other that is relatively acceptable to the other. And to ensure that communication will follow established, narrow channels, each team is prepared to assist the other team, tacitly and tactfully, in maintaining the impression it is attempting to foster. (Goffman, 1959:163)

Still, coordination with the social services is evaluated by the professionals as something good. But I could notice that from the point of view of the professionals from the health care system, the social services are usually "colder" when it comes to decision making about the mentally ill persons. This can be because professionals from the health services are in more close contact with them.

We can see this idea through the expression of one interviewee:

They consider the situation through a report but the staffs from health services is more in close contact with the patient so sometimes we have differences (…) but anyway in general collaboration is good. (Interview II)

- Mental health reform and deinstitutionalization process: an overview -

A complex transition
In regards to this issue I had the opportunity to see how health services looks nowadays and how professionals think and feel about this change. Most of the interviewees were people with long experience in the field so they have experiences of working in both settings, which I think it is very important as a positive aspect of teams because they can compare and value the difference but also be critical and talk with arguments when it comes to evaluate the new methods.

Concerning the deinstitutionalization process in Sweden, all professionals agree that the reform was very good and patients are much better nowadays for many reasons, for example in the institutions medicalization of treatments was very hard, and patients were treated mostly with very strong medications, nowadays this aspect has improved. Also patients from big institutions used to spend all their lives inside the institutions and institutionalization had very bad effects on them for the lack of social contacts and relations, even with families.

As one interviewee stated,

It is always better that they live in their own homes, but in some cases should be more levels between the hospital and living completely alone in their own houses, that was something bad from the reform and also that there were not enough places to stay for those who don't have a place, still there is a lack of places to live for mentally ill. (Interview IX)

In the opinion of the interviewees, the process has had good and bad sides. All of them agree that transition was too fast, with a lot of problems and not enough resources. Some of them think the community was not prepared for the change, to receive all this patients and some things were not enough such as housing for patients leaving the big institutions. The goods are related to the normalization principle that tried to make them as everybody, and the bad is that they are different and have different needs; they need a lot of company and support. People with mental illness living in the community are more exposed to see how the rest of society can live their lives in a "normal way" and in some cases they cannot do the same because their whole lives are very much affected by the illness.

(…) it is very good but some people still need a lot of help and support, but as soon as places where they can go exist it is better that big institutions don't exist anymore. (Interview X)

Reform was good, but life in community for patients has been difficult, they need a lot of support and understanding from people. (Interview X)

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From the point of view of methods and treatments some interviewees think that work in the field is more professional now. Professionals are more skilled and know more about some issues so it is more "scientific work".

After the evaluation
I could find in this study that after the 1999 evaluation many things have been improved, several new units have been created to attend some of the problems that appear during the transition.

In 1999 the NBHW said that:

> Personal assistance and support should not be connected solely to housing, but also to outwards-directed social activities such as e.g. recreation and daily occupation. The needs for rehabilitation and occupation are not yet satisfied In general, the problem which appears most urgently in need of resolution is the lack of meaningful daily occupation. Assistance is needed to achieve meaningful daily occupation, and not just for work and vocationally-oriented rehabilitation. Despite major efforts, however, such occupation is still missing for half of the target group. Most have not completed their basic education. This should be taken into consideration to a greater degree as a component in the rehabilitation process. (NBHW, 1999)

The most noticeable change I could find during the study visits and interviews was regarding the reintegration of people with mental illness to labor market and also regarding the lack of daily activities. I cannot say that results are already visible or positive in this aspect, but it is important to mention as a fact of an improvement in this issue the creation of new units for the specific attention of these needs.

Regarding group homes, all social workers agree that these places are still not enough and sometimes a person can wait a year for a place for and still some of them don't get it.

- Working with the most severely mentally ill group of people[3]: implications and challenges -

Integration vs. professional dependence
Regarding the integration of severely mentally ill patients in the community interviewees gave me an overview of the principal characteristics of these patients to better understand the challenges and obstacles they face in the everyday work.

It is in general very difficult for patient to accept the illness, which means that many times they refuse medication as soon as they feel better, and then relapses may occur. Also, patients in general, as soon as they feel better, they think they can go back to their activities but they can't, so part of the work of professionals is also to motivate them to follow the rehabilitation process. They have in general low tolerance to stressful

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[3] The persons being attended at the wards I visited usually suffer from psychosis or schizophrenia.

situations, and in the actual labor market it is difficult to find an activity without stress that is why is so difficult for them to reintegrate. It is very difficult to reinsert them because they are usually not welcome in job agencies or job centers because they are considerer problematic. They have an illness so employers immediately think in the problems it can cause, less capacities more sick leaves, etc. In this part of the rehabilitation process the role of Occupational Therapist and Social workers are crucial. The treatments professionals mostly apply are psychotherapy and cognitive therapy.

The more the patients get psychotic episodes the more their capabilities are reduced, mental and physical conditions get worse and worse with each episode. Severely mentally ill patients need a lot of support because they cannot manage by their own, it is very difficult for them to be independent and to have a "normal life".

The treatment depends on each patient's characteristics, could be put more emphasis on practical support or could be they need help from social services office, etc. for example they usually have very bad economic situations, they don't pay bills, so sometimes social workers have to call the social services and they need a court man to take care of patient's money.

Patients usually go to the wards but sometimes they have so low functional level that professionals should go to pick up them and persuade them to go to see the team. They don't even have the motivation to go out, in that cases they have an ambulatory team that go to the houses, nurses and doctor go to patient's homes. Regarding this I think it has been very important the creation of new units for daily activities and for work rehabilitation. These units are mostly in charge of social services but the staff working there it is usually similar to the mental health teams, usually there are Occupational therapist, social workers, couches and caretakers.

As I mentioned when talking about professional role there are some professions which are more focus in helping them to cope with everyday life situations. That is the case of the Occupational therapist which principal aim in working with severely mentally ill patients is to help them to be aware of their abilities because usually they tent to think they have more abilities than they really have, this was emphasized many times during the interviews. As stated by a professional working in one house for work rehabilitation:

> *They usually have very few activities here is the opposite, they have lots of things to do, and they should do it very good, they have to do a good job because the products go to a costumer.* (Interview IV)

The principal aim of work rehabilitation is that through work (or some meaningful activity) these persons could feel integrated in the community and that will lead to a better health that is also very important aim, that health get better through work.

> *For some people work is like medicine.* (Interview IV)

The task of the Social Worker is mostly help them to cope with the everyday situations, as well as making the necessary deals to take all necessary benefits they need from social services, such as group homes, income or personal assistance etc.

For the interviewed professionals sometimes the work becomes frustrating, especially when it comes to the most severe cases.

As explained by Tilbury (2002):

> Social work with psychosis sufferers, their families and careers can be a lengthy business. In some instances (…) success may be limited to preventing deterioration, arresting the speed of it, or ensuring as far as possible that the quality of life is maximized in the face of progressive decline. These are still very worthwhile outcomes, but very much more can be done in other instances – at best returning sufferers and their families to full recovery. The psychosis still carry an image of hopelessness since we cannot (as yet) cure the conditions, only control the symptoms to a degree while the illness takes its course; social work intervention can be seen as merely a protracted palliative. (Tilbury, 2002:76)

They work with individual cases and also in groups. Counseling is sometimes difficult to apply when patients are in the last steps of the illness because it is difficult for them to be in the reality and to follow a normal conversation. With groups they meet once or twice a week and do some leisure activities and also discuss how to cope with different difficult situations they have to face in life because of the illness they have.

Patients are very dependant on the professionals and a very illustrative example of that is the one mentioned by one of the interviewees who explained that the weekends are very hard for patients, while on Fridays the team members are very happy because the weekend is coming, the patients are happy on Monday because they can go and talk to professionals again.

> *They are usually lonely persons, most of them are old and have never been married, usually their only relatives are parents and they are very old". "(…) people suffer too much of loneliness.* (Interview II)

The work with the family it is an important part of the rehabilitation process.

Most of them live in group homes because they can't take care of themselves.

All the interviewees are optimistic and think that with all the appropriate support of social services and from professionals and controlled medication it is possible to integrate people with psychosis in the community.

> *"(…) it is a very challenging task, but it is possible". "One of the most challenging things of working with mental illness is to break the stigma".* (Interview V)

Many professionals mention, during the interviews, that some of patients with the most severe mental illness are satisfied with their lives. In my opinion this could be related to the idea of the subjective condition of the concept "quality of life". This idea makes me think that in a way they will never be independent, but it doesn't have to be a negative thing if their needs and wishes are taken in consideration.

The diagnosis as a label or stigma

Among the methods professionals use to work with psychotics patients one of the most important mentioned during the interviews was the Case Management. It imply the active participation of the clients, their family (or a support group defined by the patient), the contact person and the professionals from both medical and social services in planning the rehabilitation process.

During this process the team defines:
- The medication, they should find the appropriate medication, and sometimes they try different options for a long time until they find the adequate.
- Social support, to strength the patient to return to normal life as soon as possible. That is made in permanent coordination with social services.

Clients are divided in two groups: chronic and non chronic. Inside the first group we mostly find the young people who had experience a first psychotic episode. In these cases the principal aims of the rehabilitation process is that they can go back as soon as possible to their usual life, jobs, family, etc. If the treatment starts early it is more possible the rehabilitation. The more the patients get psychotic episodes the more their capabilities are reduced, mental and physical conditions get worse and worse with each episode, which is also why many of the chronic patients are the older ones.

Generally one third of clients achieve the recuperation; other one third doesn't achieve it but they keep under control with the medication and the last third don't get recuperation and the medication doesn't control symptoms, these constitute the group defined as chronic patients and are the most severe cases. For them the aim of treatments is to help them to cope with everyday life issues.

The method of case management is mostly applicable to the non chronic patients. In general there are good results, but it depends on the level in which the patient starts the treatment.

> *The program is better for patients with possibilities of recovery. The program is good because it gives the patient a very active place. For team work is good also because it involves more the other professions and not only the psychiatrists.* (Interview I)

In my opinion this separation between chronics and the ones with possibilities of rehabilitation or recovery it is a kind of stigma including the way services are organized they implied the inclusion of patients in some category or level of mental illness that I think could lead to stigmatization. It is not a conclusion; it is an opened question that could be good to think more about.

> (…) how does being diagnosed with mental illness affect self-conceptions in terms of being "deviant", "abnormal" or, in Goffman's terms, as having a "spoiled identity"? Moreover, how do the perceptions and reflected appraisals of "significant others" (e.g., family, friends, service providers) of persons with mental illness affect identity formation? In turn, how does identity affect the recovery process? (Markowitz, 139-140)

Following my theoretical framework I can say that in the construction of identity through interpersonal relationships the perception of others are of great importance and in a way determines the identity formation. For the case of mentally ill stigma could mean that the person is not taken seriously, which increases the feeling of marginalization. The feeling of alienation makes it even more difficult to participate in daily life. To be labeled as a chronic patient I think in some ways can affect the possibilities of recovery of patients in terms of assuming the assumed role. Maybe a more challenging attitude toward professional could make patients feel that possibilities of recovery exist.

> Stigmatization makes it impossible for patients leaving hospital to return to their former life. Both their own self-image and the way others perceive them have been shaped by the culture's predominant notions of insanity and chronicity. Persons whom psychiatry defines as chronic assume that definition and act with the expected behaviours and are treated according to these expectations. (Topor, 2001:53)

As Markowitz (2005) argue, the stigma associated with mental health treatments can affects the course of illness by lowering a person's self-esteem, constricting their interpersonal networks, and reducing their chances for employment and income, all of which increase stress. These stressors, in turn, place persons at risk for increased symptoms (Markowitz, 2005:137).

In addition psychiatric labels may produce generalized beliefs about the dangerousness of persons with mental illness, which then lead to social rejection, that can be traduce in a negative attitude to live near, socialize, or work with people with psychiatric disorders, to have a group home for the mentally ill nearby, or to have someone with mental illness marry into their family. They want to have what in sociology is called social distance (Markowitz, 2005:135).

VII- Conclusions and directions for further research

In the present and final chapter I will answer the research questions that had guided this study and also I will suggest some directions for future researches within the same field as well as final reflections about the issue and about the study as a whole.

- How is interaction within the mental health teams manifested and what is the role of the different professions involved? -
Regarding this question I can say by reviewing the results that during the deinstitutionalization process has been substantial changes for mental health staffs and this has meant a lot of new task and challenges for them. Staff should be able to work in a variety of community, residential and inpatient settings; across agencies and across service levels; in coordination with multiple professional and non-professional disciplines. As a conclusion regarding this I can say that this new emphasis in team work has helped in changing the traditional predominance of psychiatry within the filed of mental health and has open the participation for social professions that have today a fundamental role when it comes to rehabilitation of mentally ill individuals. Cooperation seems to be very good between professions. Also teamwork in the context of deinstitutionalization has created new and very important roles such as the case of "Contact persons", created within the context of the application of case management methods. The last is the new and most important treatment used nowadays and seems to be very good in the sense that involves the work of professions and the social services in close collaboration and it implies the active participation of the client and the family.

In that sense I can conclude that interaction it is manifested in a way of equality between professions but with very clear roles for each. All of them have an important and clear part during the treatment process that could not be effective if some of them are not present. So the relation between teams at the inside it is working in a proper way nowadays and in a sense of equality, shared objectives and cooperation.

In addition, the coordination between psychiatric units and social services it is very important part of the work and it seems to be working better after the changes made with the evaluation in 1999, new units were created and responsibilities where clarified. When it comes to the relation between teams and units then some problems can appear but they are not of great significance and I think it is normal it exist considering the different kind of people in numbers and shapes that have to interact following the same aims but with different rules. In that sense sectorization has facilitated everything because it let organize the work within a smaller area. The idea of the NBHW of improving cooperation between social services and health services it is really better nowadays even if there are still more things to be done.

- How do professionals see mental health reform and deinstitutionalization process nowadays? -
As a general conclusion regarding this question I can say that professionals are mostly satisfied with the change and they think they are better nowadays in what respect to methods and of quality of life for mentally ill.

On the other hand they are critical when it comes to evaluate the transition they have experienced from the closure of big institutions to nowadays, in which many problems have occurred.

Another important thing they valorize is that the evaluation of the reform in 1999 constitutes a very important step for the improvement of mental health treatments in Sweden but still there are many things that need to be improve such as quantity of housing for the mentally ill as well as a mayor efforts in preventive programs.

- What are the principal implications and challenges when it comes to work with the most severely mentally ill group of people? -
Deinstitutionalization has resulted in a shift of focus from the disorder itself to the social consequences of the disorder, to the person's ability to live a normal life and the obstacles connected with this. There are still problems for social integration of severely mentally ill persons in the community and it has to do with many things but the principal two that came up from the results of the present study are the dependence from professional support and the stigma associated to the mental illness itself. The label of being "mental ill" could become a stigma when the person tries to go back to normal life.

During the evaluation of the mental health reform in 1999 the NBHW established that to achieve the integration aimed in the reform and in the deinstitutionalization movement as a whole the general population *"(…) should have to change their negative attitudes towards mentally ill people and show more acceptance"*. (NBHW, 1999)

Even if there was a good change in the ideas about how are conceived the mentally ill persons this is mainly in the level of professionals, but not at the level of general population. In respect to this I think more work in prevention and more education in this field since early stages can help to change the bad image of mentally ill and also the stigma associate with it.

As a conclusion I can mention the fact that after the process of deinstitutionalization and with the new emphasis in social rehabilitation this stigma can be ameliorated. Anyway there is still the problem of the severe mental illnesses and the difficulty for professionals to achieve the independence of patients, which makes them carry with this "label" lifelong. That is why is of great importance that those working in community mental health care help to ensure that people suffering from mental health problems experience a sense of belonging in the community, thus enabling them to develop a network and achieve social integration.

Regarding this I can conclude that the teams working with the most severely mentally ill are very much trying to help patients to reintegrate in community. They have a very important role on it, also considering that sometimes they are the only companion or support for this people because of the loneliness they suffer. That is why this aim becomes a mayor challenge but sometimes can be also a matter of stress and frustration for mental health workers.

- Evaluation of aims' achievements and of contributions of theoretical framework and concepts -

The general purpose of the study was to describe and analyse mental health teams within the context of the Mental Health care reform in Sweden. I did that specifically by having a look at the different roles and methods professionals involved in mental health teams apply for working with the most severely mentally ill people.

Having a look at these aims I can say at the end of this report that I was able to achieve them with the contribution of previous research, theoretical framework and information from interviews. The theoretical perspective I chose to analysis my results, Symbolic Interactionism, helped me to understand the issue and keep the focus while the concepts developed let me understand some of my finding from the point of view of the social interaction of individuals in a determined field.

- Further research -

Many new interests and fields have been opened for me after this study and some of these new interests will be presented here also as a contribution for further research of other students concerned with the same area.

First of all I would say that studies regarding this issue can be analyze in different levels, at the organizational, structural and interactionist, all are interrelated and all are good fields to be developed.

If we recognize the great importance of the mental health workers' job, but also the big responsibility they carried with them and the stress associated to work with this group of patients we can find a second interesting field for further research. That is to study and analyze how professionals are affected by their job and how can they cope with the implications and responsibility they have to face.

I think there is also the need of further research about how to change hostile attitudes towards people suffering from mental health problems. Further investigation into how society could best meet the needs of mentally ill persons is essential to finally achieve their integration.

Also and finally I would suggest that could be interesting to analyze some of the issues discussed in this report but from the point of view of patients themselves. This was not the chosen focus for this study but not because of considering it as less important but because the focus and the limitation of this research didn't let us go that deep, but it became a good issue for further research instances.

- Final Reflections -

As a general conclusion I can say methods used nowadays in Sweden for working in the field of mental health recognize the importance of teamwork, cooperation and coordination between services, empowerment, and family or social networks.

I think Sweden fully follow the rules of United Nations for the treatment of the mentally ill, and according to the requirements that at an international level exists nowadays I can say Sweden is in a very good level and improving a lot the services, however more work in prevention can be done.

I can conclude by reviewing the existing literature, the reforms, and the actions taken with regards to the change from institutions to community settings that the involvement of patients in decision making about their own lives as well as the promotion of their independence in everyday life by the implementation of adequate housing in the community has meant a great advances in the way of integrating them into the society. In that way, in my opinion, this is one of the most important and sensitive objectives of the mental health reform in Sweden, to give people with severe mental illness the possibility to live their lives in society with the same rights as other citizens. As a final and general conclusion and after having an overview of how are organized social and health services for mentally ill I can say that this objective of the mental health reform has been fulfilled.

During the whole deinstitutionalization process many things were corrected and improved. It was not an easy process, but today I think Sweden has achieve a stage in which it become a good experience to be analyzed by countries that pretend to start the same process (such as my home country Uruguay), to be aware that it is very important this change but it cannot be done if community is not prepared for it. Swedish society, professionals and patients had hard times during this process but I think it has been worthwhile.

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Appendix

- Interview guide -

Team work

- Description of tasks and role in the team
- How is cooperation between the different disciplines into the team in general and in everyday work?
- Describe the cooperation specifically with Social Work.
- How is cooperation between units from health and social services?

Mental health reform and deinstitutionalization process

- What do you think about the change from institutional to community setting in the mental health field?
- What do you think about the deinstitutionalization process that has taken place in Sweden?

Working with the most severely mentally ill group of people

- What are the principal methods and theories used to work with severely mentally ill patients?
- What are the principal aims working with people with mental illness?
- Possibilities of rehabilitation and integration of people with severe mental illness in the community.