Health professionals' experiences of person-centered collaboration in mental health care

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Objective: The basic aim in this paper is to discuss health care professionals' experiences of person-centered collaboration and involvement in mental health rehabilitation and suggest ways of improving this perspective. Furthermore, the paper explains the supportive systems that are at work throughout the process of rehabilitation.

Method: The study design is a qualitative approach using three focus group interviews with a total of 17 informants with different professional backgrounds such as nurses, social workers, and social pedagogies. In addition, one nurse and one social worker participated in a semi-structured in-depth interview to judge validity.

Results: Our results may demonstrate deficits concerning mental health care on several levels. This understanding suggests firstly, that a person-centered perspective and involvement still are uncommon. Secondly, multidisciplinary work seems uncommon and only sporadically follows recommendations. Thirdly, family support is seldom involved. Lastly, firm leadership and knowledge about laws and regulations seems not to be systematically integrated in daily care.

Conclusion: Taking these matters together, the improvement of a person-centered perspective implies cooperation between different services and levels in mental health care. In order to bring about improvement the health care workers must critically consider their own culture, coordination of competence must be increased, and leadership at an institutional and organizational level must be improved so that scarce rehabilitation resources are used to the optimal benefit of people with a mental illness.

Keywords: multidisciplinary teams, person-centered collaboration, supportive systems, rehabilitation

Introduction

This article deals with health care professionals working with people with a mental illness, involvements in rehabilitation, and highlights some important choices and activities which can lead this work in terms of better personal involvement. Mental health care is a complex area and many categories of professionals are involved. Recent quality indicators derived from international standards to guide practice indicate the importance of person involvement, high quality competence, leadership, and official policy (NDHSA 2005). In future health care and social settings, we will meet people with more complex problems than at present, which will require greater multidisciplinary cooperation. The organization of the mental health service in Norway is currently undergoing a series of fundamental changes to meet these challenges. New legislation has been introduced with an aim to alter the structures, organizational practices, and coordination between professionals. Important changes imply that the focus will shift away from the domains of the health professionals to the services, and from health professionals to people with mental illness.

These changes might fruitfully be considered as a paradigm shift in our field. When paradigms shift in an event described as a revolution, current realities are challenged

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(Kuhn 1970). As described above, there are major shifts occurring in knowledge about and practice in mental health care, and these reflect new ways of meeting the peoples' care needs (SPN 1997–1998; HRW 2006). In this context, this signifies a movement towards more use of multidisciplinary work and empowerment by focusing on the peoples' own responsibility and resources in rehabilitation. This perspective may expand and strengthen traditional biomedical concepts in favor of a biopsychosocial approach in which biological and psychosocial factors, as well as person involvement interact in a dynamic system (Engel 1980; White 2005). Using the person-centered approach means that people with a mental illness are active collaborators in decision-making.

Previous research dealing with rehabilitation of people with a mental illness has focused on multidisciplinary teams (Keiser and Lund 1986; Loxley 1997; Dahl and Mo 2000; Carpenter et al 2003), their benefits and drawbacks (Zeiss 1997), the integrated care pathway (Dahl and Mo 2000; Hall 2001), interprofessional role relations (Peck and Norman 1999), family support (Scheidt 1994; Burns and Firn 2002; Piippo and Aaltonen 2004; Featherstone 2006) and leadership (Loxley 1997; Scheidt 1998). There has been an increasing focus on the importance of person participation (Kidd et al 2007; Jubb-Shanley and Shanley 2007; Happell 2008). Against this background, the basic aim of the current paper is to discuss the mental health care professionals' experiences of person-centered collaboration and involvement in rehabilitation and highlight some important choices and activities we mean can lead this work in terms of more person involvement. Furthermore, the paper will explain the supportive systems that are at work through the process of mental health rehabilitation.

Theoretical framework

Mental health care

Mental health care professionals are faced with difficult and complex decisions every day, and these decisions can dramatically affect the peoples' lives (Loxley 1997; Dahl and Mo 2000). External pressures on professionals to make good judgments and decisions have increased in recent years (NBHS 2007a, 2007b). Team work can help with bringing together skills, sharing information and achieving continuity (Glasby and Lester 2004). In such a context, multidisciplinary teams need procedures to help them make decisions (Loxley 1997). Multidisciplinary teams are composed of nurses, social workers, psychologists, psychiatrists, and other staff members and are formed according to the persons' needs for service. Each discipline involved is responsible for gathering data and participating in the planning of care. Guidelines indicate that at least three disciplines are necessary for optimal rehabilitation, and the expertise should include care, medicine, and psychosocial work (Burns and Firn 2002).

An often-cited platform in multidisciplinary work is Keiser and Lund (1986), who outline several distinctive features; such as integration of knowledge, high professional skills, and dynamic and flexible teams. The purpose of care management using multidisciplinary teams is to gain a rapid and best possible match between the peoples' needs and the skills and resources available (Øvretveit 1998; SHD 2005). A well-structured team is said to have the right mix of skills. The members must work out who does what and they must be flexible in order to respond to changing demands (Øvretveit 1998). As illustrated by Øvretveit (1998), team culture and procedures may cause the differences between creative and destructive circles.

Person involvement

There is a long history of including the voice of the person in mental health care (Kidd et al 2007). However, for people to be involved in decision-making, they need to be able to obtain and understand the information given (Øvretveit 1998). As described by Jubb-Shanley and Shanley (2007) the mental health service often fails in assisting individuals to live at their optimal level. Reasons for this may be that negative attitudes pose a major barrier to person involvement (Happell 2008). If we wish to increase person involvement, Øvretveit suggests that we not only have to develop alternatives, but that we also must change the way we communicate and relate to people with a mental illness. He also states that we need new skills and methods, which are not well developed at present.

From a biopsychosocial perspective (Engel 1980; White 2005), the starting point in rehabilitation must be the peoples' resources. We need to work with the people and engage in a good dialogue (Surber 1994). This also means treating each person differently (MHAPE 2005). The term "pathway" is used to describe people following one or more routes that are usually laid out by the team members. The team has different stops along this route to meet them and to mobilize resources. By understanding the pathways most people follow, multidisciplinary teams can plan ways to respond more quickly, offer more choices, and obtain a better match between the peoples' needs and the team-members' skills (Øvretveit 1998). Change is the core issue in mental health care, with multiple pathways that need to be understood at clinical and organizational levels to increase

personal involvement. In addition, each person has different needs at various times, so that flexible solutions are required (Øvretveit 1998). As a result, the team members must follow each person's pathway and be an available partner in the supportive system.

Family support

Families often complain that their right to be involved in care is limited. However, families represent a fundamental support system (Burns and Firn 2002). They give us the first experience with interpersonal relationships. Even when there is no longer ongoing communication with the person, these experiences usually remain an important development factor in mental health care (Scheidt 1994). Not only the person, but also his/her family must be considered as a kind of users of the mental health service. This means that when one family member suffers, the whole family is involved. Family members often consider themselves an important resource in the encounter with the mental health service. However, their expertise is often forgotten in mental health care (Featherstone 2006). Often the treatment of mentally ill people is a long-term process. In this course of events, helplessness and exhaustion are common problems among family members (SMR 1996–1997), who also need attention and support. With sufficient support, the family can be an excellent ally in serving the person (Surber 1994).

Leadership, laws, and regulations

Several authors highlight team leadership as a key strategy for effective functioning of the team members (Loxley 1997; Scheidt 1998). The Norwegian plan for mental health care (SPN 1997–1998) emphasizes establishing new organisation forms and institutions conducted by firm management, as well as competence building.

In traditional service provision, the professionals hold the power and make decisions about the care and treatment of the people with mental illness. Previous work to describe the professional point of view has focused on concepts such as partnership (Compton and Galaway 1994; MHAPE 2005), empowerment (Solomon 1994; Turner 1978), case management (Ryan et al 1999), and citizens (Sayce 2000). In recent Norwegian white papers, the focus in rehabilitation is increasingly on relationships and processes, and several concepts are used such as "*Person involvement*" (SMN 1996–1997), "*The patient first*" (NOU 1997), "*There is use for everyone*" (NOU 1998), "*A new plan in mental health care*"(SPN 1997–1998), *The Patients' Rights Act* (Lovdata 1999), "*Individual plan*" (NDH 2006), "*Guidelines to mental health work for adults in municipalities* (SHD 2005), "*National Strategy for Quality Improvement*" (NDHSA 2005), inspired by similar strategies in other countries, and "*Relatives and family – a resource*" (SHD 2007).

Methods

Sample

The current study is a qualitative approach with interviews based on data from different institutions in two municipalities as part of a larger study. A purposive sample was used indicating that the composition of informants are based on the researchers' knowledge of the population and how well they can throw light on our research question. Three focus groups (totally 9 males and 8 females from different psychiatric departments and with different professional background amplified in Table 1) were interviewed twice. Additional considerations for sample collection included two more in-depth interviews of participants from the same organization to get a deeper understanding of teamwork and person involvement. Inclusion criteria were: specialization in mental health care, at least one-year work experience after completion, working in mental health care, and the main task is rehabilitation.

All participants were fully informed orally and written instructions were delivered. It was emphasized that voluntary participation was required and that they could leave the program at any time. Information would be handled confidentially, and written informed consent was obtained before inclusion. The regional Committee for Medical Research Ethics, Health Region West, Norway approved the study.

Data collection

As described in the introduction, the organization of the mental health service is currently undergoing fundamental changes, which includes new legislation to alter structures, organizational practices and coordination between professionals in multidisciplinary teams. With this in mind, discussions in the focus groups centered on main working tasks and the time spent on these tasks, as well as engagement in multidisciplinary work and the relevance of care. An interview guide was prepared giving the range of topics, and several sub-questions were outlined to support these topics (Appendix 1a). A questionnaire was delivered on beforehand to collect sociodemographic variables and one item where they should rank their main work tasks. The first focus group interview lasted approximately for one-and-a-half hours, while the second lasted for one hour.

To get a deeper understanding and validate these findings, two more in-depth interviews with respondents further

Table 1 Major findings from three focus group interviews listing the participants' profession, institutional affiliation, views of multidisciplinary work and priority of main working tasks. N = 17 participants (9 men and 8 women)

Focus groups	N/profession	Institution	Views of multidisciplinary work	Priority of main working tasks
1.	5 female (nurses)	District psychiatric centre	– Not a main focus	
			– Difficult to establish, several challenges must be considered	2 leadership
				2 group therapy
				1 consultation
2.	3 female, 2 male (nurses, social workers, social pedagogics)	Municipal psychiatric service	– Seldom, if it happens only two different professionals are involved	3 individual therapy
			– Ideally we should have this more often in focus	2 milieu therapy
3.	7 male* (nurses, social workers, social pedagogies)	Four different departments in one psychiatric institution	– Teamwork is often associated with stress	2 leadership
			– It is described by nurses as an activity mainly in inpatient-departments	2 individual therapy
			– It is described by social workers as an activity mainly in outpatient-departments	2 consultation

Notes: N, number of participants; *1 person is missing.

explored these issues that emerged from the analysis of the previous focus group interviews and questionnaires. The main topics from the interview guide were procedures for multidisciplinary work, client and family involvement, leadership, laws, and regulations (Appendix 1b). These professionals represented different gender and professional backgrounds and belonged to the same organization. These interviews lasted approximately one hour each.

Data analysis

The whole data set generated by the three focus groups and the two individual interviews were analyzed qualitatively. First, the focus group interviews were tape-recorded and transcribed according to guidelines from Morgan (1997). Second, the interviews were read in its entirety to gain a contextual understanding of the participants' experiences. Third, content analysis was performed to identify major themes in the data inspired by several authors (Kvale 1996; Graneheim and Lundman 2004; Elo and Kyngäs 2007). There are no systematic rules for analyzing data within this tradition, and the feature of all content analysis is that many words of the text are classified into categories (Elo and Kyngäs 2007). The researchers coded independently and then came to consensus on a certain portion of the text prior to finalizing codes. By listening to all the interviews several times, important nuances were discovered by going beyond the informants' common sense of understanding searching for common and distinctive features as well as variations. Data analysis related to the individual interviews followed the same procedure described above.

Results

To give an overview of our findings, some data from the interviews are presented by direct quotations. In addition, Table 1 provides major findings from three focus group interviews by listing the participants' profession, institutional affiliation, views of multidisciplinary work, and the priority of main working tasks, while Table 2 illustrates data from the two in-depth interviews which were classified into categories.

Most important working tasks and time spent

Concerning important working tasks and priority, there seems to be a great deal of unforeseen elements when working in mental health care. One of the participants in focus group 1 says: "*When a person's discharge is suddenly decided, I always think that a plan must be prepared in case of crisis. What shall the patient do when a crisis occur and what shall the network do?*" When

Table 2 Major findings from the validation process with two informants. Data are conceptualized within the main categories: procedures for teamwork, person involvement, family support, leadership, laws, and regulations

Levels of analysis	Informant 1	Informant 2
1. **Teamwork**	– Is missing	– To some extent
	– No written guidelines from the leaders	– Depends on which part of the organisation they belong
	– Some oral guidelines	– Close collaboration with a member from his own profession
	– Normally 2 different professions work together	– Fragmented service
	– The doctor not very visible	– Admits need for more collaboration with outpatient department
	– Admits need for more collaboration	– Lack of follow-up outside the institution
	– Shortage of time	
	– Lack of follow-up outside the institution	
2. **Person involvement**	– He/she is permitted to participate	– Limited resources to person collaboration
	– Guidelines from an old fashioned culture exist where the persons are considered passive receivers	– No individual consultation
	– Many people do not trust the mental health worker	– Final reports are written without client involvement
	– Persons are mostly considered too sick to be present	– No copy of the final report is given to the person
	– Decisions are made usually without the persons	– No evaluation tool yet
	– Many persons refuse to participate	– An old fashioned culture is still present
	– New guidelines must be followed, but we are still at the very beginning	
3. **Family support**	– Seldom occurring	– Not very visible
	– The family is often uninterested	– They take seldom contact by telephone
	– The persons have often small networks	– Not an integrated part of the care
	– Family involvement is considered as a strength	
4. **Leadership**	– Not very visible	– Not very visible
	– No education given	
	– Knowledge and courses are given by the municipal administration	
5. **Laws and regulations**	– Not in focus	– Not in focus
	– No priority	
	– Older traditions are guiding the work organization	
	– No guidelines indicating what disciplines should compose a multidisciplinary team	

group 2 was asked about priority, all participants were silent and concluded after a while: "*It is the need which decides; there is always a question about priority. You must be available. There are no standards; you must meet the unforeseen and take the challenge there and than. If the person refuses to collaborate, this may be a potential for development as we can return to previous decisions. It may be a growth for both partners.*"

Teamwork

A major finding from the focus groups, when asked to describe their use of team work, was that different barriers existed. According to group 1, "*It is difficult when we do not know each other … several unwanted situations may occur*". Among the men in the latter group, one respondent says: "*… we are inclined to be frustrated when we do not reach consensus of opinion … (consequently) we often do not succeed in multidisciplinary work. I am thinking about all the time spent on team planning.*" Another participant continues: "*If we only had the capacity to follow-up our plans! That is the main drawback. The more team members involved, the more difficult it is*." One participant in group 3 says: "*In all situations where I have experienced success, the reason has been good teamwork. In contrary, when we have failed to be coordinated or there was a lack of agreement, I tend to feel*

frustrated." Another participant from group 1 explains why team work may often be neglected: "*Shortage of time, often unexpected situations occur and must be given priority, and you easily lose view (of the total work situation)*". Informant 1 in the in-depth interviews says. "*There are no guidelines telling us about what a multidisciplinary team should consist of.*" Informant 2 in the in-depth interviews is a nurse working as a group leader usually together with one similar profession and states "*I officially belong to a multidisciplinary team*". His concluding remark was however, "*Actually I do not think in terms of multidisciplinarity during my daily work.*''

Person involvement

As indicated through the process of thematic analysis of the two in-depth interviews regarding person involvement (Table 2), common examples from everyday life illustrated their frustrations. Informant 1 says: "*The persons still ask for permission when they wish to have a meal … Although the person is allowed to participate in meetings about care planning, they leave the meeting after a short while.*" Informant 2 explains: "*Final reports are sent to the persons' private practitioners or psychologists without their involvement.*" A concluding remark from Informant 1 is that "*The person needs help to find a new role.*"

Family support

When asked to describe family support the family was not very visible, although their importance is described: "*If the family members are engaged, this is a strength leading to inspiration in our work. They often need explanations and ventilation of their feelings even though the mental sick don't want to be in contact with them.*"

Leadership, laws, and regulations

Both of our informants express that leadership is not very visible and laws as well as regulations are not in focus. Informant 1 says: "*Leaders in community administration established for mental health care are important supporters by given updated knowledge about laws and regulations. However, the leaders in the institution pay little attention to new laws and regulations and how they should be incorporated in daily life.*" Informant 2 explains the situation in this way: "*We work very independently and are isolated, I would say. There is little attention from the community or from the institutional leaders to guide us towards teamwork and more person involvement.*"

Table 1 provides major findings from the three focus group interviews, comprising a representative sample of 17 participants, by listing the participants' profession, institutional affiliation, views of multidisciplinary work and priority of main working tasks. These findings indicate that neither multidisciplinary work, nor person and family involvement were considered a basic area of work. The participants' priority of main working tasks revealed that four gave leadership first priority, three consultations, five individual therapies, two group therapy, while two listed milieu therapy. An interesting feature was that in group three, nurses described collaboration as an activity mainly in inpatient departments, while the social workers' focus was mainly directed towards outpatient departments.

The authors conceptualized the statements from the two in-depth interviews within the main categories: procedures for teamwork, person and family involvement, leadership, laws, and regulations. Table 2 outlines the thematic domains and their components, which indicated that teamwork, person involvement and family collaboration were often missing. Furthermore, leadership seemed almost absent, and guidelines from laws and regulations were given little priority.

Discussion

Teamwork

The basic aim of this paper is to discuss the mental health care professionals' experiences of person-centered collaboration and involvement in rehabilitation and highlight some important choices and activities we mean can lead this work in terms of more person involvement. As regards the results from the three focus groups ranking their main tasks, it was clear that multidisciplinary work among professionals working in mental health care was not described as an important area for their role performance (Table 1). Several limits are referred to, such as difficulties to establish teams (Focus group 1), normally two professionals are involved (Focus group 2), and multidisciplinary work is inclined to produce more stress (Focus group 3). The validation of the data seems to support these findings as there is limited access to colleagues for consultation and an almost nonexistent collaboration.

Despite numerous attempts to promote teamwork, our data indicate that professionals continue to work alone or in groups of two, often functionally similar practitioners with limited opportunities to share their skills and expertise for the benefit of people with mental illness. Loxley (1997) emphasizes that similar professions may represent a barrier that is impenetrable to the persons. Furthermore, at least three disciplines are necessary for optimal care (Burns and Firn 2002). As Dahl and Mo (2000) state multidisciplinary

work is an important strategy in the effort to secure deeper understanding across all specific knowledge areas when planning care. An interesting feature, and according to the lager data set, nurses were mostly concerned with team work within the institution. Contrary, social workers were more inclined to focus across different institutions. A common concern was that follow-up outside the institution is often missing, indicating that well functional team work must be continuous and coordinated with different services and levels in outpatient departments.

Our data reveal several barriers to multidisciplinary work, which may be related to different cultures based on their ideologies and no written guidelines. In other words, years of professional education and work experience shape how health care workers understand persons' needs and influence their ways of meeting him or her (Loxley 1997; Peck and Norman 1999). According to Kuhn (1970), two different traditions may create bulkheads between them so that these paradigms are viewed as incommensurable concerning knowledge and practice. No people will profit from multidisciplinary teams if the various professions do not understand each other's cultures or if they have collaboration difficulties. The government states that if different mental health care workers are organized in multidisciplinary teams, their expertise must include discipline-specific, function-specific and common basic competence where attitudes, ethics, people involvement, and relational competence are involved.

Person involvement

The guidelines taken from Keiser and Lund (1986) have structured multidisciplinary work for many years, although the person perspective seems to be missing. During the present interviews this lack of perspective is still confirmed although person participation is a statutory right both in the planning of services and in the individual consultation. Based on the listing of main working tasks, we assume that the majority of informants are inclined to have an individual focus, although the extent to which this means person involvement remains unclear. When validating our finding it was confirmed that the rehabilitation meetings commonly takes place without the person being present. In spite of the importance of a rehabilitation focus, the person-centered perspective seems to be missing in decision-making. Such, the examples given seem to reflect that a biomedical approach is still dominating in favor of a more updated and client-centered biopsychosocial focus (Engel 1980; White 2005). However, recent recommendations from a health region board meeting strongly emphasize that the persons must be present at all meetings dealing with treatment plans (HRW 2006).

As indicated by the respondents many people with mental illness are vulnerable and withdrawn, and they have low expectations about their own contributions. According to several authors person perspectives is seldom being equal to professional perspectives creating power imbalance (Kidd et al 2007) and unclear roles (Carpenter et al 2003; Jubb-Shanley and Shanley 2007; Happell 2008). To succeed it seems obvious that the person needs information and training to develop his or her role as an active member and they should be considered experts in their own lives (NDH 2006). This implies a shift so that the original expert role we have identified, where the expert gives advice according to fixed standards, is abandoned in favor of eliciting ideas about the benefits of person involvement and flexibility to strengthen self-care. This also means that high quality expert knowledge must still constitute the platform although be used differently.

Family support

Available literature suggests that effective family support remains limited despite political promulgations (Happell 2008). Family support was neither considered a basic area of work in the focus groups, nor in Keiser and Lund's guidelines (1986) for multidisciplinary work. The validation of these findings reveals that family involvement varies, but it is normally uncommon because of lack of interest or scarce networks. However, the importance of family involvement to strengthen the person's perspective is mentioned in our data. This is also demonstrated by Scheidt (1994) and is set out in the official improvement plans in Norway (SPN 1997–1998). To improve this approach the strategy document mentioned earlier (HRW 2006; SHD 2007) suggests establishing centers for persons and relatives to strengthen self-care. Therefore, if collaboration with family and the person with mental illness is to succeed, it seems necessary to stimulate a transition from the old expert role towards a mobilizing role where a supportive system is activated.

Leadership, laws, and regulations

Good leadership is a necessary condition. Our data indicate that executive managers at regional level seem to pay little attention to teamwork, leaving the team members to clarify their own aims and operations. There is also a criticism at national policy based on new regulations which sometimes lack clarity (Glasby and Lester 2004).The foundation of multidisciplinary work must be established by leaders who take care of their teams and who ensure continuous work towards common goals (Loxley 1997; Scheidt 1998; SHD

2005). However, continuous reorganizations are a challenge for organizational changes and management. It seems that managers have a dichotomous role, which makes it difficult when combining responsibility to the organization on one hand and to the team on the other.

Management and establishing new organization forms are emphasized as an important part of quality of the delivery of services (DHSA 2005) and is perceived as fundamental for effective team functioning (Loxley 1997; Scheidt 1998). According to our informants, some updating about new laws, regulations and management exists, but the leaders of the mental health institution often seem to lack an overall strategy for cooperation and innovation. As set out in the Mental Health Action Plan for Europe (MHAPE 2005), "Poor partnership and lack of coordination leads to poor care, suffering and inefficiencies, and experience in community settings and multidisciplinary teamwork are recommended in the training of all mental health staff".

The supportive system

These new ideas stated in the previous documents could represent a shift away from an expert role towards a mobilizing role based on the persons' premises. According to Figure 1, as a starting point in rehabilitation, people must be considered to possess valuable resources about themselves. Although the situation might vary, the person-centered perspective must be kept as an active collaborator in decision-making. The families' role must also be valued and considered so that they view themselves as resourceful supporters. Furthermore, multidisciplinary teams headed by firm leaders are needed, and new laws and regulations must be followed. Several benefits have been identified by teams following the same pathway; for example, positive influence on managing care, increased efficiency and better collaboration (Hall 2001). We suggest that a main contribution to this paradigm shift will be management using competent change agents. To succeed in this direction, the supportive system following the person's pathway must be firm, clear and continuous, and time as well as patience is needed. In this way we will be able to expand our knowledge of mental health care toward more person involvement and hopefully achieve more effective rehabilitation.

Methodological considerations

Among the strengths, data from the three focus groups were validated by adding to more in-depth interviews. The authors

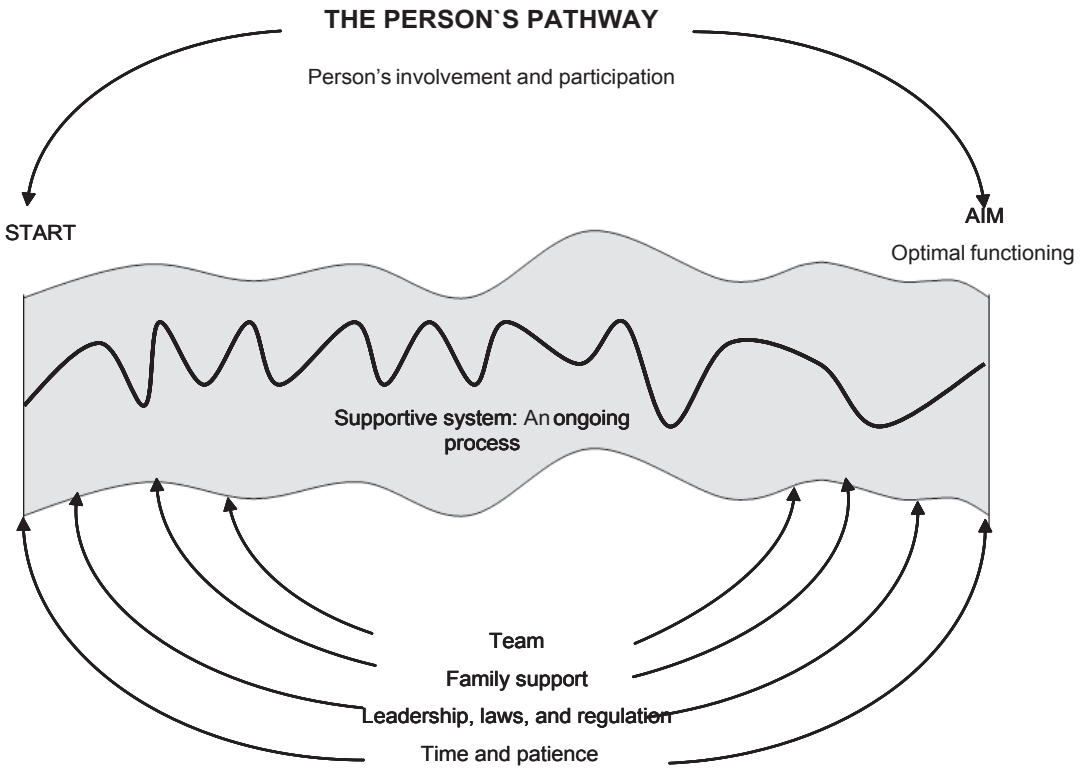


Figure 1 The person`s pathway and the supportive system described as an ongoing process where team and family, time, patience, leadership, laws, and regulations are involved.

have speculated openly about the meaning of the participants' utterances trying to secure that the meaning is shaped by their own interpretation. The content and classification of categories were discussed and validated by the authors. The findings are consistent with other studies and the Norwegian Board of Health Supervision (NBHS 2007). Among the limitation, the informants represent a purposive sample, and the selection has shaped the sample. Such, our background as persons, with many years of experience in mental health care, multidisciplinary work and client participation, might have influenced the data. During the data analysis and discussion our classification into categories lays the platform, being aware of that the totality might not so easily be preserved. Qualitative studies are not applicable to the population at large, but rather as descriptions applicable within a specified setting (Polit and Beck 2004). The study has only scratched the surface in terms of an understanding of teamwork and person involvement. Moreover, multidisciplinary teams and leadership are complex phenomena that will need a closer examination. Still another suggestion would be to study what prevent mental health professionals from change of attitudes toward more user involvement. Lastly, a person-centered approach is needed to grasp their own voices and preferences.

Conclusion

Our results may demonstrate deficits concerning mental health care on several levels. This understanding suggests firstly, that a person-centered perspective and involvement still seems uncommon. Secondly, to our surprise multidisciplinary work seems not very visible and only sporadically follows recommendations. Thirdly, families are seldom involved. Lastly, firm leadership and knowledge of laws and regulations does not seem to be systematically integrated in daily care. Taking these matters together, the improvement of a person-centered perspective implies cooperation between different services and levels in mental health care. In order to bring about improvement the health care workers must critically consider their own culture, coordination of competence must be increased and leadership on institutional and organizational level must be improved so that scarce rehabilitation resources are used to the optimal benefit of people with a mental illness. Supporting people in their struggle to achieve their dreams and goals involves utilizing all available resources in the community and organized by a dynamic and flexible multidisciplinary team.

Disclosure

The authors report no conflicts of interest in this work.

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Appendix 1a

Interview guide 1.

1. Among your different working tasks, which would you describe as most important?
   - Priority
   - Person involvement
   - The relevance of care
2. How mush time is spent on these tasks?
   - Performance
   - Challenges
   - Evaluation of the quality of your work
3. Multidisciplinary work
   - Guidelines
   - Practice

Appendix 1b

Interview guide 2.

1. Among your different working tasks, which would you describe as most important?
2. How much time do you spend on these tasks?
3. How much time do you spend on multidisciplinary work?

Areas to deepen:

- Teams
- Procedures for multidisciplinary work
- Person involvement
- Family involvement
- Leadership
- Laws and regulations