LUND UNIVERSITY

Outcomes of a Freedom of Choice Reform in Community Mental Health Day Center Services.

Eklund, Mona; Markström, Urban

Published in:
Administration and Policy in Mental Health and Mental Health Services Research

DOI:
10.1007/s10488-014-0601-1

2015

Link to publication

Citation for published version (APA):
Eklund, M., & Markström, U. (2015). Outcomes of a Freedom of Choice Reform in Community Mental Health Day Center Services. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(6), 664-671. https://doi.org/10.1007/s10488-014-0601-1

Total number of authors:
2

General rights
Unless other specific re-use rights are stated the following general rights apply:
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.
• Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying the publication in the public portal

Read more about Creative commons licenses: https://creativecommons.org/licenses/

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

LUND UNIVERSITY

PO Box 117
221 00 Lund
+46 46-222 00 00

Running head: Outcomes of freedom of choice reform

Outcomes of a Freedom of Choice Reform in Community Mental Health Day Center Services

Mona Eklund, Ph.D., Professor, Lund University, Department of Health Sciences, Lund University, Lund, Sweden

Urban Markström, Ph.D., Associate Professor, Umeå University, Department of Social Work, Umeå, Sweden

Address for correspondence:

Mona Eklund, Ph.D., Professor,

Department of Health Sciences, Occupational Therapy and Occupational Science,

Lund University, PO Box 157, SE-221 00 Lund, Sweden.

Tel +4646 2221957

Fax +4646 2221959

E-mail: mona.eklund@med.lu.se

Abstract

A freedom-of-choice reform within mental health day center services was evaluated. The reform aimed to 1) facilitate users' change between units and 2) increase the availability of service providers. Seventy-eight users responded to questionnaires about the reform, empowerment, social network, engagement and satisfaction and were followed-up after 15 months.

Fifty-four percent knew about the reform. A majority stated the reform meant nothing to them; ~25% had a negative and ~20% a positive opinion. Satisfaction with the services had decreased after 15 months. Empowerment decreased for a more intensively followed subgroup. No positive consequences of the reform could thus be discerned.

Keywords: Community psychiatry, client satisfaction, empowerment, procurement.

Introduction

Organizational reforms often take place in social and health care services, and in the western world free choice market systems have been implemented in various welfare sectors such as health care, disability services, work rehabilitation and the school sector. Some studies indicate modest efficiency gains (Perri6, 2003; Struyven & Steurs, 2005) but the dominant pattern that emerges in the literature is an absence of progress and service models that have difficulties in living up to the preconditions for a well-functioning market and meeting the political expectations (Bredgaard & Larsen, 2008; Finn, 2009; Jolley et al., 2014; Perri6, 2003; Spall, McDonald, & Zetlin, 2005; Struyven & Steurs, 2005). Experiences among users of free choice market systems can even be strikingly negative in terms of perceived inadequate service supply and service cutbacks (Spall et al., 2005).

People with psychiatric disabilities are a possible target group for free choice systems. After many years of ideological discussions and reforms, they are still not included in society today. In order to remedy that, reforms in Sweden have strongly emphasized support to meaningful everyday activities (Lindqvist, Markström, & Rosenberg, 2010; Markström, 2003). Most local authorities now offer various alternatives for productive and/or social activities for people with psychiatric disabilities. At the same time, these alternatives include a variety of support with differing foci, from social meeting places with a drop-in character to more structured alternatives with a work orientation (Tjörnstrand, Bejerholm, & Eklund, 2011).

Very little is known about the effectiveness of day centers that provide meaningful activity (Catty, Burns, Comas, & Poole, 2007; Eklund & Sandlund, 2012; National Board of

Health and Welfare, 2011). Research has, however, indicated that day centers host an unused potential for varying and grading the demands the activities put on the attendees (Tjörnstrand et al., 2011) and that they feel empowered when feeling that they manage tasks and responsibilities (Tjörnstrand, Bejerholm, & Eklund, 2013a). Empowerment is defined here as the control over one's life and recovery process (Rogers, Chamberlin, Ellison, & Crean, 1997). Furthermore, comparative studies have shown that day center attendees tend to have more valued activities than non-attendees, but that they were not more satisfied with everyday activities in general (Argentzell, Leufstadius, & Eklund, 2012). The day center attendees also had a larger number of social contacts in general, but not more close ones (Argentzell, Leufstadius, & Eklund, 2013). A conclusion might thus be that effective day centers promote empowerment, activity and social interaction, and when evaluating the outcomes of reforms and other types of interventions these variables would be adequate outcome measures.

Day centers are generally run by the municipalities in Sweden, but the government has during the past five years encouraged the local authorities to contract alternative providers when developing the support for meaningful productive activities. In 2009 the law "the Act on freedom of choice system" (Swedish Governmental Reports, 2008) was introduced. The political intention was twofold: i) to develop a system where the individual freedom of choice could be increased, and ii) to facilitate a diversity of providers that offer service of high quality, thus implying competition between providers. The law indicates that the local authorities may use private and non-governmental organizations as service providers and arrange a market system of support and care so that the user can choose among the different available alternatives. The act on freedom of choice thus opened up for reforms based on two principles, one being the users' right to choose and the second the procurement of a wide range of providers. Several municipalities in Sweden have adopted the freedom of choice law,

and have introduced reforms accordingly, but only a few have chosen to organize the day centers in accordance with its two main principles. Users were referred to publicly run day centers in their home district prior to the implementation of the act. After its launch, they have the possibility to choose among all available and approved providers in the whole area served by the city administration, as long as their individual needs have been assessed and decided upon by the local authority. These decisions are linked to an administrative voucher system, which means that "the money follows the client" all the way to the specific provider chosen by the user (Friedman & Friedman, 1990).

To the best of our knowledge, no evaluation study of a freedom of choice system exists within the context of day centers for people with psychiatric disabilities. Based on the existing research on day centers referred to above, an effective reform would be one that leads to more empowered and active users (Tjörnstrand et al., 2013a). It should also result in better satisfaction with the day center services and a higher level of engagement, as the intentions with the freedom of choice system in question was to increase the possibilities for matching individuals' preferences with available offers. According to previous research, such a match has been found to be vital for client satisfaction and engagement (Leufstadius, Eklund, & Erlandsson, 2009; Rebeiro & Cook, 1999; Tjörnstrand et al., 2011). Finally, since research has shown that one of the main advantages with attending a day center is an increased number of social contacts (Argentzell et al., 2013) one can also expect a change in that respect. It could thus be anticipated that the day center attendees' ratings of empowerment, social contacts and satisfaction with the day center services would improve with the free choice reform.

Aims of the Study

The aim of the present study was thus to investigate the outcomes of the freedom of choice reform as perceived by the users of day center services. The following research questions guided the study:

- To what extent did the users take advantage of the reform, i.e., change from one unit to another, and what were their reasons for changing?
- What were the users' opinions about the freedom of choice reform?
- Did the users' ratings of their empowerment, social network and engagement in and satisfaction with the day center services change after the launch of the reform, as indicated at a 15-month follow-up?

Material and Methods

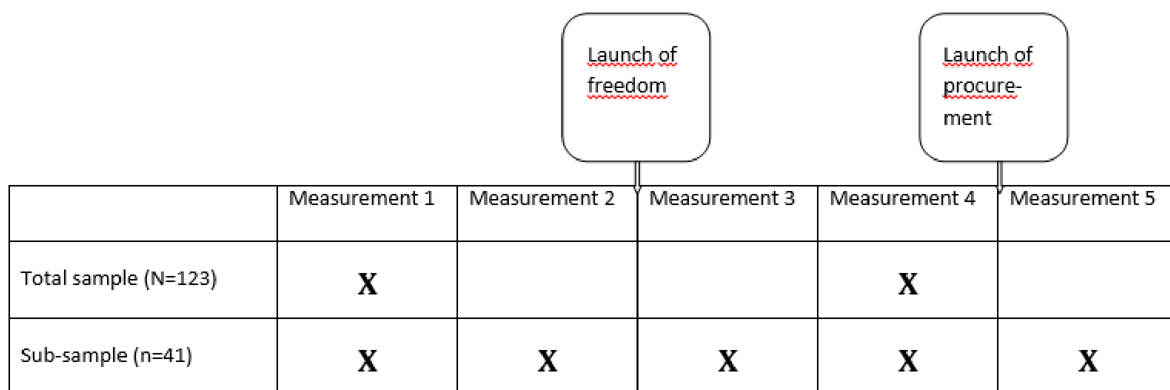
The Study Design

This was a naturalistic study following and evaluating a freedom of choice reform decided on by the local authorities in a major Swedish city and implemented by the community-based mental health services. The first principle of the reform (the user's right to choose) was implemented in 2010 and the second (procurement of private or non-governmental alternatives) in 2011. Participants were included from September 2009 (before the law was implemented) to March 2011 and completed standardized instruments about well-being, daily activities and satisfaction with the services. They were followed up 15 months after inclusion

by completion of the same instruments. All available participants were also interviewed in 2012 (from June to September) about their opinions of the reform.

The study included a time-series design with five measurement points for a subsample consisting of the first included participants over a three year period (2009 – 2012). Two of these measurements took place before the launch of the reform and formed two baselines. This was to control for natural variation in the variables assessed by the instruments before the implementation of the first principle (the right to choose) of the reform. The following three measurements were follow-ups after the launch of the reform. The first of these took place 5-7 months after the first principle was introduced and the second 12-14 months after. The last follow-up was one year after instigation of the second principle (procurement). These tighter follow-ups for a subgroup were to monitor changes while the reform was in action.

Figure 1. Scheme over the measurements.



	Measurement 1	Measurement 2	Measurement 3	Measurement 4	Measurement 5
Total sample (N=123)	X			X	
Sub-sample (n=41)	X	X	X	X	X

Ideally, there would be stability between the two baselines and, if the reform was effective, a change would be identified between the follow-ups. Figure 1 shows the measurement points for the total sample and the subsample for the repeated measurements.

The study was approved by a local ethical vetting board and registered at ClinicalTrials.gov.

Selection Procedures and Inclusion of Participants

The selected city was by far the largest area where the freedom of choice reform was implemented and offered a geographical and socio-demographic variety under the one and same political government and service organization. Four urban districts (of 14) were strategically selected. The first criterion was that the district would include at least one day center. The next criterion was to obtain geographical variation, and the districts were grouped into northern, southern, eastern and western districts. The last criterion, socio-demographic variation, decided the final selection of districts. Two of them were centrally located and two were more distant from the city center. Two districts had two day centers each, and the study thus included six centers.

Once permission was obtained on the center level, information meetings for the users were held in each center. The principles of informed and voluntary consent were highlighted, along with information about the study. Exclusion criteria were comorbidity of dementia or intellectual disability, a main diagnosis of substance use disorder, and visiting the day center less than four hours per week. These criteria were assessed by the day center staff. Approximately 50% of those who were asked agreed to participate and gave their written informed consent.

By these procedures, 77 participants were included in 2009, 41 of whom participated in the time-series substudy. New users at the selected day centers were invited to participate at the time of the later measurements and the study finally comprised a total of 123 participants who regularly attended day centers at least four hours per week. Fifty-four percent of them

were females, 88% were singles and the sample's mean age was 51 years. A majority, 53%, did not have any children, but 80% reported having a supportive friend. Twenty-eight percent were not born in Sweden. The most common geographical origins for these latter participants were Finland and the Middle East. Sixty-eight percent had completed high school or had a higher education, whereas 7% had not completed nine-year compulsory school. About two thirds, 68%, lived independently without housing support. According to the self-reported diagnoses (see background questionnaire below), 51% suffered from anxiety or mood disorders, 28% had a psychosis and 20% reported other diagnoses, most commonly a neuropsychiatric disorder. The mean score for a global rating of psychosocial functioning, the Global Assessment of Functioning (Endicott, Spitzer, Fleiss, & Cohen, 1976), was 50, indicating severe symptoms and no work ability.

The Data Collection

Two research assistants, who were occupational therapists with vast experience from working with people with psychiatric disabilities, collected the data at personal meetings with each participant in a secluded room at the day center.

Background questionnaire

A *background questionnaire* was developed to gather information about socio-demographic data, self-reported diagnosis and use of the day center services. The self-reported diagnoses were subsequently "translated" by a specialized psychiatrist into ICD-10 diagnoses (WHO, 1993). In a final round of data collection, which included all remaining participants in 2012, the questionnaire also included open-ended questions about the participants' views on the freedom of choice reform.

Empowerment

Perceived empowerment was estimated by the *Empowerment Scale* (Rogers et al., 1997; Rogers, Ralph, & Salzer, 2010). It contains 28 items and a four-point response scale is used, ranging from 1 = strongly agree to 4 = strongly disagree. A higher rating indicates more empowerment. Five subscales have been proposed; self-efficacy – self-esteem; power – powerlessness; community activism; righteous anger; and optimism – control over the future. The Swedish version was used for the present study. It has been found to have good internal consistency and construct validity for the total scale, but for most subscales the internal consistency was lower than acceptable (Hansson & Bjorkman, 2005). Therefore, only the total score was used for the present study.

Social network

One subscale from the Interview Schedule for Social Interaction (Henderson, Duncan-Jones, Byrne, & Scott, 1980) was employed. The Swedish version, termed *Interview Schedule for Social Interaction – Self Rating version (ISSI-SR)* and used for this study, has been shown to have good reliability and validity (Undén & Orth-Gomer, 1989), also when used with people with different psychiatric conditions (Eklund, Bengtsson-Tops, & Lindstedt, 2007). The ISSI-SR focuses on two main aspects, namely wider social interaction, vital for community integration (social integration), and close relationships, important for human development (attachment). Each main aspect, in turn, includes both a quantitative (number of contacts) and a qualitative subscale (degree of support). Only the quantitative aspect of social integration was addressed in the present study, to assess the size of the social network. The scoring renders a maximum score of six, where a higher rating indicates a larger social network.

Engagement in activities

The *Profiles of Occupational Engagement in Productive Occupations, POES-P* (Tjörnstrand, Bejerholm, & Eklund, 2013b), was used to assess the participants' level of engagement in the day center. It is a self-report instrument where the first part is a diary sheet covering the eight hours of a working day. In the second part, the respondent rates his or her engagement in the day center activities, in accordance with eight items that are rated from 1 (lowest level of engagement) to 5 (highest level of engagement). Only part two was used for the present study. The POES-P has shown satisfactory construct validity, face validity and internal consistency (Tjörnstrand et al., 2013b).

Satisfaction with the day center services

Satisfaction with attending the day center was estimated by means of *the Client Satisfaction Questionnaire (CSQ)* (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). It comprises of eight items measuring the clients' satisfaction with the care received and was slightly rephrased to suit the day center context. A four-point response scale is used, where 1 = very dissatisfied and 4 = very satisfied. The Swedish version used has shown excellent internal consistency (Eklund & Erlandsson, 2013).

Dropouts

For 25 of the 123 initially included participants it was not possible to await the 15-month follow-up. This was for practical and economic reasons. There was also a dropout of participants during the study period and 60 users (61% of the 98 that were possible to follow up) participated in the follow-up. The main reasons for not participating were not showing up after three scheduled meetings, declining because of illness, no longer attending a day center

or being unavailable. The dropouts did not differ from the participants on the variables used to characterize the sample: gender, age, having supportive friends, educational level, ethnic origin, self-reported diagnosis or psychosocial functioning. There were also no baseline differences on the outcomes targeted in this study: empowerment, size of the social network, engagement in activities or satisfaction with the day center services.

The interviews performed in 2012, about the users' view of the freedom of choice reform, were made with a total of 78 participants, including those 18 that could not be enrolled in the follow-up.

In the time-series substudy, which lasted for three years, 23 (56%) of the 41 in the subsample remained from baseline to the last follow-up. The dropouts did not differ from the others in any of the socio-demographic or outcome variables mentioned above. There was a tendency, however, that the dropouts had a higher education ($p=0.067$).

Data Analysis

This study was mainly quantitative, but the open-ended questions regarding the freedom of choice reform required qualitative analysis, and a simple content analysis was performed. This qualitative data supplemented the quantitative data, and the brief responses were grouped together according to their manifest content, as proposed by Kripendorff (2013).

Non-parametric statistics were considered most appropriate for analyzing the quantitative data since the instruments produced ordinal data. Wilcoxon's test (two comparisons) or Friedman's test (multiple comparisons) was used to calculate changes over time, and Spearman correlations were employed to analyze associations between variables. The Mann-Whitney test and the Chi-squared test employed to test group differences, mainly

for the dropout analysis. The SPSS 20 software was used and a p-value < 0.05 was regarded statistically significant.

Results

Day Center Participation and the Reform

Forty-four (56%) of the 78 participants interviewed in 2012 knew about the freedom of choice reform, but only 15% had taken the opportunity to move from one day center to another. Only half of these had actively decided they wanted a change. The others had moved to another day center because their former one had been closed down. When asked about their views on the reform, 33 expressed an opinion. Nineteen stated that the reform did not mean much, as indicated by expressions such as "nothing special", "doesn't matter", and "nothing, but good to know". Eight thought the reform had had a negative effect, and expressed themselves in terms of "nothing works in practice, there are only economic reasons [for the reform]", "it hinders participation" and "hard to overview". Six participants had positive experiences from the reform and stated that "nice to be able to influence", "it is good" and "I got the opportunity to change".

When comparing day center attendance between the baseline measurement and the follow-up a decrease from on average 15 to 13 hours per week was found ($n=60$; $p<0.022$). There was a statistically significant correlation between reduction in hours and satisfaction with the day center services at the follow-up ($r_s=0.27$; $p=0.041$).

Changes in the Participants' Empowerment, Social Network, Activity and Satisfaction

No changes in perceived empowerment (p=0.309), the size of the social network (p=0.298) or engagement in the day center activities (p=0.579) occurred between the baseline and the follow-up. In terms of satisfaction with the day center services, the participants' ratings decreased from baseline to the follow-up (p=0.001). No differences between "stayers" and "movers" were found on any of the outcome variables, neither when based on the baseline values (p-values ranging between 0.082 and 0.865) nor the follow-up data (p-values ranging between 0.255 and 0.906).

The Time Series Analysis

Regarding empowerment, stability was indicated over the first four measurements (the two baselines and the first two follow-ups; see Table 1). The rating at the last follow-up, after the procurement principle had been launched, differed from the others, however, and indicated a statistically significant lower level of empowerment. An initial p-value of 0.00046 remained statistically significant after Bonferroni correction. The size of the participants' social network and their engagement in the day center activities were both stable over time, as indicated by the non-significant p-values. Satisfaction with the day center services was also stable over time in this subgroup.

Table 1. Development over time in the subgroup of 41 persons included in the time-series analysis.

	Grouped median					P-value
	Base-line 1	Base-line 2	Follow-up 1	Follow-up 2	Follow-up 3	
Empowerment	77	78	78	79	61	0.009 [1)]
Social network	2.7	2.9	2.9	2.6	2.8	0.363
Engagement in day center activities	34	34	33	34	33	0.236
Satisfaction with day center services	27	27	27	25	26	0.081

[1)] Bonferroni correction for multiple comparisons was employed.

Discussion

Although 6 of the 78 participants, when interviewed two years after the reform, stated that the reform had been positive for them, the findings did not indicate any positive effects on the group level. The changes that occurred were in a negative direction, which is in line with previous research on free choice systems (Bredgaard & Larsen, 2008; Finn, 2009; Perri6, 2003; Spall et al., 2005; Struyven & Steurs, 2005). The negative changes concerned decreased satisfaction with the services at the 15-month follow-up in the sample as a whole and a lower level of empowerment at the final follow-up in the more intensely studied subgroup. The fact that satisfaction with the day center services decreased in the total sample but not in the subsample that was more intensively followed must be considered in the light of two circumstances. One is that the follow-up for the larger sample occurred on the subsample's fourth measurement, and there was also a dip in the subsample's ratings at that time (cf. Table

1). The other has to do with the sample size; that dip did not become statistically significant in the smaller sample.

Concerning the other outcomes, the social network and engagement in the day center activities, no changes could be discerned. How can we then understand this absence of improvement? Were there reasons to expect greater satisfaction, more active and improved users? And how do we understand the lack of inclination to move to another day center? These issues will be elaborated on below.

The reason for no positive effects of the reform being discerned, either in the larger or the more intensely followed subgroup, could simply be that the users were not interested in any changes and that it was the city administration who wanted a reform based on the law of freedom of choice, thus illustrating a top-down process with unclear legitimacy at the grass root level. It is also possible that many users were challenged, due to possible cognitive or other personal difficulties, in accessing the new system. The fact that almost half of the study participants reported not having heard of the reform indicates that, for them, the information had been insufficient and/or ineffective. It could also be that the reduction in hours, shown to be associated with a lower level of satisfaction with the services, counteracted any possible positive effects. The number of hours spent in the day center has in previous research been found important for engagement in the day center activities (Tjörnstrand, Bejerholm, & Eklund, in press).

There was also a low level of interest in moving to a new day center. The participants stated that the reform did not matter to them and would not make a difference. A set of further explanations may be found in the character of the reform. Theoretically, it would be easy for the user to make a choice and change to another day center, but this process can be

experienced as much more difficult in practice. The issue of geographical distance can for example be seen as a barrier. Using public transport has been shown to be anxiety provoking for the target group (Bejerholm & Eklund, 2004; Tjörnstrand et al., 2013a) and may also infer noticeable costs to the user. Other components such as access to information and a case manager that can assist in decision-making may also play a role, and scarcity of such resources was actually indicated by the result showing that only approximately half of the respondents knew about the reform 2.5 years after the principle of freedom of choice was launched. Reluctance to move may also have to do with dependence on the current day center staff, perhaps reinforced by low self-confidence. Previous research has shown that staff support is seen by the users as one of the major helping factors in activity-based rehabilitation (Eklund, 1997). Furthermore, new systems may create worries about the future and thoughts about hidden agendas, and one can also speculate that any worries among the staff may have spread to the users.

A related study (Andersson, Eklund, Sandlund, & Markström, 2014) showed that there has been a notably slow establishment of new and alternative providers and only a handful of new organizations, besides already existing publicly run units, existed in 2012 when the data collection was completed. This may be another possible explanation for the low level of interest in moving. The study by Andersson and colleagues also indicated that, so far, day center services form a market with little attraction due to limited incentives in terms of, for example, financial profit. In practice this can also mean a lack of interesting options for the users.

Furthermore, implementation of new systems takes time! Longer follow-ups may be needed to identify possible consequences.

Limitations

This study had some methodological limitations that need to be acknowledged. First, there was no control group. Theoretically, another city could have served as a control area, but since political and administrative regimes differ between cities and might influence the services in an unknown way we chose to include multiple baselines and follow-ups for a subgroup. This should constitute a sufficient measure of control for natural variation.

Furthermore, there was a considerable loss of study participants over the follow-up period, which is standard in studies of people with severe mental health conditions (Argentzell et al., 2012; Bengtsson-Tops, 2004). This may jeopardize representativity and both internal and external validity. However, the dropouts did not differ from the participants on any of the investigated variables, which suggests the study has internal validity and the sample is representative of the targeted group. The external validity must, however, be seen as limited, particularly since administrations and political regimes tend to differ between cities.

Conclusion

The freedom of choice reform did not reach the intentions of providing better services, according to the findings of this study. The satisfaction decreased for the sample as a whole and empowerment dropped for a more intensively studied subgroup. The participants were reluctant to move from one day center to another and to take the opportunity the reform provided. The reasons given for this were that the reform did not matter to them and would not make a difference. This study seems to be one of the first to study the consequences of a freedom of choice reform within community mental health. Although the study has certain limitations, such as a dropout rate of 35% from baseline to the 15-month follow-up, the result should be considered when decisions are made about similar reforms in the future.

References

Andersson, M., Eklund, M., Sandlund, M., & Markström, U. (2014). Freedom of choice or cost efficiency? The implementation of a free-choice market system in community mental health services in Sweden. *Manuscript submitted for publication*.

Argentzell, E., Leufstadius, C., & Eklund, M. (2012). Factors influencing subjective perceptions of everyday occupations: comparing day centre attendees with non-attendees. *Scandinavian Journal of Occupational Therapy, 19*, 68-77.

Argentzell, E., Leufstadius, C., & Eklund, M. (2013). Social interaction among people with psychiatric disabilities - Does attending a day centre matter? *International Journal of Social Psychiatry*.

Bejerholm, U., & Eklund, M. (2004). Time-use and occupational performance among persons with schizophrenia. *Occupational Therapy in Mental Health, 20*(1), 27-47.

Bengtsson-Tops, A. (2004). Mastery in patients with schizophrenia living in the community: relationship to sociodemographic and clinical characteristics, needs for care and support, and social network. *Journal of Psychiatric and Mental Health Nursing, 11*, 298-304.

Bredgaard, T., & Larsen, F. (2008). Quasi markets in employment policy: Do they deliver on promises? *Social Policy and Society, 7*, 341-352.

Catty, J., Burns, T., Comas, A., & Poole, Z. (2007). *Day centers for severe mental illness*. Cochrane Database of Systematic Reviews 2007, Issue 1. Art. No.: CD001710. DOI: 10.1002/14651858.CD001710.pub2.

Eklund, M. (1997). Therapeutic factors in occupational group therapy identified by patients discharged from a psychiatric day center and their significant others. *Occupational Therapy International, 4*, 198-212.

Eklund, M., Bengtsson-Tops, A., & Lindstedt, H. (2007). Construct and discriminant validity and dimensionality of the Interview Schedule for Social Interaction (ISSI) in three psychiatric samples. *Nordic Journal of Psychiatry, 61*, 182-188.

Eklund, M., & Erlandsson, L. K. (2013). Quality of life and client satisfaction as outcomes of the Redesigning Daily Occupations (ReDO) programme for women with stress-related disorders: A comparative study. *Work, 46,* 51-58.

Eklund, M., & Sandlund, M. (2012). The life situation of people with persistent mental illness visiting day centers: A comparative study. *Community Mental Health Journal, 48*, 592-597.

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The global assessment scale. A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry, 33*, 766-771.

Finn, D. (2009). The “welfare market” and the flexible new deal: Lessons from other countries. *Local Economy, 24*, 38-45.

Friedman, Milton, & Friedman, Rose D. (1990). *Free to choose : A personal statement* (1st Harvest/HBJ ed.). San Diego: Harcourt Brace Jovanovich.

Hansson, L., & Bjorkman, T. (2005). Empowerment in people with a mental illness: reliability and validity of the Swedish version of an empowerment scale. *Scandinavian Journal of Caring Sciences, 19*, 32-38.

Henderson, S., Duncan-Jones, P., Byrne, D. G., & Scott, R. (1980). Measuring social relationships. The Interview Schedule for Social Interaction. *Psychological Medicine, 10*, 723-734.

Jolley, G., Freeman, T., Baum, F., Hurley, C., Lawless, A., Bentley, M., . . . Sanders, D. (2014). Health policy in South Australia 2003-10: primary health care workforce perceptions of the impact of policy change on health promotion. *Health Promotion Journal of Australia, 25*, 116-124.

Krippendorff, Klaus. (2013). *Content analysis: An introduction to its methodology* (3rd ed.). Los Angeles; London: SAGE.

Leufstadius, C., Eklund, M., & Erlandsson, L. K. (2009). Meaningfulness in work – Experiences among employed individuals with persistent mental illness. *Work, 34*, 21-32.

Lindqvist, R., Markström, U., & Rosenberg, D. (2010). *Psykiska funktionshinder i samhället. Aktörer, insatser, reformer* [Psychiatric disabilities in society. Actors, interventions, reforms]. Malmö: Gleerups.

Markström, U. (2003). *Den svenska psykiatrireformen. Bland brukare, eldsjälar och byråkrater* [The Swedish mental health reform. Among users, enthusiasts and bureaucrats]. Umeå: Boréa förlag.

National Board of Health and Welfare. (2011). *Nationella riktlinjer för psykosociala insatser vid schizofreni och schizofreniliknande tillstånd - stöd för styrning och ledning.* [National guidelines for psychosocial interventions for schizophrenia and related disorder - support for management and leadership]. Stockholm: National Board of Health and Welfare.

Perri6. (2003). Giving consumers of British public services more choice: What can be learned from recent history? *Journal of Social Policy, 32*, 239-270.

Rebeiro, K. L., & Cook, J. V. (1999). Opportunity, not prescription: an exploratory study of the experience of occupational engagement. *Canadian Journal of Occupational Therapy, 66*, 176-187.

Rogers, E. S., Chamberlin, J., Ellison, M. L., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services, 48*, 1042-1047.

Rogers, E. S., Ralph, R. O., & Salzer, M. S. (2010). Validating the empowerment scale with a multisite sample of consumers of mental health services. *Psychiatric Services, 61*, 933-936.

Spall, P., McDonald, C., & Zetlin, D. (2005). Fixing the system? The experience of service users of the quasi-market in disability services in Australia. *Health and Social Care in the Community, 13*, 56-63.

Struyven, L., & Steurs, G. (2005). Design and redesign of a quasi-market for the reintegration of jobseekers: Empirical evidence from Australia and the Netherlands. *Journal of European Social Policy, 15*, 211-229.

Swedish Governmental Reports. (2008). Lag (2008:962) om valfrihetssystem [Law (2008:962) about freedom of choice systems]. Stockholm: Swedish Governmental Reports.

Tjörnstrand, C., Bejerholm, U., & Eklund, M. (2011). Participation in day centres for people with psychiatric disabilities: Characteristics of occupations. *Scandinavian Journal of Occupational Therapy, 18*, 243-253.

Tjörnstrand, C., Bejerholm, U., & Eklund, M. (2013a). Participation in day centres for people with psychiatric disabilities – A focus on occupational engagement. *British Journal of Occupational Therapy, 73*, 144-150.

Tjörnstrand, C., Bejerholm, U., & Eklund, M. (2013b). Psychometric testing of a self-report measure of engagement in productive occupations. *Canadian Journal of Occupational Therapy, 80*, 101-110.

Tjörnstrand, C., Bejerholm, U., & Eklund, M. (in press). Factors influencing occupational engagement in day centres for people with psychiatric disabilities. *Community Mental Health Care.*

Undén, A. L., & Orth-Gomer, K. (1989). Development of a social support instrument for use in population surveys. *Social Science and Medicine, 29*, 1387-1392.

WHO. (1993). The ICD-10 classification of mental and behavioural disorders. Geneva: World Health Organization.