DISCHARGE PROCEDURES FOR MENTALLY ILL PEOPLE

The perspective of former psychiatric patients on their social network, quality of life and future life expectations

by

Mona Dufåker

Umeå 1993
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Abstract
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The theoretical framework is based on Mead’s symbolic interactionism, Asplund’s interpretation of Tönnies’ concepts Gemeinschaft and Gesellschaft and Buber’s dialogical philosophy.

Descriptive, quantitative and qualitative data were gathered on four occasions from May 1984 to December 1986. On three occasions professionals provided information by means of structured questionnaires. Information on the last occasion was provided by former patients through interviews by means of a semistructured questionnaire.

Seventy-three patients were discharged during the research period. I was able to follow 50 through all four stages. Fifty-three patients were interviewed.

Other agencies were hardly involved at all in the discharge procedure except for the provision of home support.

The duration of and stigma attached to mental illness, being without work and gender seemed to have the most influence on the primary network. The same issues (with the exception of gender), together with place of residence, financial difficulties and inability to exert influence over one’s own situation influenced the former patients’ quality of life and their expectations of the future. Special attention has been given to their occupational situation and to their relations to the professional network. Work opportunities were highly valued but most of the former patients were excluded from the labour market. The LFP groups satisfaction with the home care workers and dissatisfaction with the psychiatric professionals seemed to be due to the former’s ability to undertake a ‘caring’ relationship.

Key words:
Mental illness; social network; professional; quality of life; future life expectations; employment; labour market;

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Signature
Mona Dufåker

Date
September 13th 1993
To my mother
and in memory of my father
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The aim of this study was to find out: (a) the role played by various agencies in the discharge procedure and (b) former psychiatric patients' own perspective on their social network, quality of life and future life expectations. The theoretical framework is based on Mead's symbolic interactionism, Asplund's interpretation of Tönnies' concepts Gemeinschaft and Gesellschaft and Buber's dialogical philosophy.

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ORIGINAL PAPERS


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A first step towards an organized care of the insane

During the 17th and 18th century the state increasingly emphasized that provision for the poor and sick was a responsibility of the parishes and towns. They would not be admitted to the state asylums. A decree in 1763 identified those who, on account of madness and contagious or incurable illness, could be admitted to state asylums. A development towards state institutions for the insane was initiated. In 1787 the plan to establish a state controlling agency was realized. The same year King Gustaf III founded the Guild of the Order of the Seraphim (Serafimerordensgillet), a government office, which despite lack of medical experts served as the national board of the institutions (with the function of monitoring the asylums) (Nilsson, 1979; Qvarsell, 1981b).

At the turn of the 19th century the conditions at the Swedish institutions were dreadful. They were the heirs of the medieval charitable institutions and they were still mainly institutions for the relief of the poor operating on tight budgets. Responsible for the care, as well as for the accounts, was the manager, a man with a lower juridical education and military or administrative qualifications. Often the manager was assisted by a preacher. The patients were considered incurable and the function of the institutions was to protect society from disorderly and dangerous individuals. Keeping people in institutions was primarily a question about morale and social control. Fears of increasing social disorder made admissions to the asylums a form of preventive detentions.

The insane were considered as possessed or bewitched and madness was a punishment for excesses of behaviour and sinfulness. The treatment was cruel and included all kinds of means of coercion from being locked up in cells or cages, or in more serious cases, to being put in chains and irons (Nilsson, 1979). Ideas about asylums reserved for the insane developed at this time (Qvarsell, 1982).

The entry of the concept of illness

The first half of the 19th century has been called the golden era of psychiatry. Psychiatry was to a larger extent accepted as a branch of medical science. Throughout Europe large asylums were established. The
asylums established in France and Germany during the first decade of the century and somewhat later in Sweden and United States showed certain similarities. Doctors started to take an interest in the care of the insane and became responsible for the treatment. Even if they did not generally have adequate training, their 'entrance' seemed to be contributory to the altered attitude towards insanity. Insanity was increasingly considered as an illness that could be cured (Qvarsell, 1981b; Qvarsell, 1993). The ideological roots of the treatment concept could be found in the nature of man concurrent with the philosophy of enlightenment. Man was considered to be a product of his experiences and environment and could therefore be remodelled in cases of unwanted characteristics (Qvarsell, 1982). Religion was important mainly as a mean to moral change. In 1823, due to optimism about existing treatment and hopes of being able to decrease the expenditures for the care of the poor, an Act of Parliament was introduced which lead to the closure of several smaller institutions. The activity was concentrated on seven large asylums across the country. A more organized form of care of the insane developed (Qvarsell, 1981b). Active treatment of the insane in an asylum established for this purpose began in the 1820s. Psychiatry was then merely a science in the making (Qvarsell, 1982).

The first asylum was established in Vadstena in 1826 and became, together with Danviken outside Stockholm, the most important of the Swedish asylums right up until the middle of the 19th century (Qvarsell, 1982). The same year (1826) the first full-time doctor, George Engström, was employed at the asylum in Vadstena. The authority in charge, the Guild of the Order of the Seraphim, conferred on the doctor legal responsibility for the treatment of the insane. They pinned hope on the doctors' ability to cure the sick and make them self-supporting (Qvarsell, 1981b).

Class division, education and protection

Around 1830 population growth coupled with an agricultural reform (laga skiftet), (which involved a strong proprietoral concentration), forced many of the small farmers to leave their homesteads and roam the country searching for a way to support themselves. Many of these former freeholders ended up in the towns hoping to get jobs in the factories (Sjöström, 1984).
It was the single poor, without social anchorage and without any financial alternatives to other forms of care, and criminals, who initially were taken care of at the asylums.

The ideal and standards of the liberal middle class left their print on what was considered to be the causes of mental illness. Almost every circumstance (poverty, drunkenness, accidents etc) could provoke insanity but the prime cause was emotional unbalance (Qvarsell, 1981b; Qvarsell, 1982). Strong emotions and passions such as pride, jealousy, a broken heart and grief prevailed over reason. The nucleus of treatment was to isolate the sick from their home situation, where the damage was inflicted on them. The object of treatment was re-education of those who had not been brought up properly and was characterized in accordance with the family ideal of the time (Qvarsell, 1981b). The doctors maintained gender divisions as well as class characteristics and tasks. The manager and/or the doctor served as the head of the family. The bourgoise father, who managed his family with authority and determination but also with kindness and compassion. Other staff members played the part of servants and the patients were regarded as children in an attempt to replace the lost or the never gained family (the 'moral treatment') (Nilsson, 1979; Qvarsell, 1982). Simultaneously the asylums were means to define society's borders of the acceptable (Qvarsell, 1981b). Insanity was a reverse image of the values and norms of the bourgoise family; the view of insanity took a normative and moralistic character.

In the 1850s, when Parliament discussed new regulations, the preventive aspect was one of the most important topics. The dean A.F. Sondén argued for new asylums and juxtaposed the insane to 'criminals, who violate the social order' and the bill recommended the state to 'take away these disturbers of the peace and render them harmless' (Nilsson, 1979, p. 452). The asylums ought to take care of the incurable, which was something new, and those, who were considered dangerous to themselves or to society (Nilsson, 1979).

The asylums grew in size and the newly-built institutions were already from the beginning intended for treatment of the insane. About 4 150 patients were considered insane but not all were in need of asylum care. In the 1851 report, which considered the expansion of the care of the insane, the need for another 1 200 beds was brought up (Psykiatriutredningen, 1992b). The number of beds should be distributed in six catchment areas (except for Stockholm) with asylums in Uppsala (250...
beds), Vadstena (350 beds), Växjö (150 beds), Lund (250 beds), Göteborg (150 beds) and Härnösand (50 beds) (Socialstyrelsen, 1982).

The 1858 statute of care of the insane implied a breakthrough for a new perspective on insanity. The doctor, not the manager, was in charge of the activity at asylums (Nilsson, 1979). The nucleus of care was to treat the insane in order to make them able to return to life outside the institutions (Qvarsevell, 1993).

**Status based on statistics, supply crisis, the relief of the poor is tightened**

In 1860 psychiatry was established as a medical science and the first professor was appointed; psychiatry became compulsory for medical students. The aims of care, treatment and cure, were established in law. Case records should be kept and a standardized classification system was introduced (Qvarsevell, 1982). The statistical description of the insane, a sort of table science, was developed. The statistics seemed to have an intrinsic value, which contributed to the status of psychiatry as a science. Generally, the qualitative understanding of insanity seemed to have reached perfection. Accordingly the psychiatrists lost interest in the individual case and the clinical psychological description of the insane person (Nilsson, 1979; Qvarsevell, 1981a; Qvarsevell, 1981b).

At the same time population growth coupled with several years of crop failure gave rise to extensive problems for large parts of the population to support themselves. The relief of the poor was cut down and the right to appeal vanished from the Poor Law system (fattigvårdsförordningen). The relief of the poor became a matter of charity (Sjöström, 1984; Lilja, 1985).

The Vagabond Law (lösdriverilagen) and the 1871 Poor Law (fattigvårdsförordning) were used to prevent people from protesting against the social conditions of society (Sjöström, 1984; Lilja, 1985).

In 1877 the asylums were transferred to the Royal Board of Health, which acknowledged the care of the insane as a medical and not just a humanitarian concern. The following year the name was changed to the National Board of Health (Åman, 1976; Nilsson, 1979).
Lack of theory and status problems

The growth of a developed, organized working class was perceived by the state as a threat to the social order (Lilja, 1983; Korpi, Olsson, & Stenberg, 1984; Lilja, 1985). The industrial development made heavy demands upon people. It became harder for the family to provide for those who could not support themselves. Population growth could neither be met by agricultural modernization nor industry's development. Society no longer had room for those who could not be used in production or in reproduction of labour (Lilja, 1983; Sjöström, 1984). The initial stage of society's democratization process influenced the view of the state. The state was no longer self-evidently the instrument of the authorities. Thoughts about the state as an instrument to control the development became apparent (Sjöström, 1984).

During the last decades of the 19th century, psychiatry's power of curing the insane lost some of its credibility. The hospitals were partly self-supporting and the insane were occupied in farming, gardening and various handicrafts but work was no longer considered as a healer. Work was mainly serving a financial purpose and furthermore it simplified the supervision of the insane. Zeal and discipline became criteria of a patient's recovery and discharge. The asylums were reproductions of the class system. It was important not to cross the class borders. Healthy people were considered to be satisfied, if they did not belong to the 'educated' class for whom special rules were applied (Nilsson, 1979).

At the turn of the 20th century the asylums grew both in numbers and size. Medical care was successful and became a model to mental care (Åman, 1976). Despite this, psychiatry had a very low status according to its opponents, owing to the lack of theory and therapeutic technique. In defence of psychiatry, the construction of miniature communities within the asylums' areas was put forward as the therapeutic technique which would give psychiatry a scientific status (Qvarsell, 1981b).

Professionalization and the introduction of a new perspective on insanity

A professionalized body of psychiatrists developed. Most of them considered mental illnesses as brain diseases, which could be identified scientifically. The psychiatrists expanded the illness concept. They started to include several new phenomena eg. neuroses. This influenced the pat-
tern of care as well. The doctors wanted as much detailed information as possible about the patient, in order to be able to make diagnoses and to recommend treatment. In turn this led to permanent supervision and control of the insane. Everything they said or did was written down in special case records (Qvarsell, 1981b).

Additional perspectives on mental illness

In 1910 two general practitioners, Emmanuel af Geijerstam och Poul Bjerre, introduced psycho-analysis in Sweden. Neither of them were orthodox followers of Freud. They both introduced their own kind of psychotherapy but they encountered severe criticism from amongst others the professor at the Caroline Institute (Karolinska Institutet), Bror Gadelius, who was the central figure within psychiatry at the turn of the century and after. According to him mental illness had a somatic basis but also reflected distortions of emotions, thoughts and will. Gadelius wanted the asylums to resemble hospitals and the main psychiatric treatment recommended was bed confinement. Furthermore he considered 'suggestion' as important in all medical treatment and work, in some cases, as a useful therapy (Qvarsell, 1981b).

The National Board of Health stated in a report that the actual number of beds in the twelve asylums were 2 000 whereas there was demand for 10 000 beds. Mental hospitals were built in Stockholm (Långbro), Västervik (S:ta Gertrud), Säter, Östersund and Vänersborg. In 1914 there were 11 000 beds but the demand had increased to 15 000 (Socialstyrelsen, 1982).

During this period the asylums were renamed. They were no longer named asylums and were redesignated (many of them were named after saints). This was a way of making a clear distinction between the past (19th century) and the present (20th century) in the care of the insane. Another distinction was the entry of psychiatric open care. A relief agency for mentally ill people was established at the General Hospital of the Seraphims (Serafimersjukhuset) in 1917, which diluted the distinction between physical and mental care (Qvarsell, 1981b).

New Poor Laws, morale versus Social Darwinism

In 1918, a new Poor Law (1918:422) was introduced. Liberal groups with a social political perspective, charitable ideas and christian
ideals pressed for the introduction of a law, which would improve the system of poor relief (Creutzer & Grip, 1988). The payments made under this law were to be means tested. The eligibility was to be determined by a local official acting with discretion. The law sanctioned compulsory admissions of unemployed people to workhouse or mental institutions (Lilja, 1984; Lilja, 1985).

The introduction of the law also implied restorations of the institutions. At the same time the number of institutions increased.

At this time various influential doctrines abounded in our society, most notably Social Darwinism. In his work about genesis of species, Darwin developed ideas about the survival of the fittest which were transferred to social and inter-human conditions. The thesis were used as arguments to consolidate the right of the powerful in society. In 1921, an institute of racial biology was established in Uppsala. Under the semblance of science, research was undertaken and lectures given about 'inferior individuals that due to the strong miscegenation were not able to keep afloat but go downhill and finally end up in prisons, reformatories and mental institutions' (Creutzer & Grip, 1987, p. 11). It has often been emphasized, that Social Darwinism was not especially influential in our country but this is not true in the care of mentally ill people. In 1935, a law (1934:171) was introduced, on the basis of the German model, which made it possible to perform compulsory sterilizations on people admitted to mental hospitals. In a period of one year about 250 sterilizations were performed (Qvarsell, 1993).

The development of psychiatric care

In 1927, the psychiatric ward established at the General Hospital in Malmö was the first psychiatric unit of the kind. A similar unit was established in Lund the following year. Gradually, new psychiatric clinics in hospitals were established and the distinction between medical and mental care continued to decline. The special legislation for mentally ill people was not in force at those clinics, where the care was regulated by the same legislation as for physically sick people. In these clinics the patients could not be kept against their will (Socialstyrelsen, 1982).

A new law (1929:321) for mentally ill people came into force in 1931. The most important change compared to previous laws was the introduction of various regulations which vouched for the patients' legal security. The Minister of Social Affairs, Sven Lübeck, made it clear that
the law was a reaction to the criticism against the mental care for depriving people of their liberty unfairly (Qvarsell, 1993). Persons, who were mentally ill and in need of care in a mental hospital, could be admitted for treatment and be kept against their will as long as a need for treatment existed, irrespective of whether they were admitted initially on a voluntary or compulsory basis (Socialstyrelsen, 1982). The doctors' opportunities to decide about compulsory treatment were restricted by the establishment of a special 'Board for the Mentally Ill', which in some cases had to decide about detention and discharge (Qvarsell, 1993).

During the 1930s the so-called Association of Relief Activities (hjälpverksamhetsorganisationen) developed at the mental hospitals (Socialstyrelsen, 1982). Family care and small mobile units were established (Jacobsson, 1983). The members of the association made early efforts to active treatment in open care. Their efforts were directed towards those, who were waiting for admission or were discharged on trial and needed after-care. The patients either had to come to the branch reception at the general hospital (or at the mental hospital) or they were visited in their homes (Qvarsell, 1981a; Perris, 1987).

Welfare ideas

There are two major roots of welfare policy. One root has developed through working people's desire to secure their survival and the other through the state's desire to secure social order. The development from a policy concentration on the poor to a general welfare policy was reflected in political discussion (Korpi, et al., 1984).

During the 1930s the worldwide economic depression and the growing fascist movements left their marks on life. Censorship made it hard for people to understand what was happening both abroad and at home (Creutzer & Grip, 1987). In 1933 about 23 per cent of the able-bodied population in Sweden were out of work. The social democratic election victory brought about a crisis plan to combat the unemployment and the stagnation of economy. The new government with Gustav Möller as the Minister of Social Affairs began to develop a modern social policy system (Lilja, 1985). Building projects were supposed to have a key role in economy and were given priority. Industry was stimulated by large orders of cement, bricks and building timber. During this decade 11 new mental hospitals with some 10 000 beds were built (Creutzer & Grip, 1987).
New grounds for judgement and treatment

During the 1930s some new methods were introduced such as the insulin coma treatment, the electro convulsive therapy (ECT) and the lobotomy procedure (Qvarsell, 1981b; Socialstyrelsen, 1982). The drugs available for treatment of anxiety were used mechanically. In the wider society, mental illness was still regarded in the same way as at the turn of the century, i.e. as brain diseases. Inner or outer causes of mental illness as classification criteria were introduced (Åman, 1976). Amongst the inner, the significance of inheritance was strongly emphasized. The new methods were not especially successful (except for ECT) and most of the patients were not offered anything other than care and occupational therapy. In everyday life at the institutions, there was a backward step. The psychiatric workers were more tolerant than earlier. Developing a trusting relationship with patients and making the environment stimulating and pleasant was considered important (a revival of the 'moral treatment') (Qvarsell, 1981b). Everything the patients said or did was recorded and was used as evidence of pathological patterns in order to understand the manifestations of mental illness. The control seemed to have an intrinsic value. Occupational therapy and socio therapy were introduced (Qvarsell, 1981b; Socialstyrelsen, 1982). Work was reintroduced as a part of the treatment plan. It was emphasized that work should be meaningful, (i.e. it should be based on real life outside the hospital or have some other value). For instance the mentally ill could assist other sick persons (Qvarsell, 1981b).

Impunity

The leading Swedish forensic psychiatrist during the first half of the 20th century was Olof Kinberg, who emphasized that recidivists were mentally ill and accordingly not responsible for their deeds. During the 1930s and the 1940s, in consequence of Kinberg's work, criminals were (to an ever increasing extent) exempted from judicial proceedings and admitted to mental hospitals instead (Qvarsell, 1981b). At this time the treatment time limit was withdrawn and mentally ill people could be detained in mental hospitals for life. In the early 1930s the mayor of Stockholm, Carl Lindhagen, criticized this system in some publications
and he attacked the doctors for certifying mental illness too easily (Qvarsell, 1981a).

At the same time people's living conditions started to attract attention from politicians. A complete revision of the social laws was introduced in the late 1930s. Policy proposals relating to collective responsibility, better material circumstances and a more humane view on those who could not support themselves or who otherwise needed help were developed but did not become explicit until the late 1950s (Korpi, et al., 1984; Lilja, 1985; Baldwin, 1990).

**New treatments and their effects**

During the 1940s and at the beginning of the 1950s the new methods (as ECT, insulin coma treatment and lobotomy) were used frequently. The effect of lobotomy was immediate. In most cases the patients became indolent and apathetic. Generally, the electro convulsive therapy was considered as a mean to influence mental functions and not as a cure (Qvarsell, 1981b).

In a ten year plan introduced by the National Board of Health in 1945, a proposal about building psychiatric clinics at the general hospitals was presented (Jacobsson, 1983; Sandlund, 1991). The intention was to treat mentally ill people at an initial stage thereby decreasing the number of patients admitted to mental hospitals. The clinics did not relief the mental hospitals as intended and the extension of mental care continued. The psychiatric clinics became important in the development of psychiatry and in influencing perceptions of mental illness (Socialstyrelsen, 1982; Jacobsson, 1983).

During the 1950s the northern countries went through a process of modernization. People's living conditions changed. The responsibility for the supply of housing, medical care and child support became, to a larger extent, a matter of the state and/or the local authorities (Lilja, 1983; Qvarsell, 1993). Modernization also meant rational explanations and solutions to various human and social problems (Qvarsell, 1993).

At the same time the introduction of psychopharmacological drugs, such as neuroleptics and antidepressants, changed the terms of psychiatric care in a striking way (Åman, 1976; Socialstyrelsen, 1982; Jacobsson, 1983). Neuroleptics, with its strongly suppressing effect on the nervous system, put an end to the yelling and crying and promoted peace and order in the wards (Creutzer & Grip, 1987). This was a great relief from
an environmental point of view. In turn the patients’ living conditions on the wards improved and became more humane; a transformation from closed to open forms of care was made possible (Åman, 1976). As a consequence of the use of psychopharmacological drugs a reduction in the number of beds was started (Socialstyrelsen, 1982). The opinions differ strongly about the implications of the psychopharmacological drugs for individual patients. Probably, there is evidence of the existence and truth of the extremes. For some the effect was revolutionary and made it possible for them to return to society but when the external walls were pulled down, many others felt incarcerated in their own bodies. How high the price was for the individual we do not know, but we do know that many have suffered from serious side effects of the neuroleptics, and today many people attest to its dangerousness (Socialstyrelsen, 1982; Creutzer & Grip, 1987).

From 1920 to 1956 the number of beds in medical care increased by 22,000. The corresponding figure in mental care was 23,000 (Creutzer & Grip, 1988).

Change of concepts and responsibility

In 1956, a general plan established that the patient turnover had increased. The demand for beds still exceeded the actual number of beds by 3,000. Every county council was supposed to have their own mental hospital and so several new hospitals were built. The development was undertaken according to the principals in the proposal and, with a few exceptions, every county council got their own hospital (Socialstyrelsen, 1982). Many people thought that the long period of reconstruction was at an end, and that only a few thousand beds were needed in order to have a complete mental care system (Creutzer & Grip, 1987). In 1958, a report from the Mental Care Delegation suggested a change of concepts (Åman, 1976). Furthermore they suggested a change of responsibility from the state to the county councils, in order to make the latter completely responsible for health and medical care. The aim was to integrate psychiatry in the general medical care, which would improve and make the care more humane (Socialstyrelsen, 1982). In 1959 opportunities were given to start voluntary care at the mental hospitals.

Up until the 1960s psychiatry as a science had developed on the basis of the guide-lines laid down at the end of the 19th century. In the Anglo-Saxon countries a debate about psychiatry and mental care started at the
end of the 1950s. Mental care was criticized largely because of the extent of compulsory care and the lack of effective treatment. The use of psychopharmacological drugs only seemed to affect the symptom of the illness and make people indolent. This debate reverberated throughout the whole western world during the 1960s (Qvarsell, 1993).

**Structural change**

In the beginning of the 1960s an industrial boom developed, which meant work for people. In principle, unemployment became a thing of the past. The problem was that work was not available where people lived and society was once again approaching a structural change of the same magnitude as the agricultural reform in the 1830s. Work was available in the big cities and people from all over the country have to leave their home districts and move to areas where they could get work (Sjöström, 1984). Work made heavy demands upon people and long distances made it too difficult to take care of dependent relatives. This, as well as the interest of the construction industry to keep the business going, promoted a further extension of the mental care (Creutzer & Grip, 1987). A government committee, the Committee of Mental Care, was responsible for the planning and development of hospital beds during most of the 1950s and 1960s. Furthermore they were responsible for the ideological development (Socialstyrelsen, 1982).

In the early 1960s theories earlier abandoned, as a result of psychiatry's emphasis on the biological perspective, became fashionable again. Influenced by the English therapeutic communities, open care and day care units were gradually introduced as complements to care around the clock (Åman, 1976; Spri, 1982; Sandlund, 1991). Day care was never met with any real response, but was nevertheless important for the future development mainly because of the introduction of new therapeutic approaches. The milieu was systematically used in a therapeutic way (Åman, 1976). Occupational therapy was replaced by individual treatment programs. Psychology was becoming more influential and various forms of individual therapy were introduced (Spri, 1982).

Before the end of the decade another six mental hospitals with nearly 4,000 beds were built (Åman, 1976).
Change of responsibility

In 1966, the government finally came to an agreement with the county councils about taking over the responsibility for the mental hospitals, lock, stock and barrel. The purpose was to integrate psychiatric care with medical care and make the county councils responsible for both health and medical care (Socialstyrelsen, 1982).

The dimensions of the mental hospitals served large catchment areas. In several areas, essential parts of the psychiatric organization were physically isolated from the rest of society, according to earlier tradition within psychiatry (Socialstyrelsen, 1982). The government subsidized redevelopment, which increased the quality of living at the mental hospitals. The government also subsidized the physical and administrative development of the psychiatric units at the general hospitals. The agreement covered such areas as special care, family care and relief activity (hjälpverksamhet). The county councils, with a few exceptions, were taking over the entire psychiatric organization except for forensic psychiatry, which would remain a governmental concern. In 1967, 23 mental hospitals with over 25,000 beds were transferred from the state to the county councils (Socialstyrelsen, 1982; Jacobsson, 1983). Furthermore, there was about 2,000 beds at the psychiatric clinics, over 5,000 beds at the county councils' nursing homes and some 1,000 beds at private nursing homes (Socialstyrelsen, 1982).

Compulsory care

At the same time as this transformation, the old Mental Care Act (1929:321) was replaced by the Health Care Act (1962:242), which was a general law including both health care and psychiatry. In 1966, the Parliament passed a special supplementary law, 'the law (1966:293) about preparation for closed psychiatric care in special cases' (LSPV) (Åman, 1976). This supplement regulated compulsory care. The intention of the law was to define those, who could be compulsory admitted and to increase the level of legal security. Throughout the years the law was strongly criticized because it stuck to the same concept of normality as previous laws - that is people could be compulsory admitted if their lifestyle was characterized by 'grave disorderly conduct' or if they were considered 'a danger to other people's property' (1966:293 § 1). In the middle of the 1960s nearly half of the patients were compulsory treated.
In 1968 a special law (1967:940), which separated the mentally retarded from the psychiatric care, was passed (Socialstyrelsen, 1982).

Mentally ill peoples movement

The standard of living increased enormously after the Second World War, but the politicians tended to identify welfare in economic terms (Korpi, et al., 1984). As peoples living conditions improved, other aspects of welfare became important (Creutzer & Grip, 1988).

In Sweden as in other countries the students’ revolt of 1968 and the movement for human rights led to severe criticism of several of society’s institutions both in political forums and in media (Åman, 1976; Lilja, 1984; Perris, 1987). A debate about mental care started. For the first time the public received first hand information about mentally ill people’s situation in mental hospitals. The impact of institutionalization was difficult to distinguish from the effects of mental illness itself (Spri, 1982).

The 1960s is often seen as a very prosperous time which 'liberated' people. They were no longer occupied solely with earning a living. As a result, they had time and opportunity to care for the less fortunate. Many people started to question the mental hospitals as caregivers. Among the first to do so, was a group of patients at Långbro, supported by progressive doctors and lawyers, who in 1967 founded the Swedish National Association of Social and Mental Health (RSMH). The association laid claims to a humane psychiatric care on people’s own terms (Crafoord, 1987; Creutzer & Grip, 1988). One of the associations slogans was 'Pull Down the Mental Hospitals' (Creutzer & Grip, 1987).

At the same time, the meta-physical principle of every man’s equality as manifested in the citizenship of the political democracy as ground for the welfare state, became more explicit. Humanitarian aspects emphasized that each person’s living conditions should be as 'normal' as possible, that is allowing each person to be himself among others (Åman, 1976). By recommending integration of the less fortunate groups, politicians emphasized that it was a human right to lead a 'normal' life, which is a good life in itself (Lilja, 1984). This is a reciprocal process between the individual and the society based on responsibility and democracy.
New perspectives on mental illness

A growing general interest in and knowledge about psychodynamic theories led to the introduction of various kinds of individual as well as group psychotherapies. Environmental factors, the family among other things, were highlighted as essential in understanding psychiatric disorders. Some psychiatric organizations started to work with families, while others just offered family therapy as a complement to individual treatment. Experiences from the therapeutic communities were utilized and treatment programmes developed. Special psychiatric rehabilitation units were developed, where ADL-, social and preliminary vocational training were emphasized (Spri, 1982).

At the time influences from abroad were strong. The concept of illness was questioned as well as the biological orientation of psychiatry. Psychological and psychoanalytical models but above all social causes of mental illness were emphasized (Åman, 1976; Qvarsell, 1993). Some of the critics even maintained that mental illness was a proper reaction to a sick society. This extensive and sometimes bitter criticism has been called 'anti-psychiatry' after the title of a book written by the English psychiatrist David Cooper (Cooper, 1971; Crafoord, 1987; Qvarsell, 1993). Cooper worked together with R. D. Laing in order to give people labelled as 'psychotics' the opportunity to 'live through' their psychosis. In 1968 they were among the originators of the conference 'The Dialectics of Liberation'. In the late 1960s and the early 1970s their work became widely known. They tackled the concept of illness and paved the way for a totally new perspective on mental illness, which in a simplified way could be understood as an adequate response to a disturbing life situation. Their ideas caused a growing interest in schizophrenia.

Svein Haugsgjerd's book 'A New Perspective on Psychiatry' exposed the strange logic of the mental hospitals and on account of this became something of a bible to many people (Haugsgjerd, 1974; Åman, 1976; Crafoord, 1987).

Cooper, Laing and Haugsgjerd were only three among many who were interested in a change of perspective within psychiatry. Offshoots from Freud appeared in many guises; more or less fantastic variations of the psychodynamic theme developed. They all got their followers, which in turn implemented several different kinds of psychotherapeutic schools (Creutzer & Grip, 1987).
The debate in other countries soon focused on the dismantling of the mental hospitals and on the social and political aspects of psychiatry. In Italy it culminated in the passage of a special law that abolished the mental hospitals in 1978 (Topor, 1983; Perris, 1987; Rotelli, De Leonardis, & Mauri, 1987). In Sweden the debate was heated between the two 'irreconcilable' traditional opinions, the bio-medical approach and the humanistic-psychodynamic perspective. Up to that point the representatives of the different perspectives largely 'ruled their own roost', where the mental hospital represented the traditional care contrary to the care given at the psychiatric clinics in general hospitals (Socialstyrelsen, 1982).

The focus was on a shift from one ideology to another. The interest in psychotherapy was very prominent and led to the establishment of a Department of Psychotherapy at both the University of Stockholm and Umeå (Perris, 1987).

**Special pilot projects**

The representatives of the psychotherapeutic model managed to be involved in some experimental activities or projects concerning open psychiatric care, that started to develop as more or less detached from both the mental hospitals and the psychiatric clinics in the general hospitals. The psychodynamic theory and the psychotherapeutic ideology of treatment became the theoretical and ideological base and have influenced most of the open care activities undertaken in several areas of the country. The following three projects, among others, were inspired by these changes.

**Västerbotten - The Vilhelmina project and the day care centre Bofinken**

In 1968 Västerbotten's county council brought to the fore the foundation of a social medical field station in the inland of the catchment area. In 1973 a joint proposal about a project including both research and developmental work was put forward by the National Board of Health and Welfare, Västerbotten's county council, the local authorities of Vilhelmina, the School of Social Work and the University of Umeå. A field station was established in Vilhelmina under the direction of the county council, local authorities and the National Board of Health and
Welfare. The main objective of the project was to find out, from a holistic perspective, the need for social and medical service and how to find joint ways to provide effective services (Mattsson, 1989).

In the same spirit and under the same management the day care centre 'Bofinken' was established in 1976. The day care centre was a 'link' in deinstitutionalization, i.e. a way to find out how many of the long-term mentally ill people could, with support from the day care centre, return to their roots. The main aim was to provide mental and social stimulation for the participants through meaningful occupation and to find new forms of supportive activities for people with social and/or mental disorders (Jacobsson, 1983; Spri, 1984; Mattsson, 1989). Initially there were many problems in establishing this unit e.g. recruiting competent staff, achieving co-operation between the county council and the local authorities and devising satisfactory working methods (Jacobsson, 1983). From the start, staff at the centre were regularly supervised by staff from the psychiatric unit in Lycksele (Perris, 1987). According to the project plan, the day care centre was to be characterized by a far-reaching integration with various activities of the local community (Jacobsson, 1983). It turned out to be very difficult to realize such integration and various activities were introduced at the centre instead.

In 1977 the activities expanded to include people in need of supportive psychotherapeutic interventions. The next year, crisis therapy, work with families and individuals were included. The centre developed into what could be defined as a first-aid unit for people with uncomplicated minor crises and various psychosocial problems (Jacobsson, 1983; Perris, 1987; Mattsson, 1989). The activity at the day care centre became increasingly organized as a closed, traditional psychiatric facility (Mattsson, 1989). Regarding the need mentioned in the project plan, the day care centre developed in the opposite direction. This was due in part to the organizational affiliation and might have turned out differently if the primary health care service or the local authorities had been in charge of the activity (Mattsson, 1989). Despite this, co-operation between the psychiatric service and the local authorities in Vilhelmina survived. Today staff from the psychiatric service supervise staff at the social service agency and participate in the education of the home care workers. Together, the agencies develop and participate in preventive work. Co-operation is more difficult with the psychiatric clinic in Umeå, mainly because of the distance (about 240 km) (Psykiatriutredningen, 1992a).
Norrbotten - The Psychiatric Activity in Luleå (Psykiatriska Verksamheten i Luleå)

In 1972, the appearance of the Psychiatric Activity (Psykiatriska Verksamheten - PV) in Luleå was the starting-point of the transformation of psychiatric care (Crafoord, 1987). As pioneers, Clarence and Karin Crafoord, drew up the guidelines for a new psychotherapeutic open care. By organizing teams, which included those with medical, psychological and social competence, they wanted to create the necessary conditions for a broader perspective on psychiatric problems in contrast to the biomedical perspective. 'Psychiatry is above all a non-medical concern' was a provocative statement formulated by the staff (Crafoord, 1987, p. 35). They emphasized a holistic perspective, where people were regarded as social beings on an individual, group and societal level. Within this holistic frame they wanted to put a humanitarian perspective into praxis. They wanted to understand and treat people as subjects; to help them to an increased understanding of their social situation so that they would be able to take responsibility for their actions and to change their situation - if they wished. Another aim was to break down the traditional hierarchy within the psychiatric organization, striving for an equal division of responsibility and labour among various psychiatric vocational categories. A division of the catchment area into districts was developed, in order to facilitate access to, and co-operation with, social service agencies, primary health care, medical care at the general hospital, schools, workplaces and the police. The teams were located in ordinary block of flats easily accessible to the public. The psychotherapeutic way of working was linked to a negative attitude towards the use of drugs. They wanted to work with motivated families on a voluntary basis. Consultations and supervision of social service agencies and primary health care became very important (Eliasson & Nygren, 1981; Eliasson & Nygren, 1983; Crafoord, 1987).

Comprehensive evaluation of PV, by Rosmari Eliasson and Per Nygren, showed an organization where the socio-material structures and ideological principals were adjusted to a special technique and not to the people in need of help. The psychotherapeutic technique once regarded as a mean had become an end in itself (Eliasson & Nygren, 1981; Eliasson & Nygren, 1983).
Stockholm - The Nacka project

In the Nacka project, 1974-80, a social psychiatric perspective was introduced (Spri, 1981; Spri, 1982). The overall object was, according to the initiator Bengt Berggren, 'to search and to offer decent and efficient alternatives to psychiatric hospital care (Spri, 1981, p. 21; Crafoord, 1987). The goals of the project were to ensure early interventions, to cooperate with other care providers, to provide qualified psychotherapy and to reduce the number of psychiatric in-patients. From the start, a research group was affiliated to the project. A radical transformation of the psychiatric care started by using psychotherapeutic methods based on psychodynamic theories. Open care teamwork and sectorization were established. The competence of medical social workers and psychologists became important. Special education for the team members was developed. Consultations, supervision and preventive work were emphasized (Eliasson, 1979; Spri, 1981; Spri, 1982; Crafoord, 1987). In 1979, Johan Cullberg, head of the research and evaluation program, wrote that the development of psychiatry meant easy access to care and included a social analysis in order to understand what was going on. He was concerned about the structural changes of society and what influence they would have on an individual’s mental health and the prospects for prevention. The individual’s social situation was studied and used in the psychiatric treatment (Cullberg, 1979). The result of the evaluation was convincing, sectorization made it possible to reach most of the population and decreased the need for in-patient service. The Nacka-project presented a concrete and positive picture of the psychiatric care heading in a humane and decent direction. The project became a complementary and future model of psychiatry and abated some of the criticism towards the biomedical model. The project became permanent as Nacka-Värmdö psychiatric sector (Crafoord, 1987; Borgå, 1993).

In the evaluation of the Nacka-project, Rosmari Eliasson emphasized that the time was right for the introduction of psychodynamic open care. The 'healing' resources in and around families had decreased and this became a reason for the psychiatric expansion. The psychotherapeutic relation became an answer to a growing need and might very well offer better opportunities to mental 'wholeness', emotional support and awareness (including political) than the traditional destructive psychiatry that otherwise would have been the only alternative to many patients. Reform ambitions, which aimed at avoiding the destructive and openly oppressive
powers of the treatment, coincided with a more revolutionary, but vague, aim to change the ideological function of psychiatry; from preservation to criticism of the social order. The main problem for the Nacka-project was to transform the ideals into practice. The psychiatric care did not become more humane by changing to ideological-symbolic means: on the contrary it could, in special cases, increase the non-symbolic power relations. The project did not replace the old; the compulsion and the violations were still there. Methods changed and the repression took new forms. The only change, according to Eliasson, was the increased opportunity to fool oneself and others. They improved the reputation of the psychiatric care but did not change its function.

More people with socially conditioned problems were offered help from the psychiatric organization, which still defined problems, offered help and solutions on an individualistic basis. Social psychiatry seemed to be an ideological mystification, which concealed its contrast: a vitalized bourgeois-individual ideology with its dream about the individual’s opportunities to create his solution, his freedom and his autonomy, with the help of experts (Eliasson, 1979).

Despite the heavy criticism from the 'left' both PV and the Nacka project have served as standard for psychiatric care throughout the country.

Closing down institutions and establishing community care

Since the beginning of the 1970s all county councils have made plans for psychiatric care, either by themselves or in association with medical care services. Often, the plans proposed extensive changes. The reorganization of psychiatric care made it possible to provide more open care treatment. Long-term mentally ill people were gradually discharged from both the mental hospitals and the psychiatric nursing homes thereby decreasing the number of beds. A transfer of patients from psychiatry to long-term medical care also took place. The open care units were organized and operating as teams, that is psychiatric workers with various competence worked together (Socialstyrelsen, 1982).

The discrepancies between what was suggested in the county councils plans and what actually led to political decisions and what was put into practice were obvious. The growing interest in psychotherapy and the initial development of out-patient services had, contrary to expectations, a retarding effect on the deinstitutionalization process. In the United States
the community mental health centers had proved to be unable to meet the needs of the deinstitutionalized patients. In Sweden, as in other countries, the rapid expansion of out-patient service and the ideological change made it hard to enlist suitable staff members (Perris, 1987).

The psychiatric organization, as such, was considered to be the main obstacle to the rapid development of psychiatric care. Resources were still to a large extent concentrated to the mental hospitals and influenced the care given. Ideological antagonism and the hierarchy within the organization were also referred to. The psychiatric workers were in some cases made scapegoats. They were neither properly trained nor did they have the right approach (Socialstyrelsen, 1982; Spri, 1982). Furthermore, they would or could not change. Local authorities were in some areas a drawback. They wanted to keep the mental hospitals intact in order to prevent unemployment and keep down local taxes. Some of the county councils would most certainly prefer not to invest more money than needed in new facilities. Another obstacle, more rarely discussed, were the difficulties faced by chief psychiatrists in handing over the responsibility for these large units. The prejudice against mental illness and mentally ill people was probably a main drawback. People, both the public and psychiatric professionals, thought that it would be better if mentally ill people remained at the mental hospitals (Socialstyrelsen, 1982; Sandlund, 1991).

Despite this, many county councils started to plan for a reduction in the number of beds in the mental hospitals. In several places throughout the country the existence or non-existence of mental hospitals was brought up for discussion. The debate was, to a large extent, promoted by the psychiatrist Lars Lindhagen. A special project, supported by the Delegation for Social Research, about a group of patients made Lindhagen draw the conclusions that about 10 000 people were incarcerated because they were unemployed and/or homeless and not because they were sick and really needed care (Socialstyrelsen, 1979; Creutzer & Grip, 1987; Perris, 1987). Suitable alternatives were not provided by the primary health care and the social service agencies. RSMH borrowed the name from Lindhagen's original project 'The Way Back' and together they toured the country in order to persuade politicians and psychiatric staff members to back their demand for the dismantling of the mental hospitals (Spri, 1984). As a result, new plans were drawn up by the county councils for the future development of the psychiatric service up to 1990 (Perris, 1987). The mental hospital beds continued to decrease in numbers to some 17 000 in 1980. Simultaneously, the number of beds at
the psychiatric clinics increased by 2 000. The total number of psychiatric beds was 28 900. In 1982, 75 per cent of these beds were still to be found in mental hospitals and nursing homes (Socialstyrelsen, 1982).

Tightening one's belt

The prosperous years of the 1960s and the early 1970s are now distant memories and people in all kinds of situations have had to tighten their belts. Our country has substantial debts overseas, declining industrial profitability and rising unemployment (Sjöström, 1984). Discussions about cuts in the public sector has started and the mental hospital budget attracted attention as it accounted for a large part of the county councils' tax revenue. The destructive elements of mental care had been focused on, and in many cases nonrehabilitative impact of treatment was obvious. Through political unity, and with reference to the groups, who had made the demand for the dismantling of the mental hospitals, but above all with cost cutting in mind, psychiatric care reforms were introduced (Crafoord, 1987; Creutzer & Grip, 1988). The National Board of Health and Welfare published 'Compulsory Treatment within Psychiatry' in 1981 and 'Psychiatric Care without Mental Hospitals' in 1982, where they outlined psychiatric care as gradually being directed towards community care. As a consequence sectorized psychiatry was introduced (Creutzer, 1987).

Sectorization meant dividing the catchment area of the county councils in to smaller sectors, which should coincide with one or more of the social service districts in the area (Spri, 1982; Perris, 1987). Every sector was supposed to take full responsibility for all forms of psychiatric service needed in the area. The complexity of mental disorders were emphasized as well as the necessity of care being directed towards medical, psychological and social aspects. The psychiatric service and the social services were to co-operate closely. The intention of psychiatric sectorization was to make the service more accessible and at the same time more humane (Spri, 1984; Sandlund, 1991). People should have the opportunity for personal psychiatric contact, that is they should meet the same psychiatric worker every time they were in need of care. Right from the start it was obvious that some sectors could not take the responsibility for all the various needs that people may have and at the same time offer a differentiated psychiatric service. As a consequence several sectors shared psychiatric facilities that were used by only a few patients
from each sector (Spri, 1982; Perris, 1987). In some counties the sector-ization was more of an administrative measure than anything else. Some counties and/or sectors took the intentions to their heart and started to build up a functioning social psychiatry.

The manifestation of the holistic view

During the same period welfare policy resulted in new legislation, - the Social Service Act (1980:620) in 1982 (SoL) and the Health and Medical Service Act (1982:763) in 1983 (HSL), which regulate all activities in social work, open and closed psychiatry, primary health care and medical care at the general hospitals. For the first time, the intentions in SoL gave expression to a collectively based support for those in need of help (Lilja, 1985). SoL and HSL have the charachter of 'frame' laws. The advantages are the opportunities to adjust activities to people’s needs and to take into consideration the special conditions of the local authorities. The disadvantages are the risk for divergence in the service provided by different local authorities. Necessary treatment efforts could be cut off on account of priorities made by the local authorities. The basic view is the same in the two laws. The wording in both shows similarities. For instance, they point out that efforts will provide for the patient’s or client’s needs and be based on respect for his/her autonomy and integrity. Actions will as far as possible be carried out in co-operation with the patient or client. The holistic view that had been trying to break through since the 1960s, became manifest in these laws (Eliasson & Nygren, 1983; Lilja, 1983). HSL is more restricted, which seems to be due to strong professional interests rather than anything else (Berglind, 1981). The social service agencies should be responsible for housing, occupation and social 'stimulation' (for instance cultural activities). In order to accomplish such a development co-operation is needed (Socialstyrelsen, 1982). Co-operation between agencies are promoted but the instructions are vague and can be interpreted in different ways by different agencies. There are no instructions about how to accomplish co-operation and who is to be responsible for ensuring implementation. In several quarters this has led to disagreements about the precise responsibility for different measures which results in people in need falling between two stools (Psykiatri-utredningen, 1992c).

The socio-political aim as to ensure that care was, as far as possible, provided in an open and decentralized way. The intention was that pri-
mary health care should provide all kinds of initial health care. Early inter­
terventions and out-patient work in the district were supposed to support
people in order that a normal life could be lead during bouts of illness.
The psychiatric service was intended as an expert form of provision for
other service providers. The intention was to keep ordinary problems out
of the psychiatric area. The social service agencies would provide housing
and sheltered employment. Co-operation was taken for granted. A joint
responsibility for the psychiatric and psychosocial health of the popula­
tion was intended to promote and lead to a dialogue between the psychi­
atric service and other service providers (Socialstyrelsen, 1982; Spri,

The deinstitutionalization of psychiatric care, that had started to
dominate the psychiatric agenda in Sweden as in other European coun­
tries, has neither been met by an extension of, or a change in use of the
social service agencies’ and the primary health care’s resources (Spri,
1991). In the Nacka-Värmdö psychiatric sector it was obvious that the
out-patient service, that had become more permanent, could not meet the
need of people with 'long-term functional psychosis' and therefore the
attention was focused on this group (Borgå, 1993).

In some areas the sectorization has functioned as intended but sector­
ization in Sweden, as in other countries, has in some respects meant a re­
gression to a medical perspective and to a differentiation of the resources
in open care from various ideological frames of reference and profes­
sional interests (Crafoord, 1987; Bean & Mounser, 1989).

Demands on legal security

In 1979, over one third of the patients were compulsory treated at
mental hospitals (Socialstyrelsen, 1982). The prevalence of compulsory
treated varied a lot between different county councils depending on
whether there was a mental hospital or not. In areas with a mental hospi­
tal the figure for compulsory treatment rose dramatically. The extreme
differences in applied compulsion promoted a debate about legal security
and an investigation under government auspices was set up (Grönvall,
1983). The intention was to develop a proposal for a new psychiatric
compulsory law, which in a better way could meet the demands on legal
security. The lawyer Lars Grönvall was appointed chairman of the inves­
tigation. He turned out to be very controversial, publicly criticizing those
autocratic doctors, who could deprive a person of his freedom and rights
for life. The Green Paper, 'Psychiatry, Compulsion and Legal Security' was published in 1984 (SOU 1984:64). The proposal about a new compulsory law, the Emergency Compulsory Mental Care Act, which substantially limited compulsory powers of doctors and strengthened legal security for the small number of people considered to be in need of care, was put forward (Creutzer & Grip, 1987; Perris, 1987). The proposal stressed that the purpose of compulsory care was to provide care in an emergency situation and seemed to have been inspired mainly by the Italian Reform Law of 1978 (Perris, 1985). Many psychiatrists and other staff members protested against the proposal and as a result the investigation was postponed and not evoked until the 1990s (Socialstyrelsen, 1982).

**Back - to what?**

In the campaign 'Back-to What?' during the spring of 1987 RSMH called attention to the problems which discharged patients meet when they are trying to return to society after long periods in psychiatric facilities. Already in 1982 they pointed out that the dismantling of the mental hospitals should encourage the abandonment of people with mental problems. The alternative to institutional care need not imply loneliness and isolation. They also pointed out that the psychiatric care should not be subjected to criteria of profitability. Furthermore, care must be planned together with patients and take their integrity into consideration. Agencies must co-operate with each other, the patient and important persons in the patient's social network. Another basic demand is everybody's right to a meaningful job or occupation. The professionals within different agencies must hold a psychosocial view, i.e. emphasize strengths rather than weaknesses of the people they are supposed to serve. RSMH declare that this is a governmental as well as a general responsibility (RSMH, 1987).

In spite of a humanistic perspective the situation for many mentally ill people has grown worse, especially in the cities (Spri, 1991). A growing number of severely ill people, who have never been in contact with or got any help at all from the authorities concerned, have become homeless (Spri, 1991).

Since the late 1970s an increasingly vociferous criticism about the growing public sector has been expressed, implying that an extensive policy is inhibiting the market from creating welfare and that a move from general to selective actions ought to be considered (Korpi, 1983;
In the beginning of the 1990s a political change of power speeded up the restructuring of the welfare state. Unemployment increased and differences in various areas, not only in income, can be spotted. Social justice has been replaced by claims of productivity and efficiency even within the psychiatric service. It has become obvious that some people can not obtain their rights or have their needs met (Hollander, 1993).

**Laws respecting compulsory care**

In 1992, 'the law (1991:1128) about compulsory care' (LPT) and 'the law (1991:1129) about forensic psychiatric care' (LRV) came into force. Psychiatric care should, to the fullest possible extent, be of a voluntary kind. In order to use compulsory care three prerequisites must be fulfilled at the same time. The person in question must suffer from a serious mental disorder. He/she must have an unavoidable need for psychiatric care around the clock. Furthermore, he/she must deny the need for care or lack capacity to express a well-founded decision. The doctor, who makes the decision about admission can not certify the person in question. Another doctor has to do that within 24 hours. The time limit for compulsory care is four weeks and can only be prolonged by a legal decision. The court may extend the care period by another four months in the first instance which can be extended for a further six months. The person concerned has a right to an appointed representative during the time spent in compulsory care.

LRV regulates compulsory care for those, who the court has handed over to forensic psychiatry and persons in custody.

**The current situation**

During the last decades Sweden has gone through drastic structural change, as for instance a continuous urbanisation and a changing population agestructure (Sandlund, 1991).

The scientific orientation within psychiatry has changed strikingly during the same period. The antagonism between the representatives of different perspectives has been replaced by a state of tolerance and eclecticism. Johan Cullberg's text-book 'Dynamic Psychiatry' (Cullberg, 1984) from 1984 is maybe the prime example of the tendency to put practical needs before theoretical principals concerning care. With a psychoanalyti-
cal perspective as a starting-point, Cullberg gives special attention to social and medical factors, which affect the course of the illness as well as a person's living conditions. His view on treatment show the same kind of eclecticism; psychopharmacological drugs, psychotherapy and social activities are considered complementary (Sandlund, 1991; Qvarsell, 1993).

Despite the fact that the strategies for the transformation of the psychiatric care are, or are about to be, carried out the recently published Swedish Green Paper 'Welfare and Freedom of Choice' establish that people who are severely mentally ill have essentially worse living conditions than others (Psykiatriutredningen, 1992c). The co-operation between the psychiatric service and other service providers are malfunctioning. In order to do something about this the proposal suggest a new function, a mediator - a case manager. At the same time the proposal suggest, that long-term mentally ill people become the responsibility of the local authorities (social service agencies); that those in need of psychotherapy may look outside the psychiatric service for help; that primary health care takes care of crisis intervention and other slight insufficiencies; that the most severe mentally ill people should be included in the concept 'functionally disabled' and be embraced by 'the law (1993:387) about support and service to certain functionally disabled' (LSS), but it leaves the definition of the group to others (Psykiatriutredningen, 1992c).

The suggestions in the proposal have been critized for putting an end to social psychiatry and the experiment of sektorization which is only ten years old. Sektorization is being replaced by a completely new organization, which signals a return to the bio-medical perspective of the old order (Costa, 1993). Criticism has also been directed towards the case manager function. The case manager is supposed to function as a mediator on an individual level but in the proposal there is room for influence at a system level as well. They hope that the case manager will provide the necessary resources, which, according to the critics, is far too optimistic. On the contrary the existence of resources is a prerequisite for the case manager's work (Intagliata, 1982; Ramström, 1992; Costa, 1993).

Concluding introductionary remarks

Psychiatry and psychiatric care have been reorganized on several occasions during Swedish history. Periods of optimism about treatment and rehabilitation for mentally ill people have been followed by more regressive periods.
The spirit of the age, i.e. the political and economical climate have had a strong influence on the care of mentally ill people, especially concerning organizational changes and legislation (Sandlund, 1991).

Instead of developing psychiatric service with consideration to its experiences and special history there is a tendency within the modern Swedish administration to pick up, transform and convert the criticism towards psychiatry and the psychiatric service into public policy of care. This peculiarity may be due to the fact that many of the county councils' representatives are administratively and economically qualified but have limited knowledge about their chief area of responsibility and are thus vulnerable to passing fads of opinion. Nevertheless, so far it has resulted in a public policy with deinstitutionalisation, community care, psychotherapy and social service as a base (Qvarsell, 1993). In turn this has led to a reduction of the number of beds, a drastic reduction of in-patient care, a continous dismantling of mental hospitals, a reduction of compulsory care, which imply changing conditions for mentally ill people, for the care and for the professionals involved (Sandlund, 1991).
AIMS OF THE STUDY.

1. To find out: (a) the role played the psychiatric service, the primary health care service and the social services in a discharge procedure of patients.
   (b) if the decisions taken by different agencies met the needs of the patients.

2. To find out, from the former patients' own perspective, whether they had a supportive social network or not.

3. To find out, from the former patients' own perspective, whether the professional network was supportive or not.

4. To compare the former patients' views on quality of life, including activities and relations, with that of the professionals (mainly psychiatric professionals).

5. To find out (a) the former patients' occupational situation before intake and after discharge
   (b) the former patients' attitudes towards work?
   (c) the predictors for having a job after discharge?
SUBJECTS

The psychiatric clinic and the catchment area.

Large parts of our country consist of sparsely populated rural areas, particularly in the north. The county of Västerbotten comprises an area of about 55,000 km² and has a population of some 250,000 inhabitants (Fig. 1).

Fig. 1. Map of Sweden
The county consists mainly of forests, arable, pasture and marsh land. Lumbering, mining and farming are the main commercial industries. The coastal town, Umeå, is the biggest town and the cultural centre of Västerbotten. There is an internal migration from the inland towards Umeå and Skellefteå. As a result, more than half of the population lives in the two coastal towns (Jacobsson, 1983). Those who have moved are mainly younger which skews age composition within the county. A larger proportion of younger age-groups can be found in these two towns (Perris, 1987).

The county was divided into three health districts, Umeå, Skellefteå and Lycksele, each with a local general hospital and its own local health authority. In 1977 the mental hospital and the university department were integrated. Three similar 'clinics' (clinic 1, 2 and 3) of general psychiatry were established. The sectors corresponded roughly to the health districts but to obtain a fair distribution of the population among the three clinics some of the local governments belonging to the health district of Umeå, were transfered to the clinic caring for the district of Lycksele.

Lycksele is the centre of the province Lappland. Apart from Lycksele the district includes the municipalities of Dorotea, Sorsele, Storuman, Vilhelmina and Åsele. The service of the clinic I encompassed a university clinic in Umeå, which was responsible for all in-patient treatment, and out-patient teams in Umeå and Lycksele. The out-patient teams were responsible for the day-to-day running of the psychiatric service, whilst the psychiatric clinic in Umeå provided treatment for the patients with either emergency or severe problems. In-patient treatment could be provided either on wards at the University Hospital or on wards at the mental hospital, Umedalen. Short-term patients tended to be treated at the University Hospital, whilst long-term patients were cared for at Umedalen. In addition, there were day care centres in Lycksele and Vilhelmina (Åström, Dufåker, & Jacobsson, 1989). The day care centre in Vilhelmina was under joint control of the county council and the local authorities (Jacobsson, 1983; Mattsson, 1989).

Co-operation in rural areas can be very difficult to achieve, mainly because of the large number of districts involved and the distance between the local professionals and the psychiatric clinic in Umeå (Psykiautredningen, 1992a). Despite this, succesful co-operation between the psychiatric service, primary health care and social service agencies has been achieved in some of the municipalities in the catchment area.
The study group

Our study group was composed of 121 in-patients from clinic I, who were receiving treatment either on wards at the university clinic, at Umedalen or at the day care centre in Lycksele on the 24 of May 1984. Information about the patients was initially provided by hospital staff on the wards in Umeå or by staff at the day care centre in Lycksele (initial patient profile - stage 1). According to the psychiatric staff, some 91 patients (79%) had the potential for a successful return or rehabilitation to life outside the psychiatric facilities. These 91 patients were comprised of two different groups. One group consisted of 66 'non-medical' patients, who were in a psychiatric facility due to social conditions such as lack of home support or poor housing. The other group included 25 day care patients, who had already started to prepare for life outside the psychiatric facility.

In a follow-up study carried out about two and a half years later (31 December 1986) 73 persons (60%) had actually been discharged (stage 2). We were able to follow up 53 of the 73 patients discharged. The 20 persons we were not able to follow up were either too ill to be interviewed (12%), refused to participate (7%), had left the county (4%) or had died after discharge (4%) (Fig. 2). The vast majority (50) participated in each of the 4 stages of our study (Åström, et al., 1989).

Fig.2. The study group, 31 December 1986

Mean age = 49 years
The distribution of missing cases on gender and age is presented in table 1.

Table 1. Missing cases.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Men</th>
<th>Women</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left the county</td>
<td>1</td>
<td>2</td>
<td>29</td>
<td>27-30</td>
</tr>
<tr>
<td>Refused to participate</td>
<td>1</td>
<td>4</td>
<td>43</td>
<td>31-61</td>
</tr>
<tr>
<td>Deceased after discharge</td>
<td>2</td>
<td>1</td>
<td>56</td>
<td>22*-73</td>
</tr>
<tr>
<td>Too ill to participate</td>
<td>5</td>
<td>4</td>
<td>61</td>
<td>38-89</td>
</tr>
</tbody>
</table>

Paper I

Our study group was comprised of 121 patients from clinic I, who on the 24 of May 1984, were receiving treatment
1) on short-term wards at the University Hospital in Umeå (n=31)
2) on long-term wards at the psychiatric hospital Umedalen (n=65)
3) at the day care centre in Lycksele (n=25)

Paper II-V

Our study group was comprised of 53 discharged patients, 26 men and 27 women from 13 different municipalities. About 30% had been ill for less than 5 years (half the group had fallen ill for the first time). Some 25% had been ill for 6 to 14 years and 45% had been ill for 15 years or more. About 40% had the DSMIII diagnosis schizophrenic syndrome. Some 38% had been treated on short term-wards, 26% on long-term wards and 36% at the day care centre.

METHODS

A four-phase design was used. Descriptive, quantitative and qualitative data were gathered from May 1984 to December 1986 (Åström, et al., 1989).

1. The initial patient profile - information was provided by the psychiatric staff on the wards or at the day care centre by means of a structured
questionnaire. The professional, who knew the person in question well, usually the 'care manager' (kontaktperson) was providing information. Information about hospital care and diagnosis was based on file data.

2. Information on those who were discharged was provided by the psychiatric professionals (usually the 'care manager') on the wards or at the day care centre by means of a structured questionnaire.

3. Follow-up assessments - information was mainly provided by psychiatric professionals in open care and some professionals from the primary health care service, by means of a structured questionnaire.

4. Patient interviews - information was provided by the former patients (the respondents). Interviews were carried out by the author by means of a semistructured questionnaire and were tape-recorded in the homes of the former patients.

Data concerning present quality of life (LQ) is based on the following question (Michalos, 1980): How does your situation compare with the lifestyle of men/women of the same age and sex in your neighbourhood? The answers were classified into:
(1) Those who considered themselves as better off or equal to others (the LQ1 group n=24).
(2) Those who considered themselves as worse off or unable to compare themselves with anyone other than fellow ex-patients (the LQ2 group n=29).

Data about future life expectations is based on the following question (Michalos, 1980): What type of life do you think you will have in 5 years time? The answers were classified into:
(1) 'I will be better off' (includes-'continues to be better off') n=24.
(2) 'I will continue to be the same as others' n=4.
(3) 'My life will deteriorate in 5 years' (includes-'continues to be worse off') n=8.
(4) 'I do not want to think of the future at all' (includes-'unable to compare with others') n=17.

According to a medical diagnosis the sample has been categorized into two groups by using the 'long-term functionally psychotic patients' concept, LFP, as a decisive criterion (Widerlöv, Borgå, Cullberg, Stefansson, & Lindqvist, 1989). The LFP concept is based on the notion of 'having
been affected by a psychosis not caused by organic disease for a continuous period of at least 6 months on some occasion during one's lifetime' and 'having shown psychotic features or residual symptoms' (Widerlöv, et al., 1989) during the period from May 1984 to December 1986. The LFP concept uses the same criterion as DSMIII (American Psychiatric Association, 1980) for schizophrenic disorder and corresponds closely to the DSMIII definition of residual schizophrenia. The LFP concept includes schizophrenia, paranoia (paranoid disorders), long-term major affective disorders with psychotic features, psychotic disorders not otherwise classified but excludes organic and toxic disease. Using the LFP concept as a base classification produces:

1. a LFP group (n=30) and
2. a group of 'others' (n=23).

The LFP variable and the DSMIII classification are highly correlated (r=0.79, p<0.01). My assumption is that psychiatric diagnoses have little relevance to how people in general experience their illness and how it is regarded by the public. Psychotic behaviour is noted but people do not differentiate between diagnoses as such (Borgå, 1993). The LFP concept is considered more appropriate in relation to social work because it includes all long-term psychotic individuals that increasingly will become clients of the social service agencies. The DSMIII results are therefore excluded.

The classifications were based on file data and have been carried out by an experienced psychiatrist (L.J.).

A social network index composed of the structural components of the former patients' social network (size, composition, contact frequency, dispersion, the meaning of the relationship and the strength and importance of emotional ties) has been elaborated. The former patients' assessments, whether they wanted more contacts or not, carried great weight in the composition of the index.

Due to a reorganization during the survey period, 15 patients were transferred from the 'research' clinic to clinic 3 (Umeå), which use systems theory as a theoretical base (Perris, 1987). About 41% of the LFP group and 14% of the others were transferred. A majority of the transferred, 11 out of 15, had been ill for more than 15 years, 3 out of 15 had been ill between 6 and 14 years and 1 out of 15 had been ill for 5 years or less. Information about these patients was provided from the out-patient service of their clinical affiliation.
Paper I

Data was collected from the initial patient profile (stage 1), the discharge procedure (stage 2), the follow-up assessments (stage 3) and the interviews (stage 4).

Paper II, III and V

Data was collected from the interviews.

Paper IV

Data was collected from the follow-up assessments (stage 3) concerning the professionals and from the interviews concerning the former patients.

Statistics

All analyses were made in a computerized statistical program, SYSTAT® (Wilkinson, 1988).

For univariate analysis chi-square tests were used as follows. For two-way square tables, in which data represent paired comparisons, McNemar's symmetry chi-square was used; otherwise Pearson chi-square or, when appropriate, Fischer's exact test was used. All tests were two-tailed. A p-value of <0.05 was considered significant.

In paper IV Pearson correlation coefficients with Bonferroni adjustments of probability values have been used. A p-value of <0.05 was considered to indicate significance.

In paper V a principal component analysis model with varimax rotation of the factors was used. The discriminant function analysis in paper V was performed with variables from the factor analysis including the use of dummy variables (0/1 corresponding to no/yes).
RESULTS

Paper I - Discharge procedures for the mentally ill

The co-operation process among psychiatry, primary health care, and social services: a regional perspective

The out-turn of the professionals' evaluation of the patients' social situation (the initial patient profile) was that some 80% of the patients had some kind of social problems. At the time of discharge efforts to minimize these problems had been undertaken in half of the cases. The professionals seemed to concentrate on those deemed to be inert or isolated. In terms of the original sample (121) some 91 patients were considered to have the potential for successful rehabilitation into the community. In a follow-up study conducted two and a half years later some 73 patients (60%) had been discharged. We were able to follow 53 of these patients, of whom almost half had the medical diagnosis 'schizophrenic syndrome'. About 72% had further contacts with the psychiatric service. Almost half of the group had contacts with primary health care and one third with the social service agencies.

Other agencies were involved in the discharge procedures but were often contacted too late. The contacts made by psychiatric professionals, at the hospital or the day care centre with other agencies showed a clear bias in favour of psychiatric open care. Nearly twice as many contacts were made with this agency as with either primary health care or social service agencies. Primary health care service was receiving advance discharge notices in one third of the cases. Moreover, the psychiatric open care rarely received an adequate level of information from the psychiatric facility concerned.

Housing and home support seemed to be successful forms of community provision. Psychiatric professionals need to be better informed about the former patients' financial problems, unemployment and the need for some form of occupation to provide appropriate forms of social service support. The professionals tended to underestimate the effectiveness of a former patient's social network owing to inadequate investigation of the issue. They were unduly pessimistic about the former patient's life situation.
The perspective of former psychiatric patients on their primary social network, quality of life and future life expectations

Most of the former patients had lengthy regular contacts with various people from different spheres. A majority of the former patients had such contacts in their neighbourhood. Relationships with family and friends were the most important and intense ones, although the respect and understanding they wanted was sometimes hard to get. Lack of a partner or a family of one’s own seemed to be mainly male difficulties, although the LFP group also shared the latter. Most of the former patients had friends with whom they had a regular contact, although they did not always get the respect and understanding they wanted. Most of the former patients saw their neighbours regularly. Those without neighbour contacts were in the LFP group.

The changes the former patients wanted were to be accepted in all their relations and to get access to the work place, where they could meet people on an equal basis or at least be able to influence their own situation. The longer the former patients had been ill the more likely that their social networks were restricted to family relations, people in the same situation and professionals rather than others.

The duration of, and stigma attached to mental illness, being without work and gender seemed to have the most influence on the primary network.

The same issues, except for gender, together with place of residence, financial difficulties, and inability to exert influence over one’s own situation influenced the former patients’ quality of life and their expectations of the future.

Former psychiatric patients’ perspective on their professional social network

The former patients main professional contacts were with the psychiatric service, which provided lengthy, regular, albeit infrequent contacts to almost all former patients. Nearly half of the former patients had, at one time or another, contact with the primary health care team. These contacts were valued for the caring dimension or for ‘instrumental’ reasons i.e. as a resource during periods of illness. The social service agen-
cies were providing home support to one third of the former patients. Only a few of the former patients had a social service agency contact due to financial difficulties or changes in their accomodation.

A majority of the former patients were satisfied with their professional contacts and they emphasized the 'caring' dimension of the contacts. The LFP group felt demeaned and misunderstood by the psychiatric professionals. The LFP group's satisfaction with the home care workers on the one hand and dissatisfaction with the psychiatric professionals on the other seemed to be connected with the professionals' ability to undertake a 'caring' relationship. Intimate relations with family and friends seemed to be a model even for contacts with professionals.

Duration of, and dependency on professional contacts seemed to be related to a low quality of life. The longer the former patients had been ill the more likely that professionals had become substitutes for 'socially attributed' as well as volutary contacts.

Paper IV - Discharge procedures for mentally ill people

The perspectives of professionals and former psychiatric patients on the latter's quality of life

The agreement between the professionals and the former patients was significant concerning home care and occupation. The latter depended mainly on a significant agreement between the professionals and the group of others. The professionals knew about the former patients occupational situation but did not consider the LFP group as potentional 'workers'.

In other life areas (housing, medical and/or psychiatric service, the need for additional care, social network and quality of life) the agreements were not significant.

The professionals equally under- and overrated the former patients' need for changes in their accomodation. The professionals did not know about and tended to overrate the former patients' financial position. The professionals equally under- and overrated the former patients' medical and psychiatric contacts. The agreement on the need for additional medical and psychiatric care was not significant. This depended mainly on a non-significant agreement between the professionals and the LFP group. Here the professionals overrated the LFP group's need of additional care.

The agreement between our social network index and the professionals' opinion of the former patients' social network was not significant.
The professionals equally under- and overrated the former patients' social network. Quality of life seemed to be especially hard to reach agreement on. The professionals were equally divided in terms of over- and underrating the former patients' quality of life. The professionals often referred to the former patients' behaviour or shortcomings.

According to the former patients, quality of life was influenced by duration of, and stigma attached to mental illness, being without work, financial difficulties, inability to exert influence over one's own situation and negative expectations of the future. Illness patterns seemed to be the all-pervading issue concerning the professionals' view on the former patients' quality of life, although some kind of occupation and social relationships would improve the situation. These disparate views brought about contrasting claims. The professionals demanded continuation of the patient role whilst the former patients mostly wanted to find some means of embarking on ordinary useful lives.

Paper V - Discharge procedures for mentally ill people

Former psychiatric patients' positions in the labour market and attitudes towards work

Most of the former patients were occupied in one way or another. Only half of them had a job or were in training (studying for a profession) to get a job in the labour market. Workmates were deemed to be of great importance to most of the former patients and half of them shared leisure time with workmates. The former patients considered 'having something to do' whether in the form of employment or some other kind of activity, as essential. Although the activity itself was reported as less satisfying the social benefits provided ample compensation.

Most of the former patients were excluded from the labour market. Most of them were without a job before admission and after discharge. Of those who had a job after discharge almost as many came from the group who had no job before the last admission as from the group who had. A small group had nothing to do and wanted some kind of occupation. About one third of the former patients either wanted something to occupy their time or a change of their current occupational situation. A majority of these were young and they wanted payed work.

Work was an aspiration and considered to have the highest potential to provide the former patients with opportunities to establish intimate as
well as more distant relationships on a daily basis with various kinds of people.

Place of living, relations to neighbours, occupational situation before admission and duration of the illness were the most important determinants of occupational situation after discharge.
The main aim of the study was to get a picture of how the psychiatric service, the social services and the primary health care service cooperated at the time of, and after discharge from, a psychiatric facility. Our assumption was that this was a lengthy process involving many people. Our basis for the research was mainly the intentions behind the two laws, SoL (a holistic view) (Eliasson & Nygren, 1983; Lilja, 1983) and HSL (good care on 'equal terms' in consultation with the patient), which were regulating the agencies concerned (Berglind, 1981; Sandlund, 1991); the intentions behind sektorization (easy access to quality care equally delivered throughout the community) (Spri, 1984; Sandlund, 1991) and the philosophy of community care (problems regarded as 'social' rather than 'medical') (Crafoord, 1987; Bean & Mounser, 1989).

A major concern was how mentally ill people experienced the help they received, what kind of help or improvements they wanted and how their needs were met, i.e. how did they view their own situation and the role of professionals involved in the discharge procedure. Very few studies have been conducted from the perspective of mentally ill people. Traditionally, psychiatric professionals have spoken for mentally ill people, although they have not always investigated their situation. To be able to understand other people and their situation you need to know the perspective of the individual concerned (Slevin, Plant, Lynch, Drinkwater, & Gregory, 1988). The perspective of mentally ill people have been ignored and devaluated not only by professionals and other experts but also by the general public i.e. mentally ill people are supposed to have false or mistaken view of the world (which implies that the world is there for us to describe in a more or less 'realistic' way). From my own viewpoint and experience, as well as that of others, it seems that even very severely mentally ill people can accurately describe their own situation just as well as any other (Börjeson, 1987). My idea was that mentally ill people can provide us with valuable information about their own situation as well as the psychiatric service. If psychiatric professionals only interpret mentally ill peoples situation we may get an irrelevant, if well-intended, perspective and as a result mentally ill people's ideas about the world will be forced out of the way in favour of the values of the 'current system', i.e. the process of colonisation will be carried into the heartlands of the informal world (Bulmer, 1986).
The outcome of our research makes it clear that there was a lack of co-operation between the psychiatric care and other service providers, except for the provision of home support (Åström, et al., 1989). The malfunctioning co-operation seemed to be a matter of negligence on the part of psychiatric professionals due to inadequate knowledge about the real constraints in the former patients' lives (living alone, financial difficulties, being unable to exert influence over one's own situation, being without work, living in Umeå) or if aware, as concerning being out of work, their unwillingness to intervene (Dufåker, Jacobsson, & Åström, 1993a; Dufåker, 1993c). The lack of co-operation may also be a manifestation of the strategy of boundaries, which marks out and enforces distinct spheres of actions, competence and responsibility between the agencies concerned (Abrams, 1980; Bulmer, 1986; Dufåker, 1993b). Do the psychiatric professionals consider most of the former patients' constraints as other agencies' obligations? And if so is this a manifestation of a strengthened medical model under sektorization?

SektORIZATION was carried out during the research period and a group made up in the main of LFP patients was transferred from the 'research' clinic to another clinic within the psychiatric organization. Under sektORIZATION fewer opportunities exist to pass patients to others within the organization (Bean & Mounser, 1989). Could it be that the well-functioning co-operation between the agencies concerning home support is only a manifestation of the psychiatric service efforts to divest themselves of long-term mentally ill people (Bean & Mounser, 1989)? To dump the really severe care efforts and the 'control' function on the home care workers?

The Green Paper 'Welfare and Freedom of Choice' (Psykiatriutredningen, 1992c) brings to the fore the lack of co-operation between the psychiatric service and the social service agencies, especially concerning the long-term mentally ill. In the report, social workers accuse the psychiatric service of negligence concerning care planning. Furthermore they call attention to the diverse views of the agencies concerned. Social workers believe they adopt a holistic perspective whilst they believe that the psychiatric professionals adhere to a bio-medical perspective i.e. they only take an interest in the pathology pattern, which contributes to the lack of co-operation (Psykiatriutredningen, 1992a).

Critics have emphasized that the lack of co-operation may be due to the lack of a social psychiatric profile (Ramström, 1992; Costa, 1993). The transformation of the psychiatric service has been neither extensive
or speedy. In the report (Psykiatriutredningen, 1992b) consideration is not given to the fact that several sectors do have a well developed form of co-operation with social service agencies, for instance Blekinge, Enskede/Skarpnäck, Nynäshamn and several of the sectors in the north (Ramström, 1992). The report is said to be in favour of a social psychiatric development. If so, they could have forced the psychiatric service and the social service agencies to co-operate by using economic pressure (Costa, 1993).

In the Green Paper 'Welfare and Freedom of Choice' (Psykiatriutredningen, 1992c) many of our findings are confirmed. The report emphasize that mentally ill people have worse living conditions than others. Mentally ill people are more often single and have diminished social networks (Dufåker, et al., 1993a). Furthermore they are more often unemployed and have financial problems (Åström, et al., 1989; Dufåker, et al., 1993a). They are unfairly treated as measured by various quality of life aspects (Dufåker, 1993c). Even if the psychiatric service in our area has improved throughout the years, mentally ill people´s situation at large has not changed much since 1986 (Psykiatriutredningen, 1992a).

Some of our findings acknowledge already known facts or tendencies. The gender differences (men are worse off than women), having a family of one's own and/or a partner (Dufåker, et al., 1993a) are factors that are confirmed by two other Swedish studies (Wessén, 1991; Borgå, Widerlöv, Stefansson, & Cullberg, 1992).

It has been shown that mentally ill people are members of diminished social networks - i.e. based on family members and other relatives (Mueller, 1980; Gottlieb, 1981; Greenblatt, Becerra, & Serafetinides, 1982; Svedhem, 1985; Morin & Seidman, 1986; Cornelis, Ameling, & de Jonghe, 1989; Holmes-Eber & Riger, 1990; Romans-Clarkson, Walton, Herbison, & Mullen, 1990; Svedhem, 1990). Our findings show that the longer the former patients had been ill the more likely that the network will be based on family members, people in the same situation and professionals rather than others (Dufåker, et al., 1993a). The LFP group also wanted the psychiatric professionals as members of their primary network on the same conditions as a family member or a friend (Dufåker, 1993b). Holmes-Eber & Riger's study confirms that fewer relatives and friends remain in the network as the number and length of admissions increase, and that the network of these individuals is composed primarily of people met through the mental health system and short-term contacts.
Traditionally, the professionals have not been seen as members of the patients' social network. In a current study (Cresswell, Kuipers, & Power, 1992), it is stated that 'it seems that professionals involved in the care of the long-term patients may be fulfilling an important function which for most people is met by their primary network - particularly friends' (Cresswell, et al., 1992, p. 1025). We found that most of the former patients had friends, which is rarely reported in research concerning this group. The former patients choice of friends, (for instance persons in the same situation), seemed to differ from what the professionals regarded as a friend (Dufåker, et al., 1993a). Seeing professionals and people in the same situation as friends may be a manifestation of the former patient's perspective, which add valuable information we would otherwise not be aware of. In turn this may contribute to our understanding of mentally ill people's relations to others and their situation at large.

Furthermore, we found that one fourth of the former patients saw death as a likely future prospect (Dufåker, et al., 1993a). Are they suicidal or contemplating suicide? Are those who commit suicide to be found in this group? Or is death as a future prospect a 'mean' of staying alive? This is an area that needs further investigations.

By using Tönnies concepts Gemeinschaft och Gesellschaft as interpreted by Asplund we get a 'picture puzzle' of great intermediary capacity by which we analyzed some of our findings (Asplund, 1985; Asplund, 1991). We have used the concepts as equivalent principles of organizations. The elements of the 'picture puzzle' can be organized in two widely separated or conflicting ways and the meaning of it is, to a large extent, the same as the meaning of the social conditions of life, which the 'picture puzzle' match (Asplund, 1985). We have used the concepts without preference in order to make distinctions clear. Buber's concepts I-Thou and I-It (Buber, 1965; Buber, 1985; Buber, 1990; Israel, 1990; Israel, 1992), which can be interpreted or seen as analogous to Gemeinschaft and Gesellschaft, have been used in order to get a shifting perspective (Asplund, 1991; Israel, 1992).

One of the distinctions is living in Umeå as opposed to living outside Umeå. According to the former patients, living in Umeå is connected with a low quality of life (Dufåker, 1993c). City life, Gesellschaft, may to a large extent be connected with difficulties in making contacts of all kinds (friends, neighbours, contacts promoting employment) (Abrams, 1980; Bulmer, 1986; Asplund, 1987; Asplund, 1991; Mosesson, 1992).
Living outside Umeå and having good neighbour relations were the best predictors for having a job after discharge (Åström & Dufåker, 1993). The same tendency (i.e. more difficult to get a job in the urban than the rural area) is shown in research concerning people with 'long-term functional psychosis' within the Stockholm county (Borgå, et al., 1992). Current investigations have also pointed out that co-operation between agencies seems to be more succesful outside of Umeå (Psykiatriutredningen, 1992a). This may be interpreted as a cultural difference, a spirit of, or reminescence of Gemeinschaft may still be vivid in the inland villages. People may to a larger extent live their lives in the same area, know each other intimately and 'intrude' on each others lives (which may include professionals as well) (Attneave & Speck, 1975; Asplund, 1991; Olsson, 1992). The mentally ill person may be known as eccentric (acceptable) but not dangerous (unacceptable) (Åkesson, 1991). The local social networks may still to a large extent be based on kinship, whose will to accept always has been more far-reaching than that of strangers (Abrams, 1980; Bulmer, 1986). Villagers may be willing to accept norm violaters provided they abide by the general rules as a villager and neighbour, which may strengthen the former patients' relationship to neighbours and make it easier for them to get a job (Gerholm, 1992; Mosesson, 1992; Olsson, 1992).

The disagreement between the psychiatric professionals and the former patients on the latter's quality of life may be a distinction of a similar condition (Dufåker, 1993c). The psychiatric professionals emphasis on illness patterns seemed to be the all-pervading issue concerning their view on the former patients' quality of life. At the same time duration of, and stigma attached to mental illness per se and being without work, seemed to be of major significance to the former patients' quality of life (including the primary social network, the professional social network and opportunities to get work in the labour market) and future life expectations (Dufåker, 1993c). The former patients wanted work, intimate relationships and recovery (Dufåker, et al., 1993a).

Given the same question, 'How does your/her/his situation compare with the lifestyle of men/women of the same age and sex in the neighbourhood?' (Michalos, 1980), the answers are so far apart as to suggest that they were guided by differing questions. Obviously the former patients interpreted the question as 'Can I be like ordinary people and, if so, what do I need to lead a good life?' and the psychiatric professionals answered the following question 'What is he/she suffering from and what
treatment does he/she need?' (Dufåker, 1993c). Disparate views (Gesellschaft and Gemeinschaft) bring about contrasting claims (Asplund, 1991); the psychiatric professionals demanded a continuation of a patient role (they relate to the former patients first of all as mentally ill people) whilst the former patients mostly wanted to find some means of embarking on ordinary useful lives (they relate to themselves first of all as men and women in various social situations) (Topor, 1985a; Barham & Hayward, 1991; Dufåker, 1993c).

Another important distinction is the LFP group's reported satisfaction with home care workers contrary to their dissatisfaction with the psychiatric professionals (Dufåker, 1993b). This seemed to be based on whether the professionals were able to undertake a 'caring' relationship or not. This is a question about the quality of the interaction. The former patients wanted 'friendship' and help to master the situation (Dufåker, 1993b; Dufåker, 1993c). The home care workers' assistance includes tasks performed by themselves, the former patients, or both together. The former patients' integrity and the home care workers' insecurity of what would be the 'right' thing to do will hopefully lead to a dialectic process, where each person distinctively responds to the other in search of a way to reach a specific goal (Asplund, 1987; Eliasson, 1987; Asplund, 1991; Eliasson, 1991). These reciprocal communicative actions will inevitably promote the kind of thorough knowledge about and participation in each others lives that characterize Gemeinschaft (Asplund, 1991). By 'giving' themselves in this process they could make possible the genuine meeting between two persons performing as subjects, which Buber calls the I-Thou relationship (Buber, 1965; Buber, 1985; Buber, 1990; Israel, 1990; Asplund, 1991; Israel, 1992). The home care workers short training and low status will probably reduce the social distance which is a very important factor for creating trust between relative strangers (Bulmer, 1986). By converting their relations into friendship the home care workers seemed to be able to undertake such a 'caring' relationship.

The psychiatric professionals seemed to fail in undertaking such a relationship (Dufåker, 1993b). The LFP group's dissatisfaction with psychiatric professionals may derive from not getting what they want. Either the former patients and the professionals do not understand each other, i.e. do not have a 'common' language, or the psychiatric professionals do not show the LFP group proper respect and understanding (Dufåker, 1993b). The change of clinic could have had an impact on the attitudes towards the psychiatric professionals. The exchangeability on a structural
and individual level is a concern of the organization as a whole. The professionals are probably overrating the organization’s way of attaining the goals and underrating their own capacity and significance as human beings. The professionals may have accommodated to the organization and allowed themselves to be shaped by a desire to fit in and be a part of the world as it is currently constituted, as Gesellschaft (Buber, 1965; Asplund, 1991; Israel, 1992). The professionalization of the psychiatric organization has developed a vocational language, a detached tool for specific purposes, that has diminished understanding and increased the distance between the professionals and the former patients (Asplund, 1991; Eliasson, 1991). The psychiatric professionals may very well emphasize that it is their task to influence people and may offer the same kind of support to the LFP group as to others assuming that most people have the same assets (equality and a language in common) for making contracts in Gesellschaft (Topor, 1985b; Rotelli et al., 1987; Asplund, 1991; Barham & Hayward, 1991) and the same opportunities to change their lives (Eliasson, 1991). Under these circumstances experiencing the other side of a relationship, of inclusion, can not be mutual without destroying the relationship or converting it into friendship. Influencing people by for instance therapy may, according to Buber, imply some progress of a person’s situation but does not regenerate a persons centre (Buber, 1965; Buber, 1985). If the intention is something else, for instance to rehabilitate long-term mentally ill people into society, shared activities outside the realms of psychiatric facilities during a long period of time may be a way to firmly establish them socially and culturally (Farkas, Rogers, & Thurer, 1987; Costa, 1993).

The main intention of the 'picture puzzle' is to use it as a theoretical tool. This implies the risk that the people concerned do not recognize their everyday life. It means that a lot of things that people experience as important within for instance psychiatric care (warmth, joy, enthusiasm, compassion) are missing. It also means that some home care workers’ behaviour may very well make people feel demeaned and misunderstood as will some of the comments of the psychiatric professionals. The alternatives are present within the same organization (in every Gesellschaft is a hidden Gemeinschaft and vice versa) but we can only apprehend one picture at a time (Asplund, 1991). The history of psychiatric care shows that psychiatry has developed from a situation where Gemeinschaft was predominant over Gesellschaft to the current situation where Gesellschaft is predominant over Gemeinschaft. During the 'moral treatment' the psy-
chiefratic workers were 'servants' taking care of the 'children' (mentally ill people). Today the education of the psychiatric professionals take place within a psychotherapeutic framework. Education is often work of a one-way kind, which may imply that something very important dies away. The psychiatric professionals' own experience of and knowledge about good care or 'caring', in which they traditionally were 'experts', may be forgotten or considered as less important.

Is my picture of the psychiatric care as Gesellschaft the 'truth'? Surely there are people who would state the opposite. Who's picture would then be the truth? The answer would be none. It is not a matter of partial bits of the 'truth' that collectively provide the 'Truth'. There are differing explicit or hidden questions behind the two answers. According to Asplund (Asplund, 1991), the 'truth' is not only in the combination, which we get when we put the two pictures together, but further more in the alternation between them. The psychiatric care is neither Gesellschaft nor Gemeinschaft, or a mixture of both. The 'truth' is often ambiguous. Regarding psychiatry as Gesellschaft makes us experience the dissonance between the negative values of the chosen, Gesellschaft, and the positive values of the not chosen, Gemeinschaft. What the LFP group may be missing is not the old psychiatric care based on the 'family' but rather a 'fathomable' world (Asplund, 1991).

It is important to keep the distinctions alive, to let the debate go on in order to find ways to make apparently conflicting goals meet. What seems to be the 'irreconcilable' is often a manifestation of our inability to find solutions due to lack of creativity.

Political decisions to a large extent decide what the society emphasize as a good life. A political election victory in favour of the 'bourgoise' parties has speeded up the reconstruction, or destruction, of the welfare state and changed the basis of a good life and the conditions that would lead to such a life (Hollander, 1993).

In trying to improve mentally ill people's quality of life the Green Paper 'Welfare and Freedom of Choice' (Psykiatriutredningen, 1992c) suggest a change of responsibility for the care of the long-term mentally ill from the county councils to the local authorities, i.e. to the social service agencies. A special agent, a case manager will provide them with the help and the support they need. The case manager is neither given any decision-making rights nor any interpretation priority (Costa, 1993). Nevertheless the report indulges in expectations that this person will influence society's contribution on a structural level so that guarantees will
be made concerning the provision of necessary resources - which according to critics are a prerequisite for the case manager's work (Intagliata, 1982; Ramström, 1992; Costa, 1993). Inspired by the American and English 'case management' systems the report do not take the Swedish 'care manager' system into consideration, (which when it functions very well can live up to the standard of any foreign model) (Costa, 1993) nor the differentiations of the public sectors and the insurance systems in the three countries (Bean & Mounser, 1989).

The psychiatric sectors, which have been more interested in the patient's life than his/her illness, and which have developed new ways of working in order to support mentally ill people outside institutions, are now, according to the critics, told to stop (Costa, 1993). Would it not be better if the psychiatric service was allowed to continue its work?

Or would it be better for the LFP group, if the local authorities that seem to be able to undertake the kind of 'caring' relationship they want, took over the responsibility? Transferring the LFP group to the local authorities may imply a further restriction of their already diminished social network. Those in the LFP group, who today have contacts with both services will most certainly lose their contact with the psychiatric service. Furthermore, a restricted network makes every contact important and irreplaceable. One may also suspect that long-term mentally ill people will continue to be in the same predicament in the future due to the current economic crisis and accompanying cuts in public welfare. In the future the only difference will be that they will be turned down by another agency.

According to Costa, transferring the long term mentally ill people to the local authorities means an end to social psychiatry as a psychiatric concept and praxis. 'The long-term mentally ill is psychiatry's raison d'être, the birth and history of psychiatry' (Costa, 1993, p. 342). A radical alternative from mentally ill people's perspective would be to transfer the psychiatric organization to the local authorities.

Mentally ill people are to a large extent denied their basic rights, that is to be full members of society. The principal of every person's equality as manifested in the citizenship of the political democracy once again has entered the scene. The Green Paper 'Welfare and Freedom of Choice' (Psykiatriutredningen, 1992c) suggest that the most severely mentally ill people should be included in the concept 'functionally disabled'. In turn, they will be included in 'the law (1993:387) about support and service to certain functionally disabled' (LSS), which was passed this year.
The proposal emphasizes integrity, self-determination and influence. Multiplicity is the starting-point and the aim is to create a society based on equal participation, where everybody has the same value, the same rights and is entitled to equal respect.

The problems with the rights of the welfare state is that certain groups need support in order to protect their rights. Rights and obligations are delivered by authorities. The decision-making process concerning mentally ill people will be dominated by professional judgements. Somebody have to decide who is supposed to be included in the law. The decision-making authority is usually the professional organization, which is affected by the rules, i.e. the social service agencies and the psychiatric service. The rights are mediated to the authorities, who are mentally ill people's representatives. The authorities are by definition good and there is no need for protection against the authorities. Instead of being mentally ill people's representatives the authorities may very well turn out to be society's safeguards against changes in the existing power relations (Lilja, 1983; Topor, 1985b). The regulations of the welfare state is directed towards symptoms rather than the basic problems (Hollander, 1993).

The consequences of passing the Swedish Green Paper 'Welfare and Freedom of Choice' (Psykiatriutredningen, 1992c) will be that psychiatry is on its way back to the hospitals taking care of emergency and short-term care, that is bio-medical illness. The continuity of care will be broken. The division between illness and health, bio-medical and social psychiatry, county councils and local authorities will increasingly become more evident than today. The ultimate consequence may be that psychiatry finally will be accepted as a medical speciality among others and what that may imply to mentally ill people in the long run is yet to be seen.
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