NOTAT NR. 2 – 2012

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Social Networks for Mental Health Clients – Resources and Solution

Høgskolen i **Hedmark**

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Notat nr. 2 – 2012

ISBN: 978-82-7671-866-9
ISSN: 1501-8555

Høgskolen i **Hedmark**

Tittel: Sosiale nettverk for personer med psykiske lidelser – både ressurs og løsning

Forfatter: Ragnfrid Eline Kogstad og Erik Mønness

Nummer: 2	**År:** 2012	**Sider:** 20	**ISBN:** 978-82-7671-866-9 **ISSN:** 1501-8555

Oppdragsgiver:

Emneord: Sosial støtte, sosialt nettverk, mental helse klienter.

Sammendrag:

Dette notatet bygger på en undersøkelse der 850 medlemmer av brukerorganisasjonen Mental Helse svarte på spørsmål om erfaringer med ulike deler av hjelpeapparatet og i hvilken grad de hadde et sosialt nettverk og hvordan dette fungerte. Det ble også krysset av for alder, kjønn, sivilstand, skole- eller yrkestilknytning og bosituasjon.
Bakgrunnen for undersøkelsen var et ønske om å forstå mer av samspillet mellom sosiale nettverk og profesjonelle tjenester. Mange studier har illustrert betydningen av sosial støtte og sosiale nettverk for personer med psykiske problemer eller lidelser, og dessuten vist at sosiale nettverk både kan bety redusert behov for profesjonelle tjenester og bedre tilgang til slike tjenester. Vi har likevel begrenset kunnskap om hvordan samspillet mellom sosiale nettverk og profesjonelle tjenester fungerer.

Ca. 4000 medlemmer fikk tilsendt spørreskjemaet og knapt 1000 svarte. Støttemedlemmene ble ekskludert fra den kvantitative analysen (men inkludert i kvalitative analyser av det samme utvalget). Cirka 1/3 av respondentene var menn og alderen varierte fra 20 til 80 år, med hovedtyngden mellom 40 og 60 år. 67 % hadde uføretrygd, 13 % var i jobb og 20 % kombinerte trygd med jobb eller studier. Respondentene har erfaringer fra alle deler av hjelpeapparatet, d.v.s. fra tradisjonelle psykiatriske sykehus, DPS-er, dagsentra, individualterapi, familieterapi, hjelpetelefoner, krisesentra, kunst- og kroppsorienterte terapier m.m.

Dataene viste at de aller fleste opplever å ha støttende sosiale nettverk. Videre fant vi at disse nettverkene på flere måter kan sies å erstatte profesjonelle tjenester. Når det gjelder hjelp til bedring, kan sosiale nettverk tilby kvaliteter som er på høyde med de profesjonelle tjenestene. Videre fant vi en positiv sammenheng mellom tillit til et sosialt nettverk og tillit til profesjonelle tjenester. Tillit til et sosialt nettverk øker også sannsynligheten for at erfaringene med de profesjonelle tjenestene blir positive.

Det er flere konklusjoner som kan trekkes av denne studien. Bl.a. tilsier funnene at nettverkskvaliteter i større grad burde inkluderes i de profesjonelle tjenestene. De åpne nettverksmøtene, hvor profesjonelle og nettverksmedlemmer møtes på mer likeverdig basis, kan her være en god modell. Videre vil det ha stor betydning om profesjonelle kan hjelpe utsatte grupper med å bygge egne nettverk.

Hedmark University College

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Number: 2	**Year:** 2012	**Pages:** 20	**ISBN:** 978-82-7671-866-9 **ISSN:** 1501-8555

Financed by:

Keywords: Social support, networks, Mental health clients.

Summary:

Background: Several studies have illustrated the importance of social support and social networks for persons with mental health problems. Social networks may mean a reduced need for professional services, but also help to facilitate access to professional help. The interplay between social networks and professional services is complicated and invites further investigation.

Aim: Compare aspects of clients' experiences with social networks to experiences with professional services and discuss the implications of the findings for service delivery.

Method: Quantitative analyses of a sample of 850 informants.

Results: Supportive networks exist for a majority of the informants and can also be a substitute for professional services in many respects. Regarding help to recover, social networks may offer qualities equal to those of professional services. Furthermore, there is a positive relationship between trust in a social network and trust in public professional services. Trust in a social network also increases the probability of achieving positive experiences with professional services.

Conclusion: Our findings imply that more network qualities should be included in professional services, and also that professionals should assist vulnerable groups in building networks.

THIS IS AN EXTENDED VERSION OF:

Kogstad, Ragnfrid Eline; Mønness, Erik; Sørensen, Tom.

Social networks for mental health clients: resources and solution. Community mental health journal 2012 DOI: 10.1007/s10597-012-9491-4

More analysis of the data are shown.

Content

Introduction

Over the past 30 years the importance of social networks, particularly for mental health clients, has been stated through a considerable amount of studies (see, e.g. Cobb 1976, Tolsdorf 1976, Hammer 1981, Winefield 1987, Sörensen and Dalgard 1988, Mitchell 1989, Nelson et al. 1992, Biegel and Tracy 1994, Sörensen 1994, Albert et al. 1998, Corrigan et al. 2004, Cox 2006, Haber et al. 2007, Dalgard and Sörensen 2009). Much of the research has been focused on definitions of social support and social networks, in addition to the identification of essential, active network factors such as size, quality, availability, density, reciprocity and utilization, how networks function and to what degree they facilitate service utilization and support recovery. The attempts at defining social support and social networks illustrate a diverse set of approaches, and one can hardly imagine any simple instrument being developed that could accurately measure social support[1] (Felton and Shinn 1992, van Daalen et al. 2005, Tello et al. 2005). Some researchers have suggested that larger meta-analyses will identify the central factors (Haber et al. 2007), while others have underscored the complexity in both environmental resources and individual needs (O'Reilly 1988, Buchanan 1995, Hardiman 2004, Williams et al. 2004, Dorvil et al. 2005, Cox 2006, Östberg 2007) and suggested that the subjective and objective aspects of social support and social networks can best be approached by the use of qualitative methods (Williams et al. 2004).

This article takes as its point of departure that social networks influence well-being and are of fundamental importance to most people. In spite of the lack of conceptual clarity, research has documented that networks in general are more supportive than unsupportive (Nelson et al. 1992), that social support acts as a moderator of life stress (Cobb 1976, Sörensen and Dalgard 1988, Williams et al. 2004, Dalgard and Sörensen 2009), and that people with a reasonable overall network size and more network satisfaction are likely to report higher factors on the Recovery Assessment Scale (RAS) and a better quality of life (Corrigan et al. 2004). Moreover, as self-reporting methods have demonstrated a high reliance (Glass and Arnkoff 2000, Haber et al. 2007), this article takes the clients' own descriptions of social support and recovery factors as valid information.

The Roles of Social Support and Professional Help in Relation to Each Other

Social networks seem to play an important role in the utilization of mental health services (Hammer 1963, Mitchell 1989, Biegel and Tracy 1994, Albert et al. 1998), although the connection is complicated. Smaller social networks and less social support are also associated with more frequent hospitalization (Biegel and Tracy 1994, Albert et al. 1998), and closely knit networks have shown a positive relationship in terms of relapse (Sörensen 1994). A spiral movement can be seen between small networks and hospitalization which results in even smaller networks that often consist of network members who met each other in a mental health context (Albert et al. 1998). By contrast, contacts that were perceived as being against treatment, while at the same time willing to provide material aid, reduced the need for professional help. If the network also provides fun and relaxation, the need for professional help was further reduced. So as a result, both high and low network density may be related to more use of professional services, but the relationship is modified by attitudes within the network and the individual network's impact on healing or relapses.

Further, there seem to be a connection between the *kind* of professional help the individual seeks and receives, and the network's quality, size and density. As large networks may prevent hospitalization, the relationship between network size and the *use of non-hospital services* may be positive. The absence of friends and family in the help-seeking process is an independent predictor not only for hospitalization, but also for compulsive admission (Albert et al. 1998). This knowledge supports the suggestion that professionals should facilitate their clients' access to network resources (Granerud and Severinsson 2006).

[1] Often, distinctions are made between social support and social networks, saying that social networks represent a more objective quantity, while social support is the active part of it or the perceived support. The relationship between social networks and social support is an interesting one as a subject to study per se, but since the focus in this article is on relations between social networks and professional services - rather than between networks and support - the concepts are used more intuitively and with less accuracy.

Additionally, as friendship programs have shown success in helping persons with severe mental illnesses (Wilson et al. 1999, Hardiman 2004, Mccorkle 2009) and recent recovery research also emphasizes the essential importance of social relationships in the recovery process (Schön, Denhov, and Topor 2009), it is time to have a closer look at the quality of social networks compared to professional services and frankly discuss whether systems and services built on social support not only complement professional services, but also delineate a better course.

Aim

The aim of this study is to further explore to what degree social networks provide relief, recovery and healing, and how the networks interact with professional help. Ways to improve service quality for more clients will be discussed as well.

For this purpose the following research questions are analyzed:

- Where did the clients experience help, support and someone to confide in?
- To what degree did network influence wellbeing?
- What is the relationship between network resources and help from the public health service system?

Material and Methods

This study was carried out in 2001 and 2002, in cooperation with *Mental Health Norway* (MHN), the largest user organization in the field of mental health in Norway. The organization has a reasonable good relationship with the government, thereby indicating a moderate or mainstream political profile, and a well-developed administrative system able to facilitate the collection of data. During the period of data collection, there were approximately 5,000 members spread over the entire country.

Population, Respondents, Sample

About 4,000 randomly chosen members were invited to take part in the study. [2] Nearly 20% - roughly 972 persons, including 122 support members - responded. In the group of support members we found relatives, friends, family members and health personnel. As the support members were removed, the user group to be analyzed amounted to 850 persons.

Table 1 - Distribution on age and gender

	Year of birth					Total
Gender	<=1919	1920-1939	1940-1959	1960-1979	>=1980	(17 missing values)
Female	4	106	318	134	1	563
Male	3	49	157	61	0	270
Total	7	155	475	195	1	833

Table 1 shows the number of respondents grouped by gender and year of birth. Seventeen persons did not reveal their age or gender.

The respondents have experiences from all parts of the mental health care system such as traditional psychiatric institutions, outpatient clinics, day centers and individual therapy. Sixty-seven percent received disability

[2] The intention was to include every second member of the 5,000 members and send a reminder to the same sample, but when it came to the second round, the organization could no longer identify every second member from the first round. In the second round, questionnaires were sent to the first 3,000 members in the new members list, so as a result, a total of 4,000 members received the questionnaire and approximately 1,500 of them received it twice.

pensions, 13% had a job and 20% combined a disability pension with a job or studies. Statistical representativeness related to the user organization or to mental health clients in general cannot be claimed, which would be problematic no matter how the sample was constructed, since prevalence in this field is calculated in variegated ways (Sandanger et al. 2002). But distribution by gender, age, disability pension, education and job, plus the fact that the informants have experiences from all parts of the health care system, suggest that the findings are relevant for groups beyond the sample involved in this study.

Instruments

The questionnaire contained 16 questions[3], dealing with gender, age, living area, job/social security, family and living situation, experiences from different help services, and opportunity to talk through bad experiences (if this was important), network and well-being, eventually strong negative experiences in meetings with the help service system or not[4], and preferred services in the future.[5]

Most questions were based on a Likert scale with 3/5/7 optional values, and the values have been re-coded so that negative values are associated with "bad", positive values are "good" and size matters, with neutral/indifferent coded as zero. Some questions demonstrated a pattern with systematic missing values, and those have been interpreted as indifferent/unsure and recoded to zero. Missing values elsewhere are unaltered.

The analysis of "network" and "well-being" are based on the following groups of questions, derived from the Verona Service Satisfaction Scale (VSSS) (Ruggeri & Dall'Agnola 1993):

Network:

- How probable do you think it is to get help from family, friends or neighbors if you suddenly have serious nerve problems?
- Do you think that family, friends or neighbors would support you if you became ill and had to stay in bed for some time?
- Do you have some warm, attentive and interested persons close to you?
- Do you feel connected to a fellowship of persons who trust each other and feel responsible towards each other?

Wellbeing[6]:

- How do you feel this time?
- Is your life disappointing or encouraging?
- How high on a scale related to the best possible life you can imagine are you?

These two groups are utilized in two ways: As a basis for a Principal Component Analysis and by just taking ordinary means. A common principal network component accounts for 66% of the variation among the four network variables (N=811), while a common principal well-being component accounts for 82% of the variation among the three well-being variables (N=783) based on a correlation matrix. These components are used in regressions. Principal components demonstrate their mutual dependence, but taking means displays better in figures since the scale and location are preserved. Taking means is acceptable since the variables are on similar scales and have a common "neutral" zero value.

[3] The questionnaire can be provided on enquiry

[4] The question was: Have you experiences which you will characterize as strong, negative experiences in meetings with public or other health care services?

[5] The largest portion – 293 informants – answered that they would like an institution where they could rest, feel cared about, have talks and be supported in the mastering of their daily life.

[6] Later investigations of wellbeing have used more detailed instruments, but at the time the study was carried out, these instruments were seen as including the most central elements in wellbeing as a phenomenon.

Statistics

The significance in the tables and figures are judged by Chi-square, while ordinary (Least Square) regressions are used once. Some figures show a LOWESS regression line (locally weighted least square smoothing), and Principal Components are used twice. Significance is documented with a p value, and the SPSS (SPSS) and SYSTAT (SYSTAT) programs have been used.

Ethical Issues

The project is registered at the *Norwegian Social Science Data Services* (NSD) which has been delegated authority from the Data Inspectorate of Norway to accept investigations involving sensitive, personal information. The collection of data was organized in such a way that the researcher could not identify the informants. Letters were sent to the members of the user organization (MHN) directly from the MHN's secretary after the project had been discussed in the MHN's executive committee. This means that the user organization had ownership of the investigation and asked its own members to participate. Answers were returned anonymously to the researcher. Since the questionnaires were sent by mail and the right to non-participation was underscored, the informants' informed consent was ensured and their rights to privacy and integrity maintained. There were no cases in which informants reported any discomfort about being asked to reply to the questionnaire.

Result presentation

The results are presented in three parts:

1) Positive and negative experiences with privat and professional help;
2) Network and wellbeing
3) The relationship between network resources and help from public/professional services

Based on this, crucial recovery factors will be discussed together with the conditions for promoting such factors.

Experiences with private and professional help systems

When asking about positive and negative experiences with a given set of opportunities, we found most positive experiences in relation to family, friends and neighbors, as illustrated in Figure 1.

Figure 1 - Positive and negative experiences with different treatment possibilities (N=850)

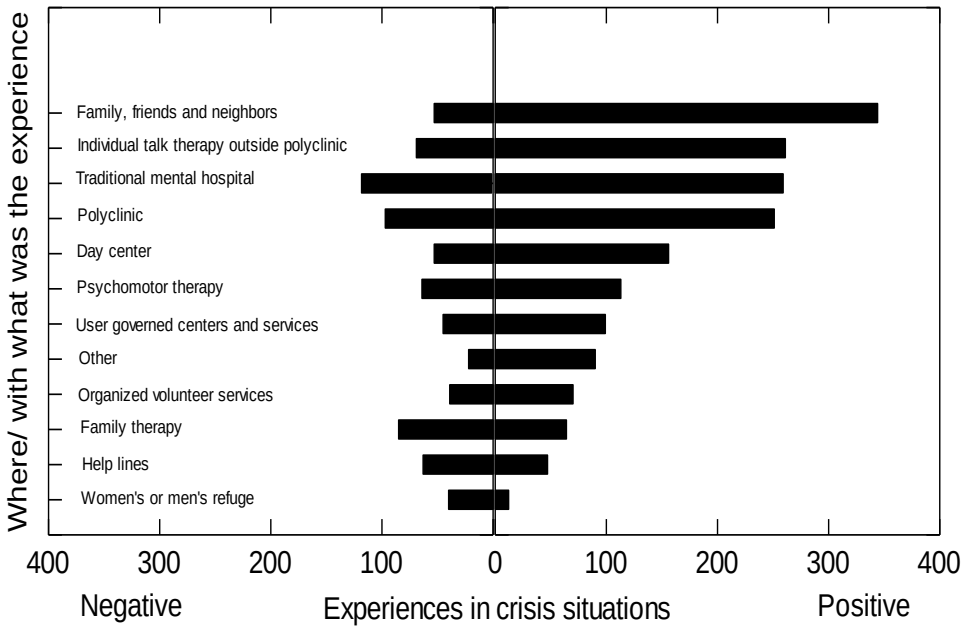


Figure 1 depicts the number of persons (out of 850) with positive or negative experiences with a range of treatment possibilities (the options are not mutually exclusive). Family, friends and neighbors are mentioned as source of help by most of the informants, and the biggest share of positive experiences is also found here. For most services, positive experiences are more numerous than negative. The exceptions are family therapy, help lines and women's or men's refuge, although the total numbers here are too small to give explanations.

It was suspected that help from social networks is more about social support than help with severe mental health problems such as earlier traumas. Therefore, we also asked where it had been possible to talk through negative experiences, and the same pattern appeared: family, friends and neighbors are at the top of the list as shown in Figure 2, which together with Figure 1 also illustrates the close connection between positive experiences and the opportunity to talk about bad experiences.

Figure 2. The place where it was possible to talk through bad experiences (N=850)

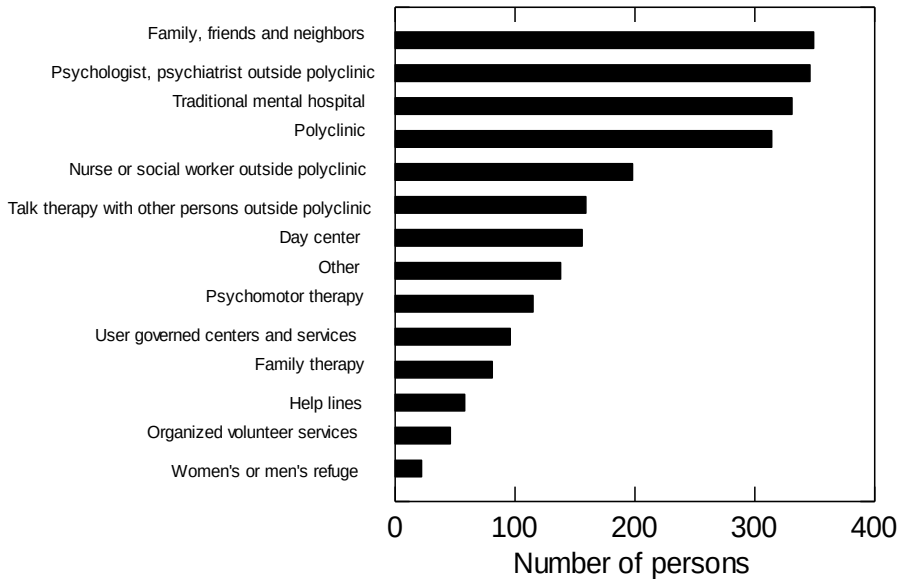


Figure 2 depicts the number of persons (out of 850) that wanted and had the opportunity to talk through their problems in different contexts (the options are not mutually exclusive). Even if family, friends and neighbors have provided most opportunities in this respect, the distance to the next option on the list, "Psychologists, psychiatrists outside polyclinic (outpatient clinic)" is small. Still, the finding that social networks represented this talking through opportunity for more people than even private psychologists and psychiatrists is worth noting[7].

Experiences with help service systems were also investigated by asking about strong negative experiences[8] in meetings with public or other help systems. More than half of the informants answered this question positively, and Table 1 shows the distribution of negative experiences in groups with different income situations.

Table 1. Income situation and strong negative (bad) experiences. The two rightmost columns show the distribution of different income situations. The middle table shows the distributions of of having bad experiences within each income group. There is a significant relation between income situation and having had bad experiences with public or other services.

	Having had severe bad experiences with public or orther services					
		Bad experiences %	Unsure/ indifferent %	No bad experiences %	N	Size of income situation group %
Income situation	Full job	39	12	49	108	15
	Part-time job	46	15	39	46	6
	Beiing/working at home	32	18	50	22	3
	Education	62	0	38	13	2
	On sick leave	68	3	29	34	5
	National insurance	53	17	31	516	70
Kjisquare=25	Total	50	15	35		
p=0.00	N	428	132	290	739	100

Table 1 depicts the distribution of income status (right-hand column) and illustrates that those in some type of activity have a lower frequency of bad experiences, while people in vulnerable social situations (on sick leave or national insurance) have also been those most exposed to strong, negative experiences. The dependence between these factors is significant.

There were found no significant relationship between age, gender and family/home situation and having had a bad experience. Even if not significant, there was a higher portion of strong, negative experiences among persons living alone (60%, N=351) or alone with children (68%, N=40), than among persons living with a partner (58%, N=191) or a partner and children (56%, N=121).

[7] The data also revealed that 164 persons had never found a place where talking about bad experiences had been possible.

[8] See note 4 for the wording of the question

As could be expected, bad experiences also affect expectancies and the *confidence in help* from public/ professional services and private help, respectively. This is illustrated in**Figure 3 a+b**, where connections between strong negative (bad) experiences and confidence in public vs. volunteer organizations and private help are shown. Here, private help means social support from family, friends and neighbors.

Figure 3 a+b - Distribution of bad experiences and confidence of getting help (N=850)

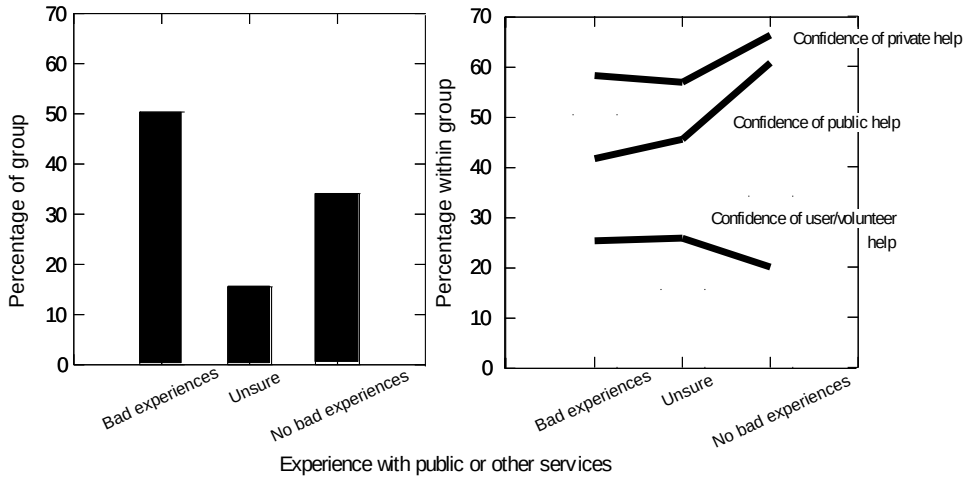


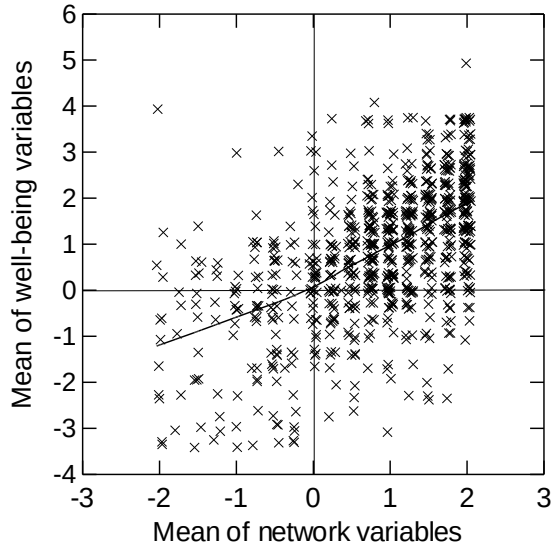
Figure 3 depicts the distribution of having had bad experiences with public or other services (3a), and the within group confidence of help from three different sources (3b). Confidence in family, friends and neighbors is generally high, but lower among groups with bad experiences with public or other services. The same pattern is found for confidence in public help.

Regarding confidence in user/volunteer organizations the tendency is reversed: no bad experiences with public or other services means less confidence in user/volunteer organizations, but the variation is small. This may still indicate that to some degree strong negative (bad) experiences are a common ground for members of volunteer/user organizations. The dependence between experiences and confidence in all three options is highly significant ($p \leq 0.00$).

Network and wellbeing

We will later illustrate how and in which way networks influence the access to professional help, but first we will see how much of wellbeing is explained by network itself.

Figure 4. Network versus wellbeing



In Figure 4, the y-axis is the mean of personal network variables and the x-axis is the mean of well-being variables. Each cross represents a person, and the scale is an indication of state: minus="bad", plus="good." It can be seen here that most people have both a network and a sense of well-being, and there is a positive correlation (Rsquare=0.29, p=0.01 N=830). However, the variation is substantial; thus life is more complicated than just having a network. The interpretation of Rsquare=0.29 is that 29% of the well-being variation can be explained by the network variation.

Principal components perform slightly better than the means (These measures were defined in the instrument chapter). A principal network component explains 30% (linear regression) of the variation in the principal well-being component.[9]

Table 2. Regression between wellbeing and exploratory variables

Dependent Variable	Well-being component	
N	764	
Squared Multiple R	0.382	
Effect	Coefficient	p-Value
CONSTANT	1.288	0.000
network component	0.476	0.000
Age	0.012	0.000
Confidence in public services	0.122	0.000
Confidence in user-governed institutions	0.067	0.032
Having have had / not have had bad experiences	0.076	0.017
Not engaged /engaged with something	0.348	0.000
Living alone or with somone	0.121	0.037

[9] Using the four individual network variables rather than the principal network component only increase this to 31%.

Table 2 shows the final regression, taken from a stepwise technique, trying to explain well-being by the network component and some other factors. The network component is the dominant factor. The other dominant factor - indicating engagement - is a dichotomous grouping of the variable "income situation", discriminating between those engaged in some kind of work/study or not. All the factors are significant and act in the expected direction.

Network Resources and Help from Public/Professional Services

As previously mentioned, the data material indicates a positive relationship between network resources and access to beneficial, professional help. In this paragraph, the relationship is examined by looking at the connections among a) Positive expectations to family, friends and neighbors and to public/professional services and b) Network resources and experience with public/professional services in general.

Table 3. The relationship between expected help from social networks and professionals. The two rightmost columns show the distribution of the trust of getting help from family, friends etc. The middle table shows the distribution of trust of getting help from public services within the first groups. There is a significant relation between the two. Having trust in family increases the trust in public services.

		Percentage of probability of help from public services				
		Improbable	Unsure	Probable	N	Size of family help group %
Probabilty of help from family, friends and neighbors	Improbable	28	35	37	113	13
	Unsure	7	48	45	221	26
	Probable	10	37	53	516	61
	Total	11	40	49		
Kjisquare=40 p=0.00	N	98	338	414	850	100

Table 3 shows the percentage of people that trust they will receive help from family, friends or neighbors in case of nerve problems: Approximately 60% have that trust, while 13% do not (right-hand column). Table 3 also shows that having trust in family/friends/neighbors is related to having trust in public professional institutions.

By contrast, when networks are weak or lacking, not only are expectations in public/professional services low, but bad experiences are also more comprehensive. As illustrated in Table 4, there is a clear relationship between weak networks and more bad experiences in health services.

Table 4. Relationship between network resources and strong negative (bad) experiences. The two rightmost columns show the distribution of network quality level. The middle table shows the distribution of having bad experiences with public services within the network group. There is a significant relation between the two. The stronger network, the smaller chance of a bad experience.

		Having had severe bad experiences with public or other services				
Network group		Percentage of bad experiences	Percentage of unsure/ indifferent	Percentage of no bad experiences	N	Percentage of network group
Weak network	**-2**	72	3	25	32	4
	-1	66	6	28	82	10
	0	51	26	23	126	15
	1	48	14	38	320	38
Strong network	**2**	46	16	38	290	34
Kjisquare=34	**Total**	50	16	34		
p=0.00	**N**	428	132	290	850	100

Table 4 illustrates the relationship between network level and bad experiences. There is an obvious decrease in the frequency of bad experiences when the network quality is increased (p=0.00). In addition, there are more people with a strong than a weak network (right-hand column). "Network group" is based upon the mean of network variables as explained in the paragraph "Instruments" and depicted in Figure 45. The values are rounded

to the nearest integer to create the groups in Table 4. Figure 5 gives an overall picture of the relationship between network resources and experiences with public/professional services.

Figure 5. Relationship between network resources and experiences with public/professional services (N=850)

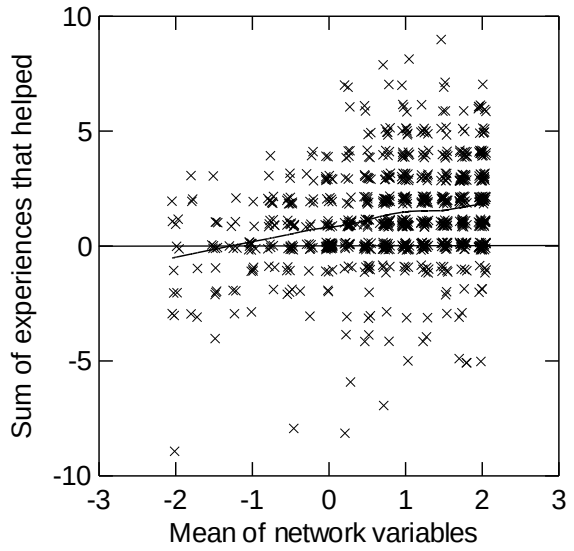


Figure 5 depicts the sum of good experiences vs. the means of network experiences and expectancies, and each cross represents a person. Bad, indifferent/unexperienced or good experiences are coded -1, 0, +1, respectively. The y variable in the figure is the sum of the experiences at "Traditional mental hospital", "Polyclinic (Outpatient clinic)", "Individual talk therapy outside polyclinic", "Day center", "Organized volunteer services", "Family, friends and neighbors", "Psychomotor therapy", "User-governed centers and services" and "Other". Since the y-axis shows the sum of good experiences (=+1), neutral experiences (=0) and bad experiences (=-1), a positive value indicates more good experiences than bad. There is a significant but slight indication (R-square=0.07) that a good network enhances the amount of good experiences.

Discussion

The statistics in this article is based on 850 participants' subjective experiences with various parts of the treatment system, social networks and volunteer organizations. We have illustrated how strong negative experiences with the treatment system are related to a relatively weak income and social situation while increased network qualities also seem to protect against bad experiences with public/professional services. Further we have looked at the impact of bad experiences on confidence in different types of help, and illustrated the relationship between expected help from the social network and expected help as well as experiences with professional services.

The data tell that a majority have received help from family, friends and neighbors, and that this help for the most part is experienced as beneficial. Family, friends and neighbors also offer help in severe cases and situations and do help with talking about traumas. The findings that people in vulnerable social situations are also more exposed to strong negative experiences in meetings with the help service system imply a double burden on people with weak social support. Not only are they deprived of help experienced as most beneficial by informants in this material, namely the social support from family, friends and neighbors, they are also more exposed to strong negative experiences when meeting with the help service system. This finding further indicates weaknesses in the mental health services when it comes to the social distribution of high quality services.

Social networks emerged as the most important help system; experienced by most of the informants and also seem to offer opportunities to talk through bad and traumatic experiences to a larger degree than other services.

Individual talk therapy followed as number two in this respect and then traditional psychiatric hospitals and polyclinics (outpatient clinics). These findings correspond with recent findings in recovery research (Schön et al. 2009) defining the social relationship aspect as the key experience related to other recovery factors. When the opportunity to talk through bad experiences here is seen as a core factor in mental health services, it is based on earlier surveys documenting the strong relationship between mental health and having someone to confide in (Strupp 1995, SSB 1998, Faktarapporten 2002).

The findings presented indicate that it is important to look beyond psychiatric and mental health services to learn how people are helped through mental illnesses. This assumption is also supported by Swindle (2000) who found that between 1957 and 1996, the proportion of people with mental health problems in the US turning to informal support from social networks rose from 7% in 1957 to 28% in 1996. In Norway there seems to be a real change in the help seeking pattern with more people seeking different alternatives to traditional services (SSB 2008)[10].

Because the material is comprehensive the statistical connections are generally strong. The spread on age categories, social situations and experiences from different parts of the service systems indicate that findings could be generalized, but in regard to the material's representativeness there are also limitations. On the one hand we do neither know the user organization's profile on different indicators, nor the informants' duration of problems or the intensity of services. On the other hand, because definitions regarding mental illness are far from standardized (Kolstad 1998, Sandanger, Nygaard, and Sorensen 2002), it is hard to claim statistical representativeness, no matter which selection procedure is used. Our position is that subjective experiences matter irrespective of the severity of symptoms and illnesses, and that the connections discovered in the material deserve attention when services are planned. The connections should also be further investigated in future studies.

Conclusion

Different types of social support seem to provide therapeutic qualities which are at least comparable to public/professional services. The findings indicate that more people could be helped if networks were established among vulnerable groups with less social support (Wilson et al. 1999, Hardiman 2004, Dorvil et al. 2000, Granerud and Severinsson 2007) and more network qualities – like a stronger focus on the satisfaction of universal human needs - were integrated into professional practices (Davidson and Strauss 1992, Spaniel et al. 2002, Borg and Topor 2003, Aderhold and Stastny 2007, Borg 2007). Also network meetings where professionals and network members meet on a more equal basis (Seikkula 2000) is a model with promising qualities, not the least in order to compensate for the exposed situation of people with weak networks. It is time to encourage research where content and outcome in different network oriented initiatives are compared more conscientiously to traditional psychiatric services.

[10] Living examples of informal or non-professional support are user-controlled houses, crisis hostels, The Berlin Runaway House, trauma-informed peer-run crisis alternatives, and the international network toward alternatives and recovery described in the book "Alternatives Beyond Psychiatry" (Statsny and Lehmann 2007), in which well-known models such as The Soteria House (see also Aderhold and Statsny 2007 and Mosher and Hendrix 2004) and open network dialogues (Seikkula 2000) are described. The content in the alternatives described are a retreat to a quiet and safe place, massage therapy, contact with nature and animals, expressive artistic activity, writing, reflection in self-help groups, political activism, protest against diagnoses, a consciously balanced lifestyle, proper diet and sufficient sleep, choice of potential helpers, thinking ahead of crises, social support, someone caring, staying close to, making inquiries, avoiding intrusion and gaining the respect of personal space.

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