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Experiences of Mental Health Service Users on Their Empowerment and Social Integration in the Community

Vasiliki Yotsidi*[a], Kalliope Kounenou[b]

[a] 2nd Department of Psychiatry, Athens University Medical School, "Attikon" General Hospital, Athens, Greece. [b] Department of Education, School of Pedagogical and Technological Education, Athens, Greece.

Abstract

The transition from institutionalized towards community mental health services demands the evolution from social exclusion to integration practices. Empowerment of people with mental disorders, through their involvement in planning and service provision, prevails as a cutting-edge in such practices. Along these lines, this study adopted a structured bottom-up research methodology to explore the experiences of people with severe mental disorders on nine areas of their community participation. Three focus groups of 18 persons with psychotic disorders who were treated on an out-patient community mental health centre were set up. Qualitative data analysis showed that the areas of treatment, housing, education, and entertainment have turned to be more accessible for mental health service users than those of employment, active citizenship, social relations, social networks and activities in the community. The latter were revealed to still be obstructed by specific personal and social variables, which should be taken into account for community-based treatment to become more responsive and tailor-made. Results are discussed in relation to the role of counselling psychology in improving community mental health services and ensuring that service providers empathize with and respond to individuals' understanding of their condition and what contributes to their care and well-being.

Keywords: community mental health, social integration, empowerment, focus groups, service users

Mental illness can have devastating effects on the individuals' life and their role in the society (Mahone et al., 2011; WHO, 2013). Therefore, it is crucial for scholars and professionals to determine what is best for the mental health system users. Indeed, the mental health care system has shifted towards a person-centered model of service provision that promotes social integration, empowerment, hope and vision (Mahone et al., 2011; Jana, Ram, & Praharaj, 2014; Williams et al., 1999). This shift echoes the transition from the institutionalized treatment into the community deinstitutionalized services for people with serious mental illness as well as the adaptation of a psychosocial model, in favor of the biomedical model, that treats individuals as citizens embedded in the social milieu (Insel, 2010). By giving emphasis on the social and interpersonal factors, along with the biological ones contributing to mental illness, the community-based mental health services have been found to empower people with severe mental illness (Wykes & Holloway, 2000) and promote their independent living and integration in the community (Drake, Szmukler, Mueser, & Thornicroft, 2011).

There is a well-established literature showing that empowerment is an appropriate treatment goal for psychosis (Berry, Allott, Emsley, Ennion, & Barrowclough, 2014; Tolman & Kurtz, 2012). What's more, people with psychotic disorders themselves identify empowerment as a key factor in the treatment process (Warner, 2009) and their recovery, overall (Neil et al., 2009). Several studies demonstrated that empowerment reduced the duration of inpatient treatment and the number of visits to health services (Corrigan, 2002; Corrigan, Faber, Rashid, & Leary, 1999). Additionally, it was found that empowerment increased the users' quality of life by building self-esteem, enhancing coping skills, strengthening social support networks and improving family relationships (Rogers, Chamberlin, Ellison, & Crean, 1997; Tveiten, Haukland, & Onstad, 2011). Despite these findings, a large body of research has documented that further initiatives should be taken in order to ameliorate the users' experience of social defeat (Marchinko & Clarke, 2011) and to enable empowerment through users' participation in the mental health system and the wider community (Millar, Chambers, & Giles, 2016; Omeni, Barnes, MacDonald, Crawford, & Rose, 2014).

Given that empowerment is principally a relational process emerging from the recognition of personal and social contextual resources (Shearer, 2009), people with mental health disorders cannot be empowered by professionals in a one-way process. Rather, mental health providers can enable the environments wherein empowerment is more likely to occur (Tambuyzer, Pieters, & Van Audenhove, 2014; Topor, Borg, Girolamo, & Davidson, 2011). To this end, the assessment of the users' self-perceived needs was underscored as a research priority that would facilitate their purposeful engagement in the attainment of health goals and foster their integration in the community (WHO, 2013). Nevertheless, mental health system users as yet have delivered little input in their treatment (Newman, O'Reilly, Lee, & Kennedy, 2015), while their voices have remained silent in the mental health research (Moltu, Stefansen, Svisdahl, & Veseth, 2012). The fact that neither people with mental health problems (Cree et al., 2015) nor their carers (Doody, Butler, Lyons, & Newman, 2017) have been adequately involved in decision-making processes has a deleterious effect on their sense of self-worth (WHO, 2010) and it increases the risk of social exclusion (Stylianidis, 2016). Additionally, there is evidence that the lack of addressing users' subjective needs, beyond symptoms reduction, impairs their quality of life (Lasalvia, Bonetto, Malchiodi, & Salvi, 2005; Wiersma & van Busschbach, 2001).

Several studies explored the subjective needs of the community-based mental health care users in relation to the perceived help (Middelboe et al., 2001; Nelson, Lord, & Ochocka, 2001) and the quality of life (Bengtsson-Tops & Hansson, 1999; Lasalvia, Ruggeri, & Santolini, 2002). Nevertheless, there are relatively fewer studies investigating the subjective needs of the mental health consumers with regard to their community participation and social rehabilitation (Brenman, Luitel, Mall, & Jordans, 2014; Hann, Pearson, Campbell, Sesay, & Eaton, 2015). Equally important to note is that the Camberwell Assessment of Needs (CAN; Phelan et al., 1995) and the patient-rated CANSAS-P (Trauer, Tobias, & Slade, 2008), which are the most widely used standardized measures to evaluate mental health users' needs so far, do not include important aspects of social integration (e.g., active citizenship, networking). Furthermore, an agreement between patient- and staff-based results of these instruments fell short (Lasalvia et al., 2005; Wiersma, Nienhuis, Giel, & Slooff, 1998), indicating that professionals' perspectives on the needs of the service users may be misleading. The lack of empirical attention to the users' social integration needs contradicts with the principles of the community-led mental health care. Moreover, it gears scientific interest in qualitative research methods in order to amplify "the voice of the consumer" (Rapp, Shera, & Kisthardt, 1993).

Previous research using qualitative methodology has documented that users' self-empowerment was associated with a sense of belonging in the community (Granerud & Severinsson, 2006). On the contrary, lack of interpersonal interaction and access to social roles are included in the main dimensions of stigma (Schulze & Angermeyer, 2003), by being related to the dis-empowerment aspect of the mental health service users' stigma experiences (Pinfold, Byrne, & Toulmin, 2005). To tackle stigma, the implementation of reforms within the mental health services rather than educational programmes to the lay public prevailed among users as the best solution (Pinfold, Byrne, & Toulmin, 2005). Interestingly, qualitative data from service users regarding the evaluation of the latest Greek psychiatric reform programme indicated that living a satisfying and contributing life was of high importance among the participants (Loukidou et al., 2013). However, given the negative effects of the Greek economic crisis to the health system (Christodoulou, Ploumpidis, Christodoulou, & Anagnostopoulos, 2012; Simou & Koutsogeorgou, 2014) the unavailability of data on the users' perspectives about their mental and social well-being indicates that there is a need for further research in this area. Besides, according to a recent systematic review (Semrau et al., 2016), more research is needed on investigating the service users' experiences of the mental health system in low- and middle-income countries, since a weak evidence base for the work being conducted across countries was found. Hence, understanding of the barriers and enablers to service user community involvement can inform the existing limited literature.

Our study adds to the current body of knowledge by providing greater detail into the subjective experiences of people with severe mental health problems about their social integration, an under-examined research subject so far. Moreover, the findings from the present study may be of added value in terms of informing clinical practice about the users' empowerment and community participation needs in a period of adverse social conditions, since people with pre-existing mental problems are a high-risk group in economic declines (Zivin, Paczkowski, & Galea, 2011). Along these lines, our study may also shed light on possible inconsistencies and further needs in the community mental health service provision, overall.

Additionally, in view of the fact that research on the service users' subjective needs with the use of focus groups is still scarce, the present study applied the focus group qualitative method, and thus it is expected to promote the individuals' active participation in decision-making processes and increase service responsiveness. Similarly, new empirical data from focus groups may complement existing epidemiological data through enhancing the validity of existing instruments for mental health service users and highlighting concerns held by them that otherwise would have been neglected (Powell, Single, & Lloyd, 1996).

Method

Rationale

This study was based on a Shared Decision Making (SDM) practice, which involves mental health users into a collaborative process for making their health care decisions (Eliacin, Salyers, Kukla, & Matthias, 2015; Joosten et al., 2008). Taking into account the positive outcomes of such a shared decision process in the mental health care system, focus group interviews were employed in the present study as this is a useful methodology for participants' needs assessment, the development of plans and policies, the improvement of existing programs and the evaluation of their results (Krueger & Casey, 2015). To this end, focus groups are ideal for exploring

experiences, ideas, opinions, wishes, and concerns, since they provide the participants with the opportunity to pursue issues in their own words (Barbour & Kitzinger, 1998).

In order to allow service users with psychotic disorders to determine the issues under examination on their own terms but also in an evidence-based way, the present study was based on the manual of the European SocPart project, which was developed in the framework of the Grundtvig Learning Partnership 2010-2012 (http://www.europeansharedtreasure.eu). This was a pioneering qualitative research that explored the self-perceived social competencies for the community participation of people with disabilities (i.e. intellectual disability, mental ill-health, drug abuse and homelessness) receiving deinstitutionalized services in five European countries. The present study adopted the SocPart project's standard interview schedule for structured interviews and focus groups called: "*Exploring barriers and opportunities*". This manual comprises of nine distinct areas of users' community participation, while for each area data are collated in four themes regarding the degree of access, the main barriers to access, the available opportunities for access and the further needs to enhance access (Table 1).

Table 1

Focus Group Interview Schedule

Areas of social integration

1. Education, 2. Leisure, 3. Housing, 4. Treatment, 5. Community activities, 6. Employment, 7. Active citizenship, 8. Social/personal relationships, 9. Supportive networks

Themes of inquiry

a. Degree of easy access for people with mental health problems (e.g., *Please estimate the members of the target group that have easy access to employment*)

b. Main barriers to easy access (e.g., *Please indicate the main barriers to easy access to community activities*)

c. Opportunities / positive aspects concerning access (e.g., *Please indicate positive aspects and opportunities available concerning access to active citizenship*)

d. Further needs of people with mental health problems (e.g., *What kind of education / educational programmes are missing for the target group?*)

The focus of the analysis was the interaction inside the group. Thus, the questions were designed to elicit collective views about the specific topic (Fontana & Frey, 2005). The moderator (in our study, the first author) did not interfere with the discussions in the group but stimulated them through introducing and probing about the issues raised by the interview schedule. Three focus groups were set up and each group only met once for about two hours. In each group, the participants were unfamiliar with each other but they had common characteristics, thus ensuring homogeneity (Stewart & Shamdasani, 2015). Participants were equally distributed in the three groups by their age, gender, and diagnosis.

Participants

Each of the three focus groups involved a small number of six participants in order to hold a constructive dialogue (Morgan, 1997). Overall, eighteen adults with psychotic disorders (e.g., schizophrenia, schizoaffective disorder, and delusional disorder) according to an ICD-10 diagnosis, participated in the study: 10 women and 8 men, aged from 32 to 54, living with family, either temporary contracted employees, or unemployed (15 individuals) who were in receipt of a disability pension. The only inclusion criteria were that participants should be current users of an out-patient community mental health centre in a low-income region of Athens and they were

not experiencing an acute psychotic episode at the time of the study. Participants were invited through their therapists to join discussion groups in order to share their experiences of community participation. Informed-consent procedures were explained at the beginning of each focus group and participants agreed to the recording of the session.

Analysis

The focus groups were transcribed verbatim by the first author. The second author checked the transcript for data accuracy and interpretative analysis of data was concurrent by the two authors (Murphy, Dingwall, Greatbach, Parker, & Watson, 1998). Verbatim statements were organized in the pre-defined by the study's manual key themes (i.e. the degree of access, main barriers, opportunities, and further needs). In addition, inductive coding was incorporated in the analysis, as new themes emerging from the data were also included, in line with the method suggested by Knodel (1993) for code mapping. Initially, the text was read and reread by the authors to become familiar with the data, and consequently, to categorize significant strips, breakdowns, and general themes. Larger categories were identified based on similarities between the codes and organized into most frequent responses. The data were managed using an excel database and a word document containing emerging codes from each transcript, to provide a data trail. The resultant themes contained only those agreed upon by the two authors, having ensured that data saturation had occurred. In order to strengthen the validity of the findings, the emerging themes were shared with a representative from each focus group to ensure that the themes remained grounded in the original data. Overall, no disagreements or major differences in opinions were reported between the three groups.

Results

The results are structured under the key themes presented in the focus groups and they are illustrated by quotations derived from the original data. The themes include users' access and barriers to various areas of social integration as well as facilitators of community participation and activities that are necessary for users' greater integration in the society. Data are provided on personal as well as societal and system-level barriers and enablers.

Access to Community Participation

There was a shared consensus among participants that the domains of treatment and housing were quite accessible for them. The easily accessed housing was related to the fact that all participants in the study were living with their families, either in their own or a rented house. An overarching theme that emerged was that treatment appeared to be a safe haven, mainly due to the availability and stability of the community mental health centre they were receiving services at.

> "I'm coming at the centre for many years now. It is close to my house and it feels like my second home. I know the people here, my therapist but also the rest of the personnel, and they know me as well."
> (man, aged 37)

On the other hand, though mentioned as well-accessed, the group discussions revealed that educational and leisure needs appeared to be met through rather informal and solitary means since the Internet and the TV were the most frequently mentioned sources of covering these needs. The lack of active forms of participation

was further confirmed in relation to the participants' limited access to community activities, active citizenship, social/interpersonal relationships and supportive networks. Their views about these aspects of community participation indicated that accessibility of more expanded forms of social interchange is a rather complex and mutual process.

> "*Most people in the community are like closed shops… they behave with unkindness. They don't trust us, neither talk to us on equal terms. I'm afraid of asking for something that I may want because they won't take me seriously.*" (woman, aged 32)

Many participants reported that access to community activities was impeded mainly due to their fear of being laughed at or rejected by other people. Their feeling of being rejected was also mentioned in the case of employment, which appeared to be the least accessible and the most problematic area for the participants in the study, also due to the prolonging economic crisis in the country.

Barriers to Community Participation

Three main themes of barriers that individuals dealt with for community participation evolved from the group discussions: (a) personal restrains; (b) stigma; (c) societal and institutional barriers. First, personal restrains were prominent across all aspects of social integration. These included the participants' lack of self-confidence and self-worth, feelings of inferiority, lack of motivation and interest, age and/or previous low educational level, past experiences of academic or work failure, as well as their preference to be with their relatives rather than with "*strangers*". All these individual factors made participants' adjustment to social circumstances "*a highly stressful experience*" and made them feel "*constantly exposed to failure*" and "*constantly at risk of humiliation and assault*". High levels of anxiety were related to the participants' sense that they were lacking social and practical skills. Thus, detachment from others stranded mainly as a defense against the risk of recurrent painful experiences in the social relations rather than as an *a priori* negative symptom of the disorder.

> "*The others at the pottery group are always doing better things than I do. The teacher tells me that it just takes more time for me than others and at the end, it will be fine. But I feel that I can't do it right by myself. I always need someone to help me sort out any problem that may come up, or to support me with finding a leisure activity and going there together. But no one in the group comes with me. I'm thinking of quitting from the pottery group altogether.*" (woman, aged 50)

Stigma, the second main theme of barriers that emerged from the discussions, was associated both with participants' own mistrust towards other people and the negative reactions experienced from others. Particularly, participants in the study mentioned their lack of confidence to meet people and the effort required to overcome the "*nervousness*", "*shame*" and "*emotional distress*" they feel about themselves having mental health problems.

> "*I constantly feel an uncertainty about how other people would think about me and I always have in my mind that other people are gossiping about me, or that they would feel pity for me when they learn about my hospitalizations.*" (man, aged 46)

Additionally, the role of the family in perpetuating the stigma processes was decisive, as participants in the study mentioned "*a sense of not being accepted by my family*" or that "*my family is ashamed of me*". The role of the media was also stressed by a participant who stated:

> "…*No news on our achievements or the good things we do is ever broadcasted.*" (man, aged 50)

Wider societal and institutional barriers to community participation included various aspects. First of all, the volunteers' initiatives regarding community activities, though very much appreciated by the participants in the study, they were also considered to be rather fragmentary and to thwart more integrated initiatives taken by specialized personnel with the active involvement of service users. The limited leisure and active citizenship opportunities, the bureaucracy, the reductions in social welfare benefits and pensions, and the cost of the leisure activities were all mentioned to impede the community participation of people with mental health disorders. Moreover, the lack of available jobs and the low wages, the high unemployment rates, the high degree of competitiveness, and finally, the discrimination against people with mental illness made the labor market "*unapproachable*" and "*frightening*" for the participants. Nevertheless, most of the participants expressed the wish to work, in order not to be so much dependent on social funding and on their families.

> *"Finding a job was always difficult for me. I worked for a while in the past in a funded programme for people with mental disorders and it was great. But the programme didn't continue and nowadays, due to the crisis, it's impossible for me to have a job. There are no opportunities out there, even for people who possess the qualifications. I don't have qualifications, and what's more, I don't feel accepted by others."* (woman, aged 43)

The emphasis on the "lack" was also evident in the group discussions in relation to the supportive networks: lack of networks overall, lack of information regarding the networks, lack of cooperation among institutions, lack of networks prior to or after hospitalization. This discourse of "lack", along with reflecting the wider remission of all kind of resources in the era of the economic crisis, resonated also with a difficulty in assuming personal responsibility when it comes to pursuing a supportive network.

> *"It's so easy to say no when I receive support from others…what I need is a un-intrusive support, someone who will persist but with discretion…more relaxing positive experiences with others and more initiatives taken by others and doing with the others would make me feel accepted and become motivated to participate."* (woman, aged 38).

Opportunities to Community Participation

The empowering role of the relationships with others (i.e. family, peers, therapeutic teams, and sensitized people in the community) was the most stated common theme for participants' social integration. Indeed, "*personal relationships*" were prevailed as more instigating with regard to community participation compared to the role of "*impersonal institutions*". Personal relationships included volunteers' contribution, the neighborhood, initiatives taken by various local agencies (e.g., cultural associations, the church) and the supportive role of the community treatment service in establishing contacts and participation.

> *"I'd like to have a saying in the activities I'm involved in. I think I can manage better than this. Yet, the others know better than I do…My family, for example, sometimes supports me, but most of the times I feel they want to control me like a child… When others trust me and show confidence in my abilities it makes me want to continue to try."* (woman, aged 46)

As it evolved in the group discussions, others function as "mirrors" for people with mental health illness and what individuals see in their reflection are not mere projective identifications, but it further functions as a self-fulfilling prophecy, which could either empower or discourage them. Experiencing social acceptance, freedom of opinion, feeling of autonomy in the relations, empathy from others and availability of support are all included

by the participants as important enablers that facilitate their empowerment and social integration. Moreover, the active connection with the local community and the local agencies for leisure activities, social relations, active citizenship and supportive networks was a common theme among the participants.

> "*Now all the people I know are from the treatment service. Having contacts with people from the neighborhood, or the local community, would make me feel less depressed.*" (man, aged 54)

To this end, a further opportunity mentioned was the communication and cooperation between the treatment centre and other local services in the community (e.g., primary health care services, the church, sports unions). Free of charge or discounted programs for adults in general, as well as for people with mental health problems (e.g., social tourism tickets) were mentioned to make easier the access to education, leisure and community activities. The local newspapers and the Internet were evolved as additional factors that contributed to the access to community activities and as a means for establishing a dialogue with the society and being involved in decision-making processes.

Another theme that emerged from the focus groups was the treatment-related facilitators. Particularly, participants stressed the importance of the following therapeutic parameters: (a) shifting mental health care from hospitalization to community mental health services as a means of "*being an equal part of the community*" and "*having no relapses*", (b) the inter-disciplinary, adequately trained, therapeutic team as providing "*a caring relationship from the whole treatment setting*", and (c) the reliable and trustworthy relations with the therapists. Along these lines, the community mental health service appeared to represent a "transitional space", in the Winnicottian term, since it intermediated both psychologically and practically in-between the persons with mental health problems and the society, through facilitating self-determination with respect to the broader societal principles.

> "*All the specialists, my doctor, my therapist, the secretary, the social worker, are really interested in me. They don't see me as a problem to fix but as a person. My doctor doesn't limit our relation to the medicines he prescribes to me…All of them are my ally.*" (woman, aged 34)

Needs for Community Participation

There was a consensus among participants that training programmes tailored to their interests (e.g., cooking, PC courses, handicraft) were necessary in order to "*be less dependent on others*". Additionally, increased leisure activities (e.g., excursions, painting, exercise, and sports) organized from local agencies were reported as an important need. Greater flexibility in the public field and cooperation between mental health services, social and employment agencies were mentioned as facilitative factors for housing and employment opportunities (e.g. subsidies, discounts, supported employment). Moreover, a treatment network (i.e. crisis intervention, hospitals, self-help groups) and alternative treatment modalities (e.g. art therapy, music therapy) were suggested to enrich the existing treatment services.

The need to increase the motivation of people with mental disorders for community participation was also commonly mentioned. Respondents often proposed that the establishment of local supportive networks, the organization of volunteers' networks and community sensitization initiatives would enable their active citizenship. Whilst a common opinion was that participants' motivation would be increased if they are informed about and involved in all phases of the organization of community activities, most others believed that people with mental

ill-health stay out from self-advocacy groups and local associations due to a generalized mistrust towards decision makers.

> "*There is no point to participate*, *we mean nothing to them…, politicians lie and care only for their own interests. In fact, no one really listens.*" (man, aged 39)

Finally, one of the major needs of the respondents pertained to the establishment of stable, safe and trustworthy relationships, including a sexual relationship that was greatly missing. A participant's wish for "*an open-hearted and open-minded society*" (woman, aged 42) incorporated what was essentially needed in relation to all the aspects of social integration examined in the study.

Discussion

The aim of our study was to explore the subjective views of people with psychotic disorders treated in a community mental health service on the barriers and facilitators to their integration in the community. Findings from the focus groups highlighted that what matters in the mental health care is not the mere transition to a deinstitutionalized setting, but rather whether people with mental health problems have access to empowering opportunities in the wider community. Incorporating these insights into existing interventions for promoting users' social integration may be beneficial for service providers to better empathize with and respond to individuals' understanding of what contributes to their care and well-being, taking into account the interplay with the wider social context.

The main finding of the study was that empowerment and social integration of people with mental disorders are still impeded by a lack of trust, mutual fears, and mutual exclusion practices. The service users involved in this study shared a common fear of being exposed to the community, as it has also been identified elsewhere in the literature (Sweeney, Gillard, Wykes, & Rose, 2015). In most areas under examination (i.e. education, employment, social relations, active citizenship and supportive networks) the respondents expressed a difficulty in pursuing their rights, especially in times of economic downturns when the wider society is plagued by hardship and lack of opportunities. More specifically, they mentioned that they were afraid of being laughed at, rejected, pitted, ashamed, humiliated, or bullied by others, based on current or past similar experiences in their social interactions. Thus, fear of being exposed to the community appeared to be related to stigma and missing opportunities for active citizenship that still exist as important barriers to social integration.

The Greek saying, "*John fears the beast and the beast fears John*", seems to exemplify the reciprocity of mistrust between people with mental illness and the wider society. This mutuality of stigma in mental health reflects Gilbert's (2002) model of shame: personal experiences of discrimination from social groups lead to both internalized shame (i.e. self-devaluation) and external shame (i.e. devalued by other, excluded), which in turn develops into reflected stigma to others, and rejection by the community. Indeed, a poor social network increases the internalized stigma (Corrigan, Larson, & Rusch, 2009) as well as the perceived stigma and discrimination (Sibitz et al., 2011; Stuart, 2008; Yanos, Roe, Markus, & Lysaker, 2008). The participants in the study pointed out the vicious circle of stigma, as they expressed self- and public stigma at the same time, that both have been found to reduce empowerment (Brohan et al., 2010), and instead, to increase avoidant coping strategies, specifically withdrawal and secrecy (Vauth, Kleim, Wirtz, & Corrigan, 2007). The emphasis given by the informants on the lack of supportive networks in the community may also reflect their difficulty to assume personal respon-

sibility for establishing relationships in a wider social context. Should community sensitization programs take into account this mutual dimension of fear and prejudice as well as their role in taming social inclusion practices, then they could promote openness and trust in social relationships.

Another overarching conclusion of the study was that community mental health care agencies may operate as "bridges" between people with mental illness and the wider community. As evolved in the group discussions, social integration demands coordinated action that would link the therapeutic work regarding the individuals' personal impediments to pursue their own needs (an inward movement) to the community work with social agents and institutions that would provide official and active integration opportunities (an outward movement). Community mental health services were suggested by the respondents to have this two-fold role: merging both personal and impersonal (i.e. institutional) resources in a joint action to address the interplay between internal and external stigma. In line with previous findings (Elstad & Eide, 2009; Elstad & Hellzén, 2010; Rise, Westerlund, Bjørgen, & Steinsbekk, 2014), the respondents stressed the importance of the community mental health service to be flexible enough to adjust to users' varying needs through amalgamating support with challenges. Indeed, focus groups discussions revealed that users' access to many areas of social life would have been lacking, if the treatment system did not take the lead in organizing initiatives for community participation. Nevertheless, education of key-figures at the community and the establishment of networks and local advocacy groups with the individuals' and their families' participation also prevailed as important needs.

Along these lines, the community-led treatment services' double role of enhancing personal responsibility in pursuing one's needs, while an action is also taken in raising collective responsibility, entails the incorporation of the principles and methods of Counselling Psychology. First of all, Counselling Psychology addresses both the personal barriers and the environmental factors that may impede individuals from self-realization and well-being (Malikiosi-Loizos, 1993). Moreover, therapists working with mental health users in the community can contribute to reducing disempowerment by promoting to users, their families and local agents the key counselling skills of empathic understanding, unconditional positive regard and genuineness in interpersonal relationships (Rogers, 1961), as it was also suggested to be a necessity in previous research (Mahone et al., 2011). These counseling skills are also of high value in the case of the relational aspects of the mental health care, which have been found to be a key facilitator to service user involvement (Bee, Price, Baker, & Lovell, 2015). The respondents in our study confirmed the previous results regarding the role of the relationships with others on promoting social integration and they outlined their need for empathic interaction with others. Along these lines, counselling interventions that enhance individuals' understanding and management of problems, and cultivate positive personal and social attitudes towards mental illness have an important impact on the social integration mission of the community-based treatment services (Mohamed et al., 2009).

This being an explorative study, it has a number of limitations in terms of the generalizability of results. Due to the small number of people interviewed, the evolving subjective experiences may not represent the complete picture of the empowerment and social integration needs of people with psychotic disorders. The service users participating in the study were well-functioning at the time of the focus group interviews, most of them were middle-aged, and they all lived with their families. These characteristics are likely to mitigate the effects of the participants' social experiences, which in other cases (e.g., people with acute symptoms, homeless) may be different. Moreover, in the group discussions, it became evident that living with the family, though its substantial help, could also have a disempowering effect. Thus, further research into the role of the family in users' social

integration as well as research into other groups of service users (e.g., marginalized or younger users) is warranted.

In conclusion, our study sheds light on the lived experiences of community mental health service users with serious disorders regarding their social integration needs. The needs that participants expressed most commonly through the qualitative approach chosen in our study deepen our understanding of the unmet needs previously studied that included the areas of daily activities, social contacts and interpersonal functioning, for which mental health users asked for more help than they received (Middelboe et al., 2001; Wiersma, Nienhuis, Giel, & Slooff, 1998). Here, our results can be of added value in interpreting findings of quantitative research on empowerment and social integration issues. The focus on the experiences of the community mental health users may be useful for researchers, service providers, and policy-makers as a means to contribute to adopting a "user-centric" model (Samudre et al., 2016) in the community-led mental health practice. Finally, the subjective perspectives of people with psychotic disorders receiving treatment on an out-patient therapeutic setting may further serve as a basis in developing tailor-made care, which identifies mental health in a continuum with well-being (Keyes, 2002; WHO, 2013) with personal and social dimensions being in a constant and dynamic interplay.

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Competing Interests

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