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ORIGINAL ARTICLE

User-Led Mental Health Service Evaluation: The Contribution of User-Focused Monitoring to Recovery-Oriented Quality Development

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Abstract User-focused monitoring (UFM) is a method of user-led mental health service evaluation that focuses on strengthening user involvement and developing the quality of services. Despite an increased emphasis on user involvement and the recovery orientation of services, scientific knowledge remains limited regarding how such goals can be realised. In this study, our aim is to explore UFM with a specific focus on how recovery processes are examined through the method in order to discuss how UFM can be developed in order to support a recovery orientation in mental health service evaluation. We sampled 20 Swedish UFM reports for qualitative analysis, and we found that UFM is a promising method for integrating a personal recovery perspective in service evaluations. By being performed peer-to-peer, the method has the unique ability to gather experiential knowledge regarding the situation of service users. UFM especially contributes to exploring service users' experiences related to social connectedness and user involvement in services. We also discuss how the method can be developed to further support a recovery orientation in UFM. This might be achieved by integrating a process-oriented approach in the evaluations and by including the user informants' own goals and views on what constitutes meaningful support in UFM. Suggestions for future developments concern incorporating personal recovery perspectives in the training of user monitors and creating structures for aggregating the knowledge produced through UFM.

Keywords Mental health · User involvement · User-focused monitoring · Service evaluation · Recovery

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Introduction

User-focused monitoring (UFM) is a method of user-led mental health service evaluation that focuses on strengthening user involvement and developing the quality of services. It is inspired by research methodology and involves people with lived experiences of mental ill health conducting a formal and independent evaluation of a service (Canow, 2018; Kotecha et al., 2007). UFM provides information about how services are perceived and the needs for further development from a service user perspective. The method can thus be seen as a way of gaining access to systematised experiential knowledge of services as well as insights into their potential support of personal recovery. Building on the results from a prior mapping study of

UFM in Sweden (Näslund et al., 2022), the aim of this study is to explore UFM with a specific focus on how recovery processes are examined through the method and to further discuss how UFM can be developed in order to support a recovery orientation in mental health service evaluation.

In the mental health sector, user involvement is increasingly encouraged in policy, practice, and research (Millar et al., 2016; Thornicroft & Tansella, 2005). Internationally, mental health services have transitioned towards community-based services, with an associated shift in focus towards citizenship, self-determination, and empowerment (Slade, 2017). Coinciding with this development, a strengthened focus on person-centredness (Chong et al., 2013) and personal recovery (Treichler & Spaulding, 2017) has led to an emphasis on the need to integrate the experiential knowledge of service users in evidence-based practice. Despite this increased emphasis on user involvement and the recovery orientation of services, scientific knowledge remains limited regarding how such goals can be realised, especially studies on the involvement of service users in organisational development and service evaluation (Rosenberg & Hillborg, 2016; Semrau et al., 2016). Furthermore, this increased focus on user involvement in policy is articulated in a context where service users still report not being consulted regarding their care (Stacey et al., 2016). Transforming the principles emerging from research on recovery and user involvement into concrete methods is reported to be an urgent matter in the research literature as well as in policy and national guidelines (Korsbek & Tønder, 2016; Morant et al., 2016). In this study we explore UFM in relation to such a recovery-oriented development of services. Our starting point is that there is potential for UFM to contribute to a recovery orientation in mental health service evaluation, and we analyse to what extent such a potential is realised. Is a focus on recovery processes visible in the UFM reports, and if so, in what way? This further lays the foundation for our discussion of how the method can be developed in order to support a recovery orientation in mental health service evaluation.

UFM as a Method of User Involvement

User involvement is connected to value-based practices and derives from strengths-based theories focused on empowerment (Drake et al., 2010; Lempp et al., 2018). A move towards user involvement practices based on systematised methods is currently underway in Sweden. UFM represents one such method that is highlighted in government commissions of inquiry (Socialstyrelsen, 2012, 2013) and that is promoted by the user movement (Gagnér Jenneteg et al., 2020). By targeting the organisational level, UFM presents an interesting case for examining current developments towards greater user involvement and more recovery-orientated services.

UFM was developed in the 1990s in England (Kotecha et al., 2007) and has been transferred to the Swedish context (Jakobsson Lund & Rosenberg, 2008). In Sweden, user organisations are commonly the provider of UFM, and they train teams of user monitors in user-focused methods of evaluating services. There are several UFM models practiced in Sweden today, most of which are based on interviews and with some based on surveys. A main premise of the method is that people with lived experience lead the evaluation process at every stage by designing the UFM, collecting data, and formulating a report of the evaluation that includes proposals for further development (Jakobsson Lund & Rosenberg, 2008; Kotecha et al., 2007). However, a prior study has illustrated that the actual user autonomy in UFM can vary (Näslund et al., 2022). Today, there are around 30 UFMs conducted annually in Sweden. Most of these are conducted in metropolitan areas in the middle or south of Sweden, which are areas with a more well-established user movement. Mental health service providers are commonly the commissioners of UFM, and the user organisations that carry out the largest number of UFMs have more general contracts with public sector actors so as to perform a certain number of evaluations annually (Näslund et al., 2022). Previously, most UFMs were performed on municipality-based mental health support services, but today they are equally often focused on region-based health care services. UFM is frequently performed on vocational services and housing support, but also on inpatient and outpatient care (Näslund et al., 2022).

Recovery Perspectives in UFM

In recent decades, coinciding with claims for involvement made by the user movement, research on personal mental health recovery has provided new

knowledge relevant to mental health practices (Onken et al., 2007; Schön et al., 2009; Slade, 2009). The user movement and the recovery movement have developed new knowledge of mental health based on the lived experiences of groups as a whole, but also focusing on the subjective experiences of the individual. This area of knowledge involves a strong emphasis on user involvement and empowerment. The recovery approach promotes a focus on activities that centre on the needs and wishes expressed by the individual rather than a primary focus on symptoms or disabilities (Rosenberg & Schön, 2020; Slade, 2009). A key aspect of the recovery process is its non-linearity and the fact that it involves experiences of progress, set-backs, and of 'pressing forward again' (Onken et al., 2007, p. 10). In light of this experiential, process-oriented understanding of recovery, the importance of focusing on the strengths and resources of the individual is emphasised (Morant et al., 2016; Rosenberg & Schön, 2020).

Evaluating outcomes of recovery-oriented interventions thereby involves a shift in focus from symptom reduction towards a more holistic perspective, including aspects of well-being related to hope, self-esteem, sense of control over one's life, and social connectedness (James & Quirk, 2017; Onken et al., 2007; Slade, 2009). Core values of a recovery perspective are autonomy, self-determination, and the conceptualisation of service users as experts-by-experience. UFM is focused on strengthening user involvement and empowerment. By being user-led it has the potential to bring a holistic understanding of mental health based on service users' experiential knowledge to the evaluation and quality development of mental health services. However, the evaluation logic, focused on a delimited evaluation site and time-frame, might create a conflict with a holistic and process-oriented recovery perspective. In this study, we analyse to what extent UFM has the potential to support a turn towards recovery orientation in service evaluations. Specifically, we have been guided by the CHIME framework (Leamy et al., 2011) that is based on a systematic review and narrative synthesis of the literature on personal recovery. The framework conceptualises core recovery processes that can be integrated in evaluations of services' recovery orientation. The framework focuses on five recovery processes: *Connectedness, Hope and optimism about the future, Identity, Meaning in life*, and *Empowerment* (Leamy et al., 2011). Leamy et al. (2011, p. 450) describe the recovery processes of the CHIME framework as seeking to '*support reflective practice. If the goal of mental health professionals is to support recovery then one possible way forward is for each working practice to be evaluated in relation to its impact on these processes.'* This presents the challenge of how a focus on recovery can be integrated in service evaluation and in quality measurements in mental health care.

Methods

This study is part of a research project focused on examining UFM in the Swedish mental health sector. A project group was set up prior to this study that included the researchers, representatives of the user movement, and public sector commissioners of UFM. This project group has provided input throughout the research process.

Data Collection

As part of a prior study focused on synthesising patterns in UFM reports (Näslund et al., 2022), we gained access to 136 UFM reports, 122 of which were compiled in a database by the NSPH (The National Partnership for Mental Health, the umbrella organisation of Swedish mental health user organisations). This database included most UFMs that are performed on mental health services in Sweden. We added a further 14 reports from Verdandi (a user organisation primarily focused on addiction) that targeted sites devoted to mental health concerns. The reports were collected through contacts with the respective organisations. Based on our access to 136 reports, for this study we performed a sampling of 20 reports for a qualitative analysis. We only included UFM reports from 2017 and onwards in our selection in order to analyse the current use of the method. Based on results from a previous mapping study (Näslund et al., 2022), we sought to include reports that were representative of the larger sample with regard to geographic location, type of service, executant organisation, and methodological approach. The most common UFMs are performed by large user organisations in middle and southern Sweden using qualitative methods and exploring either housing support, vocational services,

or inpatient/outpatient care. We therefore included a number of reports that were representative of these common characteristics, including in the sample evaluations of both region- and municipality-based service and support programmes. However, to consider the variety among the sample, we also included a couple of UFM reports that were performed in less populated areas in Sweden, UFMs that apply quantitative methods, and UFMs focused on a more "delimited" service (such as coordinated service planning or user councils) (Table 1). With regard to ethical considerations, informed consent was obtained from the organisations from which the reports were collected. This study focused on analysing UFM reports that are available to the public and are frequently accessible from the user organisations' websites. Furthermore, the data were already anonymised in the reports, so this study covers no information trackable to unique individuals.

Data Analysis

UFM reports are typically around 8000 words long. In the initial parts of the reports, the service site in question and the commission are described along with the UFM method. In the following parts, the results of the UFM evaluations are reported, frequently including both quotes from the user informants and the user monitors' analyses. Development proposals based on the results are discussed in the end sections of the report. For the analysis presented here, the reports were first inductively read through by the first author, with a focus on the main sections of the reports that cover results and development proposals. Analytical ideas were presented and discussed with the research group and with the larger project group. Based on the empirical findings and discussions in the project group, we decided to focus our analysis on how recovery processes are examined in UFMs. We performed a directed content analysis (Hsieh & Shannon, 2005) of the reports guided by the CHIME framework (Leamy et al., 2011). These core recovery

Table 1 Overview of the included UFM reports

UFM report number	Year	Service or support programme	Geographic location	Type of data
1	2017	Vocational rehabilitation	Northern Sweden	Interview
2	2017	Child and adolescent psychiatry	Southern Sweden	Interview
3	2017	Vocational rehabilitation	Middle Sweden	Interview
4	2017	Housing support	Southern Sweden	Interview
5	2017	Special housing	Middle Sweden	Interview
6	2018	Forensic psychiatry	Southern Sweden	Interview
7	2018	"Meta-report" of outpatient care	Middle Sweden	Survey
8	2018	Inpatient care	Southern Sweden	Interview
9	2018	Personal ombudsman	Middle Sweden	Interview
10	2019	Housing with special services	Southern Sweden	Interview
11	2019	Vocational rehabilitation	Southern Sweden	Interview
12	2019	Outpatient care	Southern Sweden	Interview
13	2019	Outpatient care	Southern Sweden	Survey
14	2019	Vocational rehabilitation	Middle Sweden	Interview
15	2019	Coordinated service planning	Southern Sweden	Interview and survey
16	2019	Retirement home	Northern Sweden	Interview
17	2019	Inpatient care	Southern Sweden	Interview
18	2019	User council	Middle Sweden	Interview
19	2020	Vocational rehabilitation	Middle Sweden	Interview and survey
20	2020	State subsidies for mental health	Middle Sweden	Interview

processes and their underlying dimensions (see Table 2 below) were applied as analytical 'searchlights'. The reports were read through and coded with a specific focus on the five recovery processes described in CHIME. The analysis focused not only on how recovery processes were examined, but also on how the method could be developed to further support a recovery orientation in the service evaluations. In relation to our focus on personal recovery perspectives in the UFM evaluations, an aspect of the service programmes evaluated that varies among the sampled reports, is the temporal aspect of the examined service. Especially housing services can often involve long-term relationships between residents and service providers and involve a broad focus on the resident's life situation, whereas e.g., inpatient care and specific vocational rehabilitation programmes can be more delimited regarding both time and focus. It should be noted that for this study we did not have sufficient data to draw conclusions regarding the personal recovery of service users or the recovery orientation of the services that were evaluated. Our analysis is restricted to the UFM reports and to analysing how recovery processes are examined through the method.

Results

Core components of a recovery framework, such as a focus on social connectedness and empowerment, are central to both the results and the development proposals of UFM. However, services also tend to be examined from a here-and-now perspective, which may risk limiting the ability to take a process-oriented approach to evaluating the extent of services' recovery orientation. Furthermore, this stance can risk positioning service users as care recipients in the evaluations such that they are approached as consumers of, rather than participants in, their support or treatment.

Social Connectedness in UFM

The first recovery process described in CHIME is social connectedness, and this has four underlying dimensions: *relationships*, *support from others*, *being part of the community*, and *peer support and support groups* (Leamy et al., 2011). Social connectedness is central to personal recovery, and service programmes' support of social connectedness is a core concern in many UFMs. Social connectedness is explored from

Table 2 Recovery processes and underlying dimensions (Leamy et al., 2011, p. 448) guiding the analysis

Recovery processes	Underlying dimensions
Connectedness	Relationships
	Support from others
	Being part of the community
	Peer support and support groups
Hope and optimism about the future	Having dreams and aspirations
	Hope-inspiring relationships
	Motivation to change
	Belief in possibility of recovery
	Positive thinking and valuing success
Identity	Overcoming stigma
	Rebuilding/redefining positive sense of identity
	Dimensions of identity
Meaning in life	Meaningful life and social roles
	Meaningful life and social goals
	Spirituality
	Meaning of mental illness experiences
	Rebuilding life
	Quality of life
Empowerment	Control over life
	Personal responsibility
	Focusing upon strengths

different angles, for instance, with a focus on how services have contributed to the individual's sense of social belonging, relating to both *support from others* and *relationships* (Leamy et al., 2011). In one UFM report, the importance of relationships is discussed as a key development area for a service programme: *'What needs to be prioritised on the behalf of the service users is time with staff – so-called "quality time" where one sits down and listens and talks with interest' [UFM 16]*. In several UFMs, the user informants' narratives of a need for support from others, and specifically from staff, in this area is discussed. Development proposals in UFM can further focus on addressing issues regarding a lack of social connectedness:

> A majority of those we have interviewed raised the need for a social life … We user monitors also reflect upon this and wonder about the possibilities of socialising between the different floors … Maybe a more open socialisation between the floors would contribute to an improved sense of community. [UFM 16]

Social and relational aspects are frequently discussed in relation to housing services which often involve long-term relationships among residents as well as between residents and staff. However, it is common for UFMs to mainly examine how services support relationships with staff and other service users, and less emphasis is placed on how services can support relationships to friends and family, sometimes discussed as 'natural relationships' in recovery research (Bogarve et al., 2012). However, many UFMs examine user informants' views on how relatives can be involved in their support, or the support that relatives themselves have received:

> One interviewee shared a feeling of disappointment with regards to participating actors not having picked up on relatives' risk of 'hitting the wall' and of not having received information regarding family support … It would have been favourable if the actors would have also considered the individual's relative in this case and informed of all the options available. [UFM 15]

Such a focus in UFM brings an understanding of the individuals' support being positioned in a relational context to the evaluation of services. *Being part of the community* is also core to social connectedness (Leamy et al., 2011). Several UFMs examine services' support of community participation, here exemplified by a quote from a user informant:

> [The service programme] means [the opportunity] to get out, get sunlight, and [meet] other people – participation. [The service programme] means routine, becoming tired in a normal way, in a context. It resembles the life of those without mental ill health. People are waiting for you, wondering why you aren't showing up. [UFM 11]

The quote above highlights a central aspect of social connectedness, that one's absence is noticed by others (cf. Topor, 2001). Positive examples of services' support of community participation are, as in the quote above, often discussed in relation to vocational rehabilitation programmes. Lacking integration in the community is also explored in UFM, and development proposals are presented that focus on how services can support community integration through information and support:

> Do all residents know about the user organisations and all the opportunities they create? You can meet others with similar experiences, visit 'open houses', participate in conversation groups, take courses, lectures, and participate in excursions … Provide information on the activity houses and their activity offerings and the different user organisations. Support those who want to visit these. [UFM 10]

The user monitors further discuss how involvement in meaningful activities can be supported by community integration. In UFM, the value of *peer support* (Leamy et al., 2011) and of meeting others who share similar experiences is frequently discussed: *'Arrange some form of workshop, lecture, or open house where participants can meet others in a similar situation. That way the participants can build social bonds and realise that they are not alone' [UFM 14]*. The importance of integrating spaces for peer support in services is emphasised in the development proposals of several reports.

Hope and Optimism in UFM

The second recovery process in the CHIME framework relates to hope and optimism and has the

following five underlying dimensions: *having dreams and aspirations, hope-inspiring relationships, motivation to change, belief in possibility of recovery*, and *positive thinking and valuing success* (Leamy et al., 2011). Such aspects are emphasised in some reports, but service users' personal recovery goals are not included in most UFMs. This can be connected to the evaluation rationale that puts organisational features in focus.

The underlying dimensions of hope and optimism are discussed in connection in several UFMs. The value of *dreams and aspirations*, as well as *hope-inspiring relationships*, is, for instance, highlighted as central for *motivation to change* (Leamy et al., 2011) in the development proposals of one report:

> Because several interviewees shared the experience of not getting enough contact, feedback, and support from staff, we suggest more distinct motivational conversations between residents and staff, where you exchange ideas and discuss goals and challenges that the resident experiences regarding accommodation and in general, and through that provide an opportunity for staff to provide comfort and joy to the resident upon realising their goals … [UFM 5]

Relationships to professionals can, from a recovery perspective, be discussed in terms of a coach or fellow traveller, where service provision is based on shared deliberation in partnership (Morant et al., 2016). Such a motivational focus from staff also connects to services' support of the *belief in the possibility of recovery* and *positive thinking and valuing success* (Leamy et al., 2011).

The user informants' own goals or hopes are inquired about only in a couple of the reports, and these mostly focus on time-limited vocational rehabilitation programmes. In many UFMs, the service users are instead invited to voice their opinion regarding the care or support they receive. This could risk positioning the service users in a passive position as care recipients in the evaluations, rather than in the role of active participants that is central to personal recovery (Roberts & Boardman, 2014). On the occasions that questions regarding service users' own goals for participation in the service programme are posed, the user informants' answers connect to recovery processes: '*Increased self-esteem/self-confidence. Which has led to one keeping track of desired everyday routine' [UFM 9]*. From the user informants' answers, it is further evident how goals and aspirations are intimately linked not only to a relational context, but also to a broader social context, for instance, by being related to the financial situation of the user informants: *'Having received help in applying for sickness benefits and in reviewing insurances, labour union membership,* etc.*, in order to resolve financial difficulties' [UFM 9]*. From a personal recovery perspective, the service users' own goals should be the focus of service provision (Roberts & Boardman, 2014; Slade et al., 2017). What such goals are, and how they are supported by participation in a service programme, is thereby important to include in a recovery-oriented service evaluation.

Identity in UFM

Recovery processes related to identity in the CHIME framework involve the following three underlying dimensions: *overcoming stigma*, *rebuilding/redefining a positive sense of identity*, and *dimensions of identity* (Leamy et al., 2011). Respect is described as central to challenging discrimination and stigma and as important for supporting recovery (cf. Morant et al., 2016). This involves both self-acceptance and respect from others. A major focus in UFM rests upon personal treatment from staff. The results tend to highlight respectful personal treatment in service programmes, which is discussed in one report in connection with respect for the experience and knowledge of service users:

> We asked how the interviewees get to use their knowledge and experience in the project. All interviewees gave positive answers. All perceive that [staff] are perceptive to what the client has shared regarding their background and experience. The client's background is meticulously discussed, and the client's suggestions are carefully considered before the client, together with [staff], formulates an action plan. [UFM 14]

Survey or interview questions in UFM seldom explicitly focus on service users' experiences of stigma or support from services in overcoming stigma. Still, it is evident from the user informants' statements that stigmatising experiences have become a hurdle to their personal recovery. In several UFM reports the

effects of self-stigma are discussed as hindrances for engaging in meaningful social roles:

> More than half of those asked … are interested in activities and employment but are uncertain of their own ability to participate, or in how appreciated they would be in the respective activities [or] employment. [UFM 9]

The fact that the evaluations are performed peer-to-peer may create a safe environment that allows for the user informants to share experiences of stigma. The user monitors also present possible interpretations of the user informants' answers that take self-stigma into account:

> None of those we have interviewed wish to enter employment or studies. We find that this could be a consequence of self-stigma, meaning that the individual internalises socially anticipated negative or belittling attitudes towards people with psychiatric disabilities. This includes a lack of ability for employment. [UFM 10]

The user monitors discuss development proposals for how services can contribute to rebuilding a *positive sense of identity* (Leamy et al., 2011) and strengthening self-esteem among service users: *'Is it possible to take advantage of the participants' own competence and letting one of them hold a lecture for the others … in order to strengthen self-esteem' [UFM 14].* This can further be related to the exploration of different *dimensions of identity* (Leamy et al., 2011). Activities are promoted through UFM that potentially contribute to service programmes supporting an understanding of the multiple identity dimensions of the individual, where someone can be a person in recovery, but also an employee, a knowledge bearer, a lecturer, or someone who can provide support to peers.

Meaning in Life in UFM

The fourth recovery process in the CHIME framework is meaning in life, and this relates to the following six underlying dimensions: *meaningful life and social roles*, *meaningful life and social goals*, *spirituality*, *meaning of mental illness experiences*, *rebuilding life*, and *quality of life* (Leamy et al., 2011). Meaning in life and especially rebuilding life connects to the process-oriented focus of personal recovery. UFMs tend to be oriented towards a here-and-now evaluation of a service programme that connects to the evaluation logic. However, this temporally delimited focus may lead to a lack of attention to the ways in which services support personal recovery processes.

In many UFMs, participation in *meaningful social roles* (Leamy et al., 2011) is discussed in relation to services support of work-life participation among service users. Limited work-life participation and possible health effects are recurrently discussed. Development proposals often focus on how services can strengthen the accessibility to participation in such social roles:

> What many do not know is that there is specific work-related support for this target group … If the tenants receive information about these service programmes … and that they are successful, it may plant a seed for a wish to try employment. [UFM 10]

Services' support of *meaningful social goals* (Leamy et al., 2011) is explored to a lesser extent and primarily in relation to time-limited service programmes. When such a focus is included, it is made evident how the user informants' goals are embedded in their everyday lives and contexts relating, for instance, to work-life participation, social integration, and relationships: *'I would have liked to leave here balanced, able to go back to work and have a good balance in relation to food and exercise. Being able to get back into regular life. Be a good parent' [UFM 8].* Service programmes' focus on existential or *spiritual* questions (Leamy et al., 2011) is to a limited extent discussed in UFM but is reflected in the development proposals of one report: *'We user monitors have two additional suggestions for more activities: some form of spiritual workshops or activities at [the service programme]' [UFM 5].* Another area seldom included, but brought into focus by a user informant, is the service programmes' support to service users in exploring the *meaning of illness experiences* (Leamy et al., 2011): *'One respondent expressed a wish to receive support in seeing the meaning behind one's difficulties and challenges' [UFM 8].* These areas relate to recovery as a life-changing experience (Leamy et al., 2011). How services can contribute to increased well-being and *quality of life* (Leamy et al., 2011) is discussed in several reports, for instance, through development proposals focused on everyday activities and engaging

with nature: *'To perform simpler gardening activities, perhaps planting seeds or nursing flowers. Nature and plants are in themselves good for health and quality of life' [UFM 16].*

The UFM evaluations are mainly focused on examining the user informants' views on the service or support programmes from a here-and-now perspective. Questions commonly entail a present-time focus—*'How do you perceive the support of [staff]'*—whereas the user informants tend to be more process-oriented in their answers: *'They encourage me in losing weight and in keeping up activities. They boost me when I reach my goals' [UFM 10].* Through a process-oriented focus, user informants' quotes illustrate how services can support *meaningful life and rebuilding life* (Leamy et al., 2011): *'It's fantastic that [the service programme] exists. Human conversations, human support, "back to basics". Finding structure and meaning in life'* [UFM 11]. Core to a recovery perspective is the understanding of recovery as a unique and active process or journey that is non-linear and that has many stages (Leamy et al., 2011). The here-and-now focus of many UFMs might risk failing to include in the evaluation a focus on service programmes' actual support of service users' recovery processes. Some reports do, however, include a more process-oriented question regarding the significance of the service programme for the service users' lives:

> When the question was posed regarding how the treatment has affected the respondent's life situation … [a] respondent … perceived that staff had supported them in changing their life, and this really had gotten the individual to manage to keep on fighting … A respondent had found greater insight and also a hope in having a life again. Another perceived that they had gotten increased knowledge of oneself and of others but also an insight into it not being sustainable to keep on living as they did before. Through this, trust had grown; a trust in one's ability to really become completely well … [UFM 8]

These quotes from user informants can be understood as narratives of services' support of a recovery journey that focuses on hope, personal insights, and goals. Including more questions that explore what has been helpful or a hindrance in service users' personal recovery might support a strengthened recovery orientation in the UFM service evaluations.

Empowerment in UFM

The last of the recovery processes described in CHIME is empowerment, with the following three underlying dimensions: *control over life*, *personal responsibility*, and *focusing on strengths* (Leamy et al., 2011). This category is central to UFM because empowerment is associated with user involvement, which is a main focus of the method. Survey or interview questions in UFM focus on user influence in most examined areas, such as the activities that are offered, the food, the care planning, and the available treatment. Information has been discussed as the lowest level of participation (Arnstein, 1969), but the UFM reports illustrate deficiencies in service programmes' sharing of information:

> We asked if the interviewees were familiar with having an implementation plan and if they felt that they had been involved in the establishment of the implementation plan. It turned out that almost none of the interviewees knew what an implementation plan is. [UFM 5]

Such concerns are frequently reported in relation to care planning, where even information on the existence of such a plan can be lacking.

Empowerment relates to both the individual and the collective level (McDaid, 2010). Power relations, financial issues, or broader political issues are seldom explicitly explored in UFM. However, the user informants' answers reflect the importance of such factors for their own lives and support. Power imbalances between service users and professionals are discussed by a user informant in one of the reports:

> What's sad, is that if you as a parent become a bit upset in a meeting, you are labelled, but they don't know how many times we've attended meaningless meetings … the worst anxiety is for them to come and take the child into care … I don't think one understands that fear … [UFM 15]

Many UFMs explore to what extent service programmes are person-centred, a core component of recovery that further contributes to *control over life* (Leamy et al., 2011). Services are examined with a

focus on their adaptation to the individual: *'All the interviewees say that the support they receive is adapted to the interviewee's situation and needs' [UFM 14]*. The UFM evaluations also illustrate how services' lack of communication and lack of support for self-determination can contribute to a lack of control over one's life:

> … a feeling of hopelessness among some service users appears … where factors out of their control are steering … The service users express it as them not knowing what will happen, of not being able to foresee one's planning and of feeling a lack of self-determination [UFM 19]

In one report, the user monitors discuss how strengthened user involvement in a service programme contributes to both control over one's life and to *personal responsibility* (Leamy et al., 2011): *'Other benefits of actively increasing the participants' influence and participation in a service programme is that it strengthens the sense of self-control and responsibility over one's life' [UFM 1]. Focusing on strengths* is a key aspect of empowerment but also of positive identity (Leamy et al., 2011). The user monitors discuss the need for services to attend to such strengths in care planning: *'We user monitors believe that the implementation plan should also contain interests and strengths, because this is important … in order not to become only a passive recipient of support' [UFM 5]*. The strengths-based focus of the user monitors' analyses may connect to their experiential knowledge of what supports personal recovery.

Discussion

UFM is a promising method for integrating a personal recovery perspective in service evaluations. By being user-led, the method has the unique ability to gather experiential knowledge regarding service and support programmes from a service user perspective. The method can further be applied to generate aggregated knowledge of the situation of service users, which is valuable for both the user movement and for service system developments (Näslund et al., 2022). In relation to the CHIME recovery processes (Leamy et al., 2011), UFM especially explores service user experiences that relate to services' support of social connectedness and services' structures to support empowerment through user involvement. In this section, we will discuss how UFM can be developed to further support a recovery orientation in service evaluations.

Evaluations Built on Trust

The potential of UFM to support a recovery orientation in service evaluation in part relates to the premises of the method, that UFM is user-led and based on the experiential knowledge of both user informants and user monitors. This means that the method has the unique ability to contribute to the inclusion of service user perspectives and knowledge in the quality development of service or support programmes. Person-centred and recovery-oriented services are formed around the needs and personal recovery goals of the service users (Morant et al., 2016). Thus, the inclusion of such perspectives in services' quality development is key to the advancement of recovery-oriented systems of care and support (Grim, 2019). Furthermore, our results show that UFM provides insights into services' support of personal recovery, especially with regards to social connectedness and empowerment. In part, this was due to how the questions were posed and the focus of the UFM. However, at times the user informants shared information of recovery processes, even though the interview questions did not explicitly address these. This might be connected to the trust that can be established through user-led evaluation methods such as UFM. That the evaluations are being performed peer-to-peer can contribute to opening the door to narratives of personal recovery, and this further enables the inclusion of such narratives in the evaluation of services. Including a personal recovery perspective in the training of user monitors would be one strategy to further develop the potential of UFM to support a recovery orientation in service evaluation and quality development.

Criticism has been directed to a strength-based focus and an individualisation of personal recovery and empowerment (Onken et al., 2007). The conceptualisation of empowerment in CHIME, which is focused on control over one's life, on personal responsibility, and on personal strengths, can be seen as a reflection of such a critique. Our results illustrate that in UFM empowerment is explored beyond such an

individualistic and strength-based focus, and instead the user informants' influence on their own support, but also on organisational development, are examined. Through UFM, structures for user involvement in services are thus examined with a focus on both individual and collective dimensions. However, in order not to risk consumeristic participation (Beresford, 2020; Tritter, 2009) it is important to explore the ability to approach service users as citizens in the evaluations and to examine services' ability to strengthen active citizenship.

UFM and Boundary Work

The Swedish mental health service system is highly sectorised and is defined by boundaries between government agencies, municipal support services, and regional health care services (Bergmark, 2017; Schön & Rosenberg, 2013). The mental health system has been criticised for being disintegrated, with a lack of communication between different service actors and the associated risks of falling through the cracks that these boundaries create (cf. Bjorkman et al., 2018). Organisational boundaries can further cause discontinuity and fragmentation (Grell et al., 2020; Matscheck et al., 2019). A core aspect of personal recovery is a person-centred and holistic understanding of health, recovery, and meaningful life (Slade et al., 2017), and in order for UFM to support a recovery orientation in service evaluation, and to avoid mimicking service system boundaries, it is crucial for UFM to be based on a holistic and person-centred evaluation approach (cf. Davies et al., 2014). This means that several boundaries need to be challenged by the UFM practice. By challenging boundaries between service users and the service organisation, UFM can contribute to a recovery-oriented understanding of service users as active participants in their care and support. The results of this study suggest that there are risks of service users being positioned as passive "care recipients" in the UFM evaluations, or as "consumers" who are invited to voice their opinions regarding the services they receive. Service programmes' support of personal dreams, goals and motivations are explored to a limited extent in UFM, and mostly in relation to service programmes that are more delimited in time and focus. From a personal recovery perspective, service users are understood as active participants or co-creators of their support, a support that should be focused on their personal recovery journey (Bejerholm & Roe, 2018). By attending to user-defined measures of quality and by including service users' own goals and aspirations in the evaluations, UFM can contribute to quality development that proceeds from what is meaningful to the service users. This can support the inclusion of experiential knowledge as a core knowledge base in service programmes' development work. Rather than proceeding from evaluating what already is, UFM can further contribute to imagining what meaningful support ought to be based on service users' needs.

Furthermore, it is important for UFM to challenge the boundaries of the mental health system, such as those between service programmes and the local community. Personal recovery is not restricted by such frames but is, as is illustrated in the results, integrated in the everyday lives of service users, often spanning support from several welfare institutions and certainly involving the individual's social roles and network (Bejerholm & Roe, 2018; Tew et al., 2012). In order to take a recovery-oriented approach to the evaluation and to contribute to a holistic knowledge of the situation of service users, UFM needs to proceed from an understanding of services as enacted in a broader social context. By avoiding a focus that is restricted to the frames of a specific service unit or programme, UFM will be able to develop knowledge of what really matters to personal recovery as well as knowledge of present hindrances to such recovery. The results of this study provide motivation for the user movement to engage in joint method development and to include concerns not strictly defined by the frames of a specific service programme in UFM.

UFM as a Basis for Collective Experiential Knowledge

Aggregating knowledge from the UFM method could contribute to the formulation of a collective knowledge base that is enrooted in service users' experience regarding the service system's support of personal recovery (cf. Näslund et al., 2022). Our results suggest that the logic of a service evaluation might, however, aggravate the ability to build such a collective knowledge base regarding the situation of service users. A holistic and process-oriented understanding risks being prohibited by the here-and-now focus of

the UFM practice, as well as specific service programmes' expectations of feedback that can be directly implemented. In order for the UFM practice to further support a recovery orientation in service evaluation, the commissioning and planning process of UFM might thereby benefit from being reviewed. Ideally, a system and process-oriented perspective would be built into the basic contract between the user organisations that conducts the UFMs and the commissioners. This would mean that both public sector commissioners and the user organisations share a mutual interest in capturing more aspects than just the 'quality' of a specific service programme at any given time. Thereby, tendencies can be circumvented of the knowledge produced through UFM remaining within a specific service programme, where individual managers are left alone with UFM results that really have wider significance. However, this poses questions regarding what areas need to be covered in UFM in order to further develop such an aggregated knowledge base of the service and support system's aid in personal recovery. Such questions are important for the user movement to engage in, and it is vital to incorporate the outcomes of such discussions into future developments of the UFM practice.

Because a significant number of UFMs are performed annually in Sweden, UFM provides an important source of information regarding the general situation of service users and of the service system's support for personal recovery. The NSPH has constructed a national database of UFM reports from which the data for this study were drawn, and continuous work with this database would be an important knowledge source for the user movement and the service system. By continuously aggregating data from UFM, the method could function as a sensor of recovery experiences and could highlight areas of concern. This could potentially contribute to advancing system developments steered by knowledge of needs at a grassroots level. Investing in such a database would thus be beneficial for the user movement as well as for the service system.

Conclusions

We have discussed UFM as a promising method for integrating a personal recovery perspective in mental health service evaluations. By being user-led, the method has the unique ability to compile experiential knowledge of services that can be integrated into quality development. UFM especially contributes to exploring service user experiences that relate to social connectedness and to user involvement in services. We have also discussed how the method could be developed to further support a recovery orientation in UFM service evaluations. This could be achieved by taking a process-oriented approach to the evaluation and by including the user informants' own goals and understandings of meaningful support in UFM. Suggestions for future developments concern the inclusion of personal recovery perspectives in the training of user monitors and creating structures for aggregating the knowledge produced through UFM in order to support development towards a recovery-oriented mental health system.

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Declarations

Conflict of interest The authors report no conflicts of interest/competing interests.

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