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# Social participation and recovery orientation in a "low threshold" community mental health service: An ethnographic study

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**Abstract:** Accessible and flexible "low threshold" community services have been recommended in order to assist people's social participation and recovery from mental health problems. In this ethnographic study from a Norwegian city, we studied activities and social interaction within three community mental health centres with a low threshold organisation and recovery approach. These centres were part of the same community mental health service, and aimed to function both as social meeting-places and as steps towards rehabilitation. Through participant observation and qualitative interviews, we explored in what way this service could contribute to service users' recovery. Central features of social interaction were support from both professionals and peers, along with sharing of practical advice and experiences. This encouraged social participation and seemed to enhance mutual experiences of recognition. In the article we highlight how these centres could assist recovery from mental health problems by functioning as available "resource-bases" in the community.

## ABOUT THE AUTHORS

The first author is associate professor at Norwegian University of Science and Technology (NTNU). Her research is in the area of mental health, with a special interest in how mental health services can enhance social inclusion and participation for people living with long-term mental health problems. The second author is Chief Scientist at SINTEF Research Group and Professor at NTNU with a main responsibility to support the research group on activity and participation.

Both authors are part of the research group on activity and participation at NTNU. The group is involved in developing participation research in Norway and internationally. This is with the aim of contributing to a change in professional service that puts ideals of participation into practice. In 2017, the research group was behind the book *Participation in health and welfare services: Professional Concepts and Lived Experience* (Routledge). The first author contributed as chapter author and the second author was one of the editors of the book.

## PUBLIC INTEREST STATEMENT

Mental disorders contribute significantly to the global burden of disease and affect all countries and communities. While institutionalised care and often isolation used to be the main pillar in the societal response to mental disorders, social inclusion and integration is the current drivers of mental health policies and intervention. Over some time, community mental health services that support service users' active participation and inclusion in the community has been established and developed. This research on low threshold community services in Norway aimed at exploring how such services could contribute to the recovery of individuals affected by mental health problems. Support from both professionals and peers as well as sharing of practical advice and experiences within a voluntary, flexible and minimal invasive service environment turned out to boost social participation and experiences of being acknowledged by others. Low threshold community mental health services can provide an important resource base that can support social integration and inclusion of individuals affected by mental health problems.

**Subjects: Mental Health; Health and Social Care; Medicine, Dentistry, Nursing & Allied Health**

**Keywords: social participation; peer support; community mental health; low threshold services; qualitative research; ethnography**

## 1. Introduction and background

Mental health problems are often associated with risks of social exclusion and isolation (Huxley & Thornicroft, 2003; Knapp, McDaid, Mossialos, & Thornicroft, 2007; Rogers & Pilgrim, 2005; Sayce, 2000), and a "psychosocial approach" in mental health services has been recommended (Ramon & Williams, 2005). Studies of the social situations of people with mental health problems have revealed a lack of participation in mainstream society, also when living outside institutions (Estroff, 1985; Parr, 2008). The importance of social support for mental health is well established (Huxley & Thornicroft, 2003; Kawachi & Berkman, 2001; McKenzie & Harpham, 2006). Needs for further developments of community mental health services which support service users' active participation and social inclusion in the community, has been highlighted (WHO, 2001, 2005, 2013) and discussed in the literature on mental health policy (Corrigan, Mueser, Bond, & Solomon, 2008; Huxley & Thornicroft, 2003; Knapp et al., 2007; Ramon & Williams, 2005). A psychosocial approach in mental health work aims to support social inclusion by providing accessible, flexible and "recovery-oriented" services in local communities (Elstad, 2014; Elstad & Norvoll, 2013; Whitley & Campbell, 2014; Whitley & Siantz, 2012; Whitley, Strickler, & Drake, 2012). Such services have also been encouraged as a strategy for health promotion (Dalgard et al., 2011; WHO, 2005). This article aims to contribute to an understanding of how social participation can enhance mental health, by exploring social interaction in a "low threshold" community mental health service and what attending the service means for service users and their recovery.

In Norway, accessible and flexible health services that people can access directly without applications or referrals from doctors are called "low threshold" services. Such services have no waiting lists and they usually offer a mix of professional and peer-support. The Norwegian Directorate of health have recommended further developments of "low threshold" community mental health services, in order to offer people the safety of available help when needed (Helsedirektoratet, 2010, 2014). An example of such a service are centres called "meeting places" in the community. While more traditional mental health centres offer treatment and support based on referrals and other centres in the mental health field are user-led and organised by user organisations or the voluntary sector, the "meeting-places" studied here are part of a municipal health service, combined with high degrees of user participation and peer-support. These centres' low threshold approach means that although they are led by qualified mental health professionals, people attend the service according to their own felt needs.

Internationally, services with a "low threshold" approach have been developed within what is known as "recovery-oriented" mental health services, recognising that people with experience of mental illness need to guide their own recovery (Whitley & Campbell, 2014). There are, however, variations in the mental health policy which "surrounds" such services, and the organization of services can also vary within countries (Conradson, 2003; Elstad, 2014; Parr, 2000; Philo, Parr, & Burns, 2005; Whitley & Siantz, 2012; Whitley et al., 2012). To understand the nature and common features of "Recovery Centers", Whitley et al. (2012) surveyed 24 services; most from the USA and some from Australia, Canada and New Zealand. Although these services varied in their structure, findings suggested that such settings can be empowering arenas for people with severe mental health problems by providing a hopeful, supportive and non-stigmatizing environment. Further studies of "Recovery Centers" in the USA concluded that they provided highly valued support, which enabled many users to face life in the community with confidence (Whitley & Campbell, 2014; Whitley & Siantz, 2012). These settings, which were interpreted as "safe backstage sanctuaries" that provided a physical and ontological space for recovery were discussed as "an emerging best practice" (Whitley & Siantz, 2012, p. 10). European studies have also found that accessible and flexible community mental

health services are appreciated by their users (Conradson, 2003; Elstad & Eide, 2009; Elstad & Kristiansen, 2009; Kristiansen, 2000; Parr, 2000; Philo et al., 2005).

### *1.1. Social inclusion, participation and recovery*

Changes from systems of mainly psychiatric hospital treatment towards community mental health care have contributed to a broader theoretical understanding and a more eclectic approach in mental health work in Norway as in several other countries (Knapp et al., 2007; Ramon & Williams, 2005; Ramsdal, 2013). In a psychosocial rehabilitation perspective, William Anthony (1993, p. 11) described recovery as "... the guiding vision of mental health service systems in the 1990s". According to Sépulchre and Lindqvist (2016, p. 320), "... the idea of recovery focuses on improving a person's well-being in order to regain her role as a citizen", which means that mental health professionals should support service-users towards social inclusion. The concepts of participation and social inclusion relate to peoples" experiences of belonging to communities and social fellowships (Gustavsson, 2004; Molin, 2004; Piskur et al., 2014). Many who live with mental health problems attend services in the community as part of their daily life. Low threshold community mental health services are accessible and have high degrees of user involvement in order to support service users' recovery from mental illness through processes of social participation and inclusion.

To contribute to others and receive recognition can increase people's sense of self-worth and contribute to their recovery from mental health problems (Anthony, 1993; Borg, 2007; Ebersold, 2007; Oliver, Collin, Burns, & Nicholas, 2006). In a Swedish study, to be able to give something to others was identified as central for experiencing participation among service users with a diagnosis of schizophrenia (Yilmaz, Josephsson, Danermark, & Ivarsson, 2009). Reciprocal relationships are an important part of peer-support for people recovering from mental health problems (Schon, 2010). Mead (1967) and Goffman (1961, 1963, 1967) have described how the subjective experience of our own identity develops through social interaction. Mutual trust is established through face-to-face interaction, and people recognise and confirm one another's dignity through rituals of respect, such as greetings (Goffman, 1967). According to Ware, Hopper, Tugenberg, Dickey, and Fisher (2007, p. 469), capabilities for connectedness and citizenship develops as a process over time, and connectedness implies "... the construction and successful maintenance of reciprocal interpersonal relationships." In Honneth's (1995) theory of recognition, reciprocal relationships are vital for our personal development. This is about being seen as capable human beings through positive engagement in situated fellowships and face-to-face interaction. According to Honneth (2007), to be visually observed, but not "really seen" as a person who deserves respect equals being met with "disrespect". In line with Mead (1967) and Goffman (1967), Honneth's theory highlights a need for inter-subjective relationships of recognition in which people mutually confirm one another's identity.

An overall motivation for the present study was to contribute with knowledge about social interaction and participation within a type of service that has been recommended as part of community mental health services internationally (WHO, 2001, 2005, 2013). Three community mental health centres with a low threshold approach were chosen as research sites for the study, in order to explore how a service with an accessible organisation, recovery approach and active user involvement could assist its users' recovery. Thus, aims for the study were to describe and analyse central features of social interaction at these centres and what their social participation meant for service users in their daily life situations. The centres studied are organised as one service with three settings located in different areas in a Norwegian city. The service aims to function as rehabilitation for some and mainly as a social network for others, through offering social support and activities indoors and in the local community. Activities at each centre vary over time, based on service users' choices and available resources. At the time of the study, the centres had 215 regular users and an average of 66 visitors daily.

## 2. Study design and methods

This study has an explorative, ethnographic design, which can be a useful approach towards understanding complex phenomena and the actions, experiences and perspectives of a group of people

(Goodson & Vassar, 2011; Hammersley & Atkinson, 2007; Larsen, 2007; Pilgrim, 2009; Sharkey & Larsen, 2005). The ethnographic research process is open and flexible, in order to discover new ideas and insights, both from an insider (emic) and outsider (etic) position (Delamont, 2007; Fangen, 2004). It has been argued that ethnography can reach a type of knowledge that other methods cannot reach (Pope & Mays, 1995) and according to Savage (2000, p. 1400), "Ethnography has been overlooked as a qualitative methodology for the in depth study of healthcare issues in the context in which they occur".

Active user participation in decision-making about the service is encouraged. People choose whether to participate regularly or to "drop-in" occasionally and there are no intake procedures or reports written about the users. The workforce is multi-professional; with qualified mental health professionals employed. Centre 1 is located in an old, well-kept building in a quiet residential area near the city centre. Centre 2 is located in a suburb outside the city centre, in a building surrounded by small shops. Centre 3 is located in a building containing a shop and students' flats, on the immediate outskirts of the city centre. The centres all have an open area with a large table used for "house meetings" and common meals, other areas with comfortable chairs, a kitchen, a small office and areas where arts and crafts products are made and on display.

### *2.1. Research process and role as researcher*

The first author conducted participant observation regularly, three days a week for fortnightly periods over a period of 18 months; adding up to a total of 18 weeks and all together 162 h. Following recommended guidelines (Hammersley & Atkinson, 2007; Sharkey & Larsen, 2005) initial observations of the characteristics of the localities and social interaction were followed by more focused observations of activities along with conversations and interviews while participating. The research role included (as far as possible) to avoid disturbing the "natural everyday life" in the setting and not entering a "staff role". Field notes from naturally occurring conversations, and "house meetings", along with field conversations where service users presented and talked about activities they were engaged in, were important sources of data.

### *2.2. Data analysis*

In line with ethnography, participant observation and interviews were conducted within the research context and the unit of analysis was the field diary, containing notes on observed activities and field interviews, as well as reflections and notes on methodology and theoretical issues (Delamont, 2007; Hammersley & Atkinson, 2007). The data analysis followed the principles of qualitative interpretive content analysis (Graneheim & Lundman, 2004). The full text was first read closely several times to get an overview and obtain a sense of the whole, while also writing down notes based on first associations and ideas. Next the text was re-read, this time searching for the experience-near (manifest) content, which was developed into sub-themes and then grouped together and developed into higher order themes (the latent meaning of the text). Finally, the full text was re-read, to check out that the main themes adequately represented the data. Emerging themes were presented at meetings for users and professionals at each centre. This kept the research process relatively open. Such "member checking" can also be viewed as part of the validation of findings from qualitative research (Kvale, 1996). Those attending the meetings gave valuable comments to the ongoing process of analysis and also confirmed our developing understanding as relevant for their experiences.

### *2.3. Methodological and ethical issues*

The research project was approved by the relevant Regional Committee for Medical Research Ethics and the Norwegian Social Science Data Service, and the medical officer in charge of the municipal health service permitted access to the settings. All names used in this paper are pseudonyms. In addition to formal procedures, ethical issues are also about research as practice. Participant observation in open organizations poses challenges, especially related to informed consent. Information about the study was presented in meetings for users and staff at each centre. An information-sheet was displayed on a visible board and the staff handed out copies to new visitors and others

interested. The professionals were asked to inform the first author if any users objected to her presence, in which case she would refrain from attending at certain times. No objections were reported during the research process. The first author's previous experience as a psychiatric nurse seemed to assist in gaining access to the research context and establishing contact with informants. When doing fieldwork in a familiar culture, there is always a danger of "blindness" to the novelty of issues observed. On the other hand, such familiarity can also assist in the understanding of informants' descriptions of their experiences (Hammersley & Atkinson, 2007). During our process of data analysis, the second authors' more "outside perspective" from social science and other welfare-services, assisted in creating an analytic distance, along with service users' comments from member checking during meetings at the three centres (Kvale, 1996).

## 3. Findings

Four main themes were developed based on the analysis: "Available resources to assist recovery", "Social participation", "Mutual relationships" and "Social inclusion in the service and the community". Below, findings from the study are presented with these themes as headlines.

### *3.1. Available resources to assist recovery*

Central to social interaction at the centres was mutual exchanges of practical advice between users, as well as between users and staff. Based on interpretations of such observations, these settings were understood to function as relevant resources in daily life for many users. This "scene" from a centre during the first week of the field study illustrates an observation of the atmosphere and activity:

> Anna, Jill and one of the staff are sitting at the large table talking about what is on at the cinema. When I join them and introduce myself and briefly inform why I am visiting the centre, Anna says: "this is a good place to be … there are lots of things to do here". Paul is helping Ruth to search for some information on the internet and there is a discussion about the price of decorating going on at the other end of the table. Neil tells stories from journeys he has made. "You have been a bit of a globetrotter", someone says. Photographs from an event at the centre are passed around. Anita is knitting. She says: "I don't know what I would do without this place. I suppose I would be lying in bed all day. I need something that can get me up and going. This is how this place works for me".

People used the centres differently. Some, who saw themselves as regular users, participated in activities and discussions during house meetings, while others visited regularly but mostly kept to themselves, for example reading a newspaper. Some visited the centres only occasionally, like for example two young men who, on different occasions, said that although they were now working, they sometimes felt a need to visit "their" centre. Thomas explained this as a need to relax, "throw off his mask" and "shake off some strain". Grethe, on the other hand, said that for her, to go to the centre when "feeling ill" was experienced as a challenge, and she therefore experienced this as training in order to get out. Other people were observed to "drop in" for a quick cup of coffee and a chat, or to seek support or some particular advice from one of the professionals. As one of the professionals later explained, some people would only use the centres when needing some extra support or advice.

### *3.2. Social participation*

During "house meetings", users and professionals planned regular activities or special events together, and also discussed issues and rules related to the social environment of the centres. Thus, this forum offered opportunities for users to have an influence on, and share some of the responsibility for, the content of the service. However, if a suggestion could not be followed up, for example for economic reasons, it was the professionals" responsibility to act as "gatekeepers" for the service and say No. Some activities were led by one of the professionals, others by service users. Often a weekly plan would be set up in collaboration between staff and users, with staff available to give support if necessary. According to one of the professionals, "this way, those that wish to can join in on an activity of their own choice there and then". Anita described that she found opportunities for active

participation and support between people who shared experiences of mental health problems particularly valuable. She did, however, also point out that supporting others could be stressful, and that the professionals, therefore, sometimes should support users to be able to say "no". In a conversation, one of the professionals said that although users could be skilled in particular activities, it was also important to be aware of the often fluctuating course of mental health problems, and avoid putting too much pressure on people during vulnerable periods.

### *3.3. Mutual relationships*

Maintaining an accepting and inclusive atmosphere was important for both service users and professionals. For many users, a supportive atmosphere was also important for being able to take part in activities and meetings at their centre. Karin, for example, said that she trusted that people at the centre understood her and wished her well. Without this feeling of safety, she would not have dared to participate socially. During conversations, professionals also emphasized that everyone using the centres should be seen and heard and be able to have an influence. Only a few of the users were active in discussions and decision-making during meetings, but some took on active roles in regular activities. While showing me how to decorate silk scarves, Carol, for example, told me that she would sometimes instruct other users, and at another centre, a group for physical training as well as an arts group was led by service users. Anna said: "To be able to do things here make me feel as if I'm worth something. It gives me more confidence". Some service users who did not themselves take very active roles, also spoke about opportunities to be more active as positive. Daniel, for example, mentioned this and added that it was very good to see that others "in the same position' managed to lead activities, as this gave him hope that it was possible to get better.

Social interaction between users and professionals at these centres appeared more "collaborative", compared to the first authors' previous experiences from working in more traditional mental health services. For example, during house meetings issues related to the running of the centres could be openly discussed and not just presented as information from the staff. The large open areas at each centre was common ground for both users and staff. The professionals were observed to spend most of their time together with service users, either through activities or conversations, and were seldom seen to have their own separate meetings or breaks, or to spend much time in the office. In conversations and interviews during the field study, many service users mentioned the professionals' "ordinariness" as positive. Hans, for example, said the following: "The people who work here, they are like ordinary people, they behave, in a way, just like us users. But they still know a lot about psychiatry and mental health and what to do to help". Most users described "their" centre in very positive terms, but during a conversation one user mentioned that she wished there could have been opportunities for individual therapy at the centres.

### *3.4. Social inclusion in the service and the community*

To be socially included in an environment with a calm and relaxing atmosphere was important for most of the service users. Being with others from their centre also enabled many users to take part in events in the wider community. Eve, for example, underlined that for her it was important to learn from people who had found ways of coping with mental health problems and now managed to get out and about. One centre occasionally had their own stand at a market, selling products made at the centre. Users of the centres, as a group, also participated in other activities in the community, like bowling and outdoor trips, or cultural activities like visits to the cinema, a concert or the theatre. Some said that such activities also helped them to dare to take part in events outside of the centres on their own or with other friends. As Grethe put it, support which enabled participation in the community was important in order to have something to talk about and to "be someone who takes part in things going on".

For some, however, low income was a barrier to taking part in activities outside of the centres. Joan exemplified this during a conversation: "We have an evening group outside of the centres, but sometimes this does not function because a lot of things are too expensive". Another example is from John, who had a keen interest in films and going to the cinema, but told me that this had

become so expensive that, living from a disability pension, he could seldom afford to go. Service users could receive individual support from the professionals at the centres and information and advice about how to find opportunities for active rehabilitation were available. During the day-to-day social activities and meetings at the centres, issues relating to for example vocational rehabilitation were, however less focused on than the internal life at the centres and common activities outside.

## 4. Discussion

This study contributes with knowledge about the way some people with mental health problems use a community mental health service for social support in daily life, and how some also contribute to others as peers. While findings from this qualitative ethnographic study cannot be generalized, the explorative, ethnographic design aims to enhance an understanding of the actions, experiences and perspectives of the informants (Goodson & Vassar, 2011; Hammersley & Atkinson, 2007; Pilgrim, 2009; Sharkey & Larsen, 2005). The ethnographic research process is also described as useful towards the discovery of new insights, for example about healthcare issues in the context where they occur (Delamont, 2007; Fangen, 2004; Pope & Mays, 1995).

In the study, some service users described how participating at "their centre" enhanced their self confidence. According to Mead (1967), mutual relationships are vital for feelings of self-worth and identity-formation. Being able to contribute to others has been identified as important for experiencing participation (Yilmaz et al., 2009) and this is also central to Honneth's (1995) theory on human beings' needs for recognition. Social support is important for mental health, and mental health problems can lead to social isolation (Huxley & Thornicroft, 2003; Kawachi & Berkman, 2001; Knapp et al., 2007). Some people who live with mental health problems receive such support from family and friends, while others participate in user organisations or user-led services. However, for many who live with severe mental health problems a supportive milieu which includes available help from mental health professionals can be important for enabling participation and sustaining a life situation in the community. This highlights the importance of providing a variety of community mental health services which supports different people with a variety of needs.

Some used the centres regularly, often participating in and/or actively contributing to social activities, while others visited occasionally, to "relax from tension" or to seek support from the professionals. This is in line with Kristiansen's (2000) findings from such centres in Denmark, where people's varied use of the service was interpreted as signs of variations in experiences of belonging. However, mental distress and needs for support vary among people, as well as over time for each individual, which may also influence on people's use of community mental health services. A common response in conversations with service users was that the centres were important in order to get out and have something to do together with other people in a supportive environment. For users who participate actively in the social milieu and activities or as user-representatives, such settings can also function as "training-grounds" for trying out new challenges. According to Ramon and Williams (2005), supporting people in their daily life situations require a broad psychosocial approach. Findings from this study support this view by highlighting a need for accessibility, variety and flexibility in community mental health services in order to function as a resource in daily life.

The centres provided their users with ongoing support. Another aim for this service was to also function as stepping stones towards rehabilitation for some of their users. Although information and individual advice was available, active rehabilitation, such as how to obtain a job, was not clearly described in service plans or focused on as an issue during the daily activities observed at the centres. On the one hand, regular employment is important for economic reasons, and can also provide opportunities to develop an identity as more than a "psychiatric patient" or "service user" (Ekeland & Bergem, 2006). However, as discussed by Parr (2008, p. 43), a one-sided view of social inclusion solely as efforts related to "moving on" towards for example regular employment could also limit some peoples" possibilities to achieve "… senses of placed belonging in very specific community settings." Thus, important efforts for community integration should not overlook human beings' needs

for settings where one experience social belonging, mutual relationships and possibilities to contribute to others.

Many service users in this study described being with and learning from others who shared experiences of mental health problems as valuable. Positive experiences from being with others who share an illness or disability have also been reported from other studies in mental health (Gustavsson, 1993) and of people with learning disabilities (Philo & Metzel, 2005). This has been related to needs to escape from stigmatizing responses in society, as well as to the importance of support from others who understand on the basis of their own experience (Conradson, 2003; Philo & Metzel, 2005; Philo et al., 2005; Whitley & Campbell, 2014; Whitley & Siantz, 2012). Mental illness has been described as an "invisible disability", where efforts to hide experiences such as social anxiety may lead to distress in daily life (Lingsom, 2008). In a study of the everyday life situations of women living with chronic rheumatic conditions, one informant described being with other women with a similar condition as a sanctuary where she could feel "ordinary" and where her condition was part of this "ordinariness" (Alsaker & Josephsson, 2011). In the present study, a service user who was working and who occasionally visited one of the centres explained this as a need to "relax from strain". Living with mental health problems was a shared experience and, in this way, part of "normality" in these settings, which made explaining or hiding such experiences unnecessary. Using such services may function as a "passing" strategy to avoid distress or stigmatizing responses (Goffman, 1963). However, for many who live with mental health problems, to have a place where one does not always feel "different" can in itself be valuable. This is in line with Whitley and Campbell's (2014) discussion of such settings as a "safe backstage sanctuary" (Goffman, 1959), which provides a space for recovery.

Users of the "low threshold" centres expressed positive views about the service, which is a finding in line with some other studies from similar settings (Conradson, 2003; Kristiansen, 2000; Philo et al., 2005; Whitley & Campbell, 2014; Whitley & Siantz, 2012; Whitley et al., 2012). Such positive responses could be influenced by a wish to promote the service, but it could also be due to the accessible and flexible organization of the service, which meant that people could choose how to attend. Both users and staff in this study emphasized that an inclusive and supportive atmosphere was important in order to enable participation for all service users. When people are able to use a service according to their own felt needs, it also encourages agency and can function as a way of taking responsibility for one's own mental health. This interpretation of some early findings was shared by service users who commented on early findings from the study, presented at meetings at all three centres.

## 5. Conclusion

Findings from this study supports an understanding that psychosocial interventions in community mental health settings can play a significant role in assisting recovery from mental health problems (Whitley & Siantz, 2012). Such services that are accessible and flexible, and provide social support as well as opportunities for active participation can function as available resources for sustaining a life situation in the community for many. Combining professional and peer support provides people with opportunities to receive help as well as to contribute through common activities. This also encourages developments of mutual relationships, which can promote mental health. To enhance social inclusion in the wider community is also a central aim for community mental health services. How "low threshold" services can function as stepping stones towards more active rehabilitation for some of their users should be studied and further developed as practice. Another important question is how efforts for social inclusion in the wider community can also support people's needs for social belonging and mutual relationships. Such questions should be explored based on observed practice and how service users describe their experiences (Gask & Rogers, 1998; Pilgrim, 2009).

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The authors declare no competing interest.

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