Choice as Governance in Community Mental Health Services

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List of original articles

This thesis is based on the following articles:

**Article I**


**Article II**


**Article III**


**Article IV**


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Abstract

In 2009, the Act on Freedom of Choice Systems (SFS 2008:962) was established in Sweden, and this enabled municipalities to organise services as choice models. This thesis describes and analyses the implementation of a freedom of choice system within community mental health services. Day centre services were in focus, and a case study was conducted of a major municipality that sought to be a “world-class city” in regard to citizens’ choice. The experiences of policy makers, managers, professionals, and participants were explored in interviews, and documents on a national, municipal, and city district level, as well as homepages of providers of community mental health services, were all part of the study and were analysed using content-analysis methods.

The results showed that the freedom of choice system aimed for two objectives – improvements at the individual level and financial efficiency. In practice, financial efficiency was experienced as the main objective. Increased variety of services was aimed for by the competitive model, but such variety was not observed. Instead, services tended to be more similar than specialised. Concerning new providers, they were characterised as committed professionals running companies with strained economies. Participants affected by the reform expressed anxiety and worries due to the unpredictability and uncertainty embedded in the competitive choice model. Choice within the system concerned where to go, whereas participants emphasised a wish to be able to influence the choice aspects of who carried out the service and how much time to attend the services.

The conclusion was that the freedom of choice system was implemented as a technology of governance to increase financial efficiency of services. Individual choice was not experienced as increased in any aspect except for the choice of where to go. Instead, freedom of choice actually appeared to decrease due to standardisation and hierarchical structures. Aspects that were found to be relevant when designing freedom of choice systems aiming to increase individual freedom of choice were to address predictability and continuity, to address sustainable financial premises, to analyse the predicted impact of administrative systems that are to be used, and to avoid the use of “hidden goals” in the policy-making process.

Key words: freedom of choice systems, community mental health services
## Thesis at a glance

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<td>IV</td>
<td>Fjellfeldt, M., &amp; Markström, U. Competing Logics and Idealistic Professionalism – A Case Study of the Development of a Swedish Community Mental Health Service Market</td>
<td>To explore the longitudinal development of an organisational field due to the implementation of a freedom of choice system in terms of range and characteristics of providers and services and the dynamics and professionalism that appeared.</td>
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A qualitative case study of two districts in a large Swedish municipality. Political documents were collected, and 25 semi-structured group and individual interviews were conducted with 28 agents involved in the implementation process. Various hierarchical levels were represented. Interviews took place in 2009 and 2012, which were prior to and after the reform in 2010. Directed content analysis was used to analyse the data.

Participants’ freedom of choice was influenced by detailed regulations. Freedom of choice was extended, but it was also substantially reduced depending on which aspects of the system were emphasised. Features that could be interpreted as paternalistic were structurally embedded in the market. The market did not seem to be adjusted for the average participant in community mental health services.

Data showed a top-down political process. On a policy level, individual autonomy was advocated as the market’s main purpose. The data reflected that financial efficiency dominated the agents’ experiences of the implemented system. The twofold market purpose was clearly reflected in the interviews. First-line staff hoped for improvements mainly for the users, whereas senior managers mainly focused on the market as a resource allocator.

The participants valued aspects of choice that were not addressed within the model. Policy objectives emphasised the choice of where, while participants valued the choices of by whom, how much, and when. The unpredictability inherent in the system caused unwanted harm. Continuity and predictability were considered as important.

Lack of competition meant that the expected development of the organisational field in terms of variety of services did not occur. Logics of care, choice, and advocacy appeared. Idealistic professionalism was suggested as an additional type of professionalism based on the providers’ personal commitment. Building-based sheltering services were combined with exposures to on-the-job settings. The evidence-based method IPS gained ground.

A qualitative case study of two districts in a large municipality. 18 semi-structured group and individual interviews were conducted with 20 agents situated in different parts of the organization. Interviews took place in 2009 and 2012, which were prior to and after the reform in 2010. The data were analysed first using conventional content analysis and then by directed content analysis.

A qualitative case study of four districts in a large municipality. 35 informants participated, and 46 individual interviews were conducted. Interviews were held in 2009, 2010, 2011, and 2012. The data were first analysed by conventional content analysis and then by directed content analysis.

A qualitative case study of a large municipality. A total survey was conducted based on 33 service providers’ websites, and 10 semi-structured group and individual interviews were held with 14 informants representing Day centre services entering and exiting the market. Conventional content analysis was used to analyse the data.

Lack of competition meant that the expected development of the organisational field in terms of variety of services did not occur. Logics of care, choice, and advocacy appeared. Idealistic professionalism was suggested as an additional type of professionalism based on the providers’ personal commitment. Building-based sheltering services were combined with exposures to on-the-job settings. The evidence-based method IPS gained ground.
Introduction

In 2008, the following declaration was made by the City Council in the capital of Sweden:

Stockholm will be the first municipality in Sweden to introduce freedom of choice in services for persons with disabilities. Stockholm will be the role model in efforts to give greater power to the individual municipality inhabitant. With this case, we show that even in this area Stockholm strives towards becoming a world-class city. (Stockholms stad, 2008, p. 9)

Thus, pride and high expectations were outspoken. In a round of written comments, though, local mental health user organisations objected to the proposed political agenda. They raised concerns about a choice system built on a market model with a lack of long-term stability and continuity. The mental health user organisations believed that such a system would cause harm and anxiety among participants. User organisations therefore advised against the implementation of the choice system as proposed (Stockholms stad, 2008). Accordingly, contradictory expectations were present, and a societal ambition of individual choice appeared side by side with individual concerns related to the same agenda. This raised questions regarding involved stakeholders’ different assessments and their different views of the situation.

When the Act on Freedom of Choice Systems (2008:962) was introduced in Sweden, the following five intentions were emphasised: to increase individual freedom of choice, to increase individual power, to increase the diversity of services offered, to increase the quality of services offered, and to increase the efficiency of services (SOU 2008:15). The first four intentions meant a turnabout in the mental health field that for many centuries in Western countries had been characterised by discipline, lack of freedom, and personal power. Beginning in the early 1400s, asylums were built outside the cities, and with time they extended in size, numbers, and geographic area until they contained thousands of beds (Goodwin, 1997). Many people bore witness of a situation of total institutional control. When entering the asylums, a person was stripped of their own clothes and dressed in hospital-owned clothing. Personal belongings such as money and jewellery were taken away, and movement was restricted. In the 1950s, the asylums began to be heavily criticised, and they were closed down in subsequent decades at the same time as medical advances were taking place (Rogers & Pilgrim, 2005).

Today, there are frameworks used in contemporary mental health policy and practice that concern respect for the individuals’ own rights and desires. One framework is related to the UN Convention on the Rights of Persons with
Disabilities (United Nations, 2006), which articulates a shift in the recognition of equal rights of people living with psychosocial disabilities. Another framework known as the recovery framework (Slade, 2009) includes a focus on personal recovery as distinguished from clinical recovery. Personal recovery involves, among other things, that the individual desires of the person being supported are included in the design and definition of mental health support.

Given the history of mental health services, the current national emphasis on individual freedom of choice in parallel with frameworks concerning human rights and personal recovery seem to be a radical change – a redress for persons that had been treated as incapable for many years.

These “coincidences” roused my curiosity, and I had many questions. How does a society deal with freedom of choice with regard to mental health service users? How is freedom of choice structurally designed? What characterises freedom of choice for individuals? How do persons involved experience the reform, including participants as well as professionals? How does freedom of choice appeal to the group being addressed? What characterises freedom of choice in this context, and is it a positive freedom of choice (Berlin, 1969) where persons experience increased self-governance? Or is it a negative freedom of choice where persons experience decreased state governance restrictions interfering with their personal preferences of way of life?

My curiosity about individuals constituting a society, and of the experiences of exposed individuals being affected by legal and administrative decisions and changes, led me to carry out the present study on freedom of choice in community mental health services. As a way to look for answers, I agree with the claim that “Research is formalized curiosity” (Silverman & Marvasti, 2008, p. 30). In the research context in which I was invited to take part, curiosity-driven research questions were formulated and discussed, and arrangements already set up within the project were an asset for me. Without having access to the extensive data set, this study would not have been possible to conduct in the way that it was.

In this thesis, freedom of choice as implemented in Swedish community mental health services will be explored from a participant, professional, and policy perspective. This means that this is a study about people, all with different points of departure. People who all live together and influence the context of which they are all a part. Because the idea to implement a freedom of choice system in community mental health services was a political initiative, this study begins with an investigation of structural frames and market conditions by studying political documents and interviewing policy makers.
and senior managers on a municipality level. Further experiences of professionals such as first-line managers and personnel working in the organisational field are explored. Finally, experiences of the participants in community mental health services are investigated. If the freedom of choice initiative had been a grassroots initiative, the study would probably have had been conducted the other way around.

**Figure 1. Elements examined in the study.**

![Diagram showing elements examined in the study](image)

**Aim**

The overall aim of this study is to describe and analyse the implementation of a freedom of choice system within community mental health services from a participant, professional, and policy perspective.

**Research questions**

How might the intentions of the reform be understood in relation to the experiences of the actors involved?

What characterised the structure of the specific choice model on a macro policy level?

How did the organisational field develop regarding the characteristics of the providers and the services offered?

How were the implementation process of the freedom of choice model and the choice model itself experienced by policy makers, managers, and professionals involved at a meso level?

On a micro level, how did participants experience the choice model and the implementation process?
Research overview

Freedom and freedom of choice

The concept of “freedom” has been scrutinised throughout the ages, and more than 200 senses of the word have been recorded by historians (Berlin, 1969). Positions have been criticised, and discussions have taken place. One pioneering philosopher whose contributions have developed the understanding of the concept of freedom is Berlin (1969), who distinguishes between two fundamentally different senses of freedom – “negative” freedom and “positive” freedom.

Berlin (1969) argues that negative freedom is the area within which a person can act unobstructed by others. There are two reasons to obstruct persons. The first is justice, meaning not to hurt or do things at the expense of others, and Berlin states (p. 126), “the freedom of some must at times be curtailed to secure the freedom of others.” The second is that freedom is not the only goal in life, and people need, for example peace, security, and love, which can be a reason to restrict freedom. Negative freedom is thus a freedom from interference or restrictions by others.

Positive freedom, on the other hand, derives from the wish of individuals to govern their own lives. A wish that decisions depend on oneself, not on external forces of whatever kind. Berlin (1969) argues that:

The desire to be governed by myself, or at any rate to participate in the process by which my life is to be controlled, may be as deep a wish as that of a free area for action, and perhaps historically older. But it is not a desire for the same thing. (p. 131)

Freedom in the positive sense is associated to the wish to

be conscious of myself as a thinking, willing, active being, bearing responsibility for my choices and able to explain them by references to my own ideas and purposes. (p. 131)

Positive freedom concerns freedom to do something, where the source of freedom lies within the person.

The concept of “freedom of choice” can thus be defined in many ways, and in everyday conversations, as well as in political debates, persons talking about freedom of choice might pass by one another.
Freedom of choice in different user groups

Studies conducted in the UK, the EU, and the US show that attitudes towards choice in public welfare varies among different user groups (Fotaki, 2009). Choice appears to be the most attractive to users in education and the least attractive in healthcare. The consumerist approach in healthcare has been found to be the most relevant for simple and insignificant choices such as appointment times. This leaves out treatment choices where trustworthy relationships are of importance, for example, in cases of life threatening conditions or when there are demands for continuous care. Further, it has been found that users in public services do not apply the dichotomy of passive recipient versus the active and sovereign customer that is described in the contemporary public policy discourse. Instead, concepts such as “patients” or “service users” are preferred.

Freedom of choice in mental health services

Competition by choice (Le Grand, 2007) in welfare services is based on the presence of a number of providers for the individual to select among, which is in contrast to a unitary or monopoly service where all individuals have to receive the same service. Choice might, according to Le Grand (2007), involve many different aspects, including choice of provider (where), professional (who), service (what), time (when), or method (how).

When approaching the field of research on freedom of choice in mental health services, the first striking observation is the existence of a lively debate. The UK represents a good example of the discussion. Some claim that freedom of choice within mental health confirms everyone’s individual autonomy whatever their mental state (Rankin, 2005b) and that choice improves relations between service users and care providers (Rankin, 2005a). Others say that certain conditions must be met to operationalise choice in mental health, including adequate financial resources, professional attitudes, assurance of equality, and the availability of various options (Warner, Lawton-Smith, Mariathasan, & Samele, 2006). Yet others say that too much choice causes harm and that choice systems force service providers to have an incorrect focus and to invest time and money in marketing instead of services (Holloway, 2007). In Sweden, the debate has been characterised by politicians who advocate freedom of choice systems and practitioners who criticise it (Costa, 2011; Rydberg, 2011).

Two research teams have focused on the individual and choice. One team (Weisman De Mamani et al., 2016) has studied free will perceptions and psychiatric symptoms in persons diagnosed with schizophrenia. They claim
that mental health clinicians might improve current treatments for schizophrenia by helping patients recognise situations where they do have some freedom of choice over their actions and their emotional reactions to stressful life events. Another team (Calsyn, Winter, & Morse, 2000) has studied whether mental health consumers who have a choice of treatment have better outcomes or not. In one trial, the recruitment of participants was extensive and all participants suffered from severe mental illness and were homeless at baseline. The participants constituted two groups, one with a choice condition and one without a choice condition. The results of that trial showed that participants in the choice condition visited the program staff at their offices more than participants in the non-choice condition. Additionally, participants in the choice condition increased their incomes more than those in the non-choice condition. In another study concerning choice of treatment and outcomes among individuals with severe mental illness (Calsyn et al., 2003), it was found that positive expectations were correlated with program contact and satisfaction with services. Research conducted at an individual level thus indicates that choice can have positive impacts among persons suffering from severe mental illness.

Research has also been conducted on a policy level where choice has appeared as a result rather than as a research question. One study (Watson, Thorburn, Everett, & Fisher, 2014) noted that three frameworks are currently used in mental health services – human rights, personal recovery, and trauma informed. These are all consistent with a shift away from the use of coercion. When applying these frameworks to the National Standards for Mental Health Services 2010 in Australia, the findings were considered to have implications for the directions of change in several aspects, including choice about community and inpatient care options.

In relation to social work and mental health care, the principles of autonomy and individual choice correspond to a long history of efforts that have been undertaken to enhance the empowerment of disadvantaged individuals and groups (Knapp, 2007). Policy principles regarding choice in mental health point towards greater social inclusion for people with mental health problems because choice is already possible in general healthcare (Valsraj & Gardner, 2007). Furthermore, the recovery model (Slade, 2009) that is gaining acceptance within the mental health field underpins choice models. The recovery model seeks to move away from a paternalistic approach and to allow users to regain independence and to access services they feel best meet their needs (Samele, Lawton-Smith, Warner, & Mariathasan, 2007).

In practice, though, it has been found that despite some examples of good practice, the vision of choice in mental health care is still a long way from
becoming a reality for many users (Samele et al., 2007). To enable individual choice in health and social care, Knapp (2007) claims that the following four criteria must be met: 1) a range of services that vary sufficiently must be developed, 2) information with pertinent details must be available to current and potential users and their caretakers in ways that are accessible and understandable, 3) users and caretakers must be empowered so that they can select from the options available in an informed way, and 4) users must be allowed to have control over their choices. Factors considered as limiting choice are budgetary restrictions and a growing influence of national care standards that could narrow the variety of options available from service providers (Knapp, 2007). Conflicts might arise between increased standardisation of provision and the individualisation of service in response to individual users’ preferences. Regarding citizen empowerment, Knapp (2007) further argues that it is difficult to gain experience by “shopping around” in terms of trying different providers of a product that is characterised by a high level of person-to-person elements and where there is some degree of dependency.

Autonomy in terms of personal choice and less paternalistic approaches has been requested within mental health services (Knapp, 2007; Samele et al 2007, Slade 2009, Valsraj & Gardner 2007). Autonomy is also a core principle in freedom of choice systems. Rhetorically, choice models and ideas within the recovery framework have aims and objectives that are expressed in similar words.

**Freedom of choice in the welfare sector**

Models based on ideas of competing markets have been implemented in the welfare sector worldwide (Brody, Bellows, Campbell, & Potts, 2013; Finn, 2009) in hopes that competition between providers would inspire more efficient organisational development and a more attentive approach to users.

Public markets, known as quasi-markets (Le Grand & Bartlett, 1993), are financed by tax money, but the competitive market system opens up service delivery to for-profit and third-sector organisations as well as to the public sector (Defourny, Henry, Nassaut, & Nyssens, 2010). Sometimes quasi-markets are set up as choice models as inspired by Friedman and Friedman’s (1980) voucher system, where personal vouchers enable personal choice. Le Grand (2009) advocates that choice models in public welfare based on the market mechanisms of user choice coupled with provider competition can deliver higher service quality and greater efficiency, user autonomy, responsiveness, and equity than the alternatives. The claim that market mechanisms should generate greater responsiveness is associated with the
idea of power transition from the state to the citizen. User choice coupled with provider competition is expected to change the power balance to benefit the citizen and to increase user autonomy. Certain conditions, though, must be fulfilled to make the market work. A key condition is that there must be true competition among providers.

Quasi-markets differ from conventional markets in several ways. Customers do not use their own money, the core purpose of public service organizations is to provide service and not to make a profit, the public sector is politically governed by democratic processes, the public sector is funded through tax systems, and the public sector cannot deselect customers (Ferlie, 1996; Le Grand & Bartlett, 1993).

The consequences of choice models implemented in the context of disability have been explored, and several issues have been brought up (Dowse, 2009; Spall, McDonald, & Zetlin, 2005). The market model assumes active, independent, and productive consumers. In practice, however, not all individuals can meet these expectations. Another issue concerns how fixed price compensations associated with choice systems restrict the possibilities to individualise services. Still another issue is that the market models implemented to date have shown a tendency to shift the focus towards caretakers and away from those for whom they care through heavy administrative loads associated with the model and a need for marketing to attract users (Dowse, 2009). Research has shown that choice models so far have not been delivering on their promises. Instead of resulting in increased choice and improved efficiency in services, users report experiences of inadequate service supply, service cutbacks, and an increased emphasis on cost subsidisation and assessment processes (Spall et al., 2005). Thus the use of quasi-markets in public welfare has been questioned (Mol, 2008), and Bate and Robert (2005) argue that both the pros and cons of individual choice need to be considered.

**Freedom of choice in the Swedish welfare context**

Freedom of choice in the Swedish welfare context has been described as a semantic journey from welfare as a precondition for citizens’ freedom of choice to freedom of choice as a way to administer welfare (Vamstad, 2015).

The story begins after the Second World War. During the post-war period, a number of reforms were implemented to transform Sweden into a modern society prepared to meet the challenges of a new age. The Social Democratic party carried out an expansion of the Swedish public welfare system (Vamstad, 2015). When the social democrats with Tage Erlander as the front
man in 1962 developed their political visions for a new political decade, *freedom of choice* was a catchphrase taken into the social democratic vocabulary. “Freedom of choice” was added to already well-established social democratic announcements like “justice” and “equality” (Erlander, 1962). State investment in the public welfare system was launched as being necessary for freedom of choice among citizens to be realised. The concept of freedom of choice was associated with those who were the worst off in the community, e.g. the old, sick, and unemployed, who would be the most restricted in daily life without support from the state (Vamstad, 2015).

With this allocation model, the social democrats could argue for freedom of choice in a welfare context, while the liberal side raised a request for tax reductions to achieve freedom of choice as understood in a liberal sense. From a liberal view, individual freedom of choice was restricted by state involvement in the private sphere (Vamstad, 2015).

During the 1980s a new movement in the understanding of the concept of freedom of choice began to gain momentum. Because many citizens had grown up under the modern welfare state, many of them took basic welfare for granted. A welfare system could no longer constitute the basis for an argument for freedom of choice (Vamstad, 2013). Freedom of choice as a political concept was now further developed by the right-wing parties, and freedom in this context meant individual freedom where individuals were freed from state interventions and increased influence was allocated to the private sector (Vamstad, 2015).

The first arena in which freedom of choice as a political decision was made was childcare. Because there was an acute lack of public capacity in childcare, a private initiative was taken to solve the problem by establishing two private kindergartens with support by Elektrolux, one of Sweden’s largest companies (Werne & Fumarola Unsgaard, 2014). This happened in 1983. However, the Social Democratic government legislated against public funding of private kindergartens, the so-called Lex Pysslingen. In the wake of Pysslingen, though, one year later the state opened up for the creation of parent cooperatives. This was a unique step away from the social democratic path regarding how to administer public welfare (Vamstad, 2007).

In 1991, the right-wing parties won the elections. The new government launched their “freedom revolution” where they repealed Lex Pysslingen and opened up the childcare sector to not only include parental cooperatives, but to also include profit-making private businesses as providers of childcare financed by public funds (Vamstad, 2007). Another reform was to implement freedom of choice in the school sector in 1992 (Proposition 1991/92:95). A
voucher system allowed for an amount of “school money” to accompany each pupil when choosing a school of interest. This model meant that tax money still financed the school system, but non-public schools could enter the new “school market”.

When the left-wing parties won the elections in 1994, the freedom of choice systems that had been implemented were not abolished, but they were reformed in different ways (Vamstad, 2015).

In 2004, the right-wing parties returned to governance and continued the freedom of choice program. In 2009, a new piece of legislation (SFS 2008:962) enabled municipalities to arrange any service they conducted as a choice model. In the preparatory text that preceded the new law, the government’s intentions were expressed (SOU 2008:15). Implementation of choice systems was expected to increase individual power and freedom of choice. The individual’s opportunity to select and reselect is the very core of the system, and this choice is intended to contribute to the quality of services to be maintained and further developed. Competition is intended to stimulate service providers to develop their services and to profile themselves, and this should provide incentives for greater diversity and efficiency. The system is based on continuous competition between the providers so that users’ choice determines whether the businesses will be able to survive or not. The model implies that service users have a choice between different service providers, which are to be authorised by the local authorities. Contracting is done through users’ choice, and competition within the system should be directly linked to users’ choice. Service providers can only compete with quality because local authorities fix the prices for services. Competition is meant to improve responsiveness to users’ opinions and to facilitate diversity, quality, and efficiency among service providers. In early 2016, 158 out of 290 Swedish municipalities had made use of the new legislation in practice. Six municipalities had also ceased the use of choice systems as operationalised according to the new legislation (SKL, 2016).

The freedom of choice system established in public schools in 1992 has been the focus of empirical research. Dovemark (2007) found a social practice where a shift of learning resources from resource-poor to resource-rich pupils took place. Norén (2003) found that pupils’ ability to choose schools was not due to the choice model, but was determined by admission proceedings based on grades.

Research has also been conducted on choice due to the reform launched in 2009. One study trying to understand implementation of choice in a wide range of service contexts (but not including community mental health
services) was put together by Hartman (2011). The study showed that in many cases there was someone else other than the service user who made the choice, such as a family member or government official. Another finding was that the possibilities for service users (or the actual choosers) to obtain sufficient information to make an informed choice based on knowledge about the quality of services, as well as which components the providers used when evaluating the quality of services, varied significantly.

In the context of home care services, choice has been researched on an individual level (Vamstad, 2016). It was found that participants using the service had difficulties in understanding the purpose of choice and how to make the right choice. The results showed that participants did not value having a choice among anonymous providers, but rather wanted to influence the content of services and the specific member of staff providing the care service.

Another study (Andersson, 2013) concerned choice in Swedish public care of the elderly, and especially care workers’ dilemmas. This study described how rationalisation and economic efficiency are guiding principles side by side with a discourse where individual rights and freedom of choice are emphasised. Andersson (2013) discusses the economizing of care and how the vocabulary of dignity and influence is a political construction without any anchoring in the reality of care. The dilemma between increased regulation and restrictions in the care work and individual dignity and influence is posed in a few questions:

*How, and in what way, is it possible to improve working conditions for the care workers while at the same time putting more regulation and time constraints into care work? And in what way can the elderly recipients in need of care be given more influence over care, if they cannot or are unable to make rational choices or decide about the content of their personal care? (p. 174)*

In Andersson’s (2013) study, a new time measure system was gradually implemented at the same time as freedom of choice was introduced in accordance with the Act on Freedom of Choice Systems (2008:962). Hierarchical structures were implemented due to a market rationality associated with the freedom of choice system, and both care workers and managers expressed a lack of power due to their positioning within the hierarchical structure. Managers explained to care workers how directives were coming from above and how there was nothing they could do about it. It was also found that many service providers had economic difficulties because there were other expenses that were not completely connected to the actual care work that the payments covered. Time and costs were a topic often raised among care workers, and there were many examples of how the service-
provision companies tried to save money by cutting down on the staff, for example, when they were on sick leave. Another thing found was that the time pressure and the changes made to the system had resulted in more administrative work. This led many of the care providers to express how time for elderly care was reduced.

Andersson (2013) concluded that the time-measurement system was not congruent with the financial system. The time-measurement system appeared to be filled with dilemmas inherently connected to care, and obviously there were no clear winners within this system. The municipality investigated in Andersson’s study had adopted the ideas of marketisation and freedom of choice, claiming them to be in the best of interest of the municipality’s elderly citizens. However, the political goals to improve quality of care and to strengthen the elderly customers’ rights while at the same time being more effective appeared to be rather contradictory. Political rhetoric appears to be a major force in sustaining the reform in favour of freedom of choice, no matter how hollow it is in the actual provision of care.

Research has also been conducted on a structural level. Nordgren (2010) examined the discourse of choice in Swedish health care and concluded that the vocabulary used within the discourse produced “weak patients instead of free and empowered people” by placing responsibility on patients beyond their knowledge while avoiding vocabularies about pain and suffering. What freedom of choice systems have meant in the context of Swedish community mental health services, though, remains to be investigated, and no such studies have yet been conducted as far as I know.

**Additional research in the Swedish welfare context of relevance for this thesis**

Except for the recent choice models implemented in the Swedish welfare system, the whole picture needs to be complemented with a description of market use in earlier years. For decades, Swedish municipalities have bought services from the private sector when they have not been able to provide statutory services within their own public service setting. One area in which this has been the case for many years is residential care for children (Meagher, Lundström, Sallnäs, & Wiklund, 2016). This market has had nothing to do with individual choice, but illustrates the history of a market implemented in the Swedish welfare context.

The study by Meagher et al. (2016) shows that during the last 40 years (since the early 1980s) a market has been applied to the residential care for children. It has been described as a “thin market” consisting of only small numbers of
children and youths. When researched, the history of the market has been characterised as consisting of three consecutive phases. In phase one, small-scale family-owned non-profit organisations complemented publically owned facilities. The private owners could be described as “insiders” coming from inside the field and offering “family-like” care. In phase two, a change in ideology could be traced. Medium-sized professionalised companies offered specialised care with a more diverse supply of various treatments. “Evidence-based” services were offered, and a market logic and for-profit companies became dominant. Provision of services was more related to making money than assisting vulnerable children. In the third phase, investors seeking new fields from which profit could be generated appeared. Large companies were growing by acquisition when buying established providers. These companies could be described as “outsiders” with their base in other social service fields such as disability support or elderly care, and these companies operated on a national level.

A final recent research result of relevance for this thesis concerns a finding within the Swedish social welfare system (Johansson, Denvall & Vedung, 2015). This study shows that recent state attempts to implement Evidence-Based Management (EBM) within the social welfare arena have tended to ignore the clients’ perspective. This is caused by the scientific rationale of Evidence-Based Practices (EBP) that makes randomised control trials the gold standard for gaining knowledge. In this context, users’ perspectives are considered as troublesome and less valid. This has happened despite simultaneous policy intentions (SOU 2008:18) to strengthen users’ roles in the social services.
Theoretical perspectives

In carrying out the case study, several theoretical perspectives were used to address the macro structural level, the meso organizational level, and the micro individual level. Finally, an additional theoretical framework was applied to enhance the understanding of the implementation process as a whole. During the case study process, it happened that perspectives aiming to address one level enriched the understanding of data collected on another level. The main perspectives and tools used are presented below, and several additional and more specific concepts are described in the individual articles presented as part of this thesis.

Perspectives addressing the macro, meso, and micro levels

Addressing the macro level, one point of departure was that there is no one “welfare market model” to relate to, but instead there is a range of different models (Gingrich, 2011). Additionally, different quasi-markets are not emerging in different directions simply by coincidence. Brunsson and Hägg (1992) claim that different societies use quasi-markets for different reasons, and these quasi-markets seek either to promote and ensure the autonomy of the individual or to allocate financial resources. In societies where individual rights are considered important, markets could be important tools for preventing the community from limiting individuals in various ways. In other societies, the market could play the role of an effective resource distributor. To sort out the specific markets’ structural frames in the present case, quasi-market regulation (Propper, 1993) was used as a key theoretical tool. How provider entry, prices, quality, and provision of information were regulated within the quasi-market enabled the analysis of the case study presented here.

To develop the understanding on the meso level concerning how managing agents and professionals experienced and acted upon the freedom of choice reform, tools originating from organisational theory were applied. One concept applied was decoupling (Meyer & Rowan, 1977), which explains how organisations consist of both a formal structure (which tries to maintain social legitimacy) and an informal structure (which tries to maintain efficiency within the organization). Ideally, organizations attempt to maintain a close association between the formal and informal structures. However, sometimes formal and informal structures tend to diverge, and in such situations the structures could be considered as decoupled. Another concept used was mimetic isomorphism (DiMaggio & Powell, 1983), which explains how uncertainty can cause organizations to start imitating each other. They could, for example, seek to provide all of the desired products or services they know
of in the field, and insecurity becomes a driving force to develop more similarities than differences.

Another issue of relevance when focusing on the meso level was **professionalism**. According to Evetts (2009), there are two ideal types of professionalism – occupational and organisational professionalism. Occupational professionalism emphasises relationships, trust, and opportunities for discretion. Organisational professionalism is more dependent on organisational structures, hierarchical structures, and standardised procedures. Another concept applied was “commercialised professionalism”, which implies that professionals are required to do their best for their clients but also to achieve this within tight financial constraints within competitive market models.

To address the micro level, the **continuum of consumers** (Eika & Kjølsrød, 2013) was used. The continuum means that individuals range from those who are competent to make any and all decisions to those who are incompetent to make any decisions. Further, the dimensions of choice (Le Grand, 2007) were applied, including choice of provider (where), professional (who), service (what), time (when), and method (how). Additionally, the two principal dimensions of quality – access and effectiveness (Campbell, Roland, & Buetow, 2000) – were addressed.

Thornton, Ocasio, and Loundsbury (2012) provide a thorough description of the **institutional logics** perspective:

*The institutional logics perspective is a metatheoretical framework for analyzing the interrelationships among institutions, individuals, and organizations in social systems ... The principles, practices, and symbols of each institutional order differentially shape how reasoning takes place and how rationality is perceived and experienced. (p.3)*

Institutional logics in health care are scrutinised by Mol (2008) who identified two contrasting logics – the **logic of care** and the **logic of choice**. One issue concerns personal responsibility associated with the logic of choice (Mol, 2008). When a person makes a decision that turns out to be wrong, the failure belongs to that person. The logic of choice thus adds guilt, which could be considered as counterproductive in the healthcare context. Within the logic of care, in a situation of poor outcome of a treatment, provision of comfort would be the natural response. Mol (2008) argues that the logic of care gives space to fragility, which is dismissed within the logic of choice.

Both Fotaki (2009) and Mol (2008) point out that health care and many public services concern ongoing processes rather than one-off transactions.
Mol (2008) discusses that, in a market logic, customers buy products that have a distinct beginning and a distinct end. In the logic of care, there are instead interactive and open processes that are shaped and reshaped as the results of the process become clear. Fotaki (2009) writes:

Provision of public services is rarely about acquiring products for pure consumption, but more about providers and users jointly addressing essential social and human needs. (p.87)

Fotaki (2009) proposes co-production as an alternative idea, making public services responsive and efficient and allowing users to have influence in the services they receive. A market logic relation typified by consumerism implies antagonistic relations between users and providers. Co-production, in contrast, implies that service users and providers are partners in a continuing process of inquiry. Mol (2008) discusses the same phenomenon when developing thoughts about “shared doctoring”. Within the logic of choice, customers are supposed to make decisions based on available information. However, Mol (2008) noticed that in practice many patients want the doctor to be the one who makes the decisions. This could be traced to the logic of care, where doctors make decisions based on their medical training and professional experience. Mol (2008) notes that:

First, democratically governed states were called upon to control professionals. Now, in the logic of choice, patients are invited to do so individually. They must push professionals back into their cage, the place where they know the facts and handle the instruments. At the same time the patients themselves are to make the crucial decisions, those that involve values. (p. 56)

However, Mol (2008) criticises the medical discourse where doctors are the only experts and patients are perceived as uninformed. As mentioned above, Mol (2008) proposes a “shared doctoring”, where doctors and patients experiment, experience, and tinker together. Mol states that this is far from easy, however, because shared doctoring requires that everyone concerned should take each other’s contributions seriously and respect each other’s experiences while engaging in inventive, careful experiments:

Shared doctoring requires us to take nothing for granted or as given, but to seek what can be done to improve the way in which we live with our diseases. (p. 56)

Finally, Mol (2008) does not argue that the logic of care is generally superior to the logic of choice. Instead she welcomes a discussion but advocates an accentuation to shed light on the logic of care in relation to the logic of choice in health care. In a long-term perspective, she expected that the potential consequences when implementing the logic of choice in health care would include situations where the problem might develop in which nobody would
want to invent anything if they could not make money off of the invention. Mol (2008) concludes that concerning living a life with a disease in a suffering and unpredictable body, the logic of care is more appropriate.

**Perspectives addressing the case study as a whole**

When the different levels had been addressed, there was a need for an additional framework facilitating the development of the understanding derived from the four articles of this thesis as a whole. Accordingly, the study proceeded on the basis of the argument that studying micro-level power relations could lead to knowledge about macro-level power relations. As Rose (1999) writes:

*To begin an investigation of power relations at this molecular level, however, is not to counterpose the micro to the macro ... If there are differences between the government of large spaces and processes and the government of small spaces and processes, these are not ontological, but technological. (p. 5)*

Rose (1999) gives examples of *governance* addressing both the macro and micro levels. For instance, social insurance regimes simultaneously address the security of the population as a whole and the circumstances of the individual household and its members. In the same way, regulation of the health of the population has established actions and efforts addressing the strength and vitality of the nation and its “manpower” as well as practices aimed at the maximising of individual and family health.

One relevant perspective when studying the freedom of choice reform as a whole regards how the premises and conditions of quasi-markets are the results of specific political positions with specific long-term goals (Gingrich, 2011). The right and left political wings have fundamentally different ideological objectives, and they use the market model to achieve different political goals. The right wing uses the market model to increase the power of the private sector, to decrease governmental restrictions, and to streamline the state. The left wing uses the market to increase citizens’ power, to increase governmental restrictions, and to challenge prevailing structures. Different governments thus design markets with distinct qualitative differences; they use the same means but with different aims.

Another relevant perspective focuses on governing and power relations related to freedom of choice models (Rose, 1999). To govern people in this context is not to crush their capacity to act, but to acknowledge it and to utilise it for one's own objectives. When analysing political rationales and strategies of governing, Rose (1999) uses the concepts of technologies of government and “human technologies”:
Technologies of government are those technologies imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired events. I term these ‘human technologies’ in that, within these assemblages, it is human capacities that are to be understood and acted upon by technical means. A technology of government, then, is an assemblage of forms of practical knowledge, with modes of perception, practices of calculation, vocabularies, types of authority, forms of judgement, architectural forms... and so forth, traversed and transected by aspirations to achieve certain outcomes in terms of the conduct of the governed. (p. 52)

Rose (1999) further relates governing to freedom of choice, stating that the value of freedom has become the principle of many political dreams and projects during the past decades. Ethics of freedom have come to underpin conceptions of how everyday life should be organised and how we should be ruled. Rose (1999) notes the paradox of being governed by freedom, because freedom almost by definition could be understood as the antithesis of government:

Freedom is understood in terms of the act of liberation from bondage of slavery, the condition of existence in liberty, the right of the individual to act in any desired way without restraint, the power to do as one likes. The politics of our present, to the extent that is defined and delimited by the values of liberalism, is structured by the opposition between freedom and government. (p. 62)

A political rationale and strategy implies that freedom can no longer simply be understood as an abstract ideal, but as material, technical, practical, and governmental. Rose (1999) thus distinguishes freedom as a formula of resistance from freedom as a formula of power, where freedom as realised in certain ways implies exercising autonomous individuals through their freedom as “advanced liberal”. Freedom in this context concerns the individual’s autonomy and capacity to establish one’s desired identity and to fulfil one’s potential through acts of choice. Persons that previously were to be governed are now considered as active citizens making choices in order to further their own interests. They are thus potentially active in their own government.

Rose (1996) considers the implementation of quasi-markets to be a way for authorities to gain control over economic situations where the constructed markets work as a reconfiguration of the power of the state. The phenomenon is called “governing at a distance” and implies that the state directs individuals and organizations toward political objectives through the instrumentalisation of regulated autonomy.

Client choice among service providers, purchaser-provider models, privatisation, and a focus on increased effectiveness and efficiency are placed by Vedung (2010) in a “neo-liberal wave”, where the idea of New Public
Management harbours a cluster of ideas drawn from administrative practices in the private sector and put to work in the public sector.

Figure 2. Basic elements of New Public Management according to Vedung

(Vedung, 2010, p. 271)

Vedung (2010) argues that New Public Management contains three major elements. In the first element that concerns a belief in leadership, there is a focus on increased effectiveness and efficiency. The second element involves increased use of indirect instead of direct control. Privatisation and purchaser-provider models are examples of this element. The third element concerns a customer focus where client rights and service vouchers appear among other issues.
Materials and methods
The research project and my part in it

This thesis is positioned in the social science context, specifically in the research field of social work. However, the thesis originated in an interdisciplinary research project. Three professors representing three complementary research fields have been involved in and enriched the project: Mona Eklund (project leader), professor in occupational therapy, Urban Markström, professor in social work, and Mikael Sandlund, professor in clinical psychiatry.

To enter a research project that has already been planned in broad terms provides both pros and cons. Advantages in this case have been that I have had the opportunity to work closely along with renowned and respected researchers and to learn about their way of thinking about and conducting research. They have generously shared their craftsmanship, and I have learned a lot. When entering a project, it is impossible to know how the relationships between persons taking part in the project will develop. Because there was an enabling and creative atmosphere in this group, a close cooperation continued throughout the writing of the thesis.

The disadvantage in a situation like this is that the degree of independence of the doctoral student is not as apparent to the same extent as when the doctoral student writes articles by him or herself. On the whole, I am convinced that the co-authorship has resulted in synergies and that the teamwork has meant that I have developed a level of craftsmanship that I would never have achieved otherwise. Moreover, being part of the research project has meant that during my doctoral studies I have been in contact with other networks and researchers that have contributed to my learning and writing process.

Hopefully my contribution appears in the frame story and by acting as the first author on the articles. I was given the responsibility to compile the interview material included in the articles, and even for the interviews that I did not conduct myself I have read the transcripts several times. I have searched for and evaluated documents associated with the freedom of choice implementation process, and I have read the government commissions and legislative texts in depth. I took part in the data collection for articles I, II, and IV. Because I have been in charge of propelling the writing process throughout the writing of the four articles, I have had a high degree of freedom to influence the articles regarding content as well as design and analytical methods. During
the work, I have proposed theoretical frameworks and have been suggested additional theoretical frameworks of relevance in each specific study.

My co-authors on the papers have been supportive during my whole doctoral work, initially to a larger degree and in the later stage to a lesser extent.

A crucial methodological issue I would like to emphasise regarding co-authorship concerns the opportunity for triangulation. Without the cooperation among the authors, who were situated in separated scientific fields, the triangulation procedures would not have been possible. Although, or perhaps because, there has been an enabling and creative atmosphere during the analysis process, different interpretations of the same data material have been criticised, scrutinised, and discussed.

Table 1. Division of labour within the project.

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Planning</th>
<th>Collecting data</th>
<th>Analysis work</th>
<th>Authorship</th>
</tr>
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<tbody>
<tr>
<td>Mona Eklund</td>
<td>The main features</td>
<td></td>
<td>Articles I–III</td>
<td>Co-author Articles I–III</td>
</tr>
<tr>
<td>Urban Markström</td>
<td>Articles I–IV</td>
<td>Articles I–II</td>
<td>Articles I–IV</td>
<td>Co-author Articles I–IV</td>
</tr>
<tr>
<td>Mikael Sandlund</td>
<td>Articles I, II</td>
<td></td>
<td>Articles I–III</td>
<td>Co-author Articles I–III</td>
</tr>
<tr>
<td>Maria Fjellfeldt</td>
<td>Articles I–IV</td>
<td>Articles I, II, IV</td>
<td>Articles I–IV</td>
<td>First author Articles I–IV</td>
</tr>
<tr>
<td>Project assistants</td>
<td>Articles</td>
<td></td>
<td>Articles I–III</td>
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</tbody>
</table>

When writing the articles, authorship guidelines established by the Vancouver group in 1978 (later on the International Committee of Medical Journal Editors, ICMJE) have been applied. The following four criteria are recommended:

- *Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND*
- *Drafting the work or revising it critically for important intellectual content; AND*
• **Final approval of the version to be published; AND**

• **Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.**

(ICMJE, 2017, p. 2)

Further, the following additional issues described in the recommendations (ICMJE, 2017) have been followed: authors should be accountable for the parts of the work they have done, be able to identify which co-authors are responsible for specific other parts of the work, and have confidence in the integrity of the contributions of their co-authors.

**Methodological considerations**

According to Thornquist (2003), questions of an ontological and epistemological character constitute the basis for a person’s selection of research methodology and design. This means that general assumptions about the world determine what kinds of research questions a person poses, and general assumptions about how knowledge can be obtained determine how a study will be set up and carried out.

My research methodology and design is rooted in my ontological assumption that individuals involved in a course of events are both “knowledge owners” and “knowledge carriers”. The implementation process studied in this thesis consists of opinions, decisions, agreements, and experiences among persons involved and affected by the reform, and thus it involves political decisions and agreements on a national and local level, decisions and arrangements by local officials, and decisions and experiences of both professionals and participants in the mental health service system. I assumed that the answers to the research questions were to be found among these stakeholders’ narratives, along with political documents and other data material associated with the reform because these are created by the stakeholders involved. An additional ontological assumption is that a process is experienced differently by different persons. Thus, various perspectives were needed to allow a multi-dimensional understanding of the implementation process to emerge.

I used a naturalistic research approach to answer my posed questions because my basic epistemological assumption is that an appropriate way to explore the world is to “get out and observe the field” (Silverman, 2011, p. 23). When using a naturalistic research approach, interviews and observations are preferred. Accordingly, to describe and analyse the implementation of a freedom of choice system within community mental health services from a participant,
professional, and policy perspective, I needed to find a geographical area where a freedom of choice system was to be implemented, meet and interview the persons involved, and collect documents associated with the reform and its implementation process.

My view on knowledge meant that I assigned a large degree of credibility to the actors involved, and I allowed the informants’ statements and interpretations to prevail during the research process. This meant that I valued meeting informants face to face, conducting interviews, and having the opportunity to visit the informants in their particular context within the implementation process. I believe that the experience of context makes the informants’ narratives more meaningful during the data analysis. Within the research project, it was decided that the most ethical approach was to let the project assistants who had initiated and conducted interviews with participants also perform the repeated interviews so as not to interrupt the continuity and trust that had been developed. A way to enable my contextual understanding when taking part in the participants’ narratives was to spend time and talk to persons face to face at the four Day centre services where the participants involved in the study attended. I joined meals, participated in music sessions, played games, drank tea, and “hung out” with the participants. This meant that I developed a better understanding of the participants involved in the larger research project of which this thesis is a part and the context in which the previously conducted participant interviews were carried out.

I believe that the interviewer’s experience of the person being interviewed enriches the informant’s statements and gives their words a more profound meaning. In relation to Leder’s (1990) acknowledgement of the human body, problematising the distinction between body and mind, I consider that the researcher’s own experience of the informant and the informant’s context should not be overlooked:

*Human experience is incarnated. I receive the surrounding world through my eyes, my ears, my hands … Relations with others are based upon our mutuality of gaze and touch, our speech, our resonance of feeling and perspective.* (p.1)

Leder (1990) encourages the affirmation of bodily experiences, and I believe that this approach also works for enriching a research process. My research approach accordingly differs from, for instance, a deep-hermeneutical approach as described by Thornquist (2003), where a text is understood as being its own object that goes beyond the author’s intentions and is detached from its author and context. My approach, however, goes in line with the generally accepted epistemological position (Thornquist, 2003) that
knowledge is always a result from the interaction between the perceiving subject and the acknowledged object, which means that the interpersonal consciousness has a constituent function in relation to the knowledge obtained. This means that even though I sought to let the informants’ interpretations prevail during the analysis, I also had to acknowledge my own role in the knowledge-seeking process in both interview situations and in the analyses of the collected material.

Overall research design – a case study

In order to be able to describe and analyse the implementation of choice systems in community mental health services, a longitudinal case study was set up where the course of events was followed over time (Yin, 2014). Case studies are suggested as appropriate when investigating a contemporary event where the researcher has little or no control over the process. By setting up a case study, the phenomenon can be investigated in depth and within its real-world context. Nuances and contrasts can be captured, and different voices heard. The time aspect makes it possible to obtain multifaceted knowledge and to gain a better understanding of the developmental processes that are at work. Thus for this thesis data were gathered before, during, and after the establishment of the freedom of choice reform in Swedish community mental health services.

Case study methodology is based on the use of a variety of sources (Yin, 2014). To obtain comprehensive data, agents at three different levels of the organisation were interviewed. At the structural macro level, government policy makers and senior managers were interviewed, and legislative and policy documents were collected. At the organizational meso level, professionals such as first-line managers, Day centre service staff, and representatives from Day centre service providers were interviewed, and the homepages representing the Day centre service providers were collected. At the individual micro level the participants who were attending Day centre services were interviewed. Different research methods were used as well. Semi-structured interviews were conducted with individuals, pairs, and groups of individuals. Document studies were also used. On the whole, the study design encouraged the exploration of experiences rather than the evaluation of effects.

The context of the study

In 2009, one year before Stockholm was about to implement a freedom of choice system in practice, a small research group initiated a research project there. The municipality was selected based on its size, which was assumed to
be large enough to offer nuances and variation, and it’s high aspirations regarding the implementation of choice systems.

Stockholm, the selected municipality had at the time 900,000 inhabitants and consisted of 14 city districts. A number of districts were strategically selected for the study based on their socioeconomic structure and geographical location. The community mental health service in which choice was about to be implemented was Day centre services.

Swedish mental health services are organised into inpatient and outpatient health care at specialist hospitals. Since 1995, these have been complemented by community mental health services located in the community and provided by each municipality. Day centre services, along with supported housing, represent a large part of the Swedish community mental health services. Day centre services aim to support people with psychiatric disabilities in their everyday life and are a common way for municipalities to comply with the Swedish Social Service Act (2001:453):

5 Chapter 7 § The social welfare committee shall endeavour to ensure that persons who, for physical, mental or other reasons, encounter difficulties in their everyday lives are enabled to participate in the life of the community and to live like others... The Social Welfare Board should assist the individual in securing a meaningful occupation. (Translation: Rosenberg, 2009, p. 20)

The Swedish Social Service Act (2001:453) is a rights legislation based on needs. This means that the participants in this study had a need for everyday life support as provided by the services. Participants are often advised to attain Day centre services as a complement to their medical care by their contacts in psychiatric health care.

When the study was conducted, a total of 970 persons attended community mental health Day centre services based on a professional assessment of their needs in Stockholm (Stockholms stad, 2012). Additionally, a number of persons attended social-oriented drop-in day centres where no professional assessment was needed. A report concerning Day centre services in the studied area (Saario, 2010) found that half of the target group did not attend the services provided, and the report concluded that there was a need for a wider range of activities to attract users.

Day centre services, sheltered workshops, and Individual Placement and Support (IPS) (Drake, Bond, & Becker, 2012) are interventions suggested by experts when sorting out components of modern mental health services (Thornicroft & Tansella, 2004). According to Lehtinen, Katschnig, Kovess-Masfety and Goldberg (2007), Day centres, clubs, and the like constitute...
psychological interventions aiming to structure daily life, including contact opportunities for individuals who would otherwise remain inactive. The services can also aim to increase employability, for example, through the IPS model, which means the participant is placed in a position within the regular labour market but gets relevant and individualised support to manage the work. The model advocates a “place then train” approach in contrast to the traditional “train then place” approach (Drake, Bond & Becker 2012).

Although Day centre services have often been vaguely defined in terms of the content of the services they provide, they are in most cases found to be highly valued by those who use them. Participants consider them as preventing relapse and promoting independence, and the services have been seen as helping participants to survive everyday life by facilitating problem solving at a very practical level (Bryant, 2011; Bryant, Craik, & McKay, 2005; Bryant, Craik, & McKay, 2004). There is an on-going debate over the settings in which Day centre services are provided. On one side are arguments claiming that Day centre services should be community-based and individualised and should promote social inclusion and a recovery approach where participants are exposed to the wider community (Lingwood, 2005). On the other side are arguments claiming that Day centre services should be building-based services offering shelter and safe spaces where peer support is a vital element (Bryant, Tibbs, & Clark, 2011).

Activities offered at Swedish Day centre services represent a wide range, from socially oriented activities such as reading a newspaper or playing games to more structured activities where participants often have specified schedules, individualised plans, and personal objectives, including making handicrafts, gardening, or working in a café (Tjörnstrand, Bejerholm, & Eklund, 2011). When Day centre services were mentioned in participants’ own words in the studied municipality, the following experiences were described:

_There’s a very strong fellowship here, which I think is quite unique. You get a lot of support from both users and staff. Many say it is their second home. For me it has been more like my first home, actually._ (Participant 203, 2009)

_Without this activity, I would sit at home and stare at the wallpaper. And I would be very isolated. And sleep all day. My days would be empty, and I would find it hard to get out of the apartment._ (Participant 204, 2009)

Thanks to the willingness of the participants, professionals, managers, and policymakers to participate in the study, the research team was able to follow the implementation process on several different levels. A number of project assistants were engaged to collect data, and they were all well versed in Day centre services and had knowledge of the local context. The first interviews
were conducted in 2009, and I joined the research team in 2012. I was introduced to the context of the project by meeting several times with the persons who had collected the data. We conducted interviews together in 2012, and I spent time at Day centre services and met representatives from all categories of stakeholders who had been interviewed. I was given all of the data that had been collected that was relevant to this study, and I continued to collect data for three more years.

Table 2. Time table showing 1) Implementation process, 2) Year, 3) Data collected (A = documents, B = interviews with participants, C = interviews with professionals, D = interviews with managers and policy makers, E = interviews with providers entering and exiting the market, F = services homepages)

<table>
<thead>
<tr>
<th>1</th>
<th>Initiatives to increase choice in the municipal budget</th>
<th>The City Council decided on increased choice</th>
<th>Act on Freedom of Choice Systems (2008: 962)</th>
<th>Choice established only for public providers</th>
<th>Non-public providers included</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A</td>
<td>A</td>
<td>A B C D</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

One additional study (Eklund & Markström, 2015) was undertaken within the project during this time. It was a quantitative study focusing on the outcomes of the freedom of choice reform, and data were gathered between 2009 and 2012. The study showed that 54% of the participants involved in the study knew about the reform. Of these users, 55% stated that the reform meant nothing to them, 25% had a negative opinion of the reforms, and 20% had a positive opinion of the reforms. Satisfaction with the services decreased after 15 months, and empowerment decreased among a more intensively followed subgroup.

**Methods for data collection**

When conducting the study, semi-structured interviews were carried out face to face (Creswell, 2009). Interview guides with a focus on defined subject areas, but with a lot of room for flexibility concerning informants’ opportunity to respond, were used. The questions were open ended and without predetermined response options. Even though all interviews were semi-structured, interviews with professionals, senior managers and policy makers
were more structured than interviews with participants, who were given extended room for their own reflections so as not to lose any aspect of importance from the participant point of view.

During the data collection, both individual and group interviews were held. The different types of interviews provided different frames and different kinds of data (Kvale & Brinkmann, 2009). In this case, individual interviews were intended to give informants the opportunity to develop their answers and to take the time needed without being influenced or interrupted by others. In the group interviews, however, interactions and dynamics between individuals were utilised to facilitate more spontaneous expressions and perceptions (Ritchie & Lewis, 2003). The interviewer’s task was then to create an atmosphere that allowed informants to express personal opinions in a group interview setting. To explore participants’ experiences, individual interviews were conducted. Professionals were mostly interviewed in pairs or in groups. Some of the senior managers and policy makers were interviewed individually, others were interviewed in pairs or groups.

As a complement to the interviews, document analysis (Creswell, 2009) was conducted. Documents provide opportunities to explore the sources’ own language, vocabulary, and use of pictures, figures, etc. Documents related to the choice reform were intended to increase the understanding of the process as a whole. Physical artefacts considered as being relevant to the research questions were political policy documents at the municipal and city district level preceding the choice reform, city council management protocols, local reports of relevance, and national legislation concerning choice reforms. The electronic resource, which consisted of homepages where providers presented their Day centre services, was also included in the document analysis.

Methods of analysis

A number of methods were used to analyse the interview and document material collected in the study. Conventional content analysis inspired by Graneheim and Lundman (2004) is an inductive analysis method, and it allows for an open approach in relation to the material collected. The material is read several times to get an overall picture of the content. Meaning units are identified and sorted into clusters based on similarities and differences, and clusters are then given codes reflecting the overall key content.

This open and inductive method of analysing interview material has an almost tentative character. Therefore, it was complemented with additional analysis methods to develop the analysis further. Directed content analysis (Hsieh & Shannon, 2005) relates interview data to guiding concepts associated with the
field of interest, and this method allows both data and theory to be present in a parallel process in order to enrich the analysis. Conventional content analysis according to Hsieh and Shannon (2005) differs from Graneheim and Lundman (2004) in the sense that there is an ambition to not only read and sort out material with a non-evaluative approach, but also to interpret meanings when materials are read several times and then to sort the data into themes based on the document or interview content.

The articles: collection and conduction

Article I

Political documents on a municipal and city district level were collected, and stakeholders were selected at a municipal and a city district level. A key person who was involved in putting policy into practice at the city administration was asked to participate in the study, and agreed to do so. Additionally, representatives from the whole city’s non-public Day centre services that had entered the market were asked to participate, and all agreed to do so. Further, representatives from two city districts were strategically selected to capture similarities and variations in socio-economic structure and geographical location. District 1 was a suburban area and District 2 was an inner-city area. Policy makers, senior managers, first-line managers, and Day centre service personnel were asked to participate and agreed to do so. All respondents were given written and oral information about the study beforehand, and they all gave their consent to participate.

In total, 28 agents involved in the process were interviewed. Individual interviews were preferred with managers at different hierarchal levels of the organization based on the assumption that differences in managerial position would substantially influence the data if these respondents were interviewed jointly. Group interviews were conducted with respondents in similar positions to benefit from the dynamics between individuals (Ritchie & Lewis 2003). In total 25 semi-structured individual and group interviews were carried out. In the districts, interviews were conducted in 2009 when the system was still under construction and in 2012 when the system had been running for some time. The centrally positioned key person and the representatives for non-public Day centre services were interviewed in 2012. All interviews were conducted in person except for one that was conducted by telephone to facilitate the respondent’s participation. The interviews lasted between 60 and 120 minutes and were audiotaped and transcribed.

Directed content analysis (Hsieh & Shannon, 2005) was used to analyse the collected data. This analysis method allows both data and theory to be present
in a parallel process. The transcribed data were read several times to get an overall picture of the content. Triangulation in terms of multiple analyses (Ritchie & Lewis, 2003) was used when one psychiatrist and two social scientists read the data and performed the content analysis in which the categories were identified. The categorised data were sorted into themes using guiding concepts regarding market design and construction to enrich the analysis. The analysis was conducted by first reading printed sheets of text and then using the NVivo 10 software package.

**Article II**

Extensive interview material to address the research question posed in article I was collected in 2009 and 2012 from policy makers, managers, and professionals in two city districts that were strategically selected to capture similarities and variations in socio-economic structure and geographical location. The data contained relevant information not only about the structural frameworks for choice and the characteristics of the implemented market, but also about the local market implementation process from a pre- and post-implementation perspective. Relevant interview material that was not used in article I therefore constituted the empirical material analysed in article II. 18 interviews with a total of 20 stakeholders were included.

To analyse the data, conventional content analysis inspired by Graneheim and Lundman (2004) was used initially. The interviews were read several times to get an overall picture of the content. Meaning units were identified and sorted into clusters based on similarities and differences, and clusters were then given codes reflecting the overall key content. In the next stage, directed content analysis as described by Hsieh and Shannon (2005) was used. Data were related to theoretical concepts of relevance for the study, and triangulation in terms of multiple analyses (Ritchie & Lewis 2003) was used to validate the data.

**Table 3. Example of the various stages of analysis.**

<table>
<thead>
<tr>
<th>Conventional content analysis (Graneheim &amp; Lundman, 2004)</th>
<th>Directed content analysis (Hsieh &amp; Shannon, 2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning unit (Day centre staff 2)</td>
<td>Cluster</td>
</tr>
<tr>
<td>Everyone (providers) doubles themselves. They look at others and wonder, 'What do they have?' This makes everything turn out similar instead of a variety to choose from.</td>
<td>Decreased variety of supply</td>
</tr>
</tbody>
</table>
Article III

For the study, four out of the 14 city districts were selected on the basis of variation in geographical location and socioeconomic demography. Two districts were suburban districts where inhabitants had a lower average income, and two districts were inner-city areas where inhabitants had a higher average income. Information meetings were held at public Day centre services, and participants were free to decide whether they wanted to participate in the study or not.

Interviews were conducted on four different occasions in 2009, 2010, 2011, and 2012. In total, 35 unique individuals were interviewed and 46 interviews were conducted. Approximately half of the interviews were carried out before launching the reform, and the other half after the launching of the reform on 1 January 2010.

Table 4. Interviews conducted for the study.

<table>
<thead>
<tr>
<th>Year</th>
<th>Interviews before the reform</th>
<th>Interviews after the reform</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Interviews</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>24</td>
</tr>
</tbody>
</table>

Open-ended questions were used in a semi-structured way (Creswell, 2009), and participants were given space to talk about their own issues of importance related to the study. Principles of informed consent, voluntary participation, and confidentiality were emphasised. Individual interviews were carried out face to face in calm and private rooms at the Day centre service facilities. The interviews were recorded and transcribed verbatim.

An inductive approach was used throughout the analysis of the data. Interviews were read several times, and conventional content analysis was applied to interpret meanings (Hsieh & Shannon, 2005). When the material was sorted into themes based on the content, directed content analysis was applied (Hsieh & Shannon, 2005) and the data were related to guiding concepts associated with the field of interest in order to enrich the analysis. Data collected before and after the launching of the new system represented a basic division of the material. The identified themes, however, tended to recur in the interview material consistently throughout the four years. Multiple analysis (Ritchie & Lewis, 2003) was used. The NVivo 10 software package was used throughout the analysis.
A total survey of all providers and services within the market was conducted in 2012 and 2015 to explore the longitudinal development of the organisational field. Homepages where providers presented themselves were collected. In total 33 different providers were represented. Additionally, to explore the dynamics and professionalism appearing in the organisational field, data were collected through interviews with representatives for providers who entered and exited the market from 2011 to 2015. Nine providers entered, and all of their managers were contacted by mail or by phone. Eight of them chose to participate in the study. Three providers exited the market. Two of them were able to be contacted, and both managers chose to participate. One provider could not be contacted and was therefore not included in the study. One informant was interviewed twice because the provider represented an organisation that both entered and exited the market during the time period of data collection. Interviews were often held where the community mental health services were located and took between one and two hours. Interviews were conducted face-to-face, recorded digitally, and transcribed verbatim. Conventional content analysis (Hsieh & Shannon, 2005) was used, and triangulation was conducted by multiple analyses (Ritchie & Lewis, 2003).

Table 5. Material and methods used.

<table>
<thead>
<tr>
<th>Sample</th>
<th>All providers</th>
<th>Providers entering</th>
<th>Providers exiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop outs</td>
<td>33</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Material</td>
<td>33 homepages</td>
<td>8 interviews</td>
<td>2 interviews</td>
</tr>
</tbody>
</table>
Methodological discussion

*To approach a tensed field*

When I approached the matter of freedom of choice systems as an organisational structure of Swedish public welfare, I soon become aware that I had entered a tensed field that was the subject of lively political and public debate. The tension was also reflected in research within the field. My point of
departure, though, was from another side. In practical work years before I started my PhD studies, I had met persons with psychiatric disabilities. When freedom of choice for this group was in the news, I was very curious about what it might entail. My preference in approaching the research questions was a non-positioned point of departure. Initially I had, and tried to deliberately maintain, a non-positioned point of view. Throughout the study, effort was put on striving for an unprejudiced view despite exploring a political and personally emotionally engaging topic. The strategy used was to be aware of this matter and to maintain an open approach to the objects of study.

During the time period for the study, the dilemma of “the more you know the more you realise you do not know” appeared. Combined with the intense debate regarding freedom of choice in social welfare, this caused me to doubt the possibility of finding out anything at all in the study. Fortunately, the dilemma was dealt with in literature during one of my courses:

*It is not necessary to know everything in order to understand something.* (Geertz, 1973, p. 20)

Further, the writer concludes that the solution to the difficulties of research dilemmas is not to be discouraged and to try to avoid them, but to plunge into the midst of them.

**Objectivity, validation, and generalisation**

According to Bergström (1976), objectivity has been interpreted in several different ways in the social sciences, and according to him it is impossible to say something about objectivity until the term has been defined. Bergström (1976) means that it is important to distinguish between objectivity at different levels and in different dimensions. Objectivity can, for example, be divided into a micro level (individual researchers) and a macro level (an aggregated society of social science). He argues that individual researcher neutrality is, if it even exists, not the source of objectivity, but rather the result of institutional organised objectivity and that objectivity on a macro level is possible to reach because factors affecting individual researchers on a micro level can be neutralised at a macro level.

Regarding this study, when being surrounded by strong opinions and debate within society as a whole, these ideas about objectivity are useful. By presenting results at international scientific conferences and in peer-reviewed journals, the development of the final conclusions moves the question and responsibility of objectivity from the individual PhD student to the general social scientific society of the field. Of course, the supposed objectivity on a
macro level could also be criticised. However general the setting might seem, the scientific conclusions could always be considered by critics as taking place in a limited setting and as not general enough.

Objectivity is also of concern regarding the methods used. When using interviews as an instrument, one issue to take into consideration in this case was the ongoing polarised debate among the general public surrounding freedom of choice systems. Media images and public attitudes could affect the interviewers and informants in the interview situation. However, well thought out questions along with a permissive attitude and atmosphere in the room might facilitate honest answers being given. Although this is what I tried to obtain, it is difficult to know whether all informants dared to be honest or not. An arrangement to minimise the consequences of informants not feeling comfortable enough to give what they might have thought was an unexpected or unwanted answer was to interview a number of informants at the participant, professional, and policy levels.

Concerning dimensions of objectivity, I would like to mention impartiality as a relevant dimension for this study. In the scientific setting in which the study took place, there were no funders’ expectations following the project or influencing what results were supposed to appear. The absence of political or other stakeholders facilitated objectivity with regard to impartiality.

To address the quality of the study (Yin, 2014), several aspects were taken into consideration. The construct validity was addressed through the use of multiple sources of evidence, and stakeholders representing the participant, professional, management, and policy-maker views were used together with national, central, and local documents and homepages. A chain of evidence was established over the seven years during which the study took place, and information was organised and analysed over time. Key stakeholders were also asked to review parts of the findings during the process. This happened in 2012 and 2014, when the study had been running for some time, and preliminary findings could be presented and discussed. Participants, professionals, managers, and policy makers were active in this process, and their responses led to some adjustments being made. This method for validation has been both questioned and advocated. I chose to apply the validation method because I think it offers unique options for clarifying possible misunderstandings.

Triangulation in terms of multiple analysis (Ritchie & Lewis, 2003) was also used to validate the study. Other researchers were involved in the analyses in all four articles, and different persons read and analysed the data independently and then discussed the data together. Sometimes consensus
was achieved. Sometimes different interpretations of data could be displayed when the findings of the study were presented. Internal validity was also addressed when the analytical work was recurrently exposed to the scientific community in terms of the blinded peer-review process carried out by international journals during the publication process.

External validity, defining the domain to which the study’s findings could be generalised, was addressed through the use of established theories from each particular field of interest emerging during the study. The peer-review process mentioned above also ensured the external validity because reviewers were highly familiar with the field in focus and critically read the empirical findings and the conclusions that were drawn. Finally, reliability was addressed by a careful and transparent description of the procedures used and of the material gathered so that a later researcher could follow the same procedures as described and arrive at the same conclusions. Of course, personal perspectives, experiences, and skills among persons involved in the research team matter when performing the study. However, the findings and conclusions drawn should not fundamentally diverge when repeating the study.

Mayring (2007) argues there is a need for generalisation from qualitatively oriented research and that there is a broad range of possibilities to do so, and this means that the understanding of generalisation needs to be differentiated. The aspects that need to be addressed are the aims of generalisation and the procedures of generalisation. One aim among others is that:

Descriptive studies want to prepare the ground for generalizations in the sense of collecting specific observations as a basis for discovering similarities or rules. (p. 4)

This aim was applied in the present study. During the study it was attempted to obtain a “thick description” (Geertz, 1973) by trying to find out as much as possible about the present case. Mayring (2007) also addresses procedures of generalisation. Eleven pathways are presented, and one of them reflects how generalisation can be reached by triangulation:

Triangulation means the combination or integration of several studies to come to more secure and more general results. (p. 6)

In the present study, generalization could be understood as aimed for by a descriptive study preparing the groundwork for generalization and carried out by the the generalisation pathway of triangulation.

Moreover, Mayring (2007) addresses generalization from single case studies and claims that analyses based on single studies are not speaking for
themselves; they need generalization. One aspect of relevance in relation to this study concerns the possibility to come to general conclusions from a single case study based on the longitudinal structure of the material. A single case study could offer possibilities to identify time series and to analyse trends. Another aspect concerns how single case studies can also offer experimental designs, such as when making and analysing observations before and after an intervention. The present longitudinal, single case study had a naturalistic partly experimental design where interviews were conducted before and after the freedom of choice reform was established. Thus, based on Mayring’s (2007) arguments, generalization can and should be made from single case studies like the one presented here.

**Use of theory**

Concerning theory and the use of theory within this study, O’Brien (1993) offers an illustrative metaphor:

*...A kaleidoscope... (is a) child’s toy consisting of a tube, a number of lenses and fragments of translucent, coloured glass and plastic. When you turn the tube and look down the lens of the kaleidoscope the shapes and colours, visible at the bottom, change. As the tube is turned, different lenses come into play and the combinations of colour and shape shift from one pattern to another. In a similar way, we can see social theory as a sort of kaleidoscope – by shifting theoretical perspective the world under investigation also changes shape. (pp. 10-11)*

Several theoretical perspectives have been applied during the work with this thesis, and this has made it possible to see different patterns when interpreting the data. Because the study addresses a macro, meso, and micro perspective of the phenomenon, the use of specific theories in each area has been necessary. In addition, theories trying to address the case study as a whole have also been needed in order to create a multifaceted picture of the phenomenon in question.

I have been striving to select theories that enhance the understanding of interactions between individuals and society, including how policy formulation is related to individuals involved in the policy formulation process, how policy changes appear in practice, what kinds of structural conditions are related to the reform, how individuals are positioned in the structure, and how structural conditions associated with the reform affect professionals’ and participants’ everyday lives. The chosen theories were selected on the basis of facilitating the study of these dimensions while at the same time providing the possibility to address the phenomenon as a whole. The applied theories have made it possible to understand patterns in new ways.
and to discover new dimensions in the informants’ narratives, for example, the impact of implemented hierarchical structures.

Theories included in the study are theories that were ultimately selected on the basis of facilitating answers to the research questions. Other theories have been applied along the way but were dropped over time because they did not entirely match within the study as a whole. One example is discursive theory, which was considered initially but ultimately rejected.

**Limitations and strengths**

One limitation of the study’s design concerns the sample of Day centre service participants in article III. 22 out of 35 participants were recruited in 2009 when the reform was about to be implemented and all service providers were still publicly run. This meant that these participants had an experience of attending publicly run Day centre services and could relate to a time “prior to” the reform when talking about their experiences. An additional 13 participants were recruited in 2010, 2011, and 2012 and attended the same selected four Day centre services as the first 22 participants. A risk associated with the sampling is that a general resistance to change might have affected the collected data. Ideally, a study design that allowed for inclusion of persons who were about to start to attain a service provider, as well as participants attaining non-public services, should have been applied. In practice though, there were too many difficulties associated with how this might be arranged.

Further, it could be discussed whether the sampling of participants inferred that the findings of the study were possibly influenced by the specific persons who chose to participate in the study. Persons participating in the study were perhaps persons who seized the opportunity to talk about their experiences of the reform or persons who were searching for ways to influence the future of their services. Nevertheless, it must be seen as a strength that 35 individuals attending Day centre services in four different city districts participated, which likely makes the findings reasonably representative.

The selection of only two city districts to study the implementation process from an organisational and professional perspective in articles I and II could be discussed. Additional city districts could have offered even more knowledge. However, similar patterns appearing in both city districts regardless of differences in socioeconomic and geographical variation meant that the two city districts were assessed as offering enough data to understand the issue from an organisational perspective.
My ontological and epistemological positions entailed both advantages and disadvantages. Some of the advantages were that the positions allowed for methods that provided an emerging multi-dimensional understanding and that knowledge that helped answer the research questions was found. One of the disadvantages was that one important perspective fizzled out at an early stage, namely the politicians’ perspective. At the interviews carried out after the launch of the reform, the politicians interviewed prior to the reform were unable to participate again for different reasons. I initially tried to find politicians to replace the first ones, but failed. In retrospect, I should have put even more effort into finding those stakeholders so as not to lose a perspective of relevance. This meant that I was not able to follow up on local political engagements after the implementation of the reform. However, one reason that politicians dropped out as informants could be that they considered the reform as launched and that there were now other more urgent questions to address.

The study design’s key strength is, in my opinion, that the methods used have enabled the study of a complex contemporary phenomenon close up from a variety of perspectives. Agents representing almost all positions of importance in relation to the implementation of the reform were represented, and the longitudinal approach allowed for critical moments over time to be captured and explored. Retrospectively, I would have changed some details to improve the study, as indicated above. However, I would make no changes to the case study design.

**Ethical considerations**

In the study’s various stages, different aspects of ethical considerations arose. Initially, the study was assessed and approved by the Ethical Review Board in Lund (2009/625). When the process proceeded, informed consent was taken into account (Swedish Research Council, 2011). All informants were given written and oral information about the study beforehand, and they all gave their consent to participate. They were all given contact information and told that they were able to withdraw their participation in the study at any time without further explanation. Day centre service participants were informed that participation in the study did not have any impact on their access to Day centre services, and their participation in the study was confidential. Day centre service personnel did not know about participants’ participation in the study.

The anonymisation process started when the interviews were conducted (Swedish Research Council, 2011). Because the case study design allowed for political documents and service providers’ homepages to be a part of the data
set, anonymisation in terms of in which city the study took place was not possible. The level of anonymisation increased with where in the organisational structure the informant was positioned. The key informant at the central city level was hard to totally de-identify. Therefore, a discussion about the possibility that someone might identify the informant on the basis of the specific position in the organisation preceded the interview. The informant chose to participate anyway and was asked to review and confirm the findings from the interview before the material was used. Service providers entering and exiting the market might be identified because their public homepages are open for anyone to visit. In the interview material, service providers were given numbers to allow anonymity. To a person in the vicinity of the informant, though, a total de-identifying could not be obtained because informants could be associated with the public homepages. Professionals, policy makers, and managers belonging to the two selected city districts were assigned numbers that facilitated the elimination of the connection between the informants and the data. Day centre service participants were also given numbers, implying that the connection between the names of the informants and the data was eliminated. Because participants came from four different city districts, anonymisation was not a problem among this group.
Main findings

In this section, the main findings from articles I, II, III, and IV are presented in a coherent text. Results related to the four articles are indicted by (I), (II), (III), and (IV), respectively. For further reading and context, I refer to the original articles.

Development of the quasi-market

According to an interview with a policy maker (I), participants’ access to Day centre services differed significantly between city districts prior to the choice reform. However, the choice reform meant that participants in all city districts could choose between all authorised providers within the city. An economic compensation accompanied each individual using the services, and providers were to deliver their services using that money. The new model meant that participants had to apply for attendance through a public assessor – a social worker who assessed each participant’s needs. Participants assessed as being in need for the service were approved a certain number of attendance time-units a week. One time-unit consisted of three hours. Professionals and first-line managers (II) experienced a top-down (Hill & Hupe, 2009) implementation process where the degree of perceived involvement in the process decreased with each level of the organizational hierarchy.

The quasi-market initially consisted of the 23 public-run providers that were automatically transferred from the previous organizational model to the new quasi-market model. In 2011, the market was opened up and non-public providers could enter. According to providers’ homepages (IV), two public providers exited the quasi-market and nine non-public providers entered the market during the first six years of the reform. One of the non-public providers also exited the market during this time period. According to policy makers and first-line managers (I, IV), user-led organisations were prevented from entering the market because they could not meet the entry criteria of management and staff qualifications and financial stability.

Services could, according to the providers’ homepages (IV) in 2012, be characterised as safe spaces in building-based settings (Bryant et al., 2011) that were to some extent complemented with exposed locations offering services in the form of on-the-job settings.
Picture 1. A Day centre service offering a building-based safe space where community, structure, continuity, safety, and personal flexibility are important elements.

In 2015, most providers were still safe places within building-based contexts. However, there was a trend among providers to use a job-oriented vocabulary. IPS (Drake et al., 2012) was a model that was gaining ground during the reform implementation, and IPS was considered as having a high level of evidence based on randomised control trials.

Picture 2. A Day centre service aiming to prepare participants for future paid employments. Flexibility for personal needs is also a part of the presentation.

(Photo: Andrea Björsell)
When interviewing representatives of entering providers (IV), a variety of starting points, perspectives, backgrounds, and corporative forms were found. A common element, though, was a strong personal commitment. For example:

_The firm was established after my son developed a psychosis. I discovered that resources were completely absent in the community to support young adults to get back to work or studies._ (Provider 7, Article IV)

The strong commitment to the individual shown in this study raises the suggestion of nuancing Evetts’ (2009) typology of organisational professionalism and occupational professionalism with a yet another kind of professionalism that could be called _idealistic professionalism_. Elements from both occupational professionalism and organisational professionalism were combined, while a recurring theme was a personal commitment that went beyond the trust and relationships as described in occupational professionalism. The commitment was applied not only at a person-to-person level, but also in favour of the structural level when making personal sacrifices such as their own financial situation or their position within the company.

**Dimensions and degrees of freedom of choice**

Based on interviews with policy makers and managers (I), professionals (II), and participants (III), freedom of choice within the system could be summed up in one “freedom to” statement: participants were free to choose between all public and non-public providers within the market. This implies that the choice aspect of _where_ could be considered to have been implemented.

The most important dimension of choice expressed by participants (III), though, was the choice dimension of _who_ should deliver the service:

_Now that they have removed my mentor it feels hard. So... you become somewhat powerless, when you cannot influence._ (Participant 210, 2009, Article III)

It was found during the interviews with the participants (III) that they had no influence on staffing. Another aspect of choice concerned _how much time_ to spend at the services. During interviews with participants (III), Day centre service personnel (II), and policy makers and managers (I), it was described how participants previously were admitted to Day centres services on a monthly basis. They could decide themselves how many hours a week to attend depending on their health. In the new system, specific time-units were introduced, and each participant was approved a specific number of time-units per week. The public assessor who made the time-unit decision became a first-line gatekeeper. Data showed (II) that public assessors in some districts were instructed to approve only a limited amount of time-units regardless of
the person’s needs due to the local economic situation. One participant (III) described how the time-units had affected their life:

Regarding the choice reform, I suddenly had half the activity time approved. ... I am a slow starter and have difficulties getting started, so adapting to the new routines was very very difficult for me. (Participant 509, 2012, Article III)

When relating stakeholders’ experiences (I, II, III) to Le Grand’s (2007) dimensions of choice that should be addressed in a market model implemented in the public welfare context, on a macro level the choice dimension of where could be considered to have been implemented. At a micro level however, the degree of achieved freedom of choice could be discussed. The choice aspects (Le Grand, 2007) emphasised by the participants (III) were by whom and how much, but these choice aspects were beyond the participants’ power to choose.

A number of restrictions were associated with freedom of choice according to interviews with professionals (I, II), policy makers (I), and managers (I, II). For instance, participants were restricted to choosing only among providers approved by the municipal authorities.

The degree of freedom of choice that was possible to achieve was understood by participants (III), professionals (I), policy makers (I), and managers (I) as depending on participants’ mobility. Participants were assumed to be able to manage to walk or use public transport to get to the chosen Day centre service (Stockholms stad 2008). In practice though, there was a variety in participants’ travel skills. Some participants possessed full capacity in terms of the personal finances and personal skills needed:

I have learned to use public transportation myself because I come here. I haven’t done that in many years. (Participant 203, 2010, Article III)

Others did not have the capacity to use public transport:

Users have very few opportunities to choose from. Many times it falls on trivial stuff, like they don’t have a bus ticket. (Day centre staff member, District 1, Article I)

Personal finances thus also affected the degree of freedom of choice. Yet another personal attribute noted by Day centre service personnel (I) concerned the time for consideration when choosing a new provider:

If you receive an offer of a place, you have to reply within three days. Then the person has seven days in which to begin ... It’s really hard for these people to decide whether to start or not, it may well take a month, and then you can’t do it even if you want to.
I think that will actually scare people away. (Day centre staff member, District 1, Article I)

Because restrictions and personal attributes affected freedom of choice, the question could be posed as to whether or not freedom of choice on a micro level was obtained by all participants.

Power related to structures and procedures

The document analysis (I) showed that one explicit intention with the reform was to increase participants’ power. However, documents (I) on a macro level showed that in practice participants who were organised in users’ organisations were overruled in the policy-making process. On a micro level, standardised procedures (Evetts, 2009) also affected participants’ power. The assessment procedure and use of time-units described above were mentioned by several stakeholders (I, II, III, IV). Another finding (IV) was that persons with severe mental illnesses were excluded from the services due to the assessment procedure:

There were persons that we thought were crystal clear to get support. Going in and out and not being able to sit still and all that, that’s the side effects of their medication. If you are psychotic, then you walk around doing things. But then you get no decision. Because they never kept quiet and worked. (Provider 1, Article IV)

According to interviews with policy makers, managers, and professionals (I), participants who were displeased with their decision were encouraged to appeal their assessment decisions in court. The professionals (I) reported how the participants often did not have the energy and strength to start the appeals process. The professionals (I) also described how they did not want to encourage participants to appeal because they knew that the participants would never win their appeals.

Another example of decreased professional (I) and participant (III) power due to standardisation within the model was the heavy administrative load that came with the new system:

We administer much more now, everything is about money, and you have to document everything. It is more important who’s here and who’s not here ... The more administrative work I do, the less I am able to work with the participants. And that worries me. (Day centre staff member, District 2, Article I)

The administrative burden meant less time to interact with participants, which could be understood as a shift in focus from the participant level to the organizational level, a shift within the structure that moves focus in the organisation towards caretakers and away from those for whom they care
(Dowse, 2009). This was illustrated by statements from participants (III) about how professionals were trapped in their offices because of administrative loads. The atmosphere at the services was experienced as being negatively affected:

*People get annoyed. The staff has a tremendous amount of administrative tasks to do, and they become more or less forced to lock themselves in their offices. Then the users rush around trying to find staff. This leads to irritation and a bad atmosphere at the Day centre.* (Participant 314, 2012, Article III)

Participants (III) described how they felt that they had less influence after the launch of the reform than before. An increased sense of powerlessness was found, and participants felt that they simply had to accept the current situation. They felt that after the reform they were provided with more information but had not gained more influence.

Another aspect of power relationships in the hierarchical structure was highlighted by a manager at one of the public Day centre services that closed down:

*It is much more difficult to protest because everything is already set up. I cannot say that my boss and my boss’s boss are persons who just ride roughshod over someone. What happens is a small tilting. Administering something that one might actually dislike, but you do it anyway, we know the world history of that, so I think it’s terrible.* (Provider 9, Article IV)

Concerns were raised about how the new structure might influence individual decisions and actions.

**Aspects of quality**

According to participants (III), the Day centre service activities brought quality to their everyday lives in several ways. This was described prior to the reform as well as during the implementation process. Interviews with participants (III) and professionals (II) revealed that the activities provided and the relationships between participants and professionals were considered important:

*I had so many voices in my head that I could not sit by the sewing machine. Because I was so good at sewing I could do it automatically, and because I did not have to focus on the sewing I had nothing to distract me from the voices. I could not iron because it was too difficult, then the voices took over. But I noticed when I started working with wood ... I got like a little break, a respite from these voices ... When I feel that things are too difficult or if I feel pain in my chest, then I can go down to the carpentry room and I get a little space to breathe. And it has all been with my supervisor’s support.* (Participant 210, 2009, Article III)
When relating these experiences to Campbell, Roland, and Buetow’s (2000) conceptualization of quality as the two principal dimensions of access and effectiveness, the findings suggest that access could be understood as access to a preferred activity and to preferred staff.

Interviews (III) also revealed other aspects of access and effectiveness, but in a more negative tone. Something described as early as 2009 and 2010 was that units were merged together, which meant that the remaining Day centre services became more crowded. This was not a consequence of the choice reform, but took place at the same time as the reform was implemented. Participants (III) further described how the opening hours and staffing levels at the Day centre services had gradually decreased. Detailed regulations associated with the time-unit model also affected activities so that they became much more structured:

*It has become so rigid and scheduled ... earlier it was totally free. It was enough that you had your approved hours, and then you could move freely, and there was always room for people.*  
(Participant 302, 2010, Article III)

These experiences were shared by professionals (II) who experienced that fixed time-units were disadvantageous for the participants:

*I think it’s hard to push someone, like, “You have to attend Monday morning due to your schedule”. If you miss it, I think you should be able to come another day. But now, if you have a morning scheduled you have to show up at that time. Before, it was a little freer.* (Day centre staff member, District 2, Article II)

Based on these findings, it could be suggested that both effectiveness and access decreased (Campbell, Roland, and Buetow, 2000). These effects came about even though one of the main policy objectives (I) of the reform was to increase quality. Which aspects of quality the reform was intended to address, however, were not specifically spelled out.

**Competitive mechanisms**

One intention with the reform found in policy documents (I) was that the competitive market model should contribute to increased variety of services to choose from because providers were supposed to compete with each other for customers. However, professionals at public providers (I) described how providers within the market became more similar than specialised:

*Now all providers are competing with each other. And then you start thinking that all places must contain everything. Everyone doubles themselves. Looks at others and wonders, ‘What do they have?’ This makes everything turn out similar instead of a variety to choose from.*  
(Day centre staff member, District 2, Article I)
This mimetic isomorphism (DiMaggio & Powell 1983) where providers imitated each other contradicted the reform’s intentions. Additionally, interviews with entering providers (IV) showed that the mentality seemed to be to complement each other rather than to compete with each other. Professionals (I, IV) helped participants to find meaningful activities and had the participants’ best interests at heart:

*What is so very exciting in a system like this is that you want to bring in competition, but in practice another logic prevails. You want the best for the participant, so you don’t mess with other providers in order to succeed.* (Provider 6, Article IV)

When writing about making quasi-markets work in practice, Le Grand (2009) emphasises that there must be a true competition of providers – otherwise the individuals’ choices will not make any difference.

The results of the studies presented here showed a lack of competitive environment on the organisational level. However, competitive mechanisms caused consequences on the individual micro level. Prior to the reform, professionals (II), managers (II) and policy makers (II) expressed enthusiasm about participants’ upcoming freedom of choice. To participants (III), though, the implementation process caused a substantial amount of worry. The competitive model was experienced as unpredictable with a lack of continuity. The competitive model, which according to policy documents (II) should provide participants with power and influence, on the contrary caused the interviewed participants (III) uncertainty and substantial concern for the future:

*That’s something we’re all thinking about. We worry they will close down. There have been two options I’ve heard. And it is either to close down or to move to a smaller place that costs less money.* (Participant 204, 2009, Article III)

*You feel like you’re going to die when you hear that it is possible that they will close down the Day centre. Where will you go?* (Participant 202, 2009, Article III)

For some participants, anxiety associated with cutbacks and changes turned into new symptoms:

*It takes a lot of energy. I have nightmares.* (Participant 201, 2009, Article III)

*I stress out and get a headache. I am more sensitive to sounds. I get sort of a whissing in my ears even though I am in a nearly silent room. Some people have found it really hard to understand these new things and have felt really bad and started to cry.* (Participant 311, 2010, Article III)

The concept of power expressed in the policy documents did not include the power for participants to decide to stay with their current service providers.
Therefore, long-term predictability was not possible for either the participants or professionals. This finding implies that the market rationale in terms of a competitive mechanism created a sense of powerlessness rather than a sense of power.

**Paradoxes understood as decoupling**

In a policy document preceding the reform (SOU 2008:15), four policy intentions expressed concerns about the benefits for participant in various ways. However, the only intention that could be found to be realised in practice, according to policy makers, managers, and professionals (I, II, IV) on an organisational level, was the intention of increased efficiency:

*This is very much about money. It's not really about how the participants are doing. It's about how much money there is. One suspects that the whole system is only about money. (Day centre staff member, District 2, Article II)*

The overall prevailing key concept of a “balanced budget” was mentioned and criticised several times by professionals and first-line managers (II). Interviews with entering providers (IV) showed that all new providers so far had made losses instead of profits. One public provider interviewed (IV) was forced to close down due to their financial situation. Entering providers dealt with the economic situation in different ways depending on their overall finances. These empirical findings could be understood as an informal structure where resource allocation and efficiency dominated the experiences.

In this context, another finding is of relevance. Policy makers who initiated the reform and senior managers who built the system raised concerns over participants’ abilities to make choices:

*You (the participant) could be degraded in your health by having the option to select and deselect. (Social service manager, District 2, Article II)*

Professionals and first-line managers never mentioned this issue, and this implies that a two-fold market purpose was reflected among professionals, first-line managers, senior managers, and policy makers (II). Professionals and first-line managers hoped for improvements mainly for the users as expressed in several policy documents whereas senior managers and policy makers mainly focused on the market model as a resource allocator as expressed in one policy document. The two-fold purpose of the market (Struyven & Steurs, 2005) led to different views among agents about the outcome of the reform.
On a micro level, intentions and realised intentions appeared in a similar way. A discrepancy was found between “participants in real life” as a character based on the collective interview data (III) and the “ideal participant” as a character based on the collective policy objectives expressed in national and local policy documents (III). “Real life participants” (III) expressed experiences of illnesses and anxiety that were divergent from the market model assumption of active and independent “ideal participants”. Several documents associated with the implementation of the freedom of choice system described the individual as an active consumer who contributes to the development of the organizational field (SOU 2008:15, Stockholm 2008).

When contrasting the intentions of the reform and the empirical findings on both the meso (II) and micro level (III), the concept of “decoupling” (Meyer & Rowan 1977) makes sense. In the current case, policy intentions could be considered as a formal structure by which policy makers tried to maintain legitimacy in society. The intentions could justify the implementation if the reform were to be questioned, and the catch phrase used in the formal structure was “freedom of choice”. Meanwhile, the empirical findings (II, III, IV) can be understood as implying that an informal structure was developed that tried to maintain efficiency within the organization by conducting activities that were characterised by the key concept of a “balanced budget”. The association between the formal and informal structures was poor concerning the first four policy intentions. Only in the fifth intention could the association be considered strong. The relation between the first four policy intentions and the empirical findings might be understood as decoupled. Based on the empirical findings of the decoupling of the structures regarding the individual and the structures regarding the efficiency of the organization, the main function of the market in the studied case might be to act as an effective resource distributor (Brunsson & Hägg 1992).

An illustration of the decoupling was the closure of a public provider:

There are official documents related to this closure where it has not even been called closure, it’s been called a relocation ... well you do not close anything because the support continues: you buy it from other districts, but it is just a play on words, because the day centre has really been closed, staff have been dismissed, and the participants have had to get their support in other districts. I think it is a world of difference to say that the mental health services are not closed down, since the support continues, but it’s the provider as such that has closed down. (Provider 9, Article IV)

The informant also described how it had been obvious from the very beginning that the compensation system associated with the market could not possibly cover the costs.
Discussion

Here the findings of the four articles will be discussed and interpreted from various theoretical perspectives. The findings will also be put into the context of recent research in nearby scientific fields.

Participants and choice

Freedom obtained by the reform

Berlin (1969) argues that negative freedom is the area within which a person can act unobstructed by others. Regulations associated with the reform implied that the area within which participants were unobstructed by others decreased concerning the community mental health service area. This decrease in freedom was partly with regard to the aspect of participation time (I, II, III) and partly regarding the approval needed to participate at all (IV). Thus, in this case freedom in the negative sense, having freedom to act unobstructed by others, did not seem to increase through the implementation of the freedom of choice reform.

The other sense of freedom, which Berlin (1969) calls positive freedom, concerns:

The desire to be governed by myself, or at any rate to participate in the process by which my life is to be controlled. (p. 131)

This is a wish that one’s life and decisions depend on oneself, not on external forces of any kind. In light of Berlin’s (1969) conceptualisation of freedom, positive freedom, the desire to be governed by oneself and to be part of the process by which one’s life is controlled, could be understood as the objective of the reform. This positive sense of freedom is associated with personal governance. However, in the current case governance appeared in dual ways – the individual participant had the personal freedom to influence the choice of where (I, II, III) to go, but other aspects of importance, such as by whom and how much (I, II, III), were governed by the municipality, and participants felt that they had no influence regarding these issues. This caused disappointment and frustration. All together, only one aspect of freedom of choice in the positive sense (Berlin, 1969) was found to have been implemented. Regarding other aspects, freedom of choice in the positive sense had not increased as a result of the reform.

Berlin (1969) offers a further understanding of the reform studied here:
It was shown in the studied case (II, IV) that despite the catch phrase of individual freedom of choice, one of the main goals with the reform was to save money. This finding could be understood as if the social reformer propelled persons towards a goal that was visible to the reformer, but not visible to the persons affected by the reform. Especially professionals expressed themselves as if they were not aware of the economic goal prior to the reform (I). The results showed that participants (III) perceived the reform as including a hidden goal from the beginning, while professionals (II) initially hoped for the freedom of choice goal with all its positive consequences, and not until later found out about the money-saving goal. Perhaps the attitude to the reform in question says something about the history of psychiatry. Participants were not surprised by the reform and its consequences, but they expressed a lot of disappointment, anger, and sadness (III). Perhaps they historically have been treated in a way that makes them fear the worst and avoid high expectations.

**Product or process**

According to Fotaki (2009), the choices that are preferred in healthcare involve simple and insignificant issues such as appointment times. Concerning treatment choices, trustworthy relationships are important, and choice in this regard is not usually requested. The results in the studies for this thesis showed that user organisations opposed the implementation of choice as it was proposed prior to the reform (I). It was also shown that during the implementation process, individual participants were not pleased with choice as it was manifested (III). Instead, developing and maintaining relationships was valued to a greater extent than having freedom of choice (III, IV). These findings are in line with Fotakis’ (2009) claim that the provision of public services is not about acquiring products, but about providers and users jointly addressing essential social and human needs. The findings in this study (III, IV) showed the participants’ and professionals’ common endeavour was to facilitate everyday life for persons suffering from psychiatric disabilities, and this endeavour could be understood as a process based on mutual trust. Relationships were not based on an antagonistic approach between users as customers and providers as sellers. Conversely, the findings exemplified a co-production relationship (Fotaki, 2009) or “shared doctoring” (Mol, 2008) where service users and providers were partners in a continuing process of inquiry.
The findings of this study (III, IV) suggest that the community mental health service participants’ attitude towards choice could be understood as similar to that of healthcare users (Fotaki, 2009). In contrast to users of education, which perhaps could be more understood as a product, healthcare users, and as shown in this study, community mental health service participants, can be understood as being a part of a process where trustworthy relationships are of great importance.

An active being

The meaning of being “active” as a person has been scrutinised by both Berlin (1969) and Mol (2008). As Berlin (1969) puts it, freedom in the positive sense is associated with the wish to be an active being, as having responsibility for one’s own choices and being able to explain them by references to one’s own ideas and purposes. According to policy documents related to the freedom of choice system (I), participants were described as active beings contributing to the competition on the market when making their active choice between various service providers. Mol (2008), in contrast, understands choice systems as passive systems where individuals are active only once and then are part of a passive system. Mol (2008) argues that individuals could be considered as active beings only when the logic of care appears. Within the logic of care, the patient and the doctor are both active in the search for how to cure the body or how to find a way to live life as well as possible despite a chronic illness. Activity is not about one single choice, but about a common investigation. The freedom of choice system would, according to Mol (2008), be described as a passive system. According to Berlin (1969), being active and bearing responsibility for one’s own choices is associated with the possibility to be able to explain one’s own choices by references to one’s own ideas and purposes. On the basis of Berlin’s (1969) argument, a choice system could be considered as offering citizens the ability to be active in a positive freedom of choice sense. However, the findings among participants (III) in this study suggest that they were not perceiving themselves as active beings in relation to the freedom of choice system. Experiences of immediately being “hit” by the freedom of choice system, when suddenly having only half the activity time approved, could hardly be considered as an experience of being active, neither according to Berlin (1969) or to Mol (2008).

Logic of choice and logic of care

When relating the findings in this study with the theoretical distinction between the logic of choice versus the logic of care (Mol, 2008), several examples illustrate how the logic of choice could be understood as being present during the implementation process (I, II, III, IV). Both professionals
and participants expressed how the administrative load (I, III) due to the standardised organisational structure meant that professionals could spend less time together with participants in practice. This could be understood as one example of the logic of choice. Another example would be the aspects of value requested by the participants – to be able to choose by whom to be given the mental health support and to be able to choose how much time to participate in community mental health care (III). These requested factors could be understood as a request for a logic of care in which participants and professionals are co-producers (Fotaki, 2009) and are both actively contributing to the development of the individual’s support system.

Participants expressed how they experienced less influence over their own situation as a consequence of the freedom of choice system (III). First-line managers emphasised how the system prevented any forms of protest because everything was already set up, and there was no room left for discussion or for showing displeasure (IV). The logic in the system seemed to be that participants were forced to choose (I). Several participants wished to choose to stay where they already received support, but because of the new system in place the municipality could not promise that the participants’ desired providers would remain in the freedom of choice system. Participants had to accept the situation, and this caused physical and mental harm such as anxiety and headache (III). Thus the logic of choice could be understood as counterproductive in the community mental health care context just as it is in the healthcare context (Mol, 2008). Further, participants’ experiences such as illnesses and anxiety suggest that the community mental health care context should give space to fragility, which according to Mol (2008) is dismissed in the logic of choice but is present in the logic of care.

**Choice from an organizational point of view**

When trying to understand the “big picture”, micro-level knowledge allows for a macro-level understanding and analysis, according to Rose (1999) who claims that micro and macro power structures can be understood as coherent entities that are closely involved and related to each other.

**Freedom of choice as ideology or technology**

Theoretically, the choice model could be seen as including objectives on a micro and macro level (Rose, 1999). On the individual level, individuals should gain freedom of choice and power, both of which are considered to be positive outcomes for the individual. On the macro level, the state gets happy citizens who are in control of their own lives and it gets improved efficiency of government finances. But when understanding the process in practice, Rose
(1999) claims that to initiate governmental intentions and desires, the state has to rationalise itself through the use of technologies of government. In the present case, the freedom of choice ideology can be distinguished from the freedom of choice technology. These concepts represent two different dimensions of freedom. Freedom of choice as expressed in the studied policy documents represents the political ideology, while the system for freedom of choice studied through the experiences of the stakeholders involved in the process represents the technology of governance. The freedom of choice technology was initiated by the political freedom of choice ideology. However, in practice the technology did not show characteristics typical for ideology, and the two were divergent.

This phenomenon can be related to how Gingrich (2011) understands markets in the welfare state. Welfare markets are designed based on the policy makers’ long-term goals, and a market never emerges in a particular direction by accident. The right and left wing use markets for different purposes and therefore design markets in different ways according to their fundamentally different ideological objectives. According to Gingrich (2011), right-wing governance designs a market model to increase the power of the private sector, to decrease restrictions by the state, and to streamline the state. In this case, the experiences of the stakeholders involved in the reform implementation (I, II, III, IV) show that these intentions can be understood as underpinning the design of the market. Something notable in this case is how the findings (I, II, IV) revealed that a “right-wing market design” was implemented in a traditionally “left-wing public sector”. Professionals (I, II, and partly in IV) were accustomed to working in a public sector that had been designed by a left-wing governance many years earlier, and the findings showed (I, II) how persons involved in the reform had hoped for a “left-wing market design”, according to Gingrich (2011), aiming to give citizens more power, to secure and give legitimacy to the welfare state, and to challenge prevailing structures. The results showed how the same market means were understood to be used to achieve two different aims, the right-wing political governance setting and the traditional left-wing public organization setting. This could be an explanation for why the stakeholders involved, including the participants as well as professionals, policy-making officials, and managers (I, II, III, IV), to a large extent criticised the reform.

To be governed by freedom

Rose (1999) states that freedom as it is realised in certain ways implies exercising power over others and further claims that individuals are governed by power holders who utilise individuals who believe they are acting out of their “own will”. The freedom of choice technology, however, aims to achieve
power holders’ own objectives. In the present case, the participants (III) never asked for choice. Throughout the process, it was seen how participants, through user organisations (I), advised against and individually (III) suffered from the choice reform. Prior to and during the implementation process, the market model competition mechanism was expected to, and experienced as, causing harm due to the uncertainty and unpredictability inherent in the system. Of the agents involved, the participants were the ones expressing the most negative reaction to the reform. This finding makes sense when analysing power relations at a micro and macro level (Rose, 1999). To be “governed by freedom” is a paradox because freedom almost by definition could be understood as the antithesis of government (see the discussion of negative freedom in Berlin 1969).

On a macro level, the function of the market was found to increase the efficiency of services (II). Increased individual freedom of choice and individual power were not found to be addressed in practice (I, III). Professionals and first-line managers hoped for these outcomes prior to the reform, but were disappointed by the lack of freedom and power that was actually achieved among individuals (II). On a micro level, professionals, first-line managers, and participants all expressed how participants experienced a decrease in freedom and power due to the reform (I, II, III, IV), including less influence over how much time was allotted for services and when to attain such services, less time for professionals to engage in activities due to increased administrative loads, no influence over whether the Day centre service of choice should remain open or not, and no influence on staffing.

**Governing at a distance**

An important question is how the results might be further understood with regard to governing and the relation between the state and its citizens. Prior to the new model, the state provided community mental health services to its citizens. The citizens could be seen as passive agents, receiving services from the state (Figure 4). Within the new model, citizens have been redefined into active citizens who are autonomous and empowered to influence their own situation and wellbeing (Figure 5).
According to the findings of this study, however, another scenario could be described and understood in relation to Rose’s (1999) concept of advanced liberalism, and the reform could be understood as a strategy of governing autonomous individuals through their freedom of choice. Persons who were previously to be governed were now considered as active citizens making choices in order to further their own interests. Participants were thus potentially active in their own government. Rose (1999) means that the ideal “social state” gives way to the “enabling state”, and a transition appears where the state is no longer required to meet all of society’s needs for order, security, health, and productivity. According to the choice rationale, individuals, firms, organisations, and others must – as “partners” – take on a portion of the responsibility for their own well being. The municipality establishes the quasi-market and is still in power, but in a new way according to new hierarchical structures of authority and decision-making within the quasi-market.

The technology of governance was established through the implementation of the freedom of choice reform. Policy-makers, managers, professionals, and service providers experienced that the budget within the market was extremely tight and that new techniques of control were being introduced. The participants did not experience that they were empowered or had an increased ability to influence the aspects of their services that they felt were important.

The design of the system enabled the municipality and the city districts to control the community mental health system in a new and more detailed
manner by approving the number of time-units for each individual, determining which providers could enter the market, and defining the compensation within the system. This has given the municipality greater control over both the content and cost of the community mental health service system. Under the new system, attendance at Day centre services has become more structured and less flexible, especially when it comes to attendance time. The detailed system has also reduced the possibility for individualised solutions. Even if users seemingly had a choice, the municipality had already distinctly determined what it was possible to choose from (Figure 6).

Figure 6. Policy in practice on the basis of the experiences reported by the stakeholders involved: advanced liberalism.

![Diagram](image)

The municipality governs through freedom of choice

Service suppliers  Participants

Freedom of choice quasi-market

Something noticed in the study (I, II, III, IV) was how policy makers and managers and participants had no common spaces (Figure 7). Policy makers and senior managers commented on participants, and participants commented on policy makers and senior managers. But there was no communication between the two groups. Professionals (I, IV) met both “sides” on a daily basis and had to handle policy makers’ and senior managers’ demands while handling the participants’ frustrations. Professionals were torn between participants on the one hand and policy makers and senior managers on the other. In addition, it should be mentioned that Gingrich (2011) claims that the market model always decreases the power of the professionals involved. In this case, professionals also had to struggle with both the market structure and the participants’ worries. Perhaps the concept

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of idealistic professionalism, including the strong personal committed seen among entering providers (IV), explains what characteristics were needed to be a part of the market under such challenging conditions.

Figure 7. Illustration of stakeholders' positions.

With the findings from all of the articles at hand, the implementation of the choice model could be understood as a way to “govern at a distance” (Rose 1996). A way for authorities to gain control of the economic situation and to reconfigure the power of the state. The state has used the choice model and its instrumentalisation of regulated autonomy to direct individuals and organizations toward certain political objectives. This was illustrated by a concern expressed by a first-line manager who said:

_“I think there is a risk that these people won’t think there has been a change, that they have any freedom of choice. It’s just a name._ (Community mental health service manager, District 2, Article I)

The current findings seem to be in line with Swedish research conducted on freedom of choice systems and quasi-markets in public schools. There is no evidence suggesting that the reforms have been implemented in favour of the ones the reforms concern, be they pupils (Dovemark 2007; Norén 2003) or users of Day centre services for people with psychiatric disabilities.

International research on the implementation of quasi-markets and freedom of choice systems in caring for the disabled has so far shown that such systems have not been delivering on their promises. Instead of resulting in increased choice and improved efficiency in services, users report experiences of inadequate service supply, service cutbacks, and an increased emphasis on cost subsidisation and assessment processes (Spall et al., 2005).

**Ideas associated with the New Public Management umbrella**

Several of the findings from this study can be placed within the neo-liberal cluster of ideas ascribed to the New Public Management umbrella, where
organizational structures and models that contain elements from the private sector are applied in the public sector (Hood, 1991, 1995). Vedung (2010) presents a description of the New Public Management umbrella, and several ideas presented by Vedung (2010) could be traced among the findings in the present study.

Figure 8. Basic elements of New Public Management according to Vedung where elements found in this study are marked with yellow.

Vedung (2010) argues that New Public Management contains three major elements. The first concerns a belief in leadership. Within this element, the focus on increased effectiveness and efficiency was an idea that appeared in the study (I, II, III, IV) several times on multiple levels. The issue was highlighted among policymakers and managers as well as among professionals and participants.

The second element involves increased use of indirect instead of direct control. In the study, it was found that privatisation and outsourcing (I, IV) were two of the main ideas behind implementing the freedom of choice system. Privatisation was intended to increase diversity in services (I, IV).
purchaser–provider model was introduced (I), and providers were authorised by an administrative system through which the municipality controlled which providers could be contracted by participants (I).

The third element concerns a customer focus (I, II, III, IV). This was promoted as the very core of the system when it was introduced. The municipality sought to become a role-model and a world-class city with regard to personal choice for persons with disabilities (Stockholms stad, 2008). Client choice among providers was implemented, clients’ rights were focused on in policy documents, and a kind of service voucher system was developed.

Consistency and dissimilarities of the results presented here with recent research

Although Gingrich (2011) emphasises the uniqueness of each quasi-market, the similarities found between the quasi-market studied here and the quasi-market studying freedom of choice in Swedish public care of the elderly by Andersson (2013) are striking. The similarities concern the following issues:

- New time measurements were implemented when choice was introduced, but the time measure systems were not congruent with the financial systems in either of the studies.
- Hierarchical structures were implemented due to the market rationality associated with the freedom of choice system. In both studies, there were examples of how both workers and managers experienced powerlessness due to the hierarchical structures. Directives were experienced as undiscussable and as coming from above.
- Providers had economic difficulties because there were expenses associated with the services that were not included in the payments that accompanied the participants.
- The administrative burden increased in both studies, which meant less time for professionals to spend with service users.
- The municipality had adopted the ideas of marketisation and freedom of choice, claiming them to be in the best of interest of the service users.
- A political rhetoric without any anchoring in practice was described by Andersson (2013) as a dilemma when individual rights are emphasised rhetorically while rationalism and economic efficiency are the guiding principles in the daily work. Andersson (2013) claims that the vocabulary of dignity and influence are political constructions without any anchoring in the reality of care. Similarly, the vocabulary of individual choice and power in the present study could be understood as a political construction without any anchoring in the reality of community mental health services.
Another finding consistent with recent research concerns the neoliberal turn dominating the policy process (Andersson & Kvist, 2015). Similarities were also found related to recent research on choice in Swedish public welfare conducted in the context of home care services (Vamstad, 2016). In that study, as in the present study, the informants did not seem to value the choice of anonymous providers in itself, but valued the possibility of influencing the content of the services and of choosing the specific staff members to carry out the services.

Another recent study showing relevant similarities to this study concerns the finding that users’ perspectives tend to be ignored due to attempts to implement Evidence-Based Management (EBM) within the Swedish social welfare arena (Johansson, Denvall & Vedung, 2015). In the interpretation of “evidence”, users’ experiences have been excluded for being troublesome and as less valid than findings from randomised control trials, which are considered to be the gold standard for gaining knowledge. This result shows another ongoing and parallel phenomenon where the state intervenes in citizens’ lives and where policy documents and the implementation of practices diverge. The state intention is to promote increased citizens’ influence (SOU 2008:15) and a strengthened citizen role (SOU 2008:18). However, when empirically examined, the contrary appears, and citizens’ influence and strength as users of social welfare services have in various ways been decreased. Further, the results of Johansson et al. (2015) are relevant to the present study. The community mental health service field studied here seemed to develop following an EBM model according to the findings in article IV, showing a new tendency in the field where IPS, a method considered to be based on strong evidence, was an up and coming method among providers in the market. The results from Johansson et al. (2015) combined with the results from the present study could indicate the appearance of two trends in which there is a drawing back of users’ positions in a field at the same time as there is a government policy urging for users’ positions to be strengthened.

In this context, Knapp’s (2007) factors that are considered as limiting choice are of relevance. Extended national care standards are mentioned as narrowing the variety of options available, and conflicts might arise between increased standardisation of provision and the individualisation of service in response to individual users’ preferences. In this case, the national standardisation concerns the desire to implement an EBP in social services in general. This attempt might imply that users’ individual preferences will be reduced in the long run.

Similarities found between the present study and recent studies of the organisation of Swedish welfare services raise many questions. How is the
considerable gap between policy vocabulary and empirical results possible? What implications will this gap cause in the short and long term? How can the policy-based perception of strong citizens be understood in relation to empirical results showing that even professionals experience powerlessness due to the hierarchical structures?

There are reasons to take these results, which are consistently pointing in the same direction, into consideration when organising Swedish public welfare in the future. These are relevant questions to address in order to avoid negative consequences among both service users in different areas of welfare and the professionals providing such services.

Even if there are several similarities with previous research, there are also differences. One of the unique findings in this study, in relation to the above-mentioned studies, is that the character of providers is different than providers described in other studies. The community mental health service providers participating in this study represented a logic of care where a “participants first” discourse prevailed, and financial issues and dilemmas of time were solved by managers themselves at the expense of their own economic situation. These unique findings could be related to research on the Swedish market for residential care for children (Meagher et al., 2016). In that market’s first phase, small-scale family-owned non-profit organisations complemented publically owned facilities. The private owners were described as “insiders” coming from inside the system, and the same tendency was found in this case study.

The market for the residential care for children eventually developed into other phases (Meager et al., 2016). Phase two was characterised by medium-sized companies and professionalism, and the third phase involved large companies and re-regulation. Meager et al. (2016) show that the changes were driven on the one hand by policies inspired by New Public Management, which shifted public authority horizontally to the private sector and vertically to local authorities (funding) and to the state (regulation). On the other hand, there were the responses of local authorities and private actors to the changing incentives that the policy shifts entailed. Those findings, along with Andersson’s (2013) findings that providers tend to be large shareholders prioritizing profit rather than care, could offer an understanding of how Swedish quasi-markets tend to emerge. Hopefully, the findings of this and other recent studies show the importance of putting effort into designing new quasi-markets and reshaping existing quasi-markets for the benefit of the service users and the professionals who are providing such services.
Conclusions and implications

Autonomy in terms of personal choice and less paternalistic approaches has been requested within the mental health services (Knapp, 2007; Samele et al 2007, Slade 2009, Valsraj & Gardner 2007). Autonomy is also a core principle in freedom of choice systems that have been implemented in the social service sector. Rhetorically, ideas within the recovery framework and in the implementation of choice systems have aims and objectives that are expressed in similar words. The findings of this study, though, showed that in practice neither of the parallel tracks seemed to deliver on promises of autonomy and freedom of choice for community mental health service participants.

Based on the findings of this study, I would like to address four issues of importance when designing and implementing systems for freedom of choice in community mental health services.

It is important to ensure some kind of predictability and continuity in order to avoid unwanted harm to participants caused by the unpredictability and uncertainty inherent in competitive choice systems. In particular, continuity concerning the relationships between service users and professionals needs to be addressed.

Another important issue concerns sustainable financial premises accompanying the market. If service providers cannot manage financially within the system in the long term, the question must be posed of how the development of the market will proceed.

The third issue addresses the importance of performing an impact assessment of the administrative system associated with a choice model. Each step of the introduced administration standards might imply unwanted second and third-hand consequences for participants and providers and thus for society as a whole.

Finally, it is important prior to any reform to articulate and clarify any unspoken goals in order to prevent misunderstandings and loss of confidence between politicians, officials, managers, professionals, and participants.

These issues were found to be relevant in a community mental health service context, and they might also be relevant when quasi-markets are implemented in other social welfare contexts.
However, whether or not these issues are taken into consideration in the establishment of the market in practice is determined by the long-term political intentions preceding the market reform (Gingrich, 2011). If the intention of the market is efficiency of services at the individual’s expense, this will influence the design of the market. A strong top-down implementation without attention to the participants’ perspectives during the process as a whole, as was shown in this case, illustrates a conscious market design aiming primarily to limit the studied municipality’s public expenses.

Finding answers and relating them to other research results raises new questions. Some of these questions of course concern the development of this specific quasi-market, which has been a vital part of my everyday work for several years now: How will the reform with its associated restriction of attendance time affect participants’ mental health in the long run? For how long will it be possible to maintain the logic of care among new providers under such a strained financial situation? Will the quasi-market be re-regulated in other way or direction? In that case, where and how?

Another question raised concerns the aspect of gender. In Andersson (2013), the analysis shows that the service field in question for the choice reform was highly gendered. Similarities found in Andersson (2013) and in the present study, such as changes due to the market logic, including hierarchical structures that imply experiences of powerlessness among care workers, and strained working situations where administrative loads reduce time for providing care, imply that the question of gender also needs to be addressed in this case.
Svensk sammanfattning


Insamlingen genomfördes av en forskargrupp under ledning av professor Mona Eklund. Allt insamlat material analyserades med innehållsanalyser av olika slag. Vilken innehållsanalys som applicerades i olika fall berodde på materialets karaktär. I studiens olika delar användes olika teoretiska begrepp. Analysen av fallstudien i sin helhet utgår bland annat från ett teoretiskt perspektiv som berör valfrihet och makt (Rose, 1999), och ett annat som berör definitioner av frihet (Berlin, 1969).

Avhandlingen består av fyra delstudier. Den första handlar om valfrihetssystemets design och konstruktion i form av en beskrivning och analys av kvasimarknadens strukturella ramar och karaktär. Resultaten visade att deltagare fick en ökad valfrihet såtillvida att de kunde välja vilken sysselsättningsverksamhet de ville gå till. Men valfriheten upplevdes ur andra aspekter som reducerad. Framförallt handlade detta om en tidsreglering som infördes i samband med valfrihetssystemet. Deltagare blev beviljade ett antal "pass" i veckan, till skillnad från tidigare när deltagare själva i samråd med personal styrde deltagandet utifrån dagsform och psykisk hälsa. Om valfriheten upplevdes som ökad eller minskad utifrån de strukturella förutsättningarna berodde på vilken aspekt av valfrihetssystemet som avsågs.


De slutsatser som drogs av fallstudien är att valfrihetssystemet implementerades som en styrningsstrategi för att öka ekonomisk effektivisering. Deltagare styrdes genom att få "valfrihet och makt" samtidigt som systemet syftade till att infria det långsiktiga politiska målet att effektivisera. Valfrihet upplevdes av informanterna på kommunal- och stadsdelsnivå inte som ökad ur någon annan aspekt än att deltagare kunde välja var de ville gå. Valfriheten upplevdes ha minskat i andra avseenden, på grund av ny standardisering och hierarkiska strukturer.

I studien kunde fyra huvudaspekter av hög relevans vid implementering av valfrihetssystem identifieras:

- Det är viktigt att bygga in ett mått av förutsägbarhet i en konkurrensmodell som per definition skapar oförutsägbarhet, för att minimera risken att oförutsägbarheten orsakar psykiska eller fysiska negativa konsekvenser hos dem som ska välja. Hånsyn behöver tas
särskilt till betydelsen av kontinuitet i relationer mellan brukare/klienter/patienter och professionella.

- Att skapa långsiktig ekonomisk stabilitet på marknaden för att leverantörer ska kunna finnas kvar på sikt behöver också beaktas. Denna studie visade att nya leverantörer hade stora svårigheter att kunna driva sysselsättningsverksamheter med den ersättning som hörde till systemet, och den kommunala sysselsättningsverksamhet som stängdes ned stängdes på grund av bristande ekonomi.

- Vad som också har betydelse är att genomföra konsekvensanalyser av de administrativa system som ska införas i samband med implementering av valfrihetssystem. Konsekvensanalyser bör genomföras innan valfrihetssystem införs, för att minimera riskerna för att nya administrativa rutiner får oönskade andrahands- eller tredjehands konsekvenser.

- Slutligen är det av vikt att inför en valfrihetsreform uttala och tydliggöra reformens primära mål. Detta för att förhindra missförstånd och förlust av förtroende mellan politiker, chefer, tjänstemän, professionella och deltagare.

Hur en kvasimarknad utvecklas beror på marknadsskaparnas långsiktiga politiska intentioner (Gingrich, 2011). I det studerade fallet visade informanternas erfarenheter och de insamlade dokumenten att marknaden initierats och konstruerats utifrån en politiskt medveten design. Marknadens funktion handlade inte primärt om att öka medborgares valfrihet och makt, utan om att minska kommunens utgifter i kombination med att främja privata aktörers roll.
Författarens tack / Acknowledgements in Swedish

Först och främst vill jag rikta ett stort TACK till alla personer som deltagit i studien och delat med sig av sina erfarenheter. Utan ert deltagande hade denna studie aldrig varit möjlig!


Så vill jag rikta ett tack till Johan Vamstad, docent vid Ersta Sköndal Bräcke högskola, för din insats som opponent på mitt slutseminarium. Din kunskap och granskning inspirerade och hjälpte mig vidare i skrivandets slutskede.

Tack nationella forskarkolokan i socialt arbete för spännande kurser och vädrefulla sammanhang. Tack CEPI (Centrum för evidensbaserade psykosociala insatser) för att jag har fått vara med i ett öppenhjärtligt, inkluderande och givande forskarnätverk.

Tack alla medarbetare vid institutionen för socialt arbete i Umeå! Ett särskilt tack till de granskningsgrupper jag har haft förmånen att vara med i, och till er som varit med i forskningsprofilens psyk/soma. Ett särskilt tack vill jag även

Tack mina akademiska folkmusikvänner för torsdagarnas lunchspelningar som genom åren varit en av veckans höjdpunkter! ♪♫♪♫


Tack mina svärföräldrar Astrid och Bernt Gustavsson för att ni stöttar och uppmuntrar vår familj.

Tack mamma för att du alltid finns där. Tack pappa för intresse och engagemang. Tillsammans är ni mina föredömen i nyfikenhet på livet, uthållighet i uppgifter, medmänsklighet i vardagen och i framtidstro. Egenskaper som kan komma väl till pass under en forskarutbildning i socialt arbete.

Tack Ola för att du vill dela livet med mig, tack för uppmuntran under doktorandåren och för påminnelser om vikten av att kunna hålla en viss distans till avhandlandet. Tack Asta för allt, vår stjärna i tillvaron!
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Appendix 1. Information letter 1

Initial letter addressing policy makers, senior managers, first-line managers, and professionals in Day centre services.

Information om studie rörande valfrihetsreformen inom daglig sysselsättning

Vi vänder oss till Dig för att fråga om Du vill medverka i en intervjustudie om den förestående reformen inom daglig sysselsättning för personer med psykisk funktionsnedsättning inom Stockholms stad. Studien genomförs med anledning av den reform som genomfördes vid årsstiftet och innebär att brukarna kommer att ha valfrihet att välja vilken enhet de vill besöka, samt att enheternas ekonomiska förutsättningar blir kopplade till det antal brukare som väljer dem.

Vi gör parallellt en studie för att undersöka brukarnas uppfattning om den dagliga sysselsättning de går i och om den uppfattningen förändras under den tid som förändringarna genomförs. De brukare som vill medverka kommer att intervjuas och få svara i frågor som fyllas i frågformulär vid tre till fyra återkommande tillfällen, spridda under hösten 2009 samt under vår och höst 2010. Denna del av studien leder av professor Mona Eklund, Lunds universitet.


Deltagandet i undersökningen är helt frivilligt och den som väljer att delta kan när som helst avbryta sin medverkan. Den här typen av undersökningar dock viktiga för att åstadkomma bättre vård och stöd i framtiden, och Din och andra medverkan är därför viktig. Vi hoppas att Du ska lycka dig och intresse att delta.

Projektassistent Anita Dahlstrand kommer inom kort att kontakta dig per telefon för att höra efter om Du är villig att ställa upp och om så är fallet, boka en tid för intervjun.

Har Du några frågor kring undersökningen så ring gärna eller maila.

Hälsningar,

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Appendix 2. Information letter 2

Initial letter addressing participants in Day centre services.

**Information angående en studie om daglig sysselsättning**

Vi vänder oss till Dig för att fråga om Du vill medverka i en studie som handlar om daglig sysselsättning.

I början av 2010 skedde en förändring som innebär att man som besöker Daglig sysselsättning har valfrihet att välja vilken enhet man vill gå. Vi gör därför en studie för att undersöka brukarnas uppfattning om den dagliga sysselsättningen.

Om Du vill medverka skulle det innebära att Du fyller i några formulär och besvarar frågor om Din sysselsättningssituation och Din hälsa. I hälsouppgifterna ingår även bruk av berordeframkallande medel. Alltsammans tar ca 30-45 min per gång, och vi lägger också in en paus om det behövs och hjuter på kaffe etc. De uppgifter som samlas in kommer att förvaras under lagstadgad sekrethese, och ingen enskild person kommer att kunna identifieras i de rapporter som kommer att presenteras så småningom.

Deltagandet i undersökningen är helt frivilligt och den som väljer att delta kan när som helst avbryta sin medverkan. Undersökningen är helt fristående från den psykiatriska vården, både i kommun och i landsting. Att inte delta påverkar inte Din möjlighet att få vård på något sätt. Däremot är det viktigt att genomförs den här typen av undersökningar för att åstadkomma bettre vård och stöd i framtiden. Därför är Din och andra medverkan viktig och vi hoppas att Du ska tycka det är intressant att delta.

Har Du några frågor kring undersökningen så ring gärna eller maila.

Hälsningar,

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Appendix 3. Information letter 3

Follow-up letter addressing policy makers, senior managers, first-line managers, and professionals in Day centre services.

Information om studie rörande valfrihetsreformen inom daglig sysselsättning

Vi vänder oss till Dig för att fråga om Du vill medverka i en intervjustudie om den s.k. valfrihetsreformen inom daglig sysselsättning för personer med psykisk funktionsnedsättning inom Stockholms stad. Studien genomförs med anledning av den reform som genomfördes vid årsnöten 2009/2010 och innebär att brukarna kommer att ha valfrihet att välja vilken enhet de vill besöka, samt att enheternas ekonomiska försäkringar blir kopplade till det antal brukare som väljer dem. Vi är nu inne i den senare delen av studien då vi återkommer till de personer som tidigare intervjuats, för att göra intervju två efter reformens införande.

Vi gör parallellt en studie för att undersöka brukarnas uppfattning om den dagliga sysselsättning de går i och om den uppfattningen förändras under den tid som förändringarna genomföras. Denna del av studien leds av professor Mona Hök Lund, Lunds universitet.

Men vi vill även undersöka hur personalen vid enheterna, tjänstemännens och politikernas inom stadsdelarna uppfattar reformen och hur reformen påverkar arbetet med sysselsättning till målgruppen över tid. Vi har valt att några stadsdelar där vi gör intervjuer både i samband med reformens införande och vid några senare tillfällen. Intervjuen är tänkt att spelas in på band. Blanden och de utvärderar som sedan görs kommer att förvärvas under lagenradad sekretess, och ingen enskild person kommer att kunna identifieras i de rapporter som kommer att presenteras.

Deltagandet i undersökningen är helt frivilligt och den som väljer att delta kan när som helst avbryta sin medverkan. Den här typen av undersökningar är dock viktiga för att åstadkomma bättre vård och stöd i framtiden, och Din och andras medverkan är därför viktigt. Vi hoppas att Du ska tycka det är intressant att delta.

Marla Andersson, doktorand i Socialt arbete vid Umeå universitet, är sedan årsnöten 2012 engagerad i forskningsprojektet och hon är den som kommer att intervjuas personer med anknytning till de nya sysselsättningsarna.

Har Du några frågor kring undersökningen så ring gärna eller maila.

Hållningar.
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Appendix 4. Interview guide 1

Initial interview guide addressing professionals and first-line managers.

Interview med föreståndarna/personalgrupperna för daglig sysselsättning

Beskriv verksamheten:
- organisation
- bemanning
- målgruppen, vad är den ”officiella” målgruppen?
- Arbetssätt, dvs. hur ser innehållet ut, vad erbjuds man?
- Tillgänglighet/öppettider

Beskriv hur rekrytering, hänvisning, biståndsbedömning till verksamheten ser ut

Hur ser relationen till andra verksamheter och stadsdelar ut idag? Samarbete och utbyte?

Beskriv er målgrupp just nu och deras behov. Kommer alla från stadsdelen? Går de även till andra verksamheter? Ålder, kön, grad av funktionshinder?

I vilken grad arbetar ni uppsökaende och utåtriktat gentemot brukarna och i vilken utsträckning satsar ni på information om verksamheten?

Har ni profilerat verksamheten på något särskilt sätt? År det något särskilt som just ni kan erbjuda eller som ni är särskilt bra på?

(Föreståndarna) Hur skulle du vilja beskriva bakgrunden och de utmärkande dragen i valfrihetsreformen? Varför genomför man den? Hur är den upplagd?

(Föreståndarna) I vilken mån står stadsdelen bakom reformen? Skillnad mellan olika delar av organisationen och mellan tjänstemän och verksamheterna?

Hur ser ni i verksamheten på reformen och i vilken mån står ni bakom den?

(Föreståndarna) Vilken roll har stadsdelarna haft i planeringen och utformningen av reformen?

Har ni självtagit deltagit i planeringen av den? Vilken information har ni fått?
(Föreståndarna) Hur har verksamheterna och övriga lokala aktörer förberetts för reformen?

Vilka förberedelser har ni gjort?
(Föreståndarna) Hur ser genomförandeplanen ut?

Kommer ni att ändra ert sätt att arbeta i och med reformen? Hur?

Hur tror ni att förändringarna kommer att påverka er och brukarna?

Vilka möjligheter ser du med reformen?

Vilka är riskerna?
Appendix 5. Interview guide 2

Intitial interviews with politicians and senior managers.

Intervjuer med politiker och tjänstemän inom stadsdelarna

Har ni någon uttalad policy när det gäller arbetet med personer med psykiskt funktionshinder inom er stadsdel? Vad består den I så fall av?

Har ni haft någon särskild strategi vid uppbyggandet av verksamheter för målgruppen efter psykiatrireformen?

Kan du beskriva utbudet av insatser för sysselsättning/arbetsträning för personer med psykiskt funktionshinder ser ut i er stadsdel?

Har du någon uppfattning om relationen mellan utbudet och de befintliga behoven? Är det något som diskuteras?


Var I stadsdelens organisation ligger verksamheterna inplacerade? Vad är motivet bakom den aktuella organiseringen? (t.ex. vård och omsorgsförvaltningen, IFO, handikappomsorgen, äldreomsorgen, specialiserad socialpsykiatri)

Hur ser principerna bakom resurstilldelningen ut idag för verksamheter för sysselsättning/arbetsrehabilitering? (en “fast” tilldelning på årsbasis? Någon annan princip?) Hur ser budgeten ut?

Hur arbetar ni med handläggning och biståndsbedömning när det gäller daglig sysselsättning för målgruppen? Krävs biståndsbeslut? Öppna verksamheter?

Hur ser kontakten med andra stadsdelar ut vad gäller daglig sysselsättning? Köper ni platser idag? Säljer ni platser? Samarbetar ni på andra sätt?

Hur skulle du vilja beskriva bakgrunden och de utmärkande dragen i valfrihetsreformen? Varför genomför man den? Hur är den upplagd?

I vilken mån står stadsdelen bakom reformen? Skillnad mellan olika delar av organisationen och mellan tjänstemän och verksamheterna?
Vilken roll har stadsdelarna haft i planeringen och utformningen av reformen?

Hur har verksamheterna och övriga lokala aktörer förberetts för reformen?

Hur ser genomförandeplanen ut? Hur ska reformen sjösättas?

Vad tror du kommer att utgöra de största skillnaderna med att införa reformen? Vilka konsekvenser får detta på er organisation och era verksamheter?

Vilka möjligheter ser du med reformen?

Vilka är riskerna?
Appendix 6. Interview guide 3

Follow-up interviews addressing first-line managers and professionals.

Intervjuer, föreståndare/personalgrupper. Uppföljning

Syftet är att få en uppdaterad bild av området sysselsättning för personer med psykiskt funktionshinder i stadsdelen, och identifiera förändringar sedan förra intervjuet.

-Har något hänt i frågan om valfrihetsreformen på sysselsättningsområdet när det gäller mer övergripande frågor och beslut centralt eller på stadsdelsnivå? Nya beslut? Nya riktlinjer?


-Hur går handläggning och biståndsbedömning till idag? Har rutinerna förändrats det senaste året? Hur uppfattar ni att det fungerar? (Är det så idag att verksamhetsanslaget försvunnit och ersatts av "pengarna-följer-individen"-finansiering?). Har det påverkat er? Hur delaktiga är ni i de kontinuerliga uppföljningarna som sker av individerna?

-Har kartan av verksamheter ritats om i stadsdelen, dvs. har verksamheter tillkommit, försvunnit, slagits samman? Hur har det gått/kommer att gå för de kommunala verksamheterna? Har ni någon strategi?


-Hur ser politiker och högre chefer inom stadsdelen på er och förändringarna? (stöd o uppmuntran, avståndstagande?)


-Kontakterna med andra stadsdelar, hur ser den ut och vad består den i, har den förändrats?

-Kontakten med landstinget i samband med valfrihetsreformen?
-Era samlade erfarenheter av arbetet med valfrihetsreformen så här långt, positiva och negativa.

-Vad händer härnäst? Hur ser ni på framtiden?
Appendix 7. Interview guide 4

Follow-up interviews addressing policy makers and senior managers.

Intervjuer, politiker/tjänstemän. Uppföljning

Syftet är att få en uppdaterad bild av området sysselsättning för personer med psykiskt funktionshinder i stadsdelen, och identifiera förändringar sedan förra intervjuutkastet.

-Har något hänt i frågan om valfrihetsreformen på sysselsättningsområdet när det gäller mer övergripande frågor och beslut centrat eller på stadsdelsnivå?

-Har någon upphandling skett? Varför/varför inte? Hur går upphandlingen till (sker den i varje stadsdel eller centrat?)? Hur går diskussionerna? Finns någon strategi el. önskelista på vilka aktörer man vill få in?

-Hur går handläggning och biståndsbedömning till idag? Har rutinerna förändrats det senaste året? Hur uppfattar ni att det fungerar? (Är det så idag att verksamhetsanslaget försvunnit och ersatts av ”pengarna-följer-individen”-finansiering?)

-Har kartan av verksamheter ritats om i stadsdelen, dvs. har verksamheter tillkommit, försvunnit, slagits samman? Hur har det gått/kommer att gå för de kommunala verksamheterna? Sist berättade ni om tankar kring träffpunkterna och att man eventuellt skulle kunna samarbeta med Röda korset, hur har de tankarna utvecklats?

-Har något skett när det gäller inriktning, profilering och utveckling av verksamheterna?

- Vad har hänt med personalen i verksamheterna? Finns de kvar? Hur ser de på förändringarna?

- Brukarna – har något hänt det senaste året? Fler, färre? Rör man på sig? Vad är er uppfattning om reformens inverkan på brukarna?

- Kontakterna med andra stadsdelar, hur ser den ut och vad består den i, har den förändrats?

- Kontakten med landstinget i samband med valfrihetsreformen?
-Era samlade erfarenheter av arbetet med valfrihetsreformen så här långt, positiva och negativa.

-Vad händer härnäst? Hur ser ni på framtiden?
Appendix 8. Interview guide 5

Interviews addressing service providers entering the market.

Frågor till de biståndsbedömda dagliga sysselsättningarna som tillkommit efter införandet av LOV

Syftet med intervjun är att ta reda på vilka de nya aktörerna inom biståndsbedömd meningsfull daglig sysselsättning är, hur startprocessen har upplevts samt vilken plats aktörerna upplever att de har i det svenska välfärdsystemet.

Skulle du vilja beskriva er verksamhet?

(organisation, styrelse, bemanning (yrkesgrupper? krav på utbildning/erfarenhet?), profilering, arbetssätt, tillgänglighet)

Skulle du vilja beskriva er målgrupp och deras behov?

(Hur många kan ni ta emot, hur många har ni just nu, har ni något kösystem.

Hur skulle du vilja beskriva målgruppen i förhållande till valfrihetsreformen?)

Bedrev ni någon typ av liknande verksamhet innan LOV infördes? Skulle du kunna beskriva hur processen in i systemet har gått till? Hade ni med er klienter från förut eller har ni börjat från noll?

Skulle du vilja beskriva hur rekrytering av deltagare ser ut? (uppsökande verksamhet, utåtriktat informationsarbete, värdefulla kontakter m.m.)

Hur ser ni på den valfrihetsreform som har införts?

Vad medför den för möjligheter, begränsningar, risker?

Hur kom det sig att ni valde att bli en del av valfrihetssystemet? Hur resonerade ni? Hade ni några andra alternativ? Vad övervägde ni? Hur hade situationen sett ut för er om ni inte hade valt att gå med?

Hur har själva igångsättningsprocessen sett ut och hur har den upplevts?

(Har ni fått hjälp/uppmuntran från något håll? Har ni mött motstånd från något håll?)
Vad har ni som de andra dagliga sysselsättningarna inte har? Vad är er konkurrensfaktor? Er kvalité? Kan man göra någon form av karriär hos er?

Vad är kärnan i er verksamhet, bygger verksamheten på några grundläggande idéer?

Samverkar ni med några andra aktörer?

Hur ser er relation ut till de kommunala dagliga sysselsättningarna/ psykiatrin/ Alfaprojektet/ de lokala biståndsbedömarna/ de lokala politikerna/ det lokala näringslivet/ brukar- och anhörigföreningarna?

Hur upplever ni kontakten med andra aktörer? Rita nätverkskarta!

Har ni hört några reaktioner på valfrihetsreformen från era deltagare?

När det gäller ekonomi, går verksamheten runt på det kommunala bidrag som följer med varje biståndsbedömd deltagare eller kräver verksamheten finansiering av externa medel? Hur ser ni på lönsamhet? Har ni några tröskelnivåer som ni måste uppnå?

Ser du någon tendens i antalet pass som personer som kommer till er får beviljat av sina biståndsbedömare? Beviljar man mer eller mindre nu än tidigare?

Hur ser ni på fortbildning? Har ni upptäckt något område där ni tycker att ni behöver mer utbildning/fortbildning?

Om två år, vad tror du utmärker er då?

Hur tror du att kartan över daglig sysselsättning för personer med psykiska funktionsnedsättningar har förändrats i Stockholm om två år?

Är det något mer du skulle vilja tillägga?
Appendix 9. Interview guide 6

Interviews addressing service providers exiting the market.


Nu undrar vi om du så här två år efter att vi träffades sist skulle kunna berätta lite om vad som har hänt på er sysselsättningsverksamhet?

Vad har hänt med 

   brukare?

   Personal?

   lokaler?

Hur har konkurrenssituationen sett ut? Har den bidragit till nedläggningen?

Hur är din bild av hur verksamheter specialiserar sig?

Hur skulle du vilja säga att det administrativa systemet påverkade verksamheten?

Hur upplevde du stadsdelens förhållningssätt till marknaden?

Vad är din allmänna känsla beträffande stadens sysselsättningsverksamhet?

Är det någonting mer du skulle vilja tillägga?