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Social Networks for Mental Health Clients – Resources and Solution

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Abstract
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 learn about the relationship between network resources and help from the public health service system.
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 public/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.

Keywords: Social support, Networks, Mental health Clients

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,

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).

For the purpose of this article social networks can be defined as supporting persons – family, friends or neighbors - outside the public/professional services. Network qualities were studied by asking the following questions:

- 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?

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

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[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.

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 (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).

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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 (Davidson and Strauss 1992, Spaniel et al. 2002, Borg and Topor 2003, Aderhold and Stastny 2007, Borg 2007, Schön, Denhov, and Topor 2009), it is time to 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 has been 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 is discussed as well. The following research questions were analyzed:

- What is the connection between network and wellbeing, i.e., to what extend is social support not only encouraging but also helpful when it comes to the talking through of negative experiences?

- In what way do network resources influence the expectations to public/professional services?

- In what way do network resources influence the experiences with public/professional services?

Material, Methods and Instruments

This study was carried out 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.

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.

Approximately 1/3 of the respondents were men and 2/3 women, age between 20 and 80. More than 50 % were between 40 and 60 years old. 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 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 (Kolstad, 1998, 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.

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,

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[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.
[3] The questionnaire can be provided on enquiry

eventually strong negative experiences in meetings with the help service system or not[4], and preferred services in the future.[5]

Statistical instruments used were SPSS and SYSTAT programs, chi-square tests, regressions and frequency distributions.

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

In this section the three research questions are discussed:

What is the connection between network and wellbeing?

Wellbeing was investigated by the following questions:

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[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.

- How do you feel this time?[6]
- Is your life disappointing or encouraging?
- How high on a scale related to the best possible life you can imagine are you?

There is a positive statistical correlation between network and wellbeing. The network component is the dominant factor, but another significant factor is "income situation", discriminating between those engaged in some kind of work/study or not.

We also wanted to know if wellbeing related to social support from family, friends and neighbors also could be understood by qualities in the social support exceeding what is usually expected from lay people and volunteers, and asked where it had been possible to talk through negative experiences.[7] The analysis revealed that social networks represented the talking through opportunity for more people than even private psychologists and psychiatrists, which is worth noting[8].

In what way do network resources influence the expectations to public/professional services?

The data material showed that family, friends and neighbors were mentioned as source of help by most of the informants[9] and also indicates a positive relationship between network resources and access to beneficial, professional help. In addition positive expectations to family, friends and neighbors also increase the *trust* in public/professional services. Approximately 60% trust that they will receive help from family, friends or neighbors in case of nerve problems, while 13% do not. Further, having trust in family/friends/neighbors is

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[6] The question was about how satisfying the life is now and the rspondents were asked to tick in on a scale from 1 to 7, where 1 was "Life is very satisfying" and 7 "I am very dissatisfied". See also Ruggeri (1993)

[7] 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).

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

[9] The following alternatives were given: Family, friends and neighbors, Individual talk therapy outside polyclinic, Traditional mental hospital, Polyclinic, Day centre, Psychomotor therapy, User governed centers and services, Other, Organized volunteers services, Family therapy, Help lines, Woman's' or men's refuge. Most of the informants listed family/friends/neighbors as source of help, and the biggest share of positive experiences was also found in contact with family/friends/neighbors.

related to having trust in public professional institutions. We also found that groups with bad experiences with public/professional services have less confidence in *both* family/friends/neighbors and public/professional services.

In what way do network resources influence the experiences with public/professional services?

There is a significant but slight indication that a good network enhances the amount of good experiences while weak or lacking networks not only go together with lower expectations in public/professional services, but also with more comprehensive negative experiences.

More than half of the informants answered that they had strong negative experiences with public or other health services. We found that people in some type of activity (having a job or studying) have a lower frequency of bad experiences, while people in more 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. Both network resources and some kind of activity then seem to influence the experiences with public/professional services in a positive way. This also could indicate a social gradient related to experiences with public/professional services. There were found no significant relationship between age, gender and family/home situation and having had a bad experience. But there was a higher portion – if not significant - 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).

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. Results indicate that to some degree strong negative (bad) experiences could be a common ground for members of volunteer/user organizations.

Discussion

The data in this study tell that a majority of the informants 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. Social networks emerge as the most important help system. The findings that people in vulnerable social situations (with less social support) 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 indicates weaknesses in the mental health services when it comes to the social distribution of high quality services.

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 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.[10]

Conceptual, design or methodological limitations

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[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.

Because the material is comprehensive the statistical connections are generally strong, but since the sample is made up of only 20 % of the respondents and prevalence in this field is also calculated in variegated ways, statistical representativeness can hardly be claimed. If the findings can be generalized it is by reference to distribution by factors like age, gender, disability pension, education, job and experiences from different parts of the health care system. Further, with the chosen design it was not possible to control for network size. As mentioned, earlier research has documented that smaller networks, and also closely knit networks, are associated with more frequent hospitalization and also more relapses. Such nuances – if they exist - disappear in our presentation. Last, if both users, professionals and, to a larger degree, relatives had been included in the study, the results would have been different. Asking service users only, provides us with *one* picture. But also this picture is valuable in the building of knowledge in this field, especially as service users, less than other groups, have been able to impart their experiences and opinions to a larger audience.

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, and more network qualities – like a stronger focus on the satisfaction of universal human needs – were integrated into professional practices. 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.

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