WHO IS RESPONSIBLE FOR SUPPORTING "LONG-TERM MENTALLY ILL" PERSONS?: REFORMING MENTAL HEALTH PRACTICES IN SWEDEN

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ABSTRACT

The Swedish Mental Health Reform of 1995 was intended to expand community services, improve inter-organizational co-operation between welfare agencies, and achieve goals of social participation for the mentally ill and disabled. The implementation of the reform was characterized by weak legal steering mechanisms and a strong commitment to transform norms. Time-limited economic incentives at the local level and efforts by enthusiastic key persons were salient traits. The result indicates that community-based services such as supported housing and rehabilitative methods have increased. However, inter-organizational co-operation is still difficult, and traditional norms according to which people with mental health problems are seen as ill rather than disabled remain intact.

Swedish welfare policies went through considerable changes during the 1990s. Universal welfare and health policies are still dominant: welfare is abundantly provided, legislated as a social right, universal in scope, publicly financed and organized, and delivered by an array of welfare agencies. However, during the 1990s important shifts occurred in the organization and implementation of welfare policies. Mental health, disability, and health services were de-institutionalized, and new emphasis was placed on decentralization to municipalities, co-operation in networks, and responsibility of the local community. At the same time, ambitions to increase the welfare and well-being of specific segments of the population are more prominent on the political agenda (Lindqvist & Borell, 1998). Already in the 1980s, de-institutionalization of psychiatric services began, and policy was aimed at making it possible for those with psychiatric disabilities to live independently in the community. During the 1990s, such policies were elaborated and applied to specific areas of mentally ill people's social lives, with ambitions of full participation in the community (Forsberg & Starrin, 1993; Markström, 2003; Socialstyrelsen, 1999; Statens offentliga utredningar, 1992).

This emphasis was most evident in the policy initiatives that led to the enactment of the Swedish Mental Health Reform in 1995. One important aim of the reform was to improve the living conditions of people with mental disorders through more effective efforts in terms of adequate housing, occupational rehabilitation, involvement in social networks, meaningful leisure activities, etc. Another aim was to improve inter-organizational co-operation between health services, social welfare offices, and social security agencies (Sweden, 1993-94). At the time, the policy goals and the orientation of the reform towards more community-based services were sup-

ported by almost all players and were not an issue for public debate (Markström, 2003; Statens offentliga utredningar, 2000). However, after the reform was launched, public voices were increasingly critical. Critics argued that mentally ill people, after being discharged from hospitals and psychiatric wards, were abandoned or left in the hands of local social service agencies that lacked the necessary knowledge and competence to do a proper job. Proponents of the reform argued that community services were necessary to achieve the goals of social participation (Arvidsson, 2003; Markström, 2003).

In this article we describe the background of the Swedish Mental Health Reform put into effect in 1995 and analyze the planning process and the way the new policies were implemented. We try to grasp the most salient traits characterizing the Swedish way of launching and implementing policies covering community mental health services. The questions we ask are: Who were the key players? What kind of division of labour developed between central government actors, players at the local level, and professional groups in the psychiatric services field? What dilemmas and possibilities did the reform bring about? Then we describe the context in which de-institutionalization of Swedish mental health services took place and the preparatory work done by the public investigations that were the basis of the reform. Next we describe the implementation process. This includes an assessment of the key players, the use of time-limited experimental activities (local projects) to stimulate municipalities to take action, and problems of professional knowledge. Finally, we discuss whether the Swedish Mental Health Reform was a failure or a promising shift towards increased and comprehensive community services.

DATA, METHOD, ETHICS, AND RESEARCH DESIGN

This is a case study of the policy implementation of the Swedish Mental Health Reform. The case study method provides an opportunity for thorough description and exploration of a phenomenon in relation to its context (Stake, 2000; Yin, 1994). A theoretical framework including implementation theories and the "new institutionalism" in organizational analyses is used in an attempt to understand the possibilities and dilemmas that are inherent in launching new perspectives that aim to advance and elaborate community services and redefine the responsibilities of the agencies involved.

To describe the background of the reform, we analyzed written documents and statements produced in the preparatory work undertaken by public investigations, as well as government proposals and evaluations from the National Board of Health and Welfare. Secondary studies that provide information on living conditions of psychiatric patients are also part of the empirical data. Two empirical studies were conducted between 1996 and 1999. One of them dealt with the implementation of the reform at the local level in five Swedish municipalities. The other was a case study of a vocational rehabilitation program organized as a time-limited enterprise (grants were guaranteed for 3 years). In Stake's (2000) words the first study was a collective case study, and the second an instrumental case study.

The municipalities in which the first study was conducted were selected according to the principle of "maximum dispersion." They were chosen to represent different population sizes, different levels of ambition in the field of community services for persons with psychiatric disabilities, and different degrees of access to mental hospitals in the past. Local policy documents were collected and analysed. We conducted 60 interviews, including group interviews with managers in psychiatric

and social services, as well as interviews with key persons and "enthusiasts," partners from other welfare agencies, and associations of users and relatives. All in all, 100 persons responded to our interviews. In the study of the rehabilitation program, 15 recurrent interviews were conducted with 6 staff members, 6 users and 10 case-workers in co-operating agencies. Moreover, participant observation was undertaken and a questionnaire was distributed to explore the user perspective on the formation and experiences of the program. In both of these case studies the approach was to gain as much feedback as possible from the interviewees, i.e., managers and case workers in the municipalities, representatives of users' and relatives' associations, and the participants in the rehabilitation program.

Advisory boards with strong representation of users of services were put together to support the research efforts (Markström, 1998; Markström, 2003; Markström & Sandlund, 1999). The persons who voluntarily responded were given information in advance about the aims and methods of the two studies, and about the way that we intended to present and publish the research results. They were also given the opportunity to withdraw from participation in the studies at any time according to their preferences. The users who participated also had the opportunity to read, comment on, and clarify the transcription of their own interview and the presentation of results. The limited number of persons included meant a risk of being identified, although no names of respondents were mentioned in the research reports. However, none of the respondents chose to withdraw from the studies.

THE SWEDISH CONTEXT FOR DE-INSTITUTIONALIZATION

While de-institutionalization has often been the subject of grandiose and idealistic policy statements, implementation and practices have been accompanied by an array of problems such as trans-institutionalization (Bachrach, 1976; Brown, 1988; Goodwin, 1997; Thornicroft & Bebbington, 1989), difficulties and inconsistencies in planning and inter-organizational co-operation (Bachrach, 1992a); homelessness (Bachrach, 1992b; Brown, 1988; Kiesler & Sibulkin, 1987; Leff, 1997; J. Scott, 1993); and criminality (Hodgins, 1993; Monahan, 1992). Since the beginning of the nineteenth century, psychiatric care in Sweden has been hospital-based and managed by state authorities (Eriksson, 1989). Up until the mid-1960s, institutional care was the dominant form. During the first half of that decade there were more than 35,000 hospital beds in mental asylums run by the state, which was a high figure per capita in comparison with the rest of the Western world (Forsberg, 1994; Sjöström, 1992). In 1967 responsibility for psychiatric care was shifted from the state to the regionally based county councils, which since the 1870s have had the responsibility for in-patient somatic health care. The idea was that the county councils were capable of organizing both psychiatric and somatic health care in a uniform and integrated way irrespective of the nature of the patient's disease (Markström, 2003; Meeuwisse, 1997).

In Sweden the process of reforming psychiatry began in the 1970s. This reorientation and emphasis on increased out-patient services was stated in a number of policy programs, but it was not until the first half of the 1980s that practices changed and the closing of mental hospitals began (Markström, 2003; Socialstyrelsen, 1988). A focus in almost all public investigations from that time has been the delineation of social service agencies' responsibility towards persons with psychiatric disabilities. To clarify this matter, the Social Services Act of 1982 introduced the concept of *psykiska handikapp* (psychiatric disabilities) which included long-term mentally ill

people together with those addicted to drugs and alcohol (Sweden, 1979-80). Hence, the legislative bodies anticipated that the needs of the targeted group of people would be better met if support were given in the community. Persons with mental problems would then be treated in the same way as other groups of disabled people for whom the social services had a clearly stated responsibility. However, in general this intention was not translated into practice. In the early 1990s the psychiatric services run by the county councils were still the main service providers for the mentally ill[1]; support in the areas of housing, employment and vocational activities, and psychiatric rehabilitation was in many places sadly underdeveloped. It was recognized that the care and support needs of mentally ill people were inadequately addressed, especially in terms of day care activities, employment, and rehabilitation (Markström, 2003; Socialstyrelsen, 1988).

TOWARDS A NEW PRACTICE OF MENTAL HEALTH POLITICS

In 1990, the government appointed a committee to investigate improvements in care and services for persons with serious psychiatric disabilities (Sweden, 1989). Special emphasis was placed on considering and suggesting measures for more community-based services and for delineating the division of responsibility and organization of services for the psychiatrically disabled. The final report of the committee (Statens offentliga utredningar, 1992) argued strongly that people with severe mental health problems were to be regarded as disabled. Social services would then consider more clearly their responsibility for people with mental disorders. The importance of inter-organizational co-operation between welfare agencies and the need for user influence on the management and design of services were also emphasized. It must be kept in mind that the Swedish welfare system is highly "sectorized," i.e., several players and agencies act in the field of care and social services. Since each authority must cope only with categories of clients that clearly fall within its jurisdiction, clients' needs tend to be "compartmentalized." Welfare workers tend to specialize by attending to a limited number of client attributes perceived to be within their purview (Hasenfeld, 1992; Lindqvist & Grape, 1999). If the client suffers from a psychiatric disorder, social problems, poor social networks, and unemployment, many welfare agencies become involved, and there is a great need for inter-organizational co-operation. Unless such co-operation takes place, the client tends to be endlessly bounced back and forth between agencies or "fall between the cracks."

According to the committee report, it would be easier to integrate people with psychiatric disabilities into the community if the municipalities were given clear jurisdiction (which had existed since 1982, but never actually put into practice). The most far-reaching proposal was the inclusion of psychiatrically disabled people under a new Disability Services Act, which was in preparation at that time (Statens offentliga utredningar, 1992). Launched in 1994, the Disability Services Act targeted disabled people with "large and persistent difficulties in managing daily life." Disabled people were made eligible for services that were expressed as precise social rights (in contrast to social assistance which is needs-tested), which the local municipalities were required to provide (Lindqvist, 2000).

The committee preparing the reform found that living conditions of mentally ill people were troublesome in a number of areas. Neither health care nor social services were designed to mitigate the disabling consequences of mental disorders (Statens offentliga utredningar, 1992). Better facilities in terms of accommodation, work, and

activities, meaningful leisure time, and social and vocational rehabilitation were called for. The reform set out a new division of labour between the county councils and the municipalities. The councils provide medical services mainly to those in need of round-the-clock treatment, while the municipalities' responsibilities were widened to encompass an array of services including residential facilities, work or activity, and personal support. To accelerate the discharge of long-stay hospital patients, it was legislated that municipalities must pay a fee for every day of hospital care for patients assessed as "sufficiently medically treated." This provided municipalities with strong economic incentives to develop new comprehensive services for the mentally disabled (Brink, 1994; Lindqvist, 2000).

The government did not implement all the proposals put forward by the committee; only a few substantial legislative changes were made to make it mandatory for the municipalities to improve services and support. Instead, the government's preferred steering mechanism became the transformation of norms and some economic directives. It chose to invest in time-limited funding with the aim of stimulating the development of community-based activities within social services (Sweden, 1993-94). Why did the government respond in such a manner? In our opinion, the problem that the committee faced, and did not solve, was the difficulty of delineating and defining the target group. It described the targeted group with an array of labels: persons with mental illness, psychiatrically disturbed people, long-term mentally ill, psychiatrically disabled, etc. This created uncertainty concerning many of its recommendations. How many people are to be addressed? What will the costs of the reform be? This lack of clarity is one important reason why the government did not accept several of the committee's suggestions. Such predicaments made the municipalities, the player on which the economic burden would rest, reluctant to support new legislation.

The Swedish Mental Health Reform was characterized by weak steering mechanisms in terms of specific legislative measures, but also by a strong commitment to transform norms and provide economic incentives at the local level. The reform paid tribute to a number of ideological principles such as welfare, freedom to choose, and normalization of the target groups' living conditions, as well as a number of good examples and models from English-speaking countries (Fountain House, psychiatric rehabilitation, case management, assertive community treatment). The time-limited economic incentives from the state to local agencies implied indirect economic steering of the implementation of the reform. The overall result was that projects became a huge nation-wide enterprise: more than 1,000 local projects were started in the municipalities to develop models of community-based services. What did not come about was a long-term strategy for community care. This became evident in the municipalities' new financial responsibility for the continuation of the projects, when government subsidies were exhausted (Socialstyrelsen, 1999). Reluctance and delay have often characterized the actions of the municipalities. Not until 3 years after the reform was put into force did a majority of the local municipalities conduct surveys to identify the number of clients and their various needs (Socialstyrelsen, 1999). A recent critical report shows that only 45% of the Swedish municipalities and local districts included in the survey had adequate knowledge of the needs of persons with psychiatric disabilities (Socialstyrelsen, 2003a).

IMPLEMENTATION: BETWEEN POLICY AND LOCAL CONTEXTS

It is difficult to identify when a policy process starts and when it is completed since policy goals tend to be continuously redefined and changed, influenced by local players and professional groups. The direction of the policy implementation process is therefore difficult to grasp, and it is not evident whether a top-down or a bottom-up perspective can provide the most authentic picture of the design and outcome of political initiatives (Colebach, 1998; Ham & Hill, 1993; Majone & Wildavsky, 1984). These observations stand in contrast to the more traditional approach of distinguishing policy from implementation (Sabatier, 1986).

Implementation is not only an instrumental undertaking, but also a process embedded in a complex moral order related to institutional values and aspirations of players in different organizational fields. To identify the dilemmas and opportunities that exist in the field between policy intentions and reform outcomes, we will take as our point of departure the neo-institutional perspective of organizational research. The essence of this approach is its focus on the relationship between the organization and its surroundings: organizations are thought to be permeated (rather than created) by their surroundings, which provide them with certain structural traits and operational principles as well as determined modes of behaviour (Meyer, 1994). Organizations that embrace institutionalized preconceptions within their formalized structure appear legitimate, gain access to resources, and improve their chances of survival (Meyer & Rowan, 1991). Individual organizations must also adapt to a series of separate institutional orders with contradictory logics (Friedland & Alford, 1991).

The field of mental health community services is interesting as it incorporates several organizations, including the psychiatric care system, the social services, and to some extent authorities dealing with vocational rehabilitation (labour market authorities and social security agencies). According to the logic of public employment authorities, the client must demonstrate his or her employability, if necessary by participating in various work-directed rehabilitation programs. According to the logic of social services, applied by welfare bureaucracies, the situation-specific needs of the individual must fit into routines and procedures that are reconcilable with the legitimate mission of the authority. The third logic is that of the medical branch of psychiatry, in its ideal state based on research and approved knowledge. According to this logic, the medical profession (psychiatrists) has the legitimate right to make important decisions about diagnoses and treatment interventions, which others ought to comply with. One must pay attention to such complex institutional orders when developing community mental health services. Below we intend to highlight a few themes that we consider characteristic of the implementation process. We draw on findings from our two empirical studies and other relevant research.

The Key Players

The new division of labour between the psychiatric care system under the control of county councils and the social services in the municipalities meant that community services such as supported housing and day care activities were under municipal jurisdiction. As a result of the absence of legislative steering mechanisms, the municipalities were given substantial leeway to choose implementation strategies. At the grassroots level the implementation was accomplished by the efforts of a limited number of enthusiastic key persons, who were given important co-ordinating and creative functions. Each of the five municipalities in our study created jobs for so-called “psychiatry co-ordinators” to carry out co-ordinating work. Such employees

were given considerable discretion to tailor policies to local practice. The comments of the psychiatry co-ordinator in one small Swedish municipality typify the experiences of all the municipalities in our study:

> Everything was unspecified and open. I felt that I had to produce all ideas and thoughts about what was to be done. This was not what I had expected—I thought that the plans would have been ready before I was employed, but this was not the case. The administration was short of ideas, I think.

It was evident that the process of implementation created a "vacuum field" between state policy makers and these key people on the ground, because local politicians and social service managers did not take action. Hence, implementation in this case did not follow a top-down approach (Rothstein, 1994). Community services depended on individual case workers, who were given significant leeway. This is what characterizes case workers or street-level bureaucrats in general. On the one hand, they have discretionary powers and knowledge to exercise for the purpose of enhancing the welfare and well-being of the clients. On the other hand, they are circumscribed by the jurisdiction and procedures that the organization expects them to follow (Lipsky, 1980). The development of community services was hampered by the fact that no prominent professional group took action; the field can be characterized by avoidance, rather than active competition regarding who should take on key tasks (Markström, 2003).

Organizing the Projects

The state economic incentives—more than SEK 1 billion (about C$180 million) paid out during a period of 3 years—brought about a strategy to design and develop psychiatric community services by organizing time-limited programs at the local level. A considerable number of local projects (at least 1,000 different enterprises, corresponding to a mean value of at least three projects in each of the 290 Swedish municipalities) were created, most of them oriented towards psychiatric rehabilitation, staff training, etc. "Exemplary models" (especially in the field of psychiatric rehabilitation) were found in the United States and Britain and imported, and attempts were made to adapt them to Swedish conditions. Our empirical study of vocational rehabilitation indicated substantial difficulties in terms of translating these models and practising them in the Swedish context.

The ideal model in this case (Anthony, Cohen, & Farkas, 1992) encompassed a comprehensive approach to the rehabilitative tasks, but the scope of the programs initiated in the Swedish municipalities was quite limited. Rather than adapt to the exemplary models, neighbouring agencies in the local rehabilitation field (public employment offices, social security agencies) continued with "business as usual." Since no substantial changes were made in the Social Security Act, there were no incentives for social security agencies to change their practices, i.e., to develop more flexible work modes and assessment procedures concerning work ability, sickness, and vocational rehabilitation of disabled persons. While social security agencies typically relate a person's work capacity to health status, as described in the medical certificate and measured through functional and work tests, labour market authorities normally look at the same issue from an employability perspective, which means that they consider the real chances of getting a job. Labour market authorities often demand that the person be fully ready to enter the regular labour market, i.e., healthy and motivated. That is often not the case for a person with psychiatric problems. Seen from the perspective of the individual, it may be risky to give up sick benefits or a disability pension for a rehabilitation venture that may fail because the job in

question may be too difficult to manage (Socialstyrelsen, 2001). According to clients' responses, "something to do during daytime" was the most important goal for them, since getting an ordinary job seemed to be quite unrealistic.

One advantage of projects is that they often draw positive public attention to their performance; more freedom and creativity in terms of work modes and co-operation with neighbouring agencies is supposed to take place in projects compared to regularly organized welfare bureaucracies (Markström, 2003). Organizing psychiatric community services in terms of time-limited state-subsidized projects contributed to the formation of new work models and modes of inter-organizational co-operation. However, one problematic aspect concerns the fact that the projects in our studies were not sufficiently integrated into the practices of the regular welfare agencies, making it difficult to incorporate project experiences into regular welfare organizations (cf. Powell & DiMaggio, 1991). Evidence from our study shows how some projects directed to persons with psychiatric disabilities were incorporated into regular social services in an inappropriate way, i.e., managed by people with little or no experience in work with psychiatric disabilities. The consequences of such strategies made key workers leave the organizations shortly after the projects ended.

Temporary (instead of permanent) state subsidies also make it difficult to implement important long-term priorities on the policy level (Markström, 2003). The Mental Health Reform was characterized by such "temporary structures," within which many positive experiences were collected, but at the expense of long-term priorities and firm anchoring in established local welfare structures. Thus, the project leader and the staff in the vocational rehabilitation program struggled in vain to extend the project and to convince people in decision-making positions to let the program continue. Considerable efforts were also made by project staff to enhance the external legitimacy of the program. From the perspective of the project leader, such objectives were given rather high priority compared to the more instrumental vocational rehabilitative tasks. In general, many of the local projects ended when state subsidies were exhausted. Nevertheless, it seems that the reform has brought about an expansion of psychiatric community services in terms of supported housing and sheltered living arrangements, employment and occupational activities, and psychiatric rehabilitation models (Socialstyrelsen, 1999, 2003a, 2003b).

Professional Knowledge and Qualifications

The new community services that developed in the Swedish municipalities faced difficulties in attracting qualified staff. It was not easy to recruit people with relevant professional knowledge, which meant that the staff mainly consisted of people with little education (Socialstyrelsen, 1999). Our municipality study encompasses positive as well as negative experiences concerning recruitment models. The positive example can be found in a social services agency in a small town. In the recruitment of case workers for a team responsible for supported housing services, experienced staff members with a work history in the psychiatric care system were mixed with case workers from the social services. Even a certain number of workers who did not have any experience at all in care work or social services were employed. Respondents in such teams reported a high degree of satisfaction with working conditions and co-operation. The negative example is found in a city of about 100,000 inhabitants. In this city a decision was made to transfer a long-term psychiatric care ward, including staff and patients, from the county council to the social service organization in the municipality. Since no real changes in care work and tasks took place, staff felt alienated and highly uncomfortable with their work in the new setting. Furthermore,

the former psychiatry staff felt under-utilized and repudiated in their new positions, a finding that was repeated in four of the five municipalities included in the study (Markström, 2003; Markström & Sandlund, 1999). A staff member at a sheltered house expressed this widespread sentiment:

> When I'm talking to the managers in our organization [the social services], they know nothing, nothing at all. It's as if I myself were not trustworthy. It's rather frustrating. Actually, I have been working for 35 years in the psychiatric care organization of the county council.

Since work instructions were often infrequent and inadequate, field case workers had to find their own work methods and co-operative models. In spite of poor or no guidance and steering, some indications of professionalization can be seen (cf. Macdonald, 1995), as in the efforts to build up case management teams and psychiatric rehabilitation services. Experiments in case management were positively evaluated as to clients' satisfaction, their link to other parts of the service systems, and a reduction of in-patient days (Björkman, 2000; Björkman & Hansson, 2001; Björkman, Hansson, & Sandlund, 2002). A policy of providing state subsidies to municipalities that run case management teams resulted from such experiences. This is, in our opinion, an important step towards a process of professionalization.

REFORMING MENTAL HEALTH SERVICES: A FAILURE?

At the time of writing (autumn 2004), a common opinion of the Swedish Mental Health Reform is that it is a fiasco. The media give a rather simplistic picture of discharged former patients sitting alone in untidy apartments, with no social interaction whatsoever or, at best, with a worn-out and tired mother. Mentally disordered persons' danger to public safety is periodically an issue for intense public debate. The psychiatric service system (both care and community services) is often accused of not fullfilling its responsibilities, and the reform is often blamed for having created conditions where "innocent people" are attacked. Since the reform aimed to reduce the stigmatization of and prejudice against psychiatrically disabled persons, it can indeed be seen as a failure to the extent that negative attitudes remain intact.

Clearly, the implementation of the reform has been tricky. The process of developing community services was difficult because Sweden in the early 1990s experienced an economic recession accompanied by record high unemployment rates. In these circumstances, government bodies at all levels were under pressure to reduce spending in a number of welfare areas. It also became difficult to uphold the orientation and practices of the famous Swedish "workline" in labour-market and social policy, especially for persons with mental health problems. The logic of work life and public employment authorities' criteria concerning employability did not fit well with the needs and disabilities of that group, which made vocational rehabilitation a difficult venture.

On the other hand, there have been a number of positive experiences and outcome that provide evidence for a more optimistic view of the reform. The municipalities today identify supported housing, day care activities for psychiatrically disabled persons, and many other needs as being within their purview. The number of community-based services has increased, and supportive and rehabilitative methods new to Sweden, such as case management, have been introduced. The number of persons with psychiatric disabilities in sheltered living arrangements has increased from 100 in 1987 to more than 8,000 in 2002 (Socialstyrelsen, 1988, 2003b; Statens

offentliga utredningar, 1992). Long stays in psychiatric wards have become extremely rare. The number of in-patient beds has decreased from more than 35,000 in 1967 to about 5,000 in 2002 (Socialstyrelsen, 2003b). Our conclusion is that implementation was difficult, but it was far from a failure.

In terms of implementation, the reform was too contingent on individual enthusiasts, and the emphasis on time-limited projects brought about a shortsightedness that entailed risks of fudging the responsibility for the target group. In this respect, it is difficult to overcome problems emanating from the fact that care and services for the mentally ill are mainly divided between two separate agencies with different jurisdictions, traditions, professional status, and perspectives. Long-term inter-organizational co-operation is therefore a challenge. It might well prevail as long as the state provides subsidies, but when such support is exhausted co-operation might easily turn into conflict, as one party feels that it does more for the target group than the other.

The difficulty of changing institutionalized preconceptions and modes of action regarding social services and the psychiatric care system in terms of developing mental health community services should not be underestimated. According to R.W. Scott's (1995) conceptualization of institutions as consisting of three pillars—regulative, normative, and cognitive elements—it could be said that the regulative structures have remained roughly unchanged. Regulative processes for establishing new rules and monitoring activities and sanctions have not come about. On the other hand, normative structures, underpinned by economic incentives, have been affected in the sense that new goals and objectives have been defined. Principles of community care, though difficult to put into practice, seem to be solidly anchored at the local mental health policy level. Such difficulties in implementing policies can be traced back to difficulties in altering cognitive structures, i.e., the frames through which the nature of psychiatric illness and disability is interpreted. These structures have not changed in any fundamental way. We still tend to regard this group mainly in terms of illness and disease and not in terms of disability. The long-term outcome is dependent on the persistence and robustness of early achievements, including the amount of and quality of the services provided by society, but also on the willingness of the "ordinary person" to invite psychiatrically ill persons into the community, the world of work, the educational system, and the neighbourhood. In essence it is a question of the degree of acceptance that society and its main actors have for social policy reforms in the field of mental health and illness. To change hundreds of years of negative attitudes and fear, there is an urgent need for more understanding and open-mindedness.

NOTES

1. The bulk of health care is under the control of 18 elected and tax-raising county councils and 3 regional authorities in Gothenburg, the Skåne area and the island of Gotland. The 290 municipalities have the responsibility for a wide range of social services including social care of the elderly, disability services and social assistance.

RÉSUMÉ

La réforme suédoise de la santé mentale, instituée en 1995, avait pour but d'élargir les services communautaires, d'améliorer la coopération entre les organismes d'assistance de l'État et d'assurer la réussite des objectifs d'insertion

sociale pour les personnes atteintes de maladie ou de handicap mental. Le processus d'implantation de la réforme était caractérisé par la faiblesse des mécanismes de direction légaux et par une forte volonté de transformation des normes. La réforme était également caractérisée par des incitatifs économiques à échéances fixes au niveau local et une participation enthousiaste de la part de personnes clé. Les résultats indiquent une amélioration sur le plan de services communautaires comme le logement adapté et les méthodes de réadaptation. Toutefois, la coopération entre organismes demeure difficile; de plus on note une persistance des normes conventionnelles selon lesquelles les personnes souffrant de problèmes de maladie mentale sont perçues comme malades plutôt qu'handicapées.

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