Routledge
Taylor & Francis Group

Mental health centres as 'meeting-places' in the community: exploring experiences of being service users and participants

Toril Anne Elstad[a]* and Kristjana Kristiansen[b]

[a]*Faculty of Nursing, Sør-Trøndelag University College, Trondheim, Norway;* [b]*Institute of Social Work and Health Science, Norwegian University of Science and Technology, Trondheim, Norway*

The purpose of this article is to present and discuss findings from a qualitative study within mental health centres called 'meeting-places' in the community. Ten service users were interviewed in order to explore and gain insight into what visiting the centres might mean in the daily life situations of people who experience mental health problems. The interviewees were recruited during fieldwork within these centres, aiming to facilitate the inclusion of service users who wished to share their experiences, but who might not otherwise come forward as research participants. Three main themes were identified in the data analysis: 'To belong and be recognized', 'Needs for support and challenges', and 'Participation and everyday life'. Flexible community mental health services can be helpful by offering support and challenges as well as possibilities for mutual relationships. However, the study also highlights a lack of opportunities for participation and recognition in the wider society.

Keywords: community mental health centres; users and participants; experiences

Introduction

The aim of this article is to present and discuss findings from a qualitative study within mental health centres which are part of the municipal health service in a Norwegian city. These centres, called 'meeting-places', aim to support users' social inclusion in their community as well as to increase user-participation within the service. The main theme explored in individual interviews was what visiting these centres meant in the daily life situations of service users. The organization of the centres facilitates the role of service user as well as active participant, which differs from more traditional mental health services. User participation and social inclusion are central aims for contemporary mental health policy in several countries. The study should therefore have relevance outside of its local context.

Background context

Developing mental health services to support people in their life in the community is now a central aim internationally (WHO 2001b, 2007). Norwegian policy is in line with these recommendations, as described in a government White Paper on mental

---

*Corresponding author. Email: toril.elstad@hist.no

health services (SHD 1996/97). A reduction in psychiatric hospital beds and an increase in community mental health services have been major international trends across several countries for more than 50 years (Corrigan et al. 2008; Mechanic and Rochefort 1994; Pilgrim and Rogers 2005; Prior 1993; Wright, Bartlett, and Callaghan 2008). Research from Norway shows, for example, that the number of people who were registered as patients in psychiatric hospitals declined from about 9000 in the years 1960–1970 to just under 3000 in 2003 (Hagen and Ruud 2004), and two recent reports (Kaspersen, Ose, and Hatling 2007; Ose, Pettersen, and Kalseth 2007) show an increase in community-based mental health services.

Critique of segregated psychiatric institutions began with the work of for example Goffman (1961). In Norway, Løchen's work (1976) unveiled the disparity between rhetoric and reality with regard to what psychiatric hospitals were hoping and claiming to accomplish and what actually was occurring. In many countries, the deinstitutionalization of mental health services has been welcomed by different stakeholders, including user organizations, service administrators, professionals and politicians, despite often representing different viewpoints and interests. Issues related to what the better practice is, in order to reduce marginalization and enhance the inclusion of 'vulnerable groups' in society, have been widely discussed (cf. Froestad, Solvang, and Söder 2000; Tøssebro 2004). It has also been pointed out that being physically present in a locality is a pre-requisite for inclusion, but provides no guarantee of social contact and development of social relationships (Gustavsson 1993; Kristiansen 1993). A risk of social isolation in the community for people with mental health problems has also been discussed (Pilgrim and Rogers 2005; Sayce 2000). Such discussions highlight the importance of studying relationships between ideology and service users' experiences. Sandvin and Lichtwark (2005, 69), for example, refer to Söder (1982) when addressing the issue of ideology and practice:

> Ideologies give certain directions for action. But ideologies are also simplifications, and for ideologies to be implemented it is necessary that these simplifications are adjusted to practical realities, which often reveals the inadequacy of the realism of ideologies. The result might be that the ideology is never implemented or that it is implemented but with a different outcome than expected.

Different forms of social ties, social networks and social capital have been studied and discussed, related to issues of health and welfare (Ferlander 2007; Kawachi and Berkman 2001; McKenzie and Harpham 2006; Putnam 2000). In social network theory, close relationships are described as 'strong ties' and more superficial social contacts as 'weak ties'. Social support is believed to be available in the strong ties between family and friends. Granovetter (1973), however, described how weak ties can build bridges to new social settings, such as finding and maintaining a job or having contact with neighbours. A lack of weak ties in the personal networks of marginalized groups in society may explain their relative lack of 'social capital', which refers to '...social participation in the activities of the formal and informal networks of civil society and/or as generalized trust' (Pilgrim and Rogers 2005, 39). In the International Classification of Functioning, Disability and Health (ICF), 'participation' is defined as involvement in a life situation (Bjørk-Åkesson and Granlund 2004; Molin 2004; WHO 2001a), and the notions of social capital and social inclusion appear to be intrinsically connected to participation and social interaction. Theories about experiences of recognition (Honneth 1995, 2003) also

highlight the importance of participation in social activities and the formation of mutual relationships for identity-formation and well-being.

People with mental health problems have long been described as an excluded group in society (Huxley and Thornicroft 2003; Sayce 2000; Sen 2000), and according to Bergem and Ekeland (2006), recognizing and implementing the realities of a genuine citizenship status for people with mental health problems is a central challenge for services and communities in striving towards goals of social inclusion. The Global Forum for Community Mental Health, organized by the World Health Organisation, recently sent out a message directed at reducing the social exclusion of people with mental health problems, aiming to ensure their participation in society, including an urgent need for countries to provide a network of community mental health services (WHO 2007). Community mental health centres offer settings and activities designed with the stated purpose of providing supports in daily life. However, some essential questions need further exploration, such as how people with mental health problems experience use of these community-based services, and what meaning their participation might have for their situations in the wider community.

Previous research

How people with mental health problems experience life in the community has been studied from different perspectives, and investigated by quantitative as well as qualitative research methods. Some recurrent findings from quantitative studies reveal unmet needs for social contact, relationships and activities (Bulow, Svensson, and Hansson 2002; Hansson et al. 2003; Jansson, Sonnander, and Wiesel 2003) and the importance of such factors for self-reported 'quality of life' (Borge et al. 1999; Elstad 1999; Oliver, Huxley, and Bridges 1996). Qualitative studies have reported feelings of loneliness, shame and psychological pain, fear of neglect and exclusion, passivity and needs for support but not wanting to be subjected to control (Birkeland and Kristoffersen 2004; Erdner et al. 2002; Granerud and Severinsson 2006; Green et al. 2002). Kristiansen's study of women with long-term mental health problems (2004) revealed fears of not being a good mother, issues of violence and abuse often within the service system, worries about whose version of reality is 'real', and having different perceptions of what help is helpful. Bergem and Ekeland (2004) found variations in how people with mental health problems created and sustained their identities, mentioning the need for flexible community mental health services. Borg and Kristiansen (2004) found that people with serious and enduring mental distress often recover based on their own active agency combined with non-traditional responses from service workers. Life in the community for people with mental health problems has also been studied by observations and field conversations. Reporting from a study in the USA, Estroff (1981) described how 'psychiatric clients' often had to struggle to get by. Prior (1993, 178) described the social worlds of 'ex-patients' living in local communities in Northern Ireland as '. . . a subworld of the disabled and the handicapped and the sick . . .', a world that had only superficial contact with mainstream society.

Qualitative studies have also been conducted within community mental health services. In a Danish study, Kristiansen (2000), reported variations in individual users' attachment to community mental health centres, and in a study from Norway, Lillestø and Hanssen (2000, 57) found that users had an ambivalent relationship to community day-centres, wishing most of all to 'come back to society'. In an English

study with a geographical perspective, Conradsen (2003, 507) described 'drop-in centres' as 'spaces of care in the city'. Whitley et al. (2008), reporting from qualitative evaluation research in the USA, found that centres called 'intentional recovery communities' were important for the psychosocial needs of service 'consumers'. The most prominent theme identified in their study was the importance of feeling safe, which: '. . . appeared to be the bedrock upon which positive inter-personal relationships were forged and individual growth occurred' (177).

It seems sensible to argue that community services should have a wider focus than treatment and care (Corrigan et al. 2008; Grunewald 2000; Hydén 2005). Knowledge about the social and relational aspects of mental health and mental distress based on learning from those with lived experience is important in order to develop services which support community participation and inclusion. There remains, however, a lack of research-based knowledge about the content and function of contemporary community mental health services (Ramsdal 2002). The subject of this article is what functions and meaning different aspects of such services might have in daily life for people with mental health problems.

Methodological approach and rationale

The rationale for this study was to add new insights and perspectives to existing knowledge about the role of community mental health services in people's life situations from the perspective of service users living in the community. This theme was explored in individual interviews with 10 service users in a study which was developed and conducted during participant observation (Hammersley and Atkinson 2007; Sharkey and Larsen 2005). After information rounds, five women and five men volunteered to be interviewed by contacting the first author directly or via a member of staff at the centre, during periods of participant observation from May to November 2005. The intention was that this procedure should facilitate the participation of persons who wished to be interviewed, but who might not otherwise come forwards as informants. This would, again, aid in the inclusion of informants with a variety of experiences, which was important in this study in order to gain insight into experiences from community mental health centres as part of daily life.

Study context

The research reported here was conducted within three community mental health centres in a Norwegian city. In the local mental health service plan, the centres are described as 'meeting-places' for people with mental illness living in the community. As described earlier, mental health services that aim to support people in the community have been developed in many countries. It is, however, important to note that similar terms can be used about different types of organizations. The centres that provided this study's research context are part of the local municipal health services, with staff from different health- and social professions employed. All centres are situated in mixed business and residential areas: one close to the city centre, another at the outskirts of the city and the third about 10 kilometres from the city centre. Users choose how to use the centres: there are no intake procedures or applications, no medical records are kept, and 'user-participation' in decision-making and involvement in leading activities is encouraged. According to the local plan for mental health services, the aim of these centres is to help users cope with everyday

life: a step towards rehabilitation for some and/or mainly an arena for social contact for others. Some visit the centres regularly while others 'drop in' only occasionally, and individual persons' use of the centres also varies over time.

Participants and procedure

Inclusion criteria for this study were to be a user of one of the centres, and also to have an interest in sharing this experience to contribute to this study. The research participants have been given fictional names and no demographic data were noted other than gender and approximate age, which ranged between 40 and 60 years. As the focus for the study was on the experiences of those interviewed, no medical information was sought. All informants did, however, volunteer information about previous experiences as users of mental health services during the interviews.

All the interviews were conducted by the first author. An open interview guide was used, with themes relating to the following main question: 'What does it mean to you in your daily life to participate at the centre?' Some informants did not wish their interviews to be taped. As it might be perceived as intrusive, a tape-recorder was not used (Sharkey and Larsen 2005, 177). Notes taken were summarized for the informants during the interviews, asking whether the meaning of their responses had been correctly understood. This can be considered as a validity measure in qualitative interviewing (cf. Kvale 1996, 237). In subsequent interviews, four informants supplemented some issues while three others commented that the written interview reports adequately represented their experiences. Three informants were not available for second interviews. In the autumn of 2006, meetings were held at each centre, presenting and discussing preliminary themes and findings from the analysis. These procedures were conducted in order to keep the research process relatively transparent and to facilitate feedback from informants on preliminary understandings during the research process.

Ethical issues

According to established regulations in Norway, the study was submitted to and approved by the regional committee for research ethics, the Norwegian social science data service, and the local medical officer. Before commencing the study, users and staff were informed in open meetings, and written information was handed out and also posted on announcement boards at each centre. An important principle when conducting this study was to avoid putting pressure on service users by active recruitment for interviews, according to requirements from the medical ethics committee and medical officer in charge of the services and also in line with the general approach in the research project. The research process was kept relatively open, such that participating informants could review interview transcripts, and discuss emergent findings during group discussions at the centres. This contributed to a wider understanding of the informants' perspectives, and was also based on ethical reflections, since some informants might have disliked the experience of being written about, with little influence on how their expressions might be used. As described by Kristiansen (2005, 95): '. . . within a medical approach, subjective reports are of interest primarily to uncover signs and patterns of pathology. They are asked for, and listened to, but then fitted into diagnostic categories'.

Analysis

The data analysis was based on open-ended interviews, starting with the following question: 'What does it mean to you in your daily life to participate at the centre?' The full text from all the interviews was first read through, obtaining an overall impression of the content. Secondly, each interview was read, marking all the text containing descriptions seen to illuminate the main research question. These identified descriptions from across the interviews were then re-read several times, developing and amending main themes and categories. Finally, the complete text was re-examined and explored, searching for higher-order themes and issues (Kvale 1996). The following three categories were developed from the empirical material: (1) To belong and be recognized; (2) Needs for support and challenges; (3) Participation and everyday life. These themes do to some degree overlap. However, theme one relates to 'psychosocial' aspects of using the centres, theme two focuses more on the meaning of socializing within the centres as part of daily life, while theme three relates to relationships between participation within the service and participation in the wider community.

Findings

The purpose of this study was to explore experiences of attending community mental health centres from the perspective of people who visit such settings regularly. The main focus was on the meaning of this participation in the participants' daily life situations. Findings from the interviews are presented below, using the main themes as headings. Some background information from observations during the field study has been included, in order to contextualize the findings.

To belong and be recognized

All informants in this study emphasized the importance of having an environment where they could feel safe and relaxed, in a friendly atmosphere that was free from conflicts. Some also elaborated on the importance of how you are met. Linda, for example, told how, on her first visit, one woman who visited the centre said: 'come over and sit here beside us'. This invitation was very important to Linda: 'The two of us are now best friends'. According to Jenny, there is an awareness of how they greet and receive new users at 'her' centre. This is planned by users and centre staff. Jenny compared being at the centre where she said she felt 'like an equal' to her previous experiences of a psychiatric hospital where she had often felt 'like a complete fool' in the role of patient. Grethe described her experience this way: 'in a psychiatric hospital one is not seen as a human being, – one becomes a "case" ... but I've never experienced leaving this centre feeling that I've been ignored'. This is how she described the setting:

> ... it feels safe to come here, also when you have a bad day ... It was difficult to identify myself as someone who needs help from psychiatry. At the same time, the centre felt like a safe place: you can come here also when feeling ill, as long as you can manage to sit here for a while. This can actually feel like mastery, you know, just knowing that you've been here. For someone with anxiety, this is an accomplishment.

Erik spoke about his own experiences and also what the centres might mean for other users: 'You get positive feedback ... meet others in the same situation and can

share these experiences without feeling shame. Here I don't have to explain or defend that I get a disability pension'. 'Not having to put on a mask' and 'feeling less pressure to have to live up to things all the time' were also important to Erik. Similarly, others described the centres as places where you could 'loosen up' or 'be yourself'. Grethe said: 'The ordinary activities in the neighbourhood can be too demanding after coming out from a psychiatric hospital. There you can feel like a loser because you can't manage to do the simplest of things. Here at the centre, you are never a loser'. One woman gave the following example: 'Here, we all know what it's all about. If I'm feeling low-down, like I was yesterday at the shopping centre, then here they know that I am not *only* like that'.

Several informants spoke about these places as 'their' centre, for example Ivar who referred to 'his' centre this way: 'We are a close gang here at our centre. People come here to be social and for instance to celebrate our birthdays'. How to spread information to potential users was an issue discussed in meetings at the centres, and some user-representatives were observed to be actively engaged in how the centres were presented in brochures and on the internet. In the interview, Maria also spoke about the importance of information. She had heard from others that their local doctor had informed them about these centres and that visiting the centre could prevent being admitted to psychiatric hospital: 'If my doctor had informed me about the centre, it would have been useful. Doctors and other health professionals should be more aware of different opportunities and rights. There is a lack of information'.

Needs for support and challenges

When interviewed, Erik said: 'To come here can be a little like being at work. It is a kind of learning process, too. You get important experiences and dare to behave more freely'. In line with this, conversations at the centres were observed often to be about practical things, such as food prices, food recipes, how to get a bank loan, buy a flat or decorate a room. Sometimes people would give practical advice to one another. Conversations were also about previous holidays, or shared experiences like a bus trip or the centre's Christmas party. When staff participated in these settings, it was as ordinary conversation partners. These were observed to be like familiar, everyday conversations that could take place anywhere in our culture.

In the interviews, some users talked about mutual support, available companionship, and sometimes the development of friendships. David said: 'There is not much "illness-talk" at the centre, since there is a "house rule" against too much of this.' However, he also added: 'Sometimes it's necessary to talk about one's problems and the things one struggles with ... others may have experienced the same, and this can be positive'. Both Maria and Andreas described how, in their experience, 'meeting like-minded' could mean 'finding comfort in sharing the same fate'. Similarly, Grethe said: 'Those who know how it feels can give others good ideas and help start a process that has positive effects'.

All users emphasized the need for having professional staff available at the centres. Jenny said: 'The professionals are very important ... they are together with us and listen to us. I can ask for advice if there is some trouble in my daily life'. According to Maria: 'When you're ill you want the staff to have good professional knowledge and to understand what the matter is'. This appeared to be related to keeping the setting conflict-free and feeling safe, and also a concrete need for help and advice in one's daily life situation. Ivar said about this:

> Here you are backed up in your everyday life if you need it ... It is very important that those working here have professional knowledge. Here we have the safety of knowing that there are professionals available who can handle the situation if something should happen.

Karin said: 'People here are nice. But I still don't want the users to take over. It's important that the staff takes care of things and organize activities, – otherwise it might be chaotic. The way things are here suits me fine. I need a very long time to connect to new people'.

Participation and everyday life

Responses to what participation at the centre meant in daily life in general were mainly about having somewhere safe to meet people and to have opportunities to participate in activities together with others. Alternatives were often described as being left alone, and on one's own. Linda, for example, described 'lying on the couch at home' as her alternative, adding 'that's what I used to do before'. When asked about what centre-participation meant for her, Karin answered: 'for example, one doesn't have to walk around town alone all day. It would be boring and lonely in the long run'.

Another typical response was related to reducing experiences of mental distress. Andreas said that the centre was 'very important' for him in order to get out either on his own or be together with others. For him, this social participation also served as a way of avoiding his experiences of strong anxiety. In his own words: 'When you're alone, you can get yourself into a state of anxiety and crisis. Together with others, you can train yourself not to think like this'. Jenny compared participating at the centre to her earlier experience of psychiatric hospitals this way:

> It's very important to have somewhere like this to go to. Before one didn't have alternatives to hospital admission ... it was quickly in and out of hospital. Because of this centre, I haven't been inside a psychiatric hospital for ten years. It's like an anti-depressant without side effects.

Grethe likened her depression to being in a 'vacuum-land', explaining that somebody then has to help in order to 'let in air and open up a way out'. Sharing positive experiences with others at the centre could, again according to Grethe, help this way: 'Experiencing something, – then being able to tell others about it is very different from living in a vacuum. Actually, not only to tell others, but also knowing yourself that you have done something helps'. Similarly, Erik said: 'To participate socially here helps me to feel less isolated in general. In this way, to participate here can help me manage to do other things as well, outside of the centre'. According to Karin, visiting the centre also helped her to have contact with others outside of the centre. She said the following: 'I feel proud to participate here. Managing to come here also helps me to take part in other things. I get more self-confidence'.

Discussion

The purpose of this study is to illuminate different aspects of what it means to attend community mental health centres in a context of user-participation and social inclusion, based on the experiences of regular service users. A main finding from 10 individual interviews was a very positive description of these centres. On one hand,

this is not surprising, since all the study participants had chosen to visit the centres on a regular basis. It also reflects a sense of belonging, since these centres are based on both professional- and peer-support. This indicates that services focusing on user participation and social inclusion are appreciated by their users.

To belong and be recognized

To feel socially included and safe was important for all those interviewed in this study. Some related this to needs for safety and support in order to avoid or reduce experiences of mental distress. Others felt that participation at these centres could prevent (re)admissions to psychiatric hospitals. It was also important for the users to participate in an environment where one felt equal and respected. Honneth (1995, 2003) highlights needs for fellowship, where one is seen as a fellow human being and recognized for one's competencies, not merely as a person observed and tolerated. Relationships of mutual recognition provide opportunities for experiencing solidarity, social inclusion and increased self-worth. Grethe's expression: 'here you are never a loser' when speaking about the atmosphere at 'her' centre provides an illustrative example. Some of the interviewed referred to the centre as 'our place'. It was also observed that users of the centres informed potential new users about the centres. This can be understood as expressions of anticipated fellowship and belonging.

Whitley et al. (2008) found that 'intentional recovery communities' were important for the psychosocial needs of 'service consumers'. Feeling safe was vital for the development of positive relationships and individual growth, and this also allowed 'consumers' to function better in 'everyday society'. The present study supports these findings. The expressed needs for protection from the pressures of the wider community identified in this study do, however, also highlight that there are barriers to social inclusion in society for people who experience mental distress. Tøssebro (2004) has discussed the distinction between tolerance in society in general and individuals being 'tolerated'. The need for environments where one can be seen and respected; not merely 'tolerated', may indicate a lack of opportunities for experiencing true recognition as fellow citizens in society.

Support and challenges

Through talking about everyday experiences, people gave one another practical advice and feedback. Conversations that involve mutual sharing of experiences might support one's identity as someone who has something worthwhile to give to others. Such conversations can be understood as 'normalizing' and 'identity-forming', especially when staff also share experiences and reactions from their own daily lives. Mutual support may enhance self-confidence and strengthen people's identity as someone who contributes rather than being viewed solely as 'service users'. Some centre-users emphasized that participation in activities and sharing experiences at the centres helped building confidence and gave them something to talk about when meeting other people. Others emphasized opportunities for 'training' and learning to cope with everyday life. This is in line with findings suggesting that 'bridging' social capital is of particular value as it supports vertical exchange and enables people to 'get ahead' rather than just 'get by' (Usher 2006).

For some participants in this study, contact with others who 'shared the same fate' was important, including the sharing of good advice based on 'illness-

experience'. Gustavsson's research (1993) describes how some persons with mental illness prefer the company of others who share the same experience over others who do not. This raises interesting questions about social inclusion and community integration, for example how one defines 'community', and related feelings of belongingness. As pointed out by Bricout and Gray (2006, 5): 'Communities exist both as a physical place, whether defined by local convention, political boundaries or shared perceptions and as a locus of affiliation or identification ...'. Seen in the light of theories about social networks and social capital; can 'weak ties' that are developed within community mental health services also increase people's 'bridging social capital', leading to new experiences and activities in the wider society?

Participation and everyday life

The community mental health centres studied in this research project played a central role in the daily life of many of their users. Alternatives were often being alone and not participating together with others. Contrary to findings in a study by Lillestø and Hanssen (2000), none of the informants in this study expressed ambivalence about their participation at the centres. This difference may be related to methodology, or it can reflect differences in the study contexts, including changes in policy and organization. A Danish study (Kristiansen 2000) found variations in how people used and identified with community mental health centres. In the present study such variations were also observed. Bergem and Ekeland (2004) discussed a need for flexible community mental health services based on self-determination for the users. Findings in this study support the view that open and flexible community services may have the potential of increasing personal social networks and feelings of recognition through mutual relationships and peer-support. Such services may provide opportunities and challenges, and can also function as a safe retreat, in order to gather the strength to move on towards greater participation in community life. According to service users in this study their participation also aided in participating socially outside the community mental health service arenas. However, some of the interviewed also describe these services as places where one could get away from 'society', indicating some need for 'sanctuary' or 'asylum', often due to the experience of barriers to true social inclusion in the outside world.

Some methodological considerations

The purpose of this study has not been to generalize or evaluate, but to gain insight into different aspects of what regular use and participation in community mental health centres mean in people's daily life situations. From observations by the first author, and from comments by some of those interviewed, one can note that this inclusion procedure facilitated participation in the study of service users who might not otherwise have been interviewed. By including the views of some service users who are otherwise seldom heard, the study adds a new perspective to the knowledge-base about the experiences of mental health service users in the community.

No attempt was made to actively recruit informants. This was a pre-requisite for gaining access to the setting from those in charge of the services, and is also an important principle in research ethics, because of protecting anonymity and ensuring informed consent. It is, however, important to consider that the interviews are based on 'self-selection' among people who have chosen to use community mental health

centres, often on a regular basis, and that the inclusion of more 'peripheral' service users might have lead to more critical views. People who occasionally drop in to community mental health centres have elsewhere been found to have different affiliations to the service (Kristiansen 2000).

Another important point is that all informants volunteered some information about previous treatment from other mental health services, and some compared their previous experiences to their present situations. Thus, their frames of reference would be influenced by a contrast between 'before and now'. On one hand this indicates progress in making mental health services more useful and less repressing. On the other hand, previous negative experiences may also reduce people's ambitions. Persons who use other services or participate in a user-organization may have different experiences and views.

Concluding remarks

Open and flexible community mental health services provide support which may aid in coping with life in the community for some of the users. To have professional help available without having to give up control in one's life-situation may increase feelings of security and agency, and may prevent (re)hospitalization for some. To experience mutual relationships and recognition contributes to self-confidence and well-being. Community mental health centres can also be seen as protective communities within the larger community. Without such 'protective environments', would people with severe mental health problems be left behind in institutions? Or is it the settings and supports offered by society that limit social contact? Important questions remain unanswered about the use of community mental health services and about creating opportunities for people with mental health problems to receive recognition also in the larger community. Further research into community participation and inclusion, as well as how different types of community mental health services might aid in such processes, is necessary.

References

Bergem, R., and T.J. Ekeland. 2004. Identitet og integrasjon. Menneske med psykiske lidingar i små samfunn [Identity and integration. People with mental illness in rural communities]. *Tidsskrift for Velferdsforskning* 7, no. 2: 64–77.

Bergem, R., and T.J. Ekeland. 2006. Psykisk sjuke som medborgarar [People with mental illness as citizens]. *Tidsskrift for Velferdsforskning* 9, no. 1: 26–38.

Birkeland, A., and K. Kristoffersen. 2004. Opplevelse av behov for hjelp hos psykiatriske pasienter som bor i egen bolig [The experience of need for help of psychiatric patients who live in their own home]. *Vård i Norden* 24, no. 4: 15–9.

Bjørk-Åkesson, E. and M. Granlund. 2004. Delaktighet – ett centralt begrepp i WHOs klassifikasjon av funktionstillstånd, funksjonshinder och helsa (ICF) [Participation: A central concept in the WHO's classification of function, disability and health (ICF)]. In *Delaktighetes språk* [The language of participation], ed. A. Gustavsson, 29–48. Lund: Studentlitteratur.

Borg, M., and K. Kristiansen. 2004. Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health* 13, no. 5: 493–505.

Borge, L., E.W. Martinsen, T. Ruud, Ø. Watne, and S. Friis. 1999. Quality of life, loneliness, and social contact among long-term psychiatric patients. *Psychiatric Services* 50, no. 1: 81–4.

Bricout, J.C., and D.B. Gray. 2006. Community Receptivity: The ecology of disabled persons' participation in the physical, political and social environments. *Scandinavian Journal of Disability Research* 8, no. 1: 1–21.

Bulow, P., T. Svensson, and J.H. Hansson. 2002. Long-term consequences of the reformation of psychiatric care: A 15-year follow-up study. *Nordic Journal of Psychiatry* 56, no. 1: 15–21.

Conradsen, D. 2003. Spaces of care in the city: The place of a community drop-in centre. *Social and Cultural Geography* 4, no. 4: 507–25.

Corrigan, P.W., K.T. Mueser, G.R. Bond, R.E. Drake, and P. Solomon. 2008. *Principles and practice of psychiatric rehabilitation. An empirical approach*. New York: The Guilford Press.

Elstad, T. 1999. Sosial integrasjon blant mennesker med alvorlige psykiske lidelser [Social integration among persons with severe mental illness]. Trondheim, Norway: NIS-rapport 2/99, SINTEF Health Research.

Erdner, A., M. Nystrøm, E. Severinsson, and K. Lutzen. 2002. Psychosocial disadvantages in the lives of persons with long-term mental illness living in a Swedish community. *Journal of Psychiatric and Mental Health Nursing* 9: 457–63.

Estroff, S. 1981. *Making in crazy: An ethnography of psychiatric clients in an American community*. California: University of California Press.

Ferlander, S. 2007. The importance of different forms of social capital for health. *Acta Sociologica* 50, no. 2: 115–28.

Froestad, J., P. Solvang and M. Søder, eds. 2000. *Funksjonshemming, politikk og samfunn* [Disability, politics and society]. Oslo: Gyldendal Akademisk.

Goffman, E. 1961. *Asylums*. Harmondsworth: Penguin Pelican Books.

Granerud, A., and E. Severinsson. 2006. The struggle for social integration in the community – the experiences of people with mental health problems. *Journal of Psychiatric and Mental Health Nursing* 13: 288–93.

Granovetter, M. 1973. The strength of weak ties. *American Journal of Sociology* 78: 1360–80.

Green, G., C. Hayes, D. Dickinson, A. Whittaker, and B. Gilheany. 2002. The role and impact of social relationships upon well-being reported by mental health service users: A qualitative study. *Journal of Mental Health* 11, no. 5: 565–79.

Grunewald, K., ed. (2000) *Psykiska handikapp – møjligheter och rettigheter* [Psychiatric disability – possibilities and rights]. 2nd ed. Stockholm: Liber Forlag.

Gustavsson, A. 1993. Livet i 'integrasjonssamfunnet' – en analyse av nærhetens sosiale betydning [Life in 'the integration-society' – an analysis of the social meaning of closeness]. In *Mot normalt? Omsorgsideologier i forandring*, ed. J.T. Sandvin. Oslo: Kommuneforlaget.

Hagen, H., and T. Ruud. 2004. Pasienter i psykisk helsevern for voksne [Patients in adult psychiatric services]. Trondheim, Norway: Rapport 3/04, SINTEF Health research.

Hammersley, M., and P. Atkinson. 2007. *Ethnography*, 3rd ed. London: Routledge.

Hansson, L., M. Sandlund, A. Bengtsson-Tops, O. Bjarnason, H. Karlsson, T. Mackeprang, L. Merinder, L. Nilsson, K. Sørgaard, H. Vinding, and T. Middelboe. 2003. The relationship of needs and quality of life in persons with schizophrenia living in the community. A Nordic multi-center study. *Nordic Journal of Psychiatry* 57, no. 1: 5–11.

Honneth, A. 1995. *The struggle for recognition. The moral grammar of social conflicts*. Cambridge: Polity Press.

Honneth, A. 2003. *Behovet for anerkendelse* [The need for recognition]. Copenhagen: Hans Reitzels Forlag.

Huxley, P., and G. Thornicroft. 2003. Social inclusion, social quality and mental illness. *British Journal of Psychiatry* 182: 289–90.

Hydén, L.C. 2005. *Från psykiskt sjuk till psykiskt funktionshindrad* [From mentally ill to mentally disabled]. Lund: Studentlitteratur.

Jansson, L., K. Sonnander, and F.A. Wiesel. 2003. Clients with long-term mental disabilities in a Swedish county – conditions of life, needs of support and unmet needs of service provided by the public health and social service sectors. *European Psychiatry* 18, no. 69: 296–305.

Kaspersen, S., S.O. Ose, and T. Hatling. 2007. *Psykisk helsearbeid i kommunene: Disponering av øremerkede midler i kommunene 1999–2005* [Community mental health services: Use of earmarked grants in the municipalities 1999–2005]. Trondheim: Report A1216: SINTEF Health research.

Kawachi, I., and L.F. Berkman. 2001. Social ties and mental health. *Urban Health* 78, no. 3: 458–67.

Kristiansen, K. 1993. *Normalisering og verdsetjing av sosial rolle* [Normalization and social role valorisation]. Oslo: Kommuneforlaget.

Kristiansen, K. 2004. Madness, badness and sadness revisited: Ontology control in mental health land. In *Gender and disability research in the Nordic countries*, ed. K. Kristiansen and R. Traustadottir Lund: Studentlitteratur.

Kristiansen, K. 2005. Owners of chemistry, hope and evidence. In *Resistance, reflection and change. Nordic disability research*, ed. A. Gustavsson, J. Sandvin, R. Traustadóttir, and J. Tøssebro. Lund: Studentlitteratur.

Kristiansen, S. 2000. Interaction patterns among users of a Danish community care centre. *International Social Work* 43, no. 3: 325–36.

Kvale, S. 1996. *InterViews*. Thousand Oaks: Sage Publications.

Lillestø, B., and J.I. Hanssen. 2000. Pasientfellesskapets' betydning for mennesker med alvorlige psykiske lidelser [The meaning of 'the patient fellowship' for people with severe mental illness]. In *Usynlighetskappen. Levekår for funksjonshemmede*, ed. T.I. Romøren. Oslo: Akribe.

Løchen, Y. 1976. *Idealer og realiteter i et psykiatrisk sykehus. En sosiologisk tolkning* [Ideals and realities in a psychiatric hospital. A sociological interpretation]. *Oslo: Universitetsforlaget.*

McKenzie, K., and T. Harpham. 2006. *Social capital and mental health*. London: Jessica Kingsley Publishers.

Mechanic, D., and D. Rochefort. 1994. Deinstitutionalization of the mentally ill – efforts for inclusion. In *Inescapable decisions – the imperative of health reform*, ed. D. Mechanic. New Brunswick: Transaction Publishers.

Molin, M. 2004. Delaktighet inom handikappområdet – en begreppsanalys [Participation in the disability-area – an analysis of the concept]. In *Delaktighetes språk* [The language of participation], ed. A. Gustavsson. Lund: Studentlitteratur.

Oliver, J., P. Huxley, and J. Bridges. 1996. *Quality of life and mental health services*. London: Routledge.

Ose, S.O., I. Pettersen and J. Kalseth. 2007. Opptrappingsplan for psykisk helse: Utvikling i kommunale brukerrater og dekningsgrader fra 2001–2004 [National mental health plan: Changes in user rates and coverage ratios for municipal services from 2001 to 2004]. Trondheim: Report A1312, SINTEF Health Research.

Pilgrim, D., and A. Rogers. 2005. *A sociology of mental health and illness*. 3rd ed. Berkshire: Open University Press.

Prior, L. 1993. *The social organisation of mental illness*. London: Sage Publications.

Putnam, R.D. 2000. *Bowling alone. The collapse and revival of American community*. New York: Simon & Schuster.

Ramsdal, H. 2002. Om formingen av det kommunale psykiatrifeltet [Shaping the new field of municipal community mental health work]. In *Samfunn og psykiske lidelser*, ed. R. Norvoll. Oslo: Gyldendal Akademisk.

Sandvin, J., and W. Lichtwark. 2005. Gradual improvement or deterioration in disguise? In *Resistance, reflection and change. Nordic disability research*, ed. A. Gustavsson, J. Sandvin, R. Traustadottir, and J. Tøssebro. Lund: Studentlitteratur.

Sayce, L. 2000. *From psychiatric patient to citizen. Overcoming discrimination and social exclusion*. Houndmills, Basingstoke: Palgrave MacMillan.

Sen, A. 2000. Social exclusion: Concept, application, and scrutiny. Asian Development Bank Report, Social Development Papers 1.

Sharkey, S., and J. Larsen. 2005. Ethnographic exploration: Participation and meaning in everyday life. In *Qualitative research in health care*, ed. I. Holloway. London: Open University Press.

SHD: St. meld. nr. 25. 1996/97. *Åpenhet og helhet* [The Norwegian government's White Paper on mental illness and mental health services]. Oslo: Sosial-og Helsedepartementet.

Søder, M. 1982. Om osynliggjørende av funktionshindrades behov [On rendering the needs of disabled people invisible]. *Tidsskrift for Nordisk Forening for Pedagogisk Forskning* 3: 15–20.

Tøssebro, J. 2004. Introduksjon – integrering og inkludering, historikk og politikk [Introduction – integration and inclusion, history and politics]. In *Integrering och inkludering*, ed. J. Tøssebro. Lund: Studentlitteratur.

Usher, C. 2006. Social capital and mental health in the urban south, USA: A quantitative study. In *Social capital and mental health*, ed. K. McKenzie and T. Harpham. London: Jessica Kingsley Publishers.

Whitley, R., M. Harris, R.D. Fallot, and R. Wolfson Berley. 2008. The active ingredients of intentional recovery communities: Focus group evaluation. *Journal of Mental Health* 17, no. 2: 173–82.

WHO. 2001a. *International classification of functioning, disability and health (ICF)*. Geneva: World Health Organization.

WHO. 2001b. *Mental health: New understanding, new hope, world health report*. Geneva: World Health Organization.

WHO. 2007, 1 June. Community mental health services will lessen social exclusion, says WHO. http://www.who.int/mediacentre/news/notes/2007/np25/en/print.html.

Wright, N., P. Bartlett, and P. Callaghan. 2008. A review of the literature on the historical development of community mental health services in the United Kingdom. *Journal of Psychiatric and Mental Health Nursing* 15, no. 3: 229-37.