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Ethnography of an informal community mental health service: Exploring the place, people and participation at The Dragon Café

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Research questions

What is The Dragon Café?

What makes people with mental health challenges attend this informal community mental health service?

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ABSTRACT

Background: Mental health services in the era following deinstitutionalisation have strongly followed a social support framework of intervention; thereby attempting to increase social connections and support for people with mental health challenges (MHCs). This shift in mental health care provision led to the establishment of statutory community mental health services, but such services do not fully address the needs of people with MHCs who are in their communities. Therefore, with the unavailability and inadequate statutory community mental health services came several barriers for people with MHCs who were unable (or unwilling) to access these formal services. Nevertheless, there are informal community mental health services, such as: (a) faith communities, (b) clubhouses, (c) user-led organisations, (d) day centres and (e) mental health cafés, that may or may not receive funding from the government. However, these providers offer social facilities where people with (MHCs) can socialise, interact, and participate in activities, including employment, learning and creative activities.

Methods: This is a constructivist and interpretivist ethnographic study that seeks to understand what The Dragon Café is, as well as to establish the relationships between the place, people and participation in the café. The researcher has used visual and textual data collection methods, including a 3-dimensional video, a floor plan, photographs, fieldnotes from observation and informal conversations, semi-structured interviews, a reflective diary and memoing in order to gather information.

Findings: There were five key original findings from this study, not evident in previous literature, and as such, these data fill a gap in knowledge and provide important contributions to the empirical literature. First, the café in this study differs from other informal community mental health services established for specific populations based on diagnosis, work or activity only. The Dragon Café provides a space primarily for socialisation and reducing feelings of loneliness and isolation among those who attend.

Second, this study offers an original and detailed ethnographic description of the outdoor and indoor physical environment of a mental health café, using visual and textual data to provide a footprint of the research setting, activities and people in a way that has not been documented previously. Moreover, it

provides empirically substantive information on the mental health café in this study, which can be used for future comparative research of informal community mental health services in general and mental health cafés in particular.

Third, this study provides the first narratives and experiences of the loss of the place, people (friendships) and participation (activities) among people with mental health challenges who attend a mental health café. They were obliged to deal with several difficult issues following the closure and reconfiguration of the mental health day centres in the UK they were attending. Fourth, this study contributes to the academic field by providing detailed information about how free access and participation in a mental health café offers participants more choice, without the structured and compulsory participation criteria common in other informal community mental health services such as Recovery Colleges. Notwithstanding the perception of choice among the participants, this study is unique in that it is the first to alert us to the differences in power and authority between the patrons and management in a mental health café; and in particular, how this dissonance determines attendees' behaviour and actions.

Fifth, this study developed a novel conceptual model which established that relationships between place, people and participation in a mental health café are intertwined; each of these are connected in the interaction under study. The development of a conceptual model is not an effort to produce a discourse on space, but rather a thick description (Geertz, 1973) of the actual outdoor and indoor spaces of the crypt where The Dragon Café is located to assist in identifying the ways that the interactive modalities of place, people and participation, identified by observations and participants' narratives, can contribute to understanding, and potentially developing, informal CMHS in general and mental health cafés in particular. By applying such a theoretical model, we can gain a greater sense of how elements of the whole environment under study are co-dependent and influence our understanding of what makes people with mental health challenges attend informal CMHS in general and The Dragon Café in particular.

Discussion: Mental health cafés are situated in the culture of informal community mental health services and align with the mainstream notion of public spaces, where people meet to socialise with others, while at the same time offering a particular and unique set of resources and social activities. This study found that The Dragon Café offers a more diverse and enriched environment for social engagement and connection than is available from the more basic informal community mental health services or drop-in centres.

Conclusions: Mental health cafés, such as The Dragon Café draw on the two cultures of mainstream cafés and informal community mental health services to provide a more enriched environment for patrons with MHCs to become involved in a space fostering social engagement and connection. In particular, the Dragon Café avoids the more structured and compulsory participation requirements of informal community mental health services. The less formal and more egalitarian approach of The Dragon Café resulted in high demand for its environment, resulting at times in overcrowding. This unintended consequence of its popularity, in turn, compromised the quality of social integration for those who attended.

Recommendations: This study argues for more research into the issue of authority and power dynamics in mental health cafés, together with an exploration of the factors that hinder or enable community integration for people with MHCs. In terms of methodology, this study recommends more ethnographic research using visual and textual data collection methods, in order to add to the limited research activity that has focused on: (a) mental health cafés, (b) informal community mental health services and (c) Recovery Colleges. Furthermore, it is suggested that quantitative studies should be employed to measure the cost-effectiveness of mental health cafés when compared to other mental health services, such as hospital admissions.

Practically, this study argues for the revalidation of the UK tertiary institutions mental health curricula to include the issue of informal community mental health services during training, lectures and placements. Also, this study suggests that future research should, at least theoretically, consider the use of socio-ecological model to explore factors that influence community integration for people with

mental health challenges. The novel conceptual mode should be used alongside the detailed ethnographic descriptions of the outdoor and indoor physical environment for the future development and reconfiguration of informal community mental health services. In terms of treatment options and policy, this study suggests the re-evaluation of the National Institute for Health and Clinical Excellence (NICE) guidelines, so that the guidelines include informal community mental services as treatment options; thereby addressing people with MHCs, rather than psychiatric conditions.

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Acronyms and Meanings

Acronyms	**Meaning**
ESRC	Economic and Social Research Council
CMHS	Community Mental Health Services
WHO	World Health Organisation
DH	Department of Health
MHCs	Mental Health Challenges
ULOs	User-Led Organisations
SCIE	The Social Care Institute for Excellence
UK	United Kingdom
SWLSTG	South West London and St George's Mental Health NHS Trust
SLaM	South London and Maudsley NHS Foundation Trust

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> *Dear Miss Bardi, Your email is timely, as today is the deadline for the first round of applications to the programme. By the end of today, provide me with a CV, a list of your university marks and anything you can give me by way of a research proposal. I appreciate that this is a big ask given the short deadline.* With all good wishes, Peter Bartlett.

I would not have completed this PhD without the words of encouragement from my family and friends, but particularly my relentlessly kind and thoughtful mum, Lady Grace Obiageli Bardi, who, despite being thousands of miles away in Nigeria, rang me constantly to remind me to write, eat and rest, and "*do not sleep on the couch, it will give you a headache and then you cannot write*." My gratitude also goes my non-supervisory adviser, Professor Martin Knapp at the LSE, my PhD Buddy; Dr Muhammad Ladan who motivated me and kept me accountable for the progress of my thesis, and last, but not least of all, Professor Gopal Netuveli, Dr Calvin Moorley, and Dr Paul Watts who nurtured my critical mind during my Master of Science (MSc) in Public health, and the public health and health promotions students who fostered my confidence through their belief in me.

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SPACE (Appendix 1). Nicola, thank you so much for reading and providing such useful feedback that enabled me to write the proposal that got me the ESRC scholarship; and for your subsequent eagle-eyed feedback, especially the way that you hand wrote the comments on the side of the printed paper and emailed to me.

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Finally, the first credit and my utmost gratitude genuinely belong to one person, Sarah Wheeler, Founder and Creative Director of The Dragon Café. Therefore, in this final lap of my PhD and the fourth anniversary of Sarah's passing, I pay this tribute to Sarah for creating something that made it possible for me to access a crypt in a church where I saw myself in others and others in me through my ethnography of The Dragon Café. It is there that I learned the true meaning of the word, SPACE.



Image 1 Sarah Wheeler and Josephine

In Memoriam

I dedicate this PhD thesis to my father, Sir Gabriel Iwebunankiti Bardi, my aunty, Mrs Caroline Ngozi Enweis (aka. Mummy), my brother, Jude Chiejine Bardi and my uncle, Dr Andrew Azuka Enwesi.

Preface

"*I've suffered from very severe, kind of psychotic mental illness since the age of eight, and it's been a very, very long and devastating journey. I was drinking all day, smoking 60 a day. I mean, I was a wreck, and I had given up hope completely.*"

(Wheeler, 2015).

[To be continued]

CHAPTER ONE INTRODUCTION

1.0 Introduction

This thesis is an ethnography that seeks to answer the questions: (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service?*. My ethnographic intent is to understand, thickly describe and establish the relationship between place, people and participation at The Dragon Café, thereby providing a detailed account of the café and its diverse population. First, this study examines how The Dragon Café situates, among other informal community mental health services (CMHS) and its meaning for those attending this resource. Informal CMHS offer support to vulnerable populations, such as people with MHCs, the homeless and immigrants (WHO, 2001; Thornicroft, Deb and Henderson, 2016), and they provide spaces where people with MHCs can attend to socialise.

This thesis will narratively synthesise findings from five of these services as follows:

(i) faith communities (Carpiono, 2007; Fakhr El-Islam, 2008; Rogers and Pilgrim, 2008; Padella *et al*., 2012; Smith *et al*., 2013),

(ii) clubhouses (Fountain House, New York City, 1999; Stoffel, 2008; Dudek and Aquila, 2012; Chen, 2016; Chen and Oh, 2018; Clubhouse International, 2017),

(iii) user-led organisations (Rogers and Pilgrim, 2008; Social Care Institute for Excellence, 2009; Rose *et al*., 2016),

(iv) day centres (Needham, 2011; Peloso and Valentini, 2016) and

(v) mental health cafés (Coggins, 2017; Thomas, 2013, Guy's & St Thomas' Charity, 2015; Lees, 2016).

Chapter Two: This chapter presents a review of the literature, including a thematically synthesised scoping review, which aims to identify the range and nature of the research evidence on mental health cafés, and their role as a mental health community resource. There is also a narrative literature review of five informal CMHS, including mental health cafés, which aims to: (a) situate mental health cafés among other informal

CMHS, (b) identify any gap in the literature relative to informal CMHS in general and mental health cafés in particular and (c) provide the rationale for the ethnographic study.

Chapter Three: In order to present a transparent ethnographic research process, this chapter provides details of: (1) the research paradigm for the study, (2) philosophical underpinning, (3) theoretical framework, (4) methodology and (5) the overall research process for the ethnography; detailing the ethical considerations, data management, rigour, reflexivity and memoing. The chapter also describes data collection methods, including the thick description of the observations and informal conversations, and substantial semi-structured interviews that were thematically analysed.

Chapter Four: This chapter details the findings from the ethnography, including: (1) observation and informal conversations, and (2) semi-structured interview data. It begins with the observation and informal conversation data, using images and videos to visually illustrate the research setting, and the rhythm of the day at the café in relation to the place, people and participation in the café. Participants' verbatim quotes complement this visual data to capture how their experiences of the café relate to, or result from, social activity with other attendees, and the researcher's reflective notes. This chapter concludes with the consolidation of the core findings from the ethnography.

Chapter Five: This chapter begins with a discussion of the findings from the ethnography in relation to previous literature on informal CMHS. It identifies key areas of new knowledge and the originality of the findings as well as demonstrating the value of sociological theories to advance understanding of mental health cafés. The discussion considers the limitations of theory; it also addresses the issue of how theory may serve any future investigations relating to mental health cafés.

Chapter Six: In this final chapter, the study is summarised. It concludes with the limitations and wider implications of the study, recommendations for theory, practice, policy and future research on informal CMHS in general and specifically on mental health cafés.

To begin this thesis, mental health policy and the changing status of mental health care in the UK will be outlined, recognising the transitions from the end of the asylums with their substantive in-patient services to CMHS and the contribution of informal CMHS. It is important to describe the historical context of CMHS in the UK; to detail the events that led to the introduction of statutory CMHS in the UK; how and why they were introduced, and the gaps in their service provision. This historic contact of CMHS then leads into the other services in the community, such as informal CMHS that provide spaces where people with MHCs can attend, and as such, directly or indirectly address some of the gaps in statutory CMHS provision.

1.1 Policy

As far back as 1961, community mental health was identified as the process of reducing the number of persons suffering from mental illness in the community (Caplan, 1961). In the last few decades, record numbers of people with MHCs are now being cared for in the community; with the number of people with MHCs in the community doubling after: (a) the deinstitutionalisation in the UK's mental health services and closure of the asylums, (b) reduction in the number of acute mental health hospitals and (c) the transfer and requirement of more mental health care provision within the community (Turner *et al.,* 2015; Gilburt *et al.,* 2014; The King's Fund, 2017). The closure of the asylums led to three primary pathways of mental health care provision, including: (1) discharging patients from the hospitals to the community, (2) diversion of care from hospital-based admissions to the community and (3) establishing care in the community (Rogers and Pilgrim, 2001; Gilburt *et al.,* 2014). Research evidence suggests that before the start of the closure of the asylums in the 1960s and the introduction of statutory CMHS, religious organisations, family members and friends provided care for people with MHCs in the community (Wright, 1997; Rogers and Pilgrim, 2001; Turner *et al.,* 2015). In other words, care in the community existed before the asylums existed.

In the UK, community care was part of the 1930 Mental Health Act (Rogers and Pilgrim, 2001; Killaspy, 2006), which was further developed in 1948 (Fawcett and Karban, 2005; Fawcett, Weber and Wilson,

2012). Subsequently, the 1959 Mental Health Act and the 1962 Hospital Plan were introduced in England and Wales by the UK government to formally integrate community mental healthcare into the broader hospital system, however, there was insufficient funding and inadequate access to statutory CMHS (Fawcett and Karban, 2005; Turner *et al.,* 2015). The impetus to transfer mental health care to the community began in 1954 in the UK and continued through to 1959 following debates and recommendations for two service provisions: (1) Inpatient care provided by hospitals for people with MHCs who required specialist care; and (2) Community care provided by local authorities (Gilburt *et al.,* 2014; Turner *et al.,* 2015).

In the 1970s and 1980s, the UK government re-organised the health service and introduced the 1990 National Health and Community Act for local authorities to become responsible for community-based care. A series of changes took place after the introduction of the 1990 National Health and Community Act (Fawcett and Karban, 2005; Turner *et al.,* 2015). Some of these changes included the amendment of the 1983 Mental Health Act, the introduction of the 1991 Care Programme Approach and the introduction of statutory CMHS (SCMHS), such as: The Home Treatment Team, Crisis Resolution and Assertive Outreach Teams (Fawcett and Karban 2005; Killaspy, 2006; Wright *et al.,* 2008; Gilburt *et al.,* 2014). Statutory CMHS were established to reduce the incidence of mental health crises in the community, support people with MHCs to live independently in the community and promote the social connection of people with MHCs towards community integration (Killaspy, 2006; Tucker, 2010; Fieldhouse, 2012).

Community integration is about enabling people who are coping with MHCs to improve their social and support networks, take on social roles alongside other community members and have increased choice and control over their treatment options and lives (Aubry and Myner, 1996; Gumber and Stein, 2017). However, the adequacy and suitability of CMHS for addressing the needs of people with MHCs are still being contested (Pinfold, 2000; Sayce, 2003; Rogers and Pilgrim, 2008; Tucker, 2010; Peloso and Valentini, 2016). However, despite the above, formal CMHS in the UK remain scarce, and people with MHCs became vulnerable to homelessness, leading to the use of police stations as a place of safety, arrests

for being disorderly and imprisonment (Fawcett and Karban, 2005; Gilburt *et al.,* 2014; Turner *et al.,* 2015).

During the 2007 Global Forum for Community Mental Health, the WHO (2007a), called for an urgent action for countries to provide an integrated care pathway for CMHS. This call was to remind countries of their role to empower the socially excluded to participate within society, and "claim their right to secure participation in the community*"* (WHO, 2007a, p.1). Similarly, more recently, the UK Centre for Mental Health (2015) identified community mental health as a public health concern that should form part of the UK health system. Indeed, over the past 20 years, community-based services for individuals with mental illness have advanced ahead of all other mental health services. Nevertheless, McNicoll (2013) reports that there remains a lack of alternative services in the community for people with MHCs.

As stated above, there are informal CMHS that provide spaces where people with MHCs can attend to meet, socialise and participate in creative activities. These services may or may not be associated with statutory CMHS, but they are easily accessible to people with MHCs in the community or those discharged from acute mental health hospitals (WHO, 2007a). Therefore, this thesis reviews informal CMHS to present their typologies and contribution to community mental health services in the UK. However, before proceeding further with the thesis in its relevant stages, I must explain my motivation to study an informal CMHS in the first place and set the scene for the study. After all, motivation is the singular determinant of conscious and unconscious human thoughts and feelings which are transformed into actions towards choosing and effectively achieving goals (Bargh, Gollwitzer, and Oettingen, 2010; Wright, 2015; Legault, 2016).

1.2 Motivation for the study

My motivation to conduct this study began many years ago when I had an intrinsic need to satisfy my curiosity about my own experience of anxiety as an international student from Nigeria studying in the UK. After a year of undiagnosed and untreated anxiety with no hope of paying the tuition fees for the second

year of study, and even less understanding of how to satisfy my curiosity, I quit my studies and volunteered to work with a homeless charity and women's refuge. Here, I noted that my colleagues and the service users also expressed symptoms of anxiety and these external factors further influenced my motivation to understand mental health (Reiss, 2012; Legault, 2016), which made me want to understand this condition that affected people regardless of their ethnic background, social status or gender. In Nigeria, there is little meaningful support provided to people with MHCs and symptoms are highly stigmatised. Now my interest in mental health had developed to the point where I decided to complete a Bachelor of Science in Mental Health Nursing.

During my training and clinical practice, I was disappointed by the way that some mental health nurses treated the people in their care. For example, I witnessed patients labelled as 'bed number five' or 'the one that paces the floor'. This led me to think about the relative merits of acute inpatient and CMHS and alternative support, and resources available to people experiencing mental health distress. In particular, I became concerned about the loss of autonomy among the people entering acute mental health services and the way health professionals excluded or denied privileges to those trying to remain independent. This realisation made me want to avoid being in a clinical space where people had limited choices regarding what to do. Therefore, I requested an elective placement to a community mental health service, with the explanation that I was keen to develop my nursing skills in a more robust way to broaden my understanding of the UK mental health care provision on acute wards and in the community.

The following year, I got my wish, and the next two years, I went on placements to community mental health services, including the Home Treatment Team, Assertive Outreach Team, Community Drug and Alcohol Services and the Assessment and Brief Treatment Team. Disappointingly, I noted that many of the nurses in the community mental health services had similar negative attitudes and values to those on acute mental health wards. However, the people with MHCs who attended the community mental health services looked more relaxed than those accessing acute wards.

When I qualified as a mental health nurse, I knew exactly the kind of nurse that I wanted to be, but found it challenging to find a clinical setting that would match my values and attitudes to people with MHCs. My search for a community mental health service closer to my ideals continued until 2014 when I joined LinkedIn and wrote a summary with a conclusion that read something like "*I would like to do a PhD in Social and Community Psychiatry*". A few days later, I received a message from Alan Sarll, who suggested that I should contact Sarah Wheeler, Founder and Creative Director of The Dragon Café and consider researching The Dragon Café for my PhD. I emailed Sarah, and we met several times to discuss my plan to investigate the experiences of people who attend the café. Therefore, as a novice ethnographer, the natural history of my fieldwork began on 1st December 2014, the first time that I walked into the crypt of St George the Martyr and met Sarah Wheeler (Image 1). After this meeting, we kept in touch, and I met Sarah several times at the café to discuss a research plan. Sadly, in 2016, two years after our first meeting, Sarah died:

> *Sarah's passing remains one of the most challenging experiences of my PhD journey. I wanted to give up my PhD because I did not know what to do in the absence of the person who opened the door for me to access the café, but instead, I persevered to answer the one question that Sarah had asked: why do people visit The Dragon Café*?

Looking back, I can see how my intrinsic and extrinsic motivations, not least my decision and commitment to know more about mental health nursing practice in the UK prompted me to pursue a PhD in mental health and wellbeing, with an ethnographic intent to explore a central research questions: (1) *What is The Dragon Café*? and (2*) What makes people with mental health challenges attend this informal community mental health service*?. To answer these questions, it seems logical to present the scene of the study setting, describing who set up The Dragon Café, and why it was established, what the café offers to those who attend, who funds the café and finally, a section on the current research evidence on the café. From now onwards in this study, I will refer to the research setting as 'The Dragon Café' or 'the café, and I will refer to myself as 'the researcher', 'I', JNB for Josephine NwaAmaka Bardi or Josephine.

Postscript

Continued from the preface

"*During that period of psychosis, I had spent a lot of time in pubs, but I also spent quite a lot of time in cafés; and on reflection, once I had emerged, I realised that cafés were the healthier option*."
(Wheeler, 2013).

1.3 Setting the scene for this research study

To understand the historical context of The Dragon Café and set the scene for this study, I obtained written consent from Sarah Wheeler (Appendix 2) and I accessed two YouTube videos that are available online in the public domain, which were produced by Tabase (2015). Wiles *et al*. (2008) propose that "a research participant who agrees to have their photograph taken or be subject to video recording has no legal rights over the subsequent use of their image" (p.12). Similarly, Salzmann-Erikson and Eriksson (2012) argue that online archival data in the public domain does not require ethical approval or consent. Nevertheless, because I was using the videos for a different reason other than what they were originally intended for (Pink, 2007; Iphofen, 2015), I obtained verbal consent from the gatekeepers to use the videos as part of my thesis to support the historical background of the café, as well as to set the scene for the research setting. I transcribed the videos to present only Sarah's narrative of her experiences of MHCs (Basset and Stickley, 2010) which illuminated the profundity of Sarah's experiences before and after she established the café and provide an initial answer of what The Dragon Café is. As Sandelowski (1991) attests:

> "The narrative framework affords the researcher special access to the human experience of time, order and change, and it obligates us to listen to the human impulse to tell tales." (p.165).

At the beginning of the documentary video, Sarah Wheeler narrates a detailed description of her experiences of psychosis. We gain a historical and an emancipatory sense of her identity and learn what prompted her to establish the café. Sarah uses the first person 'I' to set the stage of her narrative by orienting to time, age (age of eight) and place (pubs and cafés) (Labov and Waletzky, 1967; Howard, 2006) and by doing that, Sarah makes hers a narrative of compelling experiences. What emerged from

Sarah's narrative of her memorable past were extreme experiences of MHCs, embodied from a young age as an identity, and continuing into adulthood; her perceived consequences of a dual lifestyle; the realisation of a preferred lifestyle; and Sarah's descriptions of what The Dragon Café is:

> "*Dragon Café is like an antidote – a sort of creative and social antidote to the loneliness, which is almost endemic to the system that we live in*." (Wheeler, 2015).



Image 2 Sarah Wheeler

Sarah continues her description of the café as a space for social connection through creativity and interactions:

> "*It's quite a multi-dimensional space. You've got food, different creative groups or well-being activities. We have art, poetry, and singing*." (Wheeler, 2015).

She acknowledges the lack of adequate statutory or formal community mental health services when compared to the number of people with MHCs:

> "*The formal services are not reaching anywhere near the amount of people who are suffering mentally*." (Wheeler, 2015).

Sarah concludes her narrative by suggesting a more social model of care, rather than a medical model that focusses on illness and treatment, and highlights the importance of services for social connection and wellbeing for people with MHCs:

> "*Mental health services are nowhere near as effective as they could be, and they need to change. And in a way, they need to become more communal and less focussed on the individual, the label and the problem, because people with mental health problems like myself, we just become feeling like we're a problem. But actually, if you connect people up that is the social power to get us to well-being*." (Wheeler, 2015).

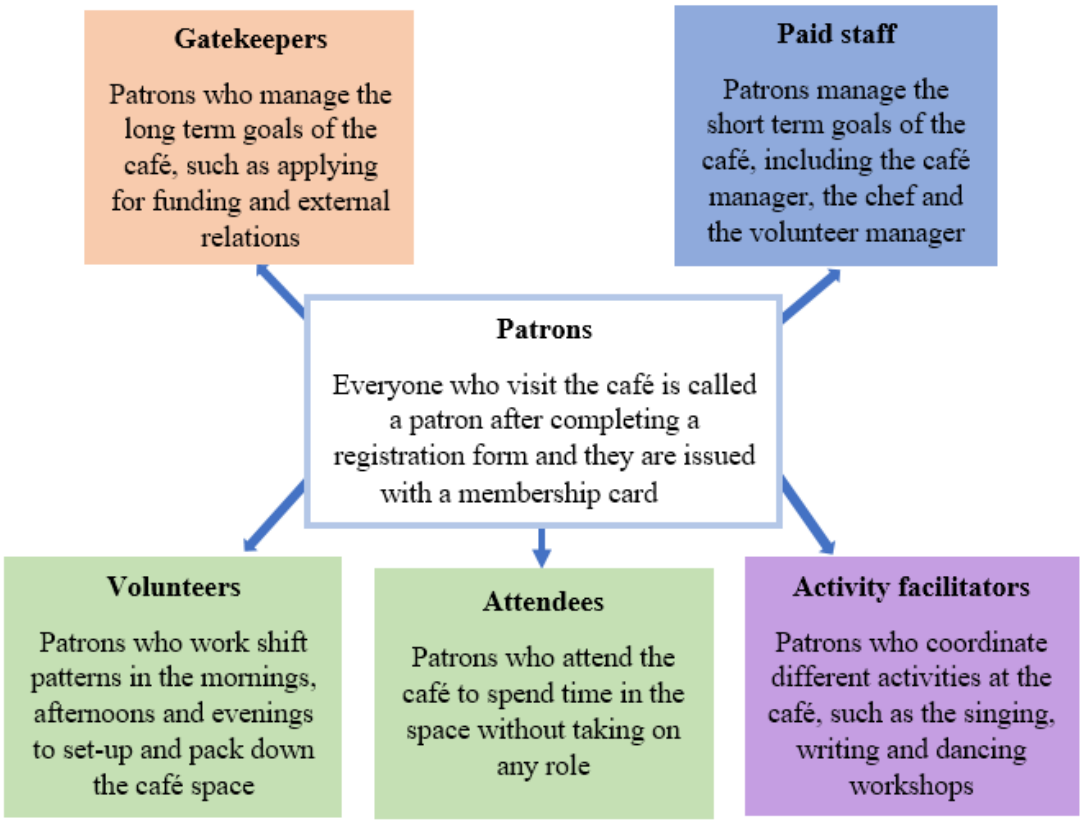
To summarise, Sarah's narrative of her experiences of MHCs from childhood into adulthood shows the trajectory of events that led to the establishment of the café and her vision for this facility. She describes the café as a communal non-judgmental place and a remedy for loneliness and isolation for people with MHCs. The Dragon Café evolved from this personal conviction. In addition to Sarah's definition and description of the café above, and the two paragraphs below, which tell us about what the café is, I also provide thick descriptions of the place and space of the café, alongside participants views, and how they define the café through their interactions and experiences in the space (See chapter 4). A combination of the three enabled diverse answers to what the café is and as such answered the research questions: (1) *What is The Dragon Café*? and (2), *What makes people with mental health challenges attend this informal community mental health service*?

The Dragon Café officially opened in October 2012 as a creative project located in the crypt of a church in South East London (Thomas, 2013). It opens every Monday from 12 midday to 8.30 pm, except during the holidays and in August when they close for a month. It is free for all, with an average of 200 people visiting weekly, and it provides affordable vegetarian meals, coffee, hot chocolate and assorted fruit. It also provides a variety of scheduled wellbeing and creative activities, such as writing, singing, chess, dance, football, all day ArtSpace and open mic. Drawing on the definition from the World Health Organisation [WHO] (2001), activity is defined here as "the execution of a task or action by an individual" (p.12). The Dragon Café is funded by voluntary and non-voluntary organisations, including Southwark Council, Guys & St Thomas' Charity, The Dispossessed Fund, London Catalyst, The Tudor Trust, NHS South London and Maudsley, Deutsche Bank, NHS Southwark Clinical Commissioning Group, Better Bankside and The Hospital Saturday Fund.

The café is supported by 50 volunteers who work different shift patterns; 8.00 am to 12.00 pm, 12.00 pm to 6.00 pm, and then from 6.00 pm when the pack down of the space starts until 9.00 pm when the café closes. In addition to the volunteers, there are activity facilitators who coordinate the activities and paid staff who manage the key roles in the running of the café, such as the operations manager, volunteer manager and the café manager. Anyone who wishes to attend the café completes a registration form, and

they are referred to as a patron after they have registered and been issued with a membership card. There are five typologies of the patrons: (1) gatekeepers, (2) volunteers, (3) paid staff, (4) attendees and (5) activity coordinators (Figure 1).

Figure 1 Typology of patrons at The Dragon Café



Having set the scene about The Dragon Café, what it offers and who attends, it is logical to show a summary of how the café advertises its services to the general public. To do this, an image the outdoor banner of the café is presented below (Image 3). This is followed with a description of current empirical research evidence relating to the café, and further justify the methodological decision that informed this doctorate study.

Image 1 Outdoor banner of The Dragon Café



What is empirically known about The Dragon Café?

In this section, the existing research evidence relating to The Dragon Café will be outlined, which suggests that there are unpublished in-house studies, including: (a) a service evaluation, (b) a Service User Research Enterprise (SURE) report using survey and semi-structured questionnaires (Thomas, 2013), (c) a small case study on the impact of grant awards using focus group discussions and semi-structured interviews with eight participants (Guy's & St Thomas' Charity, 2015), (d) impact assessment screening (Coggins, 2017) and (e) a thematic analysis of the visitor's comments book (Gatta, 2016). Therefore, to the best of this researcher's knowledge, there is currently no ethnographic study of The Dragon Café, thus justifying the use of the methods described in the methodology chapter of this thesis. The next section will outline the aims and objectives of the study.

1.4 Aim and objectives of the study

The current study aims to answer the questions: (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service*? It aims to establish the relationship between the place, people and participation in the café. The objectives are listed below:

1. To understand what makes people with mental health challenges attend The Dragon Café.
2. To describe how people with mental health challenges socially construct their individual and collective experiences at The Dragon Café.
3. To interpret the meaning that people who attend The Dragon Café attach to their experiences at the café.
4. To generate empirical research and contribute to the international debate and literature on informal community mental health services in general, but more specifically on mental health cafés.
5. To explore theoretical perspectives on the mental health café phenomenon.

The first question is, what is a mental health café? There is no known definition of a mental health café. Therefore, using a collection of terms from published and unpublished studies on relevant databases and

websites, and findings from this study, I developed an operational definition of mental health cafés as follows:

> A mental health café is an informal community mental health service that provides a space where anyone, with or without mental health challenges, can attend to eat and drink, socialise, and access free creative activities.

In its focus on mental health cafés as a specific kind of informal CMHS, the next section is a review of the literature which begins with a scoping review on mental health cafés. That review is followed by a narrative review of informal CMHS to provide a better sense of how the phenomenon of the mental health café is situated within a broader cultural context of informal CMHS.

To begin the investigation of mental health cafés in the context of informal CMHS, it is necessary first to consider the definition of 'community' because for some groups of people, such as those with MHCs who experience reduced social ties, the importance of substantial face-to-face communication cannot be overestimated as it is crucial for social connection (Clark, 2001; Warner, Talbot and Bennison, 2012). This point was further highlighted in the seminal work of Bell and Newby (1972), who describe the community using three distinctive concepts. The first is the community as geographical proximity, the second is the community as the local social structure, and the third is community based on close social interactions that exist across and between places (Bell and Newby, 1972; Warner, Talbot and Bennison, 2012). Indeed, with the influence of mobile phones, the internet and emails, there has been a shift in the notion of communities as face-to-face entities, with faceless and fast communication styles compressed through time and space (Warner, Talbot and Bennison, 2012). For this study, I draw on the definition of community offered by Thornicroft, Deb and Henderson (2016) because it comprises of the principles and practices required in the promotion of mental health care by providing accessible, adequate and acceptable mental health care through an extended care pathway. In other words, when developing mental health care for people with MHCs, it is important to ensure that services are accessible, adequate and acceptable. This in fact, echoes my point in the introduction regarding the lack of adequate formal and informal CMHS.

CHAPTER TWO REVIEW OF THE LITERATURE

2.0 Introduction

In this chapter, the review of the literature is presented, which is divided into three sections. Firstly, there is a scoping review of mental health cafés that examines the scope, size, and nature of available research evidence on mental health cafés. Secondly, a comprehensive narrative literature review was conducted: (a) to identify the research evidence and current knowledge relating to five informal CMHS, including mental health cafés, (b) to enable the categorisation of the patterns and trends in the literature regarding informal CMHS and (c) to identify gaps in the literature or contradictions in the body of knowledge (Aveyard, 2015; Onwuegbuzie and Frels, 2016). The review of the literature also enabled the establishment of a theoretical framework for the current study, informed the development of the research questions and provided a justification for this PhD study (Onwuegbuzie and Frels, 2016). Thirdly, there is a summary of the findings from the scoping and narrative reviews. Finally, this chapter concludes with a section addressing the issue of the gaps in the literature and the justification that sets the scene for the ethnography. This study can now be situated within the existing literature on mental health cafés.

2.1 Scoping review on mental health cafés

This scoping review was conducted to examine the scope, size, nature and characteristics of available research evidence on mental health cafés for those who attend. The rationale for conducting a scoping review was decided when an initial search of the literature showed limited research evidence on mental health cafés. Therefore, a scoping review was appropriate because it allowed for a broader search and inclusion of all available studies (Arksey and O'Malley, 2005). Also, adopting a scoping review enabled a rigorous and transparent method for charting the research evidence on mental health cafés, and the identification of any gaps in the literature (Arksey and O'Malley, 2005). However, as with all scoping searches , there were limitations in conducting this review due to: (a) the absence of any quality appraisals of the included studies, (b) the vast amount of literature that was generated from the scoping search which

took time to process, and (c) the synthesis of the different types of research findings (Arksey and O'Malley, 2005; Pham *et al.,* 2014).

2.1.1 Aim and objectives

The aim of this research is "to determine the scope, size and characteristics of available studies on mental health cafés, as well as to summarise and narratively synthesise the findings, using the following objectives:

1. Examine the scope, size, nature and characteristics of available research evidence on mental health cafés.
2. Chart the research evidence on mental health cafés
3. Establish the role of mental health cafés for people with mental health challenges
4. Identify any gaps in the existing literature and provide a rationale for carrying out a literature review addressing five informal community mental health services, including mental health cafés

2.1.2 Methodological Framework

The current scoping review adopted the methodological framework created by Arksey and O'Malley (2005) for carrying out scoping reviews in order to increase the rigour, reliability and transparency of their findings (Table 1). The consultation stage took place first between the researcher and the (her?) supervisory team, where the relevance of the scoping review topic was discussed.

Table 1 6 Stages of the scoping review framework

Stage 1	Identifying the review question
Stage 2	Identifying relevant studies
Stage 3	Study selection
Stage 4	Charting the results/characteristics of selected studies
Stage 5	Collating, summarising and reporting the results
Stage 6	Consultation

2.1.3 Identifying the scoping review question

The scoping review question is: "What is the evidence regarding the role of community mental health cafés for those who attend them?"

2.1.4 Study design and identifying relevant studies

Informed by the Arksey and O'Malley (2005) scoping review framework, a standardised approach to the identification, extraction and narrative synthesis of the studies was used to access multiple databases in order to enable a comprehensive scoping of the existing literature.

2.1.4.1 Search strategy

An initial search was conducted via Google Scholar on 10th March 2016 to identify search terms (Appendix 3), leading authors and relevant citations (Pham *et al.,* 2014). Subsequently, the scoping search was updated on 26th May 2016 on the EBSCO host using four databases, including Academic Search Complete, CINAHL Plus, PsychARTICLES and PsycINFO. As recommended by Arksey and O'Malley (2005), exhaustive searches were conducted to obtain a comprehensive overview of a large body of literature, including both seminal and recent studies. Dates were used as pre-set in the databases from 1964 to 2016. To limit selection bias, additional searches were conducted on Medline (1990 - present), ProQuest (1956 – present) and Scopus (1882 – present) (Gough *et al.,* 2012).

The use of a scoping search without a data range enabled the identification of grey literature, dissertations or theses on the International Bibliography of the Social Sciences (IBBS), ProQuest, Networked Digital Library of Theses and Dissertations (NDLTD) and Search Oxford Libraries Online (SOLO). The final scoping search included hand searching the reference lists of all included studies to identify further references (Arksey and O'Malley, 2005; Pham *et al.,* 2014); however, this method failed to identify any

additional articles. To determine the most relevant studies that addressed the aims and objectives of the scoping review, inclusion and exclusion criteria were developed (Table 2).

Table 2 Scoping review inclusion and exclusion criteria

Inclusion	Exclusion
• All qualitative studies that addressed the scoping review topic	• Quantitative, scientific studies or clinical interventions
• Studies on community mental health cafés	• Studies not written in the English language
• Studies involving people with experiences of mental health challenges	• Studies with participants under the age of 18 years
• Studies written in the English language	• Studies with inpatients
• Studies that included the word 'café', such as mental health cafés	• Studies with people living with physical health challenges or learning disabilities

2.1.4.2 Study selection

The results from this scoping search are illustrated in the flowchart (Figure 2) and presented in the summary of included studies (Appendix 4). The initial scoping search yielded from the scoping search 4,998 research articles across all databases, and other sources, but the majority showed inadequate relevance to the scoping review topic, so duplicates and studies that did not meet the inclusion criteria were removed (Table 3). Finally, 111 full-text articles were read and 12 artciles were identified for inclusion in the review.

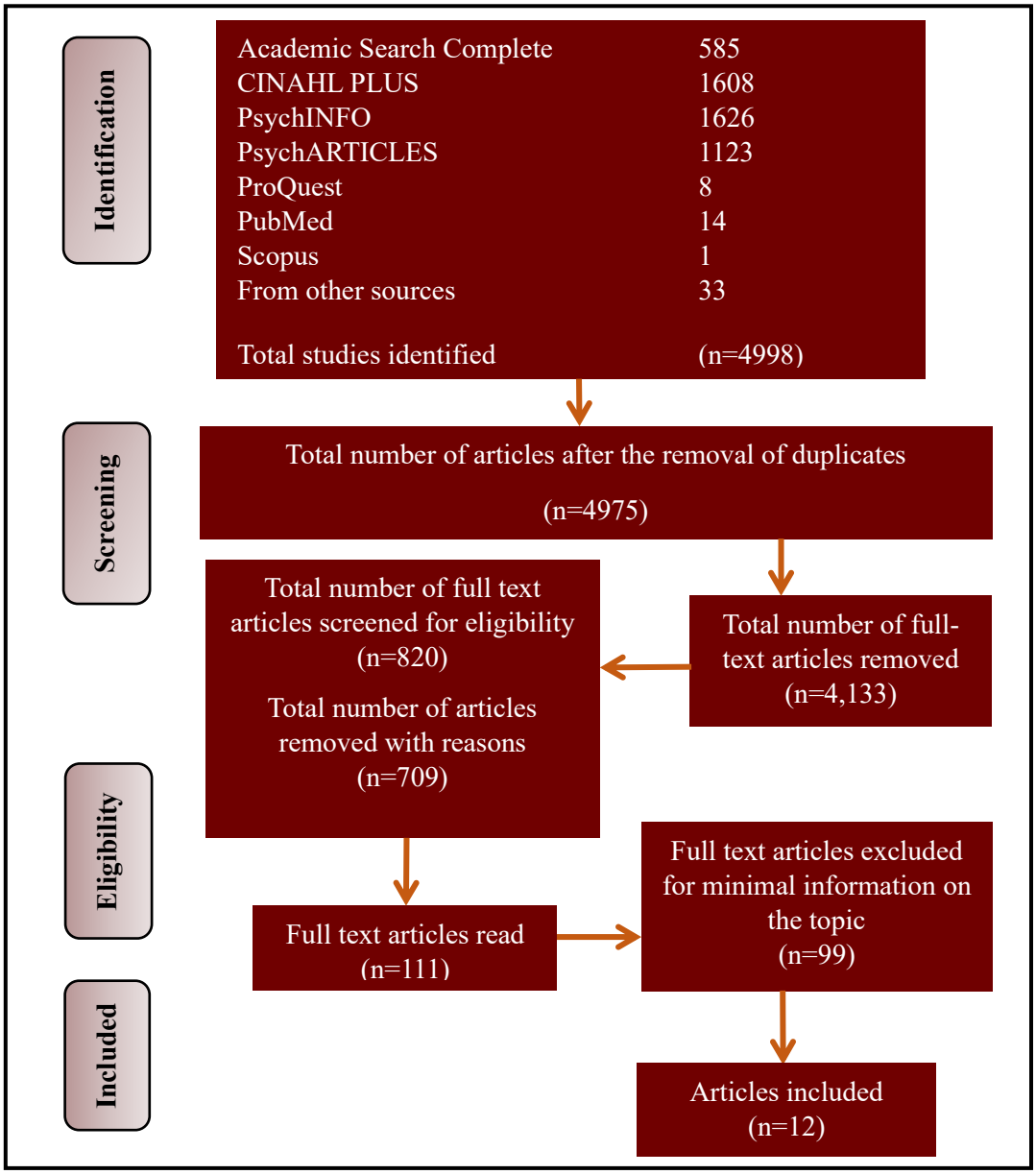
Table 3 List of resources assessed from the scoping search

Type of paper	Quantity
Journal articles	111
Books	8
PhD Thesis	3
Conference papers	2
Magazine	2
Newspaper articles	7
Total	133

The most common reason for the removal of articles was their focus on in-patient service and services that were not specifically mental health cafés. Of the twelve included articles, seven were on community

mental health cafés for people living with dementia and three were on community mental health cafés for people with a broader range of MHCs, such as people with substance misuse (McDonald, 2010; Campbell *et al.*, 2011) and Jewish survivors of concentration camps (Fried and Waxman, 1988). Below is the flow chart (Moher *et al.*, 2011) (Figure 2) that shows the scoping search results, including the number of studies that were identified and screened before they were removed or included.

Figure 2 Flow chart of search results from the scoping search



2.1.4.3 Charting the results/characteristics of selected studies

There was no ethnographic study, and there were significant differences in the methodology adopted by the studies (Table 4).

Table 4 Identification of studies by the methodology used

Authors	Methodology	Number of studies
McDonald (2010)	Narrative review	1
Fried and Waxman (1988), Mather (2006), Dow *et al*. (2010)	Programme evaluation	3
Jubb *et al.* (2003), Peters (2007)	Audit	2
Campbell *et al.* (2011)	Action research	1
Halse, (2014), McFadden and Koll (2014)	Report	2
Pratt *et al.* (2005)	Practice development	1
Halley *et al.* (2005)	Survey	1
Morrissey (2006)	Reflective account	1

Of the twelve studied included in the scoping review, six studies were published in the UK (Jubb *et al.,* 2003; Halley *et al.,* 2005; Morrisey, 2006; Peters, 2007, Campbell *et al.,* 2011; Halse, 2014) the others were published in Turkey (McDonald, 2010), Sweden (Fried and Waxman, 1988), Canada (Pratt *et al.,* 2005), United States (McFadden and Koll, 2014) and Australia (Mather, 2006; Dow *et al.,* 2010). Seven studies were conducted from 1988 to 2006, and the remaining studies were conducted in 2010 (n=1), 2011 (n-1) and 2014 (n=2). There were significant differences between the populations who attended the cafés; one study was conducted with people who experienced Post Traumatic Stress Disorder (PTSD) (Fried and Waxman, 1988), another study was for people recovering from addiction (Campbell *et al.,* 2011), and the remaining nine studies include two with people in the early stages of dementia (Pratt, 2005; Mather, 2006), two with participants who were newly diagnosed with dementia (Morrisey, 2006; Halse, 2014), one with young people living with dementia (Jubb *et al.,* 2003) and four with people living with dementia as well as their carers (Halley *et al.,* 2005; Peters, 2007; Dow *et al.,* 2010; McFadden and Koll, 2014).

Broadly speaking, all the studies referred to their settings as cafés. Cumulatively, there were similarities and differences in the key findings from all the studies with frequently occurring benefits and challenges identified in the included studies to enable a logical flow when discussing the findings. Direct verbatim

quotations are used to provide supportive meaning to the interpretation of data (Onwuegbuzie and Frels, 2016). The next section is a discussion of the most relevant dominant themes that were identified from the included studies that informed this study.

2.1.5 Collating, Summarising and Reporting the Findings

This stage of the scoping review discusses the identification, frequency, understanding and interpretation of the themes from the twelve included studies (Arksey and O'Malley, 2005). This was influenced by thematic analysis of common words which were compared across the included studies to identify themes (Braun and Clarke, 2016). The articles were read and reread to identify the common terms used by the authors and the participants; then, these words were combined into categories which, in turn were combined into five themes. These themes were used to develop a critique from the included studies, and which systematically organised the five broad categories from the findings, including (1) access to a safe and communal pace, (2) a place to make social connection and friendship through shared experiences, (3) learning through group participation, (4) the autonomy to make an informed decision about what to do in the space and (5) funding as the determinant for sustaining the cafés. These broad categories were grouped to produce a narrative analysis, using the themes of: (a) café, (b) space, (c) social inclusion, (d) learning, (e)participation and (f) empowerment (Appendix 5).

2.1.5.1 *Access to a safe and communal space*

The idea that mental health cafés play a vital role in community life was highlighted in the participants' descriptions of the cafés as safe spaces. In the survey involving people living with dementia and their carers. Halley *et al.* (2005) reported that participants preferred access to a café style space where they felt safe and could wander around without restrictions, rather than a commercial café space where they would be expected to sit in one place throughout their visit. Generally, dementia cafés were perceived to provide safe spaces for people living with dementia and their carers (Morrissey, 2006; Dow *et al.,* 2010; McFadden

and Koll, 2014). However, Dow *et al*. (2010) highlighted the importance of developing culturally and linguistically relevant dementia cafés because some participants from "culturally and linguistically diverse backgrounds" (p.253) may experience barriers to accessing some dementia cafés.

Two studies (Fried and Waxman 1988; Mather, 2006) concluded that for people with post-traumatic stress disorder and people living with dementia, access to a warm and enabling atmosphere gave them a sense of safety, encouraged group cohesion, a feeling of belonging, and a sense of identity. Another study, Peters (2007), found that carers of people living with dementia expressed feelings of respite when their family members were at the cafés which they perceived as safe:

> "He said he felt his wife was safe and it gave him some time out… and some said it was nice to know that there are others going through the same experience and having someone to talk to and they enjoyed being able to come into a safe place." (p.21).

Another area that was identified from the results of this review was the benefits of access to sober cafés for people recovering from substance misuse. In earlier sober cafés, such as the Inkerman Café, which was established by Florence Nightingale in 1855, McDonald's (2010) reports that soldiers and their families attended to drink chocolate. Similar findings were also observed in the action research conducted by Campbell *et al.* (2011) where people recovering from addiction found serenity café to provide a space to socialise and engage with others in recovery without the need to drink or face the risk of drinking alcohol:

> "In early recovery, I would find it difficult to be around anyone drinking and even to be around my family members if I am honest. It is a great idea to have somewhere to go where you can just pop in and feel safe." (p.135).

> "New Year was a big problem for me. It was fantastic to go [to Serenity Café] because the entire town is drunk, and it scares me. Having a place to go where I wasn't even thinking about alcohol made you relaxed about the whole thing. I was expecting to have a rubbish time." (p.134).

2.1.5.2 *A place to make social connection and friendship through shared experiences*

Relationships with others was cited by all twelve studies as important for social connection; social interaction and sharing experiences with people who understand and appreciate the need for improved emotional and social wellbeing. For example, in their programme evaluations with people in the early stages of dementia (Pratt *et al.*, 2005) and people living with dementia and their carers (McFadden and Koll, 2014) participants described: (1) reduced feelings of isolation, (2) increased self-esteem through shared experiences of learning coping strategies from others (Jubb *et al.,* 2003; Halley *et al.,* 2005; Pratt *et al.,* 2005; Morrissey, 2006; Peters, 2007; Halse, 2014), and (3) participants who live on their own looked forward to attending the café to avoid loneliness (Dow *et al.,* 2010). Likewise, Campbell *et al.* (2011) suggest that people recovering from addiction viewed the out-of-hours sober café as a social environment that enabled abstinence through social interaction and support:

> "Evenings are a big thing in early recovery, and weekends. Go to a meeting, get home at 09:30 pm, and I still look at the clock at [09:50 pm]. Because that's the time, I would have to get to the off license before it closes. And I still do it, still have that check. So, I have to do something to distract myself." (Campbell *et al.*, p.135).

Similarly, Jewish survivors of the holocaust still living with post-traumatic stress disorder indicated that "loneliness was replaced with a sense of family and community" (Fried and Waxman, 1988, p.254). Further, Peters (2007) showed that people with dementia and their carers expressed a sense of companionship with others at the café, which helped them to focus on their strengths, rather than on their diagnosis. Two studies (Halse 2014; Mather, 2006) found that young people in the early stages of dementia, who previously experienced social isolation, loss of confidence and the loss of control, described an increased sense of belonging through interaction with people who shared similar experiences. However, in another study (Jubb *et al.,* 2003), young people living with dementia preferred to socialise with people of their age because they had things in common:

> "I don't want to sit around discussing the Second World War; I wasn't even born then." (p.34).

In the same study, most of the young people with dementia expressed that before attending The Coffee Shop, they had lost contact with all their friends and felt isolated:

> "The only time I have contact with the outside world is when we attend hospital appointments." (p.35).

Furthermore, participants reported how friendships helped to situate them in a wider social context of their everyday social interactions with others (Fried and Waxman, 1988; Halley *et al.,* 2005; Campbell *et al.,* 2011). For example, people recovering from addiction described engagement in recovery-oriented friendships as positive and empowering (Campbell *et al.,* 2011). Also, two programme evaluations of dementia cafés (Halley *et al.,* 2005 and Mather, 2006) provided evidence that established friendships reduced feeling of loneliness and stigma:

> "You know you're not on your own; other people are going through the same thing." (Halley *et al.,* 2005, p.147).
>
> "To be able to communicate with other people with similar problems. Great for encouraging me (carer) to keep going. Fellowship is very uplifting." (Mather, 2006, p.292).

2.1.5.3 *Learning through group participation*

The experiences of group participation and learning together through collaborative actions were reported in all the included studies as a key link to reduced feelings of stigma and increased social interaction. Four studies noted that participant's perceived collective participation as freedom from stigma (Halley *et al.,* 2005; Mather, 2006; Dow *et al.,* 2010; Halse, 2014; McFadden and Koll, 2014). In a UK survey-based study with people living with dementia and their carers, Pratt *et al.* (2005) found that group participation was beneficial for improving the memory functions of people living with dementia. Creative writing was also identified as core part of group activity. For example, a study with people in the early stages of dementia (Halley *et al.,* 2005), and a UK study with young people living with dementia (Jubb *et al.,* 2003) discovered that group participation in creative writing was highlighted as the main learning activity for group participation, such as writing their life stories:

> "We share things. I write things down – must do that. It helps. We help each other . My memory's a lot better than it was and coming to the group has helped a lot with that." (Halley, *et al.,* 2005, p.15).

> "It is good to leave a part of you behind so that people can get to know the real you." (Jubb *et al.,* 2003, p.35).

The availability of education and learning resources enabled the continuation of knowledge acquisition through the provision of learning opportunities, including guidance, information, and advice, such as: (a) books and leaflets (Jubb *et al*., 2003; Peters, 2007; Dow *et al*., 2010), (b) point of entry into other relevant services (Halley *et al*., 2005; Morrissey, 2006), and (c) access to the internet and iPad (Halse, 2014). Similarly, for people recovering from addiction Campbell *et al*. (2011) noted that in group participation the members' feelings of decreased social and coping skills they had developed during addiction were nullified by access to increased learning opportunities through engagement with volunteering, traineeship and employment.

Halse (2014) reported that intergenerational learning was observed among people newly diagnosed with dementia in the United States as vital for learning between people recently diagnosed with dementia and 50 students aged from 8-11 years who were known as 'Dementia Ambassadors'(p.10). For example, when one of the attendees expressed that she did not like computers, but loved bird watching, one of the young Dementia Ambassadors downloaded an app for bird watching which enabled the participant to enjoy bird watching. In the same study, engaging in a variety of focused and reminiscence activities, such as craft, exercise classes and dance was perceived as a source of learning (Halse, 2014). However, Mather (2006) and Morrissey (2006) observed that some people in the early stages of dementia required a lot of encouragement to find coping strategies through participation in activities that they previously enjoyed but were now finding challenging or in new activities.

2.1.5.4 *Empowerment through autonomy to make decisions*

Decision making renders it possible for participants to identify individual needs and decide on how to meet those needs within the café; an outcome resulting in self-reliance with increased feelings of autonomy and empowerment (Jubb *et al.,* 2003; Halley *et al.,*2005; Pratt *et al.,* 2005; Mather, 2006; Dow *et al.,* 2010; Campbell *et al.,* 2011). For instance, Halley *et al.* (2005) reported that for people with early stage of dementia and their families, the flexibility and autonomy to decide which activity to participate in offered diversity of choice and facilitated their participation:

> "People are also able to drop in and out when they please, and there is no expectation that people will attend for the full three hours, although the majority do." (p.693).

An Australian study by Mather (2006), with participants in the early stages of dementia, found that attending the Memory Lane Café created a self-reliant and self-help environment which empowered participants to make decisions about their needs, as well as how to meet those needs. Jubb *et al*. (2003) also highlighted that the young people living with dementia established a drop-in facility where they could make decisions, such as the establishment of a community group called "people relying on people" (p.35). For people recovering from addiction (Campbell *et al*., 2011), decision making about engaging with volunteering, traineeship or employment resulted in an increased sense of purpose and ownership, which participants associated with empowerment:

> "I need community involvement and a sense of purpose. The Serenity Café feels like inclusion and a feeling of giving something back." (Volunteer, p.139).

> "Serenity Café gave me responsibility. Addicts don't cope with that very well; I would have run a mile from that in the past." (Volunteer, p.140).

In other studies (Mather, 2006; Morrissey, 2006) suggest that initially, people in the early stages of dementia did not participate in decision making, rather, staff members made the decisions and planned the structure of the activities. However, over time and with a lot of encouragement, participants reported that they felt empowered to make their own decisions and this increased their confidence and sense of belonging.

2.1.5.5 *Funding as a determinant to sustaining the cafés*

Funding was identified as central to sustaining the different cafés referred to above (Jubb *et al*., 2003; Halley *et al*., 2005; Dow *et al*., 2010). For example, Dow *et al*. (2010) and Greenwood *et al*. (2017) noted that due to the funding issues, there is uncertainty surrounding the frequency of the opening times and the sustainability of the Memory Lane Café in Australia; thereby negatively affecting people living with dementia, their family members and the carers. According to the authors, some participants were happy with the frequency of opening times at the café, but others wanted the café to open more often. Still, it did not matter what participants wished for because the frequency of opening times was totally dependent on the availability of funding (Dow *et al*., 2010).

Another concern that authors raised was about the geographical location of the cafés which made it difficult for some people who travelled a long distance to attend the cafés and therefore, often prevented them from attending (Jubb *et al.,* 2003; Dow *et al*., 2010). Also, Dow *et al*. (2010) report that funding for was vital to facilitate the opening of culturally and linguistically relevant dementia cafés; pointing out that some people may experience other barriers, such as immigrant status and language. So, they may not attend existing cafés that do not meet their cultural needs, and this may result in delayed diagnosis of dementia or mental health challenges. Likewise, other studies found that linguistic gaps and limited language skills contributed to the underutilisation of health services and differences in access to mental health services (Brisset *et al*., 2013; Ohtani *et al*., 2015).

2.1.5.6 Summary of the scoping review

This scoping review aimed to determine the scope, size and characteristics of available studies of mental health cafés, as well as summarise and narratively synthesise the findings. The broad-ranging nature of this scoping review revealed five significant points of benefits and challenges within the mental health and dementia café phenomenon.

Given that this scoping review was underpinned by the framework offered by Arksey and O'Malley (2005) framework, an exhaustive scoping search was conducted with search terms that enabled a comprehensive overview of all published and available literature. However, irrespective of the sheer volume of literature, there were more studies on dementia cafés and minimal studies on mental health cafés for people with a broader range of MHCs. Five key findings were identified from the included studies: (1) Access to a safe space that provides a sense of belonging, (2) social connection and friendship through shared experiences, (3) learning through participation, (4) empowerment through autonomy and choice, and (5) funding as a determinant of sustaining the cafés.

The first of the five findings was determined as central to all the other points because participants referred to the cafés as safe spaces that promote social interaction, collective learning and a sense of community through participation in creative activities (Fried and Waxman 1988; Halley *et al.*, 2005; Mather, 2006; Morrissey, 2006; Peters, 2007; Morrissey, 2006; Dow *et al.,* 2010; Campbell *et al.,*; McFadden and Koll, 2014). Consistent with these findings, Curtis (2010) concludes that informal CMHS that are perceived as safe spaces by people with MHCs is vital for their social. A safe space is also pivotal for people living with dementia who wish to walk around freely (Halley *et al.* 2005), rather than a commercial café space where they will be expected to sit in one place throughout the duration of their stay. Similarly, Cipriani and Danti (2014) suggest that wandering is a major behavioural change among adults living with dementia but wandering can be controlled when psychosocial needs are met, such as interacting with familiar faces in a safe space.

The second finding of social connection and friendship through shared experiences was viewed as key to increasing interactions and maintaining friendships (Fried and Waxman, 1988; Jubb *et al.,* 2003; Halley *et al.,* 2005; Pratt *et al.,* 2005; Mather, 2006; Morrissey, 2006; Peters, 2007; Dow *et al.,* 2010; Halse, 2005; Campbell *et al.*, 2011; McFadden and Koll, 2014). It is important to note, here that without dementia cafés, some participants may not have a space to visit where they could make friends, especially as some reported that they live alone, and others stated that they would not have any friends because they lost their

so-called friends after the diagnosis of dementia (Jubb *et al.,* 2003). In this sense, Ansberry's (2019) study on the loss of friendship after the diagnosis of dementia is pertinent. Similarly, a 2017 survey of friendship and dementia by the Scottish Action for Dementia organisation reported that two out of three people living with dementia reported that they lost friendships after their diagnosis (Alzheimer Scotland, 2019).

Social connection for people with MHCs covers more than just access to a mental health café, and it is also about being an active citizen who participates in the community through education (Leach *et al*., 2010), volunteering and work (Le Boutillier and Croucher, 2010; Hall *et al*., 2019). In this case, the findings from this review offer significant insights into participants' reported feelings of empowerment due to the autonomy to decide and choose what activity to participate in or not participate in (Halley *et al.,* 2005; Morrissey, 2006; Mather, 2006; Peter, 2007; Dow *et al.,* 2010; Halse, 2014; McFadden and Koll, 2014). This finding is not to imply that social connection is a linear process because it is not (Bates, 2002; Chan *et al.,* 2015). Rather, social connection is a stepped process, more so among people with MHCs who experience it differently, depending on diagnosis, access to support and social networks (Webber *et al.,* 2015).

Previous studies identified shared experiences through group participation in art and creative practice as useful for learning and social interaction among people with MHCs (Secker *et al*., 2011; Crawford *et al.,* 2013; Stickley and Clift, 2017). In other words, it is vital to include a variety of creative activities, learning resources and a sense of community to enhance the social context in which people with MHCs can experience feelings of social connection. Furthermore, funding was found to determine the sustainability of the cafés because funding pays for most of the services that are paid for within the cafés.

Conclusively, all mental health cafés are similar in their provision of inclusive, non-stigmatising, empowering commercial café style space, where people with MHCs can attend to socialise and participate in activities. Some of the cafés, such as out of hours cafés, only provide a space to chat and drink a cup of tea or coffee, some provide vocational, and employment skills, while others provide creative activities and information about other services. In many respects, therefore, there are not many differences between

fully funded and partially funded mental health cafés except the availability of funding, which is a, if not the key determinant to the sustainability and accessibility of mental health cafés. This scoping review indicates that most of the research evidence on MHCs was explicitly established for people living with dementia. Therefore, the findings on mental health cafés in relation to this thesis remain speculative because of the scarcity of studies on people with a broader range of MHCs. In the section that follows, the literature review of the five informal CMHS is explored in greater detail to situate mental health cafés among other informal CMHS.

2.2 Narrative literature review of five informal community mental health services

This section details the review of the literature on five informal CMHS, including mental health cafés, so as to identify the similarities and differences between: (1) faith communities, (2) clubhouses, (3) ULOs, (4) day centres and (5) mental health cafés. It discusses their history, organisation, funding, benefits and drawbacks of the services that they provide for people with MHCs. Specifically, this review examines these similarities and differences to situate mental health cafés among the other informal CMHS, identify any gaps in the literature and provide a rationale for the ethnography of a mental health café, using the following question: *What are the key processes within informal community mental health services for people with mental health challenges who access such services?*

2.2.1 Search strategy

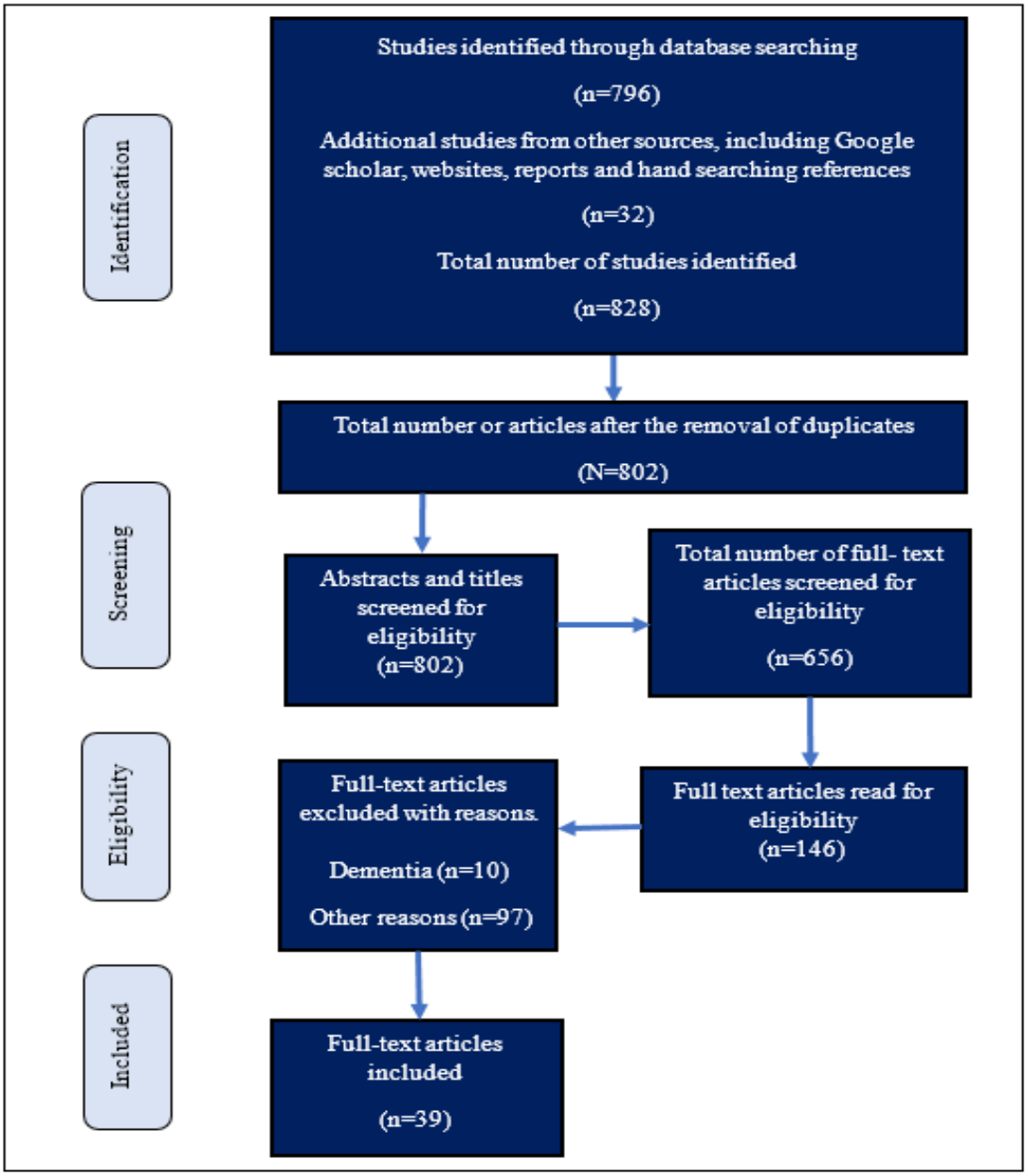
This search strategy details the process that resulted in the selection of the studies that were included in the narrative review. The initial search was conducted via Google Scholar on 22nd April 2017 to identify grey literature, key citations and develop the search terms. These search terms (Appendix 6) were used to carry out comprehensive searches on 22nd April 2007 to 2nd May 2017 on six databases (Academic Search Complete, PsychINFO, PsychARTICLES, CINAHL Plus, PubMed and ScienceDirect). Boolean phrases AND and OR and SmartText were used to search for available studies from 2007 to 2017. Using the same

databases, a review of reviews was conducted to locate any existing literature that compared mental health cafés to other non-statutory CMHS, but this yielded no results. In June 2019, the literature search was updated with date limits from 2008 to 2019, using the same databases and search terms. In addition to the research articles retrieved from the searches, the references within the retrieved articles were hand searched; a procedure that identified one duplicate study which had already been included in the scoping review. Also, to ensure that all available studies were accessed, the British Library inter-library loans department was contacted, and articles were obtained.

2.2.1.1 Results

828 articles were extracted from the literature search. 26 duplicates were removed, leaving 802 titles and abstracts to be screened for eligibility; 655 full-text articles screened for eligibility; 146 full-text articles were read, and 104 articles excluded. The reasons for exclusion were: (a) because they did not meet the inclusion criteria, (b) they were not relevant to the review question and thesis, (c) because they were more focused on *dementia, *acute in-patient hospitals, *informal services located within in-patient hospital, *statutory CMHS, nursing care homes, *physical health and *other types of cafés, such as commercial and cyber internet cafés. Nine articles on dementia cafés and one on a mental health café were excluded because they had already been reviewed in the scoping review (Appendix 7). A total of 39 articles met the inclusion criteria, as follows: faith communities (n=10), clubhouses (n=9), ULOs (n=6), day centres (n=14) (Figure 2).

Figure 2 Flow Diagram for the narrative literature review



2.2.1.2 Characteristics of the included studies

There were two ethnographic studies (Rose *et al.,* 2016; Liou and Jarrott, 2018) in the 39 articles included in this literature review, but neither was on mental health cafés. Most of the articles were published between 2010 and 2018 (n=36), others were published from 2007 to 2009 (n=3) and all the included studies explicitly used participants with MHCs who attended one of the five CMHS. The locations of the included studies were the United States (n=14), Sweden (n=8), the United Kingdom (n=6), Hong Kong

(n=3), and the remaining articles (n=7) were one each from India, Norway, Canada, the Netherlands, the Caribbean, Israel and Taiwan. The authors used qualitative (n=24), quantitative (n=12) and mixed methods (n=2) research paradigms. Table 5 below shows the distribution of studies by methodology, which adds to the methodological gap in the existing literature; the section details an overview of the typologies on the five informal CMHS, including mental health cafés.

Table 5 Identification of studies by the methodology used

Methodology	**Number of studies**
Community-based participatory research	2
Case study	3
In-depth qualitative interview	8
Fieldnotes	1
Reflective diaries	1
Observations	4
Semi-structured interview	8
Structured interview	0
Unstructured interview	1
Secondary data analysis	1
Service assessment/evaluation	2
Focus group discussion	2
Action research with photography	1
Ethnography	2
Grounded theory	1
Time-use diary	1
Survey	4
Longitudinal case-controlled and naturalistic design	2
Cross-sectional data	3
Questionnaires	6
Case-control study	1
Retrospective multi-site study	2

2.2.2 Typologies of informal community mental health services

This section begins with a critical description of the typologies of informal CMHS, including mental health cafés. It describes the: (a) history, (b) organisation, (c) funding, (d) benefits and drawbacks, and (e) examining any similarities and differences. In addition, six core areas of focus in the included studies were identified and narratively synthesised: (1) non-judgmental communal space that creates acceptance and a sense of belonging, (2) increased social connections through participation in employment, volunteering

and creative activities, (3) improved interpersonal relationships through shared understanding (4) autonomy and choice (5) recovery from learning to cope with symptoms of mental health (6) the funding and sustainability of services.

2.2.2.1 Faith communities

Faith communities include different types of religious organisations, such as Christians, Muslim, Jewish, as well as other religious bodies where a group of people who share similar religious beliefs attend for worship (Koenig, King and Carson, 2001; Koenig, 2009; Murthy, 2015). Religion has been recognised as a coping strategy for people with MHCs (Sullivan *et al*., 2013; Karpf, 2014) and as such, faith communities are perceived as an important resource for community health to address the social, emotional, and physical health needs of those who attend (Allen, Davey and Davey, 2010; Caplan and Cordero 2015; Caplan, 2019; Hardison-Moody and Yao, 2019).

Faith communities may be funded by the government or self-funded through donations from members (Smith and Suto, 2012; Smith *et al.,* 2013; Murthy, 2015; Connolly and Granfield, 2017; Caplan, 2019; Hardison-Moody and Yao, 2019). Research evidence suggests that faith communities existed long before the establishment of the asylums, providing non-medical care for people with MHCs (Fawcett and Karban, 2005). The first mental health hospitals were founded in monasteries by benevolent people, such as bishops, royalty, and merchants, and they were managed by priests (Koenig, McCullough and Larson, 2001; Fawcett and Karban, 2005). These earlier faith communities supported both members and non-members of their respective religions who experienced psychiatric difficulties and are reported to have treated people with MHCs with more compassion than today's mental health practitioners (Taubes, 1998; Koenig, 2009). In addition, the influence of religious practices for people with MHCs is viewed as guiding human behaviour that prevents self-damaging tendencies and compulsive forms of coping strategies, such as substance misuse (Marsiglia *et al.,* 2005; Caplan, 2019).

Studies suggest that although community members respect faith leaders as trusted messengers of, e.g., God (Murthy, 2015), some faith leaders lack adequate training on how to support people with MHCs and other vulnerable groups. The need for a collaborative partnership between mental health practitioners and religious groups, to increase the awareness of mental health among religious members and provide more inclusive mental health support in the community, is an issue that has been highlighted by several authors (Johnson and O'Brien, 1981; Rogers, Stanford and Garland, 2015; Bilkins *et al*., 2015). However, Martyn (2010) and Virdee *et al*. (2016) argue that ongoing collaborative working relationships between faith communities and mental health practitioners may be a challenge, because the two services do not have the same understanding of mental health.

Also, it has been suggested that religious beliefs may act as barriers to treatment due to some faith leaders who only preach about faith and prayer as an intervention using God's power (Bryant *et al*., 2013; Sullivan *et al*., 2013). This view is echoed by Caplan and Cordero (2015) who found that some faith communities are barriers to treatment and diagnosis because of existing beliefs, such as "His grace is sufficient for you; my strength is made perfect in your weakness", "I can do all things through Christ who strengthens me", and "Let the weak say I am strong" (p.205). Therefore, some faith communities may directly or indirectly act as barriers to mental health interventions, and this might also encourage discrimination and exclusion of members with MHCs who insist on attending statutory mental health services for their treatment.

Studies have shown that some health professionals may also present barriers to treatment and diagnosis (Chiu *et al*., 2017) because patients may be reluctant to share their religious beliefs with health professionals for fear of being viewed as having delusions or by alienating the professional in some way (Caplan and Cordero, 2015). However, Sullivan *et al*. (2013) contend that the major barrier is the lack of constructive relationships between faith leaders and mental health practitioners. For example, while healthcare practitioners promote a medical model, some faith communities view mental health symptoms as the will of, e.g., Allah (Padela *et al*., 2012; Bryant *et al*., 2013), a lack of faith and prayer, sin and demons (Caplan, 2010). Other members of such communities might interpret mental health delusions as

possession by the evil spirit (Fakhr El-Islam, 2008). This misunderstanding between mental health practitioners and faith communities may suggest that MHCs might go unnoticed and therefore actually sustained among faith community members.

Furthermore, some mental health treatment recommendations may conflict with a patient's religious/spiritual beliefs or faith community teaching, causing the patient to choose to follow one or the other, but not a combination of both (Sullivan *et al*., 2013). Also, more subtle conflicts may occur when a mental health provider fails to acknowledge or appreciate the important role that a patient's religious or spiritual beliefs and practices play in illness and treatment experiences (Caplan, 2014). The point here is that religion and psychiatry are similar: both can be conceptualised to understand and describe the human experience and human behaviour; as such, religion can play a tremendous role in helping people with MHCs who attend faith communities to cope with the symptoms of mental health.

2.2.2.2 The clubhouse

The clubhouse, also known as Fountain House, was established in 1948 in a United States (US) hospital by a self-help patient group and volunteers (Fountain House, New York City, 1999; Dudek and Aquila, 2012; Raeburn *et al*., 2014; Clubhouse International, 2017). More clubhouses were then established to provide vocational and employment opportunities (Wong, 2010; Chen, 2016; Chen and Oh, 2018; Gorman *et al*., 2018) for people with MHCs to experience reduced symptoms of mental health (Webb, Charbonneau, McCann, and Gayle, 2011; Pernice-Duca *et al*., 2015) and increased social connection (Carolan, Onaga, Pernice-Duca, and Jimenez, 2011). Globally, there are 325 clubhouses located in 33 countries, as well as 36 states in the US (Mosaic Clubhouse, 2017) which are funded by the government and vocational rehabilitation agencies (Fountain House, New York City, 1999; Clubhouse International, 2017). Clubhouses follow a recovery and psychosocial rehabilitation model with no direct delivery of a mental health medical model, such as counselling or medication (Dudek and Aquila, 2012; Hultqvist *et al*., 2016; Chen and Oh, 2018; Gorman *et al.*, 2018).

Clubhouses are free to anyone with MHCs, but attendance and participation are based on membership and compliance with the rules that govern all clubhouse members: an obligation to participate in the work-ordered day (Carolan, Onaga, Pernice-Duca, and Jimenez, 2011; Raeburn *et al*., 2013; Raeburn *et al.,* 2016; Clubhouse International, 2017). Such a day will include: (a) supported employment, (b) education, (c) housing and (d) other activities that promote recovery and social integration (Stoffel, 2008; Chen, 2016). Therefore, people with MHCs who attend the clubhouse are members instead of consumers, service users or clients (Dudek and Aquila, 2012; Chen, 2016) and they participate in the day-to-day running of clubhouses (Dudek and Aquila, 2012; Clubhouse International, 2017). Working with staff members to complete tasks, such as (1) clerical work, (2) educational and employment support, (3) food preparation, (4) building maintenance, (5) registration and intake of new members, and (6) training (Wong, 2010; Gumber and Stein, 2017; Chen and Oh, 2018).

Clubhouses aim to provide a therapeutic space (Gumber and Stein, 2017) that promotes recovery (Stoffel, 2008; Carolan, Onaga, Pernice-Duca, and Jimenez, 2011; Dudek and Aquila, 2012) and to enable people with MHCs to achieve their potentials (Raeburn *et al*., 2016; Hultqvist *et al*., 2016). In addition, clubhouses are reported to reduce stigma, promote respect in the community, workplace and among the friends and family members of people with MHCs (Fountain House, New York City, 1999; Clubhouse International, 2017). In that sense, the clubhouse movement aligns with the concept of social capital (Bourdieu, 1977; Putnam, 2000; Berardo, 2014), because it supports people with MHCs to build social networks and relationships within the clubhouses, as well as outside of their immediate family. Further, family members and caregivers of people who attend the clubhouse have reported respite from caring for the family member, reduced stress levels (Gumber and Stein, 2018), reduced the burdens of care, such as financial, emotional and social (Suro and Weisman de Mamani, 2012) and improved emotional and physical health outcomes (Pernice-Duca *et al*. 2015). Therefore, clubhouses provide social, psychological and vocational benefits for those who attend, while reducing the burden of care for the family and friends of clubhouse members.

2.2.2.3 User-led organisations

User-Led Organisations (ULOs) also known as (a) self-help organisations (SHOs), (b) consumer-run organisations (Brown, 2000; Brown *et al*., 2008), (c) consumer-run drop-in centres (Brown, Wituk and Meissen, 2010), (d) self-help groups (SHGs) (Beresford *et al*., 2011; Beresford and Carr, 2012), (e) mutual-aid groups or peer-support groups (Wilson and Kent, 2015) and (f) user-managed groups are established by their members for their members (Boyce *et al*., 2010). ULOs provide educational, creative and social activities (Seebohm *et al*., 2013; Payne, Allen and Lavender, 2017) for people who share similar experiences and or healthcare services (Beresford and Carr, 2012; Wilson and Kent, 2015). The SCIE (2009) reported that ULOs facilitate peer support and increased social connections through shared experiences, using their local knowledge and networks to represent the voice of the members, as well as promoting diversity through their non-discriminating practices.

ULOs began as a civil rights and mental health service user movements in the 1960s, 1970s and 1980s (Rogers and Pilgrim, 2001; Campbell, 1992; Smith-Merry and Sturdy, 2013; Rogers and Pilgrim, 2014), and they are described as a not-for-profit social enterprise that is managed by people who access support services, such as people with MHCs (The Social Care Institute for Excellence [SCIE], 2009, Brown *et al*., 2007). The first ULO in the UK was established after a group of disabled residents diverted money that was meant for residential care homes and set up accommodation in the community which was accessible to other disabled people (SCIE, 2009). This initial effort soon attracted interest groups such as MIND which advocated for change and demanded civil and economic rights for people with MHP in the community (Turner *et al*., 2015).

Furthermore, ULOs are also described as social movements which lead to collective action and activism-for-change by people who campaigned to advocate for alternative service provision (Campbell, 1996; Branfield and Beresford, 2006; Smith-Merry and Sturdy, 2013; Rogers and Pilgrim, 2014; Rose *et al*., 2016). Social movements are collective forms of protest carried out by people who want to challenge the social structures which disadvantage them in various ways (Crossley, 2002; Del Castillo *et al*., 2016). In other words, ULOs were established through social movements as a joint action between a group of people

with shared experiences who sought to address the way that things that concern them are done; by taking steps to do things for themselves, and by suggesting how services should be provided for them (Bates, Bevan, and Roberts, 2003; Jasper, 2010; Barrett *et al.,* 2014; Wilson and Kent, 2015).

Afterwards, additional ULOs were established in the UK as centres for independent living to promote choice, autonomy, human rights (Brisenden, 1986; DH, 2009, 2010; Beresford and Carr, 2012; Swain *et al.,* 2012) and a voice (SCIE, 2014). Equally, Brisenden (1986) and Boyce *et al.* (2010) suggest that other groups, such as people with learning disability and cancer groups, challenged the unfunded informal care that family and friends provided. The UK government funds ULOs, but 75% of the management team consists of members (Brown *et al*., 2007; Munn-Giddings *et al*., 2009; SCIE, 2009; Rose *et al*., 2016). ULOs for people with MHCs include organisations, such as the National Service User Network (NSUN) (National Service User Network for Mental Health, 2013), Hearing Voices Network (Dillon and Hornstein, 2013; Branitsky, 2017) and the Mental Health User Movement (MHUM) (Rogers and Pilgrim, 2008).

The SCIE (2009) recommends that involvement in ULOs should be more than being a member so that members can participate, take control of their lives and of the care that they receive. ULOs interpret joint participation as empowering through peer-to-peer support (Wilson and Kent, 2015), shared decision making and redistribution of the power imbalance between healthcare practitioners and ULO members (Hodge, 2005; Beresford *et al.,* 2011). However, research evidence indicates that ULOs have had little success in influencing service provision, and so, they do not always represent the views of their members (Forrest *et al.,* 2000; Beresford and Carr, 2012). For example, a person with MHC is expected to accept the medicalised model of treatment to prove that they are mentally incapacitated before they can obtain welfare benefits (Beresford *et al.,* 2002; Rose *et al.*, 2016). Notwithstanding, ULOs promote autonomy and choice (Elstad and Eide, 2009), as well as advocacy with the aim of helping their members to become self-determined and overcome social isolation (Campbell, 1996; Boyce *et al*., 2010; Rose *et al.*, 2016). Swain *et al*. (2012) suggest that ULOs for people with MHCs have increased their links with similar groups, by adopting the social model of disability and using this to fight the medical model of treatment,

prejudice, stigma, and discrimination. In this case, ULO members can be described as experiencing increased social connection through their collective action.

2.2.2.4 Day centres

Day centres, also referred to as: (a) drop-in centres and community hubs (Lockett, Seymour and Pozner, 2008; Tjörnstrand, Bejerholm and Eklund, 2013), (b) daycare centres (Tretteteig, Vatne and Rokstad, 2017) or (c) day services (Bryant, 2011) are commissioned, regulated, and funded by the local councils or charitable organisations (Argentzell, Håkansson and Eklund; 2010; Peloso and Valentini, 2016; Liou and Jarrott, 2018). Day centres offer communal space with paid or unpaid carers in a setting outside the home. People attend themselves or are escorted to day centres, and they return home on the same day (Tjörnstrand, Bejerholm and Eklund, 2013; People First, 2017).

Day centres are categorised into three types: (1) meeting places, (2) workplaces and (3) activity-oriented places. The meeting-oriented day centres are where people meet to socialise without the need for creative or employment activities (Tjörnstrand, Bejerholm *and* Eklund, 2013). Activity oriented day centres provide spaces for people with MHCs to meet, socialise and partake in activities (Argentzell, Håkansson and Eklund, 2010), and in work-oriented day centres, people socialise and engage in the acquisition of vocational, learning and occupational skills that will be useful for them to seek employment (Eklund and Sandlund, 2016). For example, the work-oriented day centres have been reported to exclude attendees who do not want to partake in the work-oriented activities (Peloso and Valentini, 2016). Therefore, sometimes, the services provided in the three types of day centres might exclude people with MHCs who may wish to attend one or the other types of day centres (Tjörnstrand, Bejerholm *and* Eklund, 2013).

In the UK, day centres were established to reduce the use of residential homes by enabling people to live in their homes and provide respite for family caregivers or relatives of people with physical or MHCs (Rodgers, 1967; Liou and Jarrott, 2018; Rokstad *et al*., 2018), by offering early intervention of mental

health care prevention of increased mental health symptoms, relapse and readmission and strengthening the recognition of carers (DH, 2014). Day centres also provide emotional support to address an individual's need for social contact and sustained relationships between people with MHCs (Sweeney *et al*., 2016); support supplied through a combination of treatment and signposting attendees to other services (Clark, 2001; Eklund *et al.,* 2014).

Generally, in the UK people with MHCs access day centres following an assessment of their social care needs or personal budget, through referrals from health care providers or the local authority that funds the centre (DH, 2014; Eklund and Markström, 2014), and they fill out registration forms on arrival (Central and North West London NHS Foundation Trust [CNWL], 2017). This means that although day centres are beneficial for attendees and their family members, some people with MHCs without a personal budget may not be able to access day centres; however, they may be able to access drop-in centres and community hubs (Sweeney *et al*., 2016).

Drop-in centres and community hubs provide spaces for attendees to socialise and collectively participate in a range of activities (Forrest *et al.,* 2000; Lockett, Seymour and Pozner, 2008; Tjörnstrand, Bejerholm and Eklund, 2013; People First, 2017). They are open at different times of the week to offer a variety of services, including social support and out-of-hours support for those who attend (Hill and Cheston, 2017). Also, unlike day centres which require attendees to have a personal budget, attend assessments and book appointment to participate, drop-in centres and community hubs are free for anyone in the community to visit without without being obliged to make an appointment (Lockett, Seymour and Pozner, 2008). Therefore, compared to public spaces with rules on how to behave, drop-in centres and community hubs, facilitate a collaborative relationship between staff members and attendees, enabling an inclusive environment.

In the UK, day centres existed, as informal community care providers for vulnerable groups, even before the closure of the asylums (Catty, 2001). Then the government formalised their role to fill the gap left by

the closure of the established long-stay asylums that had provided a range of occupations and activities for people with MHCs (Johnsen, Cloke and May 2005; Catty *et al.,* 2005; Catty *et al.,* 2007). Historically, day centres were initially set up to support the homeless (Llewellin and Murdoch, 1996; Johnsen *et al.,* 2005), people with MHCs living with friends and family members, and those living in hostels (Robinson and Coward, 2003). However, in recent times, day centres were established for different populations, such as people living with dementia (Tretteteig, Vatne and Rokstad, 2017; Rokstad *et al*., 2018), and people with a broad range of MHCs (Bryant, 2011; Campbell *et al*., 2011).

Furthermore, the majority of day centres have closed down due to the lack of funding and because some people are reluctant to attend other services (Bryant, Tibbs and Clark, 2011). As a result, people with MHCs may have a choice of the type of day centre to attend, but funding bodies determine the kind of day centres and activities to fund, so availability determines choice (Bryant, Tibbs and Clark, 2011). However, several studies compared the benefits of day centres for people with MHCs, and they report that those who attended day centres valued: (a) work roles and fewer hospital admissions (Argentzell, Leufstadius and Eklund, 2011), (b) vocational rehabilitation (Eklund *et al.,* 2014), and (c) opportunities for group and person-centered therapy and treatment for psychiatric symptoms (Tjörnstrand, Bejerholm and Eklund, 2013).

The CNWL (2017) reports that day centres empower people with MHP to participate in needs assessment; a process that can lead to the planning, implementation, and review of their goals. However, day centres are dependent on the local authority for funding and regardless of the apparent benefits, UK local authority funded day centres for people with MHCs are closing at an increasing rate (Bryant, Tibbs and Clark, 2011; Needham, 2011). Thus, the continued closure and reconfiguration of day centres has meant that people with MHCs must seek access to other informal CMHS, such as mental health cafés.

2.2.2.5 Mental health cafés

In the UK, mental health cafés have been established, funded and managed by: (a) the local authorities, (b) voluntary organisations, (c) clinical commissioning groups (CCGs) and the National Health Service (South West London and St George's Mental Health NHS Trust [SWLSTG], 2017). Some of these initiatives include recovery cafés (SWLSTG, 2017) and out-of-hours cafés for people recovering from addiction (Campbell *et al*., 2011; NHS England, 2017; Surrey and Borders Partnership NHS Foundation Trust, 2017; Kent's Police and Crime Commissioner, 2017). Other mental health cafés have been established by individuals or healthcare practitioners, and they may or may not receive funding from any of the funding bodies listed above. Such cafés are managed by their users, such as The Dragon Café (South London and Maudsley NHS Foundation Trust [SLaM], 2013; Thomas, 2013; Guy's & St Thomas' Charity, 2015; Coggins, 2017; Dragoncafé.co.uk, 2017; Maudsley Charity, 2017) and by health care practitioners (Jubb *et al*., 2003; Halley *et al*., 2005; Peters, 2007).

The sustainability, ease of access, opening times and frequency of the opening times of mental health cafés depend totally on the availability of funding (Jubb *et al*., 2003; Halley *et al*., 2005; Dow *et al*., 2010; NHS England, 2017). Fully funded mental health cafés have been established in several locations; they are open all year round with 24 hours access, including evening and out-of-hours services that provide an alternative to the Accident and Emergency units (SWLSTG, 2017; Campbell *et al*., 2011; Surrey and Borders Partnership NHS Foundation Trust, 2017). Mental health cafés that are established by individuals have fewer funding opportunities with a small number of locations and reduced opening hours; for example, only being able to open once a week (Dow *et al*., 2010) or four times a month, such as The Dragon Café (Coggins, 2017). These issues, which are the results of limited funding, could mean that some people with MHCs are only able to access mental health cafés that are local to them, or they are obliged to travel a long distance to where their preferred cafés are located (Jubb *et al*., 2003; Halley *et al*., 2005). The next section is the narrative review of five informal CMHS, including mental health cafés.

2.2.3 Narrative synthesis on informal community mental health services

This section is a narrative synthesis of the findings from the narrative review on five informal CMHS. I identified six core areas of focus, including (1) non-judgmental safe space that creates a sense of belonging; (2) increased social connection through participation; (3) improved interpersonal relationships through shared understanding; (4) Empowerment, autonomy and choice; (5) recovery from learning to cope with symptoms of mental health; and (6) funding as a determinant for the sustainability of services. This section concludes with a discussion and synthesis of the findings from the scoping and narrative reviews.

2.2.3.1 *A non-judgmental safe space that creates a sense of belonging*

The perception of safe space was paramount in the included studies because all other experiences can only take place when people with MHCs are able to access a space. Authors ascribed different views to a safe space, including (1) non-judgmental spaces that accept people regardless of their health status (Virdee *et al*., 2016; Prince *et al*., 2017), (2) enabling environment with a sense of belonging (Pernice-Duca *et al*., 2015; Wilson and Kent, 2015; Liou and Jarrott, 2018), and (3) spaces offering inclusivity and acceptance (Connolly and Granfield, 2017). Other studies found that participants' perceptions of a safe space were related to non-hierarchical relationships between members and staff (Wong, 2010) which made participants feel empowered with increased autonomy and choice (Bryant, Tibbs and Clark, 2011; Sutton, Bejerholm and Eklund, 2019). Similarly, other studies report that a safe space produced feeling of reduced anxiety caused by social stigma when participants visited familiar spaces (Argentzell, Håkansson and Eklund 2010; Bryant, Tibbs and Clark, 2011; Tjörnstrand, Bejerholm and Eklund, 2015).

In studies of people with MHCs who attend faith communities, religious buildings are reported as safe spaces where people support each other (Travis *et al*., 2012; Bryant *et al*., 2013) and have open discussions about mental health (Caplan and Cordero, 2015). For example, Conolly and Granfield (2017) reported

that faith communities are accepting and inclusive because attendees do not need to belong to a faith community to attend, due to their open-door policy. In other studies, participants reported that ULOs, had a safe and supportive environment that improved social connection, as well as positive emotional and clinical outcomes because members were able to meet and collectively contribute towards making a positive change (Wilson and Kent, 2015; Longden, Read and Dillon, 2017). Likewise, participants in two participatory studies found that a safe space meant somewhere to air their views (Rose *et al.*, 2016) and share their thoughts with others towards achieving a common goal (Elstad and Eide, 2009; Payne, Allen and Lavender, 2017). In a more recent study with 101 adult members of the hearing voices network authors (Hearing Voices Network, 2017; Longden, Read and Dillon, 2017) found that participants described a safe space as a non-judgmental communal environment where they could meet others who share experiences of voice-hearing, but by their name and service ethos such ULOs may introduce direct and indirect access barriers for others who are not voice hearers.

Furthermore, barriers to accessing some informal CMHS may limit the perception of a safe space, especially in faith communities, day centres and ULOs that require access and participation criteria to be fulfilled before someone can attend or participate in the activities offered. For example, Rogers and Stanford (2015) observed that some faith community members were refused access because they did not have a diagnosed mental health challenge, and in the clubhouses, people with MHCs must become members and participate in work-related activities (Mowbray *et al.*, 2008; Wong, 2010; Hultqvist *et al*., 2016; Prince *et al*., 2017). To put it differently, the perception of safety was prominent among the studies, but access and participation criteria introduced barriers which may limit attendance and reduce degrees of social connection for some people with MHCs.

2.2.3.2 *Increased social connection through participation*

Participation emerged as a source of social connection that seemed to permeate participants' motivation for attending informal CMHS. For example, in faith communities, praying together was viewed as

participation which enabled a source of healing, increased acceptance and social connection (Caplan and Cordero, 2015; Virdee *et al*., 2016). Participation in clubhouses was associated with the development of transferable work skills (Wong, 2010; Chen and Oh, 2018) and reduced mental health symptoms because participants talked more about the activities and less about the symptoms of MHCs (Pernice-Duca *et al*., 2015). However, six of the nine studies on clubhouses implied that participating in a work-ordered day in a clubhouse was obligatory and so the benefits may be overstated (Tang, Ng and Yip, 2010; Wong, 2010; Pernice-Duca *et al*., 2015; Chen and Oh, 2018; Gumber and Stein, 2018; Liou and Jarrott, 2018). However, when compared to day centres and mental health cafés, there was limited evidence to suggest that attending clubhouses and ULOs included the provision or participation in creative activities (Boyce *et al*. 2010; Prince *et al*., 2017).

Participating in ULOs was reported to promote the participatory capability of their members (Brown 2009; Elsta and Eide, 2009; Boyce *et al*., 2010) and this achievement was associated with increased social connection, which resulted in improved wellbeing and health outcomes (Wilson and Kent, 2015). Nevertheless, dependency on a particular group has been reported to limit community integration (Elsta and Eide, 2009). Similarly, day centres were found to offer a range of meaningful services, such as peer support, education, vocational and social activities that increased social connection, but participants were observed to experience reduced community integration as a result of dependency on the same group (Boyce *et al*., 2010; Tjörnstrand, Bejerholm and Eklund, 2015; Sutton, Bejerholm and Eklund, 2019). Other reasons that studies provided for participants' reluctance to engage in community integration include the fear of behavioural symptoms of mental health resulting in self-stigma (Virdee *et al*., 2016; Phutane *et al*., 2019) and familiarity with specific informal CMHS together with the expected loss of existing friendships (Boyce *et al*., 2010; Hultqvist *et al*., 2016).

2.2.3.3 *Improved interpersonal relationships through shared understanding*

The importance of interpersonal relationships between participants and health professionals, friends and family members were highlighted by several studies (Sullivan *et al*., 2013; Pernice-Duca *et al*., 2015; Chiu *et al*., 2017; Connolly and Granfield, 2017; Gumber *et al*., 2019). For example, Sullivan *et al*. (2013) reported that mutual relationships between faith leaders and health professionals enabled referrals to and from faith leaders to health professionals, resulting in increased trust, understanding and reduced stigma for people with MHCs. According to Goffman (1961), stigma is "a discredited attribute that could be readily discernible, such as one's skin colour or body size, or could be hidden but discreditable if revealed, such as one's criminal record or struggles with mental illness" (p.3). Sullivan *et al*. (2013) also found that the lack of relationship between some faith leaders and mental health professionals was a significant barrier to treatment; the authors suggest that one way to reduce stigma is through face to face contact in order to establish interpersonal relationships between mental health professionals and faith community members with MHCs.

2.2.3.4 *Empowerment, autonomy and choice*

In all the included studies autonomy and choice regarding the activities to take part in was important for the MHC population's participation, and as such, people with MHCs felt empowered to make decisions about where to attend, what to do in the 'safe' spaces, who to interact with and how to do so. Some authors found that participants who attended day centres (Eklund and Markström, 2014), ULOs (Brown, 2009) and clubhouses (Elstad and Eide, 2009) reported feeling empowered, especially when staff members encouraged them to decide on the work project to participate in and which staff to work with (Hultqvist *et al*., 2016; Chen and Oh, 2018).

According to other authors, autonomy enables shared decision making which promotes rehabilitation (Hultqvist *et al*., 2016), with increased control, empowerment and the participant's ability to live independently and to act on their own choices (Brown, 2009; Wong, 2010; Sutton, Bejerholm and Eklund,

2019). In contrast, Wong (2010) identified barriers to autonomy and choice, due to the power dynamics between gatekeepers and members. To emphasise, a significant criticism of shared-decision making was that members in some clubhouses did not have autonomy or choice to make decisions due to the paternalistic attitude and long-term dependency relationships which leave gatekeepers as the decision-makers (Wong, 2010). Similarly, Liou and Jarrott (2018) conducted an ethnographic study of a day centre and observed additional barriers to autonomy and decision making when participants were compelled to give up their autonomy and freedom to comply with the expectations of staff members. Furthermore, there is evidence to suggest that shared-decision making did not apply in some ULOs (Gorman *et al*., 2018) and day centres which are funded by local authorities because funders have alternative agendas to participant's expectations' and goals (Boyce, 2010; Chow and Priebe, 2013; Eklund and Markström, 2014). Notwithstanding, these exceptions, on the whole, studies found that participants felt empowered with increased autonomy and choice, but shared-decision making was not found in some of the services due to the influence of funders and gatekeepers.

2.2.3.5 *Recovery from learning to cope with symptoms of mental health*

One critical finding was the notion of recovery as a panacea for people with MHCs. Recovery has been defined as an individual's process of learning to manage their illness and pursue a meaningful life in the community (Deegan, 1988; Brown, 2009; Slade, 2009; Carolan, Onaga, Perkins and Repper, 2015; Hultqvist *et al*., 2016). A considerable amount of studies (n=15) recognised recovery as the ideal health outcome scenario for people with MHCs who attended (s) faith communities (Travis *et al*., 2012; Bryant *et al*., 2013; Virdee *et al*., 2016; Rogers and Stanford, 2015; Chiu *et al*., 2017; Connolly and Granfield, 2017), (b) clubhouses (Wong, 2010; Hultqvist *et al*., 2016; Prince *et al*., 2017; Chen and Oh, 2018; Gorman *et al*., 2018) and (c) day centres (Iecovich and Biderman 2012; Iancu *et al*., 2014; Eklund and Markström, 2014; Peloso and Valentini, 2016; Sutton, Bejerholm and Eklund, 2019).

Brown (2009) suggests that recovery in ULOs is linked with friendship and leadership through shared decision making and a non-hierarchical approach (Brown, 2009; Brown *et al*., 2007). Chen and Ho (2018) found that Clubhouses enable recovery when recovery journeys and psychiatric symptoms are discussed openly. In Sweden participants who attended a day centre associated their recovery with being able to take control of their own lives (Eklund and Markström, 2014). Likewise, the term 'recovery capital' was used to describe the number of resources, such as social networks, work, health, religion and relationships among participants with substance misuse (Travis *et al*., 2012; Connolly and Granfield, 2017) and among people with schizophrenia who reported reduced symptoms of psychosis (Virdee *et al*., 2016). Equally important are inferences from some studies of faith communities that associated the absence of recovery with the lack of prayer (Caplan, 2019) because faith leaders and members viewed prayer as an intervention and a source of healing and recovery from psychological distress (Caplan and Cordero, 2015). Therefore, the issue of recovery is viewed diversely among people with MHCs and in different informal CMHS; however, regardless of the diverse views, recovery is associated with positive outcomes for people with mental health challenges.

2.2.3.6 *Funding as a determinant for the sustainability of services*

Lack of funding was identified as a major barrier that compromises the sustainability and diversity of activities that services are able to provide (Brown, 2009; Bryant, Tibbs and Clark, 2011; Gorman *et al*., 2018). For example, insecurity and uncertainty about the availability of funding were highlighted as the main impediment to sustaining day centres. Moreover, many of such centres are closing down as a consequence of participants' reluctance to attend other services due to the anxiety of going into a new place (Bryant, Tibbs and Clark, 2011). Indeed, regardless of the apparent benefits that day centres provide, local authority funded day centres for people with MHCs are closing at an increasing rate (Johnsen, Cloke and May, 2005; Needham, 2011; Bryant, Tibbs and Clark, 2011). Another example of a funding casuality is Serenity Café, the out-of-hours crisis service that was established in 2012 in Edinburgh for people

recovering from alcohol and drugs addiction, which closed down in 2018 due to financial constraints (Edinburghnews.scotsman.com, 2018; Pringle, 2018).

Likewise, Gorman *et al*. (2018), found that clubhouses would close without funding, but more importantly, the authors suggest that clubhouses must also comply with the regulations from the funding bodies, which in most cases have a specific goal to increase the number of people who attend, without due consideration to the participants' goals to socialise and choose how and what to participate in. Gorman *et al*. (2018), further confirms the idea that obtaining external funding allows ULOs to provide activities and programmes, but the cumbersome and rigid requirements from funding bodies may conflict with the organisational and operational ethos of informal CMHS. Therefore, limited funding could hinder the sustainability and accessibility of some informal CMHS and limit access to, and participation in the services offered for some people with MHCs, especially with the inadequate number of statutory CMHS (DH, 2016; Killaspy, 2006; Pilgrim, Pescosolido, and Rogers, 2011; Gilburt *et al.*, 2014; Turner *et al.*, 2015).

2.2.4 Conclusions from the scoping and narrative reviews

For this section, the prominent issues from the scoping review regarding mental health cafés and the narrative review on informal CMHS were pooled. These issues were: (1) access to an inclusive safe space, (2) group participation, (3) interpersonal relationships and social connection, (4) autonomy and choice as prerequisites for empowerment and recovery, and (5) funding for sustaining the services. These prominent areas have been critically synthesised to demonstrate the overall relevance of the included studies in relation to each other. The review of the literature also included the differences and similarities between the five informal CMHS, limitations of the findings, and the researcher’s review of the evidence and interpretation of the findings. It is important to note here that the findings from both reviews are open to a range of interpretations, so these interpretations are not exhaustive, but they highlight a critical and fair assessment of the findings from the reviews.

In addition to a synthesis of the prominent issues, there is a section on the theoretical frameworks and concepts that were identified from the included studies, and other concepts that were discussed in the reviews. The studies included in both reviews sufficiently addressed the aims with a combined conclusion that informal CMHS are similar in their provision of safe spaces where people with MHCs can attend to experience vocational, psychological, and social interaction benefits. However, informal MHCS differ regarding why and how they were established, what they are, who can attend and participate, and in their management structures.

2.2.4.1 *Access to an inclusive safe space*

The notion of the importance of being able to access an inclusive, safe space was noted in both reviews as central to bringing people with MHCs together (Morrissey, 2006; Peters, 2007; Brown, 2009; Phutane et al., 2012; McFadden and Koll, 2014; Caplan and Cordero, 2015; Liou and Jarrott, 2018). However, inclusivity does not always mean the same as acceptance, without which there may be no perception of belonging (Hall et al., 2019). For example, Bryant, Tibbs and Clark (2011) suggest that it is not the physical space of day centres that make them a safe space, but the attendees' perception of access, support and autonomy. Indeed, evidence from both reviews suggests that informal CMHS provide safe, non-judgmental spaces, but in practice, it seems that some services are only for specific populations. However, the authors in both reviews omitted to explore the factors that might influence attendance and participation as a result of access barriers that are associated with a specificity of population and service provision.

Furthermore, the findings indicate that some informal CMHS may introduce direct access criteria within the name of the service to attract certain populations, such as dementia cafés (McFadden and Koll, 2014), Alzheimer cafés (Morrissey, 2006), the hearing voices group (Rose *et al*., 2016; Longden, Read and Dillon, 2017). Likewise, the Serenity Café in the UK was an out-of-hours and sober café, where people recovering from addiction can attend instead of the Accident and Emergency (A&E) (Campbell *et al*., 2011). For this reason, although mental health and substance misuse or addiction are sometimes comorbid,

having a mental health challenge is not the same as having an addiction (National Institute for Health and Care Excellence, 2016), so people with MHCs without an addiction, who are in crisis may attend the Accident and Emergency (A&E) instead of Serenity Café.

In the same way, there is also a possibility that services without a diagnosis in their name, such as some faith communities (Rogers and Stanford, 2015), clubhouses for people with schizophrenia (Tang, Ng and Yip, 2010; Virdee *et al*., 2016) and dementia cafés that are called different names, such as 'The Coffee Shop' (Jubb *et al*., 2003), Poppy Café (Halley *et al*., 2005) or the Talking about Memory Coffee Group (Pratt *et al*., 2005), may introduce additional barriers to access because the information, activities and services provided are not oriented to include people with a broader range of MHCs. This point is not to dispel that fact that some services were established to provide for specific populations, instead, it shows how different service access and participation criteria may introduce further barriers to access by the general MHC population.

2.2.4.2 *Group participation, social connection and dependency on informal CMHS*

Socialising through group participation in activities and sharing experiences were reported in both reviews as beneficial for developing friendship with others who share similar experiential knowledge. The WHO (2001) defines 'participation' as "a person's engagement in a life situation" (p.10). However, a broader and closely related view of participation in relation to informal CMHS is the definition used by Brown, Wituk and Meissen (2010) who define 'participation' as 'an individual's feeling that they are part of a community and their ability to take part in all facets of that community and society'.

A number of studies associate the importance and benefits of group participation with:

(a) acceptance and reduced stigma (Bryant, Tibbs and Clark, 2011; Sullivan et al., 2013),

(b) increased social interaction (Pernice et al., 2017),

(c) community integration (McDonald, 2010; Sutton, Bejerholm and Eklund, 2019),

(d) improved social, employment and vocational skills (Campbell et al., 2011; Tjörnstrand, Bejerholm and Eklund, 2015) and

(e) forming social networks, friendship and better interpersonal relationships (Halley et al., 2005; Argentzell, Håkansson and Eklund, 2010; Bryant, Tibbs and Clark, 2011; Harley, Boardman and Craig, 2012).

Other studies mentioned (f) reduced loneliness and isolation combined with increased feelings of self-worth (Jubb *et al*., 2003; Fried and Waxman, 1988; Halley *et al.*, 2005; Dow *et al.*, 2010; Wilson and Kent, 2015), (g) improved memory (Pratt *et al.*, 2005), and (h) increased control and autonomy to make decisions (Mather, 2006; Dow *et al.*, 2010; Sutton, Bejerholm and Eklund, 2019). Likewise, participants who attended day centres and participated in the work roles, got involved in (i) vocational rehabilitation (Eklund *et al.*, 2014) (j) and group and person-centred therapy (Bejerholm and Eklund, 2013) with (k) fewer hospital admissions (Argentzell, Leufstadius and Eklund, 2011).

In his seminal study of people helping others who share similar problems, Riessman (1965) proposes that participation is seen as reciprocal giving and receiving roles where people help themselves as well as others and in so doing, develop friendship roles which they can use outside the initial setting. Such friendships, according to Wright (1984), are also visible in day centres where voluntary relationships are perceived as enabling people to foster collective and individual interest towards achieving their life goals with reduced social isolation.

According to Iancu *et al*. (2014), social isolation has been linked to social anxiety, self-stigma, perceived lack of interpersonal and communication skills. Self-stigma refers to internalised negative stereotypes about mental health (Corrigan, Watson and Barr, 2006; Park, MinHwa and Seo, 2019); a perception which is precipitated by public stigma which contributes to the experience of self-stigma (Vogel *et al*., 2013). Consistent with these findings, Borkman (1990) observed that socialising together is helpful for people with MHCs because they can share experiential knowledge and coping strategies which inherently promote understanding and acceptance in a supportive space, resulting in a sense of belonging. As well as understanding aspects of participation that involves taking part, passive participation, where people only

watch those who take part in the activities, was also identified as integral for those who may be anxious when visiting an informal service for the first time and for those others who do not wish to take part (Nordström *et al.,* 2009; Tjörnstrand, Bejerholm and Eklund, 2015).

The notion of group participation as a panacea for friendship and social connection may not necessarily be true, as attending and participating in the same informal CMHS has been linked to reduced community integration due to several reasons. Foremost of which is the evidence that dependency on the space results in attendees' reluctance to attend other spaces (Tjörnstrand, Bejerholm and Eklund, 2015; Peloso and Valentini, 2016; Hultqvist *et al*., 2016; Sutton, Bejerholm and Eklund, 2019). An equally significant aspect of group participation in a single service acting as a barrier to community integration, was social anxiety, which is associated with social stigma and self-stigma as experienced when people with MHCs visit unfamiliar social spaces (Iancu *et al*., 2014).

Tjörnstrand, Bejerholm and Eklund (2015) suggest that people with MHCs might become alienated from the outside world due to the perception of rejection, otherwise known as social stigma from people outside informal CMHS. Consequently, the dependency on one informal CMHS may result in financial implications for that due to an increased number of attendees. For example, it has been reported (Clark, Tibbs and Clark, 2011; Kaplan, Salzer and Brusilovskiy, 2012) that even when some services closed due to financial constraints, participants were reluctant to attend other services due to the anxiety of going into a new space. As a consequence, dependency on one informal CMHS results in little interaction with people in the outside world, the lack of transition to other settings, and perhaps even social isolation and loneliness.

Dependency on one informal CMHS may also result in people feeling that they can only receive a specific service in a particular informal CMHS due to facilitators to access and participation, such as criteria for access, and ethos of membership. For example, service provision and participation, such as in clubhouses where people with schizophrenia might prefer work-oriented activities (Hultqvist *et al*., 2016), hearing voices group in ULOs where people want to share experiences of voice-hearing (Longden, Read and

Dillon, 2017) and simply due to the ease of participating with people who understand as a result of shared experiences, such as was observed in dementia cafés (Dow *et al.*, 2010). Other benefits of dependency can be seen int the Serenity Café for people recovering from addiction as it provides a specific intervention for people to remain sober, such as their provision of a sober night club (Campbell *et al*., 2011). Another example is Stockholm's Café 84 for survivors of concentration camps (Fried and Waxman, 1988) as it provides specific activities and interventions for post-traumatic stress disorder, and, more importantly, the experiences of the holocaust may only apply to a specific population. Therefore, the dependency on a space may be beneficial for sustaining the familiarity of that space as social, employment and interactional interventions for some people with MHCs.

2.2.4.3 *Autonomy and choice as prerequisites for empowerment and recovery*

An opposing view to autonomy is that people cannot live autonomously with all the rules and regulations that govern societies (Owen *et al*., 2009). From this point of view, with access criteria, specific population groups, structure and compulsory participation and anticipated recovery, it is doubtful that the people with MHCs in the review had complete autonomy (Owen *et al*., 2009; De Spiegelaere, Van Gyes and Van Hootegem, 2016). However, autonomy exits on a continuum, not a dichotomy; therefore, people with MHCs may experience different *levels* of autonomy. Therefore, what seems clear here is that the definitions of autonomy and choice that have been put forward see individuals as having capacity. However, historically, some people with MHCs have been labelled as lacking capacity (Rogers and Pilgrim, 2001; Owen *et al*., 2009; Deegan, 2014). Thus, in the absence of shared decision making between people with MHCs and care providers (NHS England, 2012; Slade, 2017; Curtis *et al*., 2010), there is a chance that if someone is already assumed to lack capacity to make a decision after many years, it is probable that it may be difficult, if not impossible, for that same person to begin to make decisions when they attend informal CMHS; they would not know how to do so. Consequently, people with MHCs may do as they are told, and if they have been institutionalised, they may assume that they are making the decisions, especially if they like the activity that they have been asked to take part in.

The above point in no way undermines the fact that people with MHCs are capable of making their own decision; rather, it is an attempt to present an alternative view to the findings in the included studies. It shows that the concept of recovery may not apply to some people who are unable to or are prevented from making their own decisions. In other words, although the definitions above are relevant to view autonomy as both fundamentally moral and rational, it may not be related to recovery as it applies to people with MHCs. Notwithstanding, findings from this review suggest that recovery was linked with participation and empowerment by authors (e.g., Duff, 2012; Pernice-Duca *et al*., 2015) who maintain that access to social spaces, where people with MHCs can choose to take part in between activities, to take their minds off symptoms of mental health and develop relationships can enable their recovery. Likewise, Kaplan, Salzer and Brusilovskiy (2012) propose that community participation is the platform for recovery-oriented service.

Consistent with those views, other authors suggested that clubhouses provide therapeutic spaces that promote recovery and enable people with MHCs to achieve to their full potential when they participate in the work-oriented activities (Stoffel, 2008; Dudek and Aquila, 2012; Raeburn *et al*., 2016; Gumber and Stein, 2017). The above view is reinforced by Chen and Oh (2018) who maintain that clubhouse staff encouraged members to have autonomy and choice about what work to participate in, and with which staff member. However, the same authors also present a contradictory view that clubhouses adopt an 'understaffed' principle by intentionally not hiring enough staff, which gives the impression of staff shortage in order to encourage members to engage in work activities (Chen and Oh, 2018). Notwithstanding, as discussed earlier participating in work programmes enables clubhouse members to acquire transferable work skills as well as empowering them to seek employment outside of the clubhouses.

An alternative view from Hultqvist *et al*. (2016) suggests that although choice leads clubhouse members to develop increased control, empowerment and ability to manage their own lives and interactions outside of the informal space, they do not have complete autonomy or choice. The reason for this limitation is the

paternalistic approach in clubhouses which leads to long-term dependency relationships, with members depending on staff members to make decisions for them. Moreover, members must participate if they want to continue attending and remain members of the clubhouse organisation (Pernice-Duca *et al*., 2015). Similarly, authors have concluded that people who visit day centres (Sutton, Bejerholm and Eklund, 2019) and dementia cafés (Jubb *et al*., 2003; Pratt *et al*., 2005; Mather, 2006) are empowered, through an increase in degrees of control and autonomy, to act on their choices. A contradictory view suggests that some people with MHCs who attend day centres are forced to participate in activities in a way that complies with the expectations of staff (Liou and Jarrott, 2018). Therefore, recovery promotes community integration when people with MHCs have autonomy and choice to decide how they interact, socialise and engage informal CMHS.

2.2.4.4 *The importance of funding*

As discussed earlier, funding was a strong focus in both reviews as it informs the sustainability of informal CMHS (Brown, 2009; Dow *et al*., 2010; Bryant, Tibbs and Clark, 2011; Gorman *et al*., 2018). Undoubtedly, informal CMHS cannot provide their services without funding (Foreman *et al*., 2018), so some informal CMHS may close if the needed funding cannot be accessed (Gorman *et al*., 2018). More specifically, opening times and the availability of space are dependent on funding; therefore, without it there is uncertainty about the continuity of some informal CMHS, such as dementia cafés (Jubb *et al*., 2003; Halley *et al*., 2005; Dow *et al*., 2010). Unquestionably, informal CMHS have to comply with their funding bodies if they want to remain open (Bryant, Tibbs and Clark, 2011; Gorman *et al*., 2018). According to Gorman *et al*. (2018) some funders' main goal is to increase the number of members that attend clubhouses, but Brown *et al*. (2007) warns that informal CMHS should be cautious when obtaining funding in order to avoid compromising their ethos and management autonomy. Following on from the synthesis of the reviews, the next section presents the theories that were identified from the studies included in the review and how these further elucidate or limit the application of theories for understanding informal CMHS.

2.2.4.5 Summary of the review of the literature

In this section, the dominant and similar findings from the scoping and narrative reviews were discussed, so they are now summarised to show how they relate to each other. Informal CMHS differ in the populations that attend due to access criteria, organisation structure, frequency of opening times and mode of participation; all of which impact the autonomy and choice of those who attend them. However, the current reviews demonstrate significant research evidence suggesting that informal CMHS are similar in their provision of safe spaces, where participants could: (a) attend to meet people with experiential knowledge, (b) socialise and (c) participate in vocational and creative activities. Findings also suggest that these benefits resulted in reduced loneliness and isolation and increased social interaction for people with MHCs. Indeed, people with MHCs are among the most excluded population in society, with loneliness and social isolation reported as risk factors that increase the symptoms of mental health, relapse and hospitalisation. When compared to other informal CMHS, those who attended clubhouses reported increased community integration due to the frequency of their attendance.

There were other reasons for reduced community integration among people with MHCs, including: (a) the attendance of the same informal CMHS which led to increased dependency on the informal CMHS, (b) social stigma which made participants reluctant to integrate into the wider society, and (c) the existence of access and participation criteria. Thus, the participants' meanings of 'safe space' were adaptive in the sense that the informal CMHS that they visit, why they visit them, and their experiences in that space might impact the meaning that they attach to that informal CMHS. In other words, services with funding that introduce access and participation barriers, or restrictions to participation, may indirectly induce feelings of exclusion which will ultimately result in loneliness and isolation for those who may only have the option to attend the service where they, for whatever reason, have been refused access. Thus, access to a safe space / place where participants could meet and socialise with others was crucial for developing interpersonal relationships with people who share similar experiences, family and friends, faith leaders and health professionals.

The concept of place and space in relation to health and social interactions has been explored in the literature (Lefebvre and Nicholson-Smith, 1991; Pinfold, 2000; Dummer, 2008, Miller, 2011; Uitermark, Nicholls and Loopmans, 2012). Thrift (2006) emphasises the use of space as a mobility paradigm for people to get closer to their experiences. This view was also highlighted by Parr (2007; 1999;2000) who explored mental health and public space, Pinfold (2000) and Curtis (2010) who focused on the geography of space, place and mental health, and concluded that space is vital for the interaction between people with MHCs and their surroundings. However, the authors suggest that mapping the experiences of people with MHCs based on a specific setting can be a challenging effort (Curtis, 2010) because people have no precise boundary in terms of their movement and transition from one space to another. In this case, with the continued mobility of people with MHCs between spaces (Desjarlais, 1997; Milbourn *et al*., 2015), such as those who visit informal CMHS, and other settings, including hospitals, there may be other spaces that contribute to their perceptions and experiences of, for example, a safe space. These might include: (a) other peer support groups (Repper and Carter, 2011), (b) family support (Hochgraeber *et al*., 2013) and (c) care from statutory CMHS, such as the home treatment team (Edward, 2014).

Human geography is about space, place, and time as social practices of spatial and historical development (Thrift, 2009; Miller, 2011; Uitermark, Nicholls and Loopmans, 2012), mental, physical and social spaces (Lefebvre and Nicholson-Smith, 1991), and interactions between people and places alongside their relationships in those spaces change over time (Rodman, 1992; Lawson, 1983; Nordström *et al*., 2009; Miller, 2011). Space and time are intertwined for the co-construction of social norms and practices within different places and spaces (Auyero, 2006; Nordström *et al*., 2009; Miller, 2011). Buildings and architectural characteristics are central to the creation and co-creation of social life in relation to place and space (Ledinek Lozej and Lawrence-Zúñiga, 2003). This evolution happens for different reasons, such as the desire to create: (a) therapeutic landscapes (Parr, 1999; Pinfold, 2000), (b) refuge and peace (Stickley and Freshwater, 2009), (c) power, and surveillance over the those with less power (Rabinow and Foucault, 1982; Uitermark, Nicholls and Loopmans, 2012), (d) gendered spaces, such as spaces where only men are allowed or to where women are relegated (Bourdieu (1977), (e) shelter for social relations (*Catty et al.*,

2005; Nordström *et al*., 2009), and (f) for creating collective actions and developing new ones (Auyero, 2006; Uitermark, Nicholls and Loopmans, 2012; Campbell, 2016). These notions of place and space are further explored alongside the novel conceptual model in the discussion chapter (see Chapter 5.1.5).

In conducting the scoping and narrative reviews, I concluded that the best way to show what a mental health café is, was to describe what it is not. However, knowing the typologies, differences and similarities between informal CMHS is not enough, especially with the scarce research evidence and methodological limitations of ethnographic research on mental health cafés for a broader range of MHCs. Therefore, it is in part through illuminating the findings from the reviews that this study contributes to the empirical literature on informal CMHS. As a result, with only one seminal study of a broader range of MHCs and no ethnographic study on mental health cafés, it is reasonable to state that this review of the literature has identified: (1) a theoretical framework, (2) the rationale for the doctoral study, and (3) the research questions, which are detailed in the sections below.

2.2.5 Theoretical influences and concepts drawn from the review of the literature

The central role of theory in qualitative research remains the focus of an ongoing debate relating to the acquisition of knowledge through several conceptual framework lenses that are useful for understanding and contextualising findings. This section begins with the discussion of one theory and one model identified from the studies included in the reviews: (a) the social movement theory (Buechler, 1995; Rose *et al*., 2016) and (b) the socio-ecological model (Bronfenbrenner, 1977; Hardison-Moody and Yao, 2019). Further, to orientate the reader to how the theories and concepts that resonate throughout the reviews influenced this researcher's choice of theory, and how they informed discussion of the findings from the ethnography, this section continues with discussions about the concepts of: (a) 'stigma' (Goffman, 1963), (b) 'power' (Foucault, 1972), (c) the 'social model of care', (d) the 'recovery approach model' and (e) 'social capital'.

The social movement theory

Social movement theory has been defined as 'a collective action' and 'activism for change' by people who have a common outlook on society, such as a sense of injustice, and who are therefore campaigning for alternative service provision with the aim of achieving a common goal (Campbell, 1996; Branfield and Beresford, 2006). In this study, the findings from the literature review suggest that social movement theory can be understood in two ways. The first involves the definition that currently exists, which is used to explain situations where service users, such as those who attend user-led organisations and day centres, collectively organise themselves to bring about a change in service provision because they were dissatisfied with the services they received (Rose *et al.*, 2016). An alternative definition is one that I developed from the findings of the scoping and narrative reviews, as follows:

> *"A social movement is an action that can bring about social change by an individual or a group of individuals who may or may not share similar health status but who seek to address the needs of a group of people who share similar health experiences, such as people living with dementia or people with a broader range of mental health challenges."*

As described above, the social movement theory may not always be about people with MHCs who are dissatisfied with services received, or organised by, a group of people who receive similar services.

The socio-ecological model

The socio-ecological model enables an understanding of the interpersonal relationships between an individual, family members, as well as immediate and broader society. As such this model facilitates an examination of the complex relationships between the individual and the wider community (Bronfenbrenner, 1977; Hardison-Moody and Yao, 2019). Findings from this review emphasised the importance of the space where people socialised, participated and developed social connections within and outside the informal community mental health services.

Hardison-Moody and Yao (2019) used the socio-ecological model to describe: (1) the intrapersonal dimensions of the participants' behaviours; (2) participants' attitudes and knowledge; (3) their

interpersonal networks such as social connections, relationships; and (4) the community resources evident among faith communities. Other authors in the review identified the following reasons for why participants might be reluctant to attend other services or engage in community integration: (a) social anxiety (Bryant, Tibbs and Clark, 2011; Phutane *et al*., 2019); (b) dependency on and / or a lack of familiarity with informal CMHS (Iancu *et al*., 2014); and (c) social stigma (Virdee *et al*., 2016). Therefore, when planning and developing informal CMHS, there is a need to identify and incorporate social norms, as well as adopting the socio-ecological model as a framework in order to understand the multifaceted relationships between people with MHCs and the social factors that determine their reluctance to become involved in community integration.

Stigma

Stigma has been described as a visible or invisible 'mark' that disqualifies a person or group from full acceptance (Goffman, 1963; Sullivan *et al*., 2013). Goffman (1963) provides a broader stance that "stigma is a deeply discrediting attribute that reduces someone from a whole and usual person to a tainted, discounted one, the stigmatised, thus are perceived as having a spoiled identity" (p.3). Societal stigma and the discrimination of people with MHCs have been identified as the most critical hindrances to community mental health services (Goffman, 1963; WHO, 2001, 2007; Stuart, 2016; Park, MinHwa and Seo, 2019). Similarly, findings from the reviews included in this study suggest that stigma is a key barrier to community integration for people with MHCs (Argentzell, Håkansson and Eklund 2010; Bryant, Tibbs and Clark, 2011; Tjörnstrand, Bejerholm and Eklund, 2015).

The literature in this review has shown that informal CMHS enable access to non-judgmental and non-stigmatising spaces that create a sense of belonging and encourage people with MHCs to share their experiences with others who can understand their situations and their experiences. However, the social stigma surrounding mental health is a key indicator for the levels of reduced social interaction among people with mental health challenges (Goffman, 1961; Hall *et al*., 2019) resulting in: (a) social isolation,

(b) increased experiences of mental health symptoms, (c) relapsing and (d) readmission (Killaspy *et al*., 2013; Hall *et al*., 2019). Davidson, Kitzinger and Hunt (2006) suggest that inequalities become accepted by those in the lower gradient and unless society is structured more equitably, it may be difficult or currently even impossible to implement a non-stigmatising society. The authors added that such a model requires a society that is structured in ways that consider how everyone can flourish within it by: (a) eliminating the disabling impact of social structures in the environments and (b) making the society more inclusive and less stigmatising (Davidson, Kitzinger and Hunt, 2006). So arguably, in the absence of a less stigmatising society, people with MHCs will NOT experience positive social experiences.

According to several authors (Corrigan 1998, 2007; West *et al*., 2011; Mohtashami, 2018; Park, MinHwa and Seo, 2019) stigma is associated with: (a) discrimination (Pimlott Kubiak *et al*., 2011), (b) loss of (*social* or what?) status (Goffman, 1963; Link and Phelan, 2001; Niedzwiedz, 2019), and (c) the labelling of internalised identities which influence agency and choice (Crocker, 1999; Marcussen, Gallagher and Ritter, 2018), resulting in social isolation and reduced community integration (Chiu *et al*., 2017). In other words, people with MHCs are resistant to engaging with people and other spaces outside their usual informal CMHS, due to their internalised societal stigma; a situation which can often result in self-stigma (Corrigan, 2004; Corrigan, Watson and Barr, 2006; Niedzwiedz, 2019). Thus, the issues of (a) discrimination towards people with MHCs (Hatzenbeuhler *et al*. 2013; Niedzwiedz, 2019), (b) the anticipation of rejection due to the acquired status of stigma, and (c) the loss of status (Chiu *et al*., 2017) can, in combination or individually, potentially result in low self-esteem and avoidance of interactions and situations located in broader public spaces (Link and Phelan, 2014). Thus, even in the absence of being stigmatised, the awareness that social stigma exists can and frequently does result in self-stigma and altered identity for people with MHCs.

Power

I draw on Foucault's (1972) definition of power as a tool for interpreting the construction of social reality, where those who are in power control interactions between people, and in so doing control people's identity in a given social space (Dreher, 2016). Findings from the literature review suggest that power dynamics between the funding bodies and those who manage informal CMHS conflict with their attendees' views of their autonomy to make decisions (Brown *et al*., 2007; Foreman *et al*., 2018; Gorman *et al*., 2018). As Foucault (1980) put it:

> *"*A person cannot think thoughts that are outside the structure of which that person is part*"* (p.5).

In other words, the structure of informal CMHS in itself represents power, and this guides the actions and choices of people with MHCs who attend those services. For example, findings from this review suggest the reduced autonomy and choice among people with MHCs is primarily due to the power dynamics between the gatekeepers and members who attend clubhouses (Liou and Jarrott, 2018; Wong, 2010). Therefore, power in this context does not refer to oppression and repression, but to the Foucauldian view which perceives that power coexists in multiple social spaces and in different kinds of relationships (Kelly, 2009).

Generally, findings from the literature review suggest that participants felt empowered and self-reliant when they were able to make their own decisions regarding how or if to take part in the activities available at the informal CMHS (Jubb *et al*., 2003; Mather, 2006; and Morrissey, 2006; Campbell *et al*., 2011). In other words, people with MHCs who attended the informal CMHS, and who had the autonomy to make decisions, felt more empowered and in control of their choices when compared to others who did not have the opportunity to make their own decisions. Indeed, the issue of power imbalance between service providers and service users remains a concern in mental health care provision, particularly when service managers prescribe what service users should do without consideration for the service users'

wishes (Bhui, 2018). This inequity means that for some people with MHCs, their agency and autonomy could be undermined when their decision-making power is limited.

Mental health challenges can be disabling and, as a result, service users can experience a loss of power in different spaces, such as clinical settings (Kelly, 2006; Lally *et al*., 2017), or when interacting with some mental health professionals (Slade *et al*., 2014). Therefore, it is probable that once conditioned into a disempowering way of living, those people with MHCs who attend informal CMHS, where their choices are limited, may be prone to accepting such a situation as 'normal'. Put another way, if autonomy and choice are prerequisites to recovery, then this may be lacking among people with MHCs who have no autonomy regarding how they participate within some informal CMHS. However, this observation does not suggest that other biopsychosocial influences cannot improve the recovery of people with MHCs in other social spaces, such as their homes. Yes, as the findings from the reviews suggest, not acknowledging the presence of a power gap between service providers and attendees can be highly counterproductive. By failing to see how such a gap impacts on the autonomy of people with MHCs to participate fully in informal CMHS, and how this may impact on their recovery, can be equally negative. From this perspective, individual agency among people with MHCs may be reduced as a central focus in the presence of power within informal CMHS. Therefore, recognising the influence of power in such community resources may help with the development of informal CMHS, where enabling the agency and autonomy of people with MHCS is the focus of service provision.

The Recovery Approach

Principle 1 in the National Institute for Mental Health in England [NIMHE] (2005) section relating to guiding the recovery process in mental health care, states: "The user of services decides if and when to begin the recovery process and directs it; therefore, service user direction is essential throughout the process." (p.4). I have drawn on this study from the NIMHE because it coincided with the

'modernisation of day centres' process that began in 2003 (Bryant, Tibbs and Clark, 2011); the document is therefore relevant to participants' narratives evident from this study's findings.

The concept of recovery is firmly situated in mental health care (Repper and Perkins, 2003) with a consensus involving four dimensions used as measures in recovery-oriented service provision: (1) individualised/person-centred, (2) empowerment, (3) purpose and (4) hope (Ellison *et al*., 2016). According to Deegan (2002) and Fisher (1993) mental health 'recovery' is the change and recuperation from serious emotional distress (Anthony, 1993), or as Copeland (2008) and Shepherd, Boardman and Slade (2008) put it, recovery is an individual's ability to live, work and engage in the community while experiencing symptoms of mental health challenges.

Findings from the reviews in this study provide significant evidence to suggest that recovery is directly linked with a non-hierarchical approach (Brown, 2009; Brown *et al*., 2007). Emphasis is placed upon participation; a context where people with MHCs feel empowered because they are involved in decision making or in which they can make decisions about whether and/or how to participate in informal CMHS (Elstad and Eide, 2009; Sutton, Bejerholm and Eklund, 2019). Recovery was also associated with learning to cope with symptoms associated with mental health challenges (Travis *et al*., 2012; Bryant *et al*., 2013; Virdee *et al*., 2016; Rogers and Stanford, 2015; Chiu *et al*., 2017; Connolly and Granfield, 2017). However, in the absence of autonomy and choice, this study argues that recovery may not happen at all or may only happen very gradually. In other words, people with MHCs have to feel empowered in order to experience recovery. Empowerment has been described as 'the ability to take control over one's life' (Rogers *et al*., 1997, Rogers *et al*., 2010), and recovery has been defined as 'a person's way to live a meaningful and contributing life, regardless of their illness symptoms' (Slade, 2009). Taken together, it seems safe to conclude that, in order to experience recovery, people with MHCs need to feel empowered.

The mental health recovery approach was introduced as a result of economic issues, consumer rights and social movement among people with MHCs (Field and Reed, 2016). When the recovery paradigm

emerged in the UK mental health care arena, it became the central principle informing the process of placing people with MHCs in control of their care, which is now recognised internationally in mental health policies, research and practice (New Freedom Commission on Mental Health, 2003; Ellison *et al*., 2016; Le Boutillier *et al*., 2011). The recovery approach can be viewed through two lenses. The first is the medical and clinical approach to recovery, which suggests that an individual can return to their previous state of health (Petersen *et al*., 2014). For example, some health practitioners focus on symptomatic aspects of mental health as the outcome measures of recovery, with increasing expectations of people with MHCs to recover (Davidson and Roe, 2007). The second lens for viewing recovery is a social model, which can be understood as a 'person-centred process' that does not focus on treatment or hospitalisation; this model gives the service user autonomy regarding how they define what recovery means to them (Lukens & Solomon, 2013). In other words, as Slade *et al*. (2014) suggest, recovery is an individual's subjective experience, because perceptions and experiences of recovery differ.

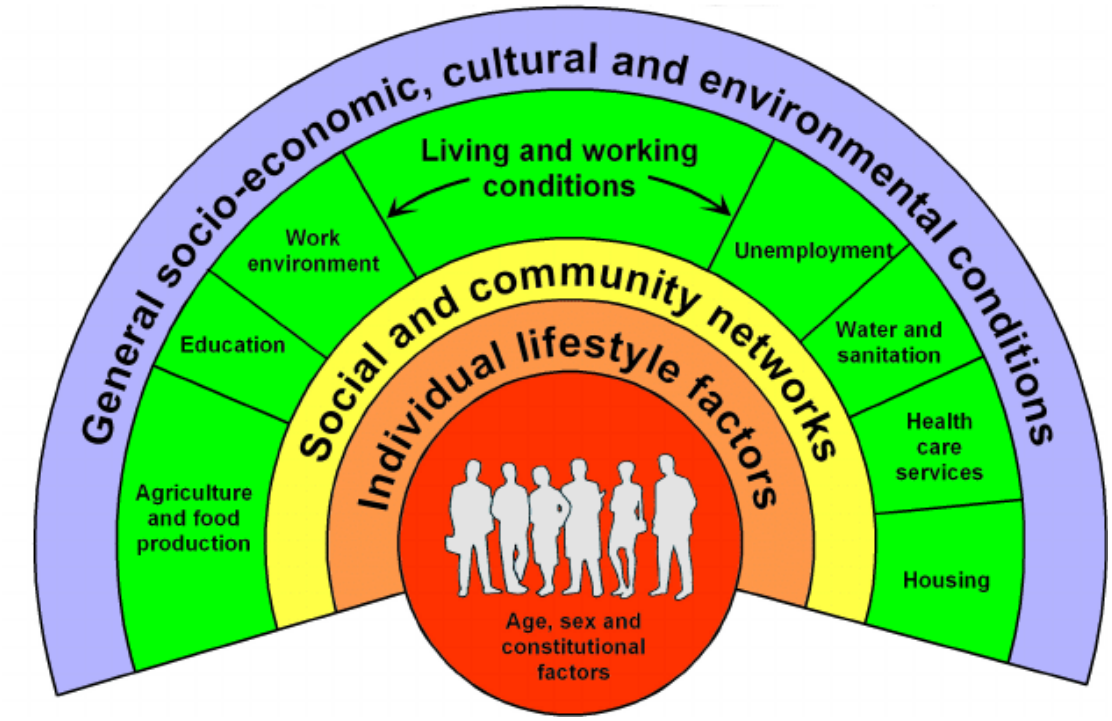
The above notions of recovery are the guiding principles that transformed mental health care provision from a wholly medical model to one which includes a social model of care dimension (Anthony, 1993). Indeed, recovery can be a transition of individual change and community integration for people with MHCs, enabling 'accepting' social conditions that encourage recovery and recovery-oriented practices (Tew *et al*., 2011). Thus, there is a link between the social model of care and the issue of recovery. As such recovery focuses on the wider processes within the society, which otherwise would give rise to increased social stigma and discrimination relating to people with mental health challenges. However, although this link between recovery and social indicators exists, the role of social factors in the recovery of people with MHCs is still unclear (Tew, 2011; Field and Reed, 2016).

There is substantial evidence to indicate that the meaning of recovery in relation to people with MHCs remains ambiguous (Pilgrim, 2009; Ellison *et al*., 2016), with even less clarity about what a recovery-oriented practice should look like (Le Boutillier *et al*., 2011). This dispute about the meaning and

practice of recovery for people with MHCs introduced diverse aspects of understanding, which make it challenging to implement a recovery-oriented practice (Lieberman *et al*., 2008; Slade *et al*., 2014). Pilgrim (2009) argues that this variance in the understanding and practice of recovery-oriented practice might improve if mental health practice was informed by (the findings of) multiple ethnographic investigations (Pilgrim, 2009). Therefore, while acknowledging the findings from this study's literature review, it is important to highlight that in the absence of a clear understanding of what a recovery-oriented practice should be, it might be difficult to fully associate recovery as an outcome for people with MHCs who attend a CMHS.

Social model of care (mental health)

The social model of care, sometimes referred to as the 'social model of disability' (Hughes, 2010), represents a trend which has evolved out of the recovery movement (Beresford *et al*, 2010; Beresford, Perring, Nettle and Wallcraft, 2016) and which explores the social, cultural, political and environmental factors which impact health and wellbeing (Marmot, 2003). In this case, a social model of care places mental health in the social contexts within which people with MHCs exist, while using practices and evidence to collaborate with communities and individuals, in order to help prevent or weaken mental health challenges faced by those people and to support their recovery. The social model of care believes that prevention and recovery are best achieved in a holistic way. Such an approach integrates care by considering the mental, physical and social factors of people's lives as the determining influences on the health and wellbeing if people with MHCs, rather than just looking at only one factor (Henningsen 2015). In this case, the findings from the literature review suggest that the social model of care for people with MHCs should be viewed through a multidimensional lens that sees more than the individual. Such a model should also include the society and structures that facilitate or act as barriers to hinder people with MHCs from integrating into the community; the socio-cultural context in which that person exists. After all, the wider determinants of health include where people are born, grow, live, work, and age (Dalhgren and Whitehead, 1991).



Source: Dahlgren and Whitehead (1991)

As the diagram above shows, it is not only the physical and structural conditions in which people live that determine their health outcomes, but also psychosocial factors. These factors include: (1) lifestyle, (2) social and community networks, (3) social status, such as living and working conditions, and (4) general economic, social and environmental conditions, including mental health policies. In other words, all these determinants are interlinked, so they interact with each other inversely and conversely, thereby influencing the lives of people with MHCs, for example. Therefore, to facilitate a social model of care for people with MHCs, researchers and policy makers must first understand the determinants of those people's health; one of which would be ensuring that people have access to the type of informal CMHS that meets their social integration needs.

There is a polar opposite of the social model of care: the biomedical model of care. This latter model is based on the belief that mental challenges are brain diseases that require pharmacological treatment in order to deal with and manage biological abnormalities (Deacon, 2013). To put it simply, the difference between a biomedical model and a social model for a participant in one of the studies cited in this

literature review would be: (a) taking medication only for mental health challenges (the biomedical model of health) as opposed to (b) when people with MHCs co-create and socially construct knowledge and meanings through their social interactions in an informal CMHS (the social model of health). However, politically, the biomedical model of care is hegemonic and that makes it difficult (or even inappropriate) to implement the social model of care in some spaces (Beresford, 2002; Faulkner, 2015; Beresford, Perring, Nettle and Wallcraft, 2016). In other words, the biomedical model of care is currently the dominant model in the UK. Beresford (2002) and Hogan (2019) argue that for some health professionals to fully embrace the social model of care, they would require political engagement and a greater focus on societal structures, rather than on those individuals with MHCs.

As far back as the 1950s, Thomas Szasz called for a reform of the health system towards a more holistic model of care (Szasz, 1956). Similarly, the WHO (2001, 2007) highlighted the need for a paradigm shift from acute in-patient mental health care to community-based mental health care. This called-for shift was based on the premise that community-based mental health care was: (1) less stigmatising, (2) can accelerate early intervention, (3) was more cost effective when compared to the in-patient model and (4) respected the human rights of people with MHCs. To achieve the shift from acute in-patient care to community-based mental health care, the WHO (2007a) encouraged countries to adopt collaborative multi-disciplinary working relationships between mental health service providers. Such a collaboration would enable a more holistic care pathway that includes or considers: (a) housing, (b) employment, (c) crisis support and (d) increased social integration for people with MHCs; all factors which align with the social model of care. The calls from Szasz (1956) and the WHO (2007a) complement findings from this study which suggest that the UK government continues to transfer care from in-patient provision to the community (Killaspy *et al*., 2013). However, the government also continues to close mental health day centres, despite the benefits reported by the people with MHCs who attended those centres which are no longer operating (Bryant, Tibbs and Clark, 2011; Peloso and Valentini, 2016). This positive evidence aligns with the social model of care, but there remains an inadequate supply of informal and

statutory CMHS in the UK, resulting in many instances where the needs of community-based people with MHCs are unable to be met (Gilburt, 2014; Turner *et al*., 2015).

The most recent NHS England publication 'Community Mental Health Services Framework for Adults and Older Adults' (2019) suggests that 'community' is about people's lives. It specifies that informal community mental health services should be central to a social model of care and involve a "triple integration of mental health, physical health and social care*"* (p.17). However, the care model in this framework does not mention informal community mental health services, as it is more about the medical model of treatment, rather than a social model. The framework recommends the biopsychosocial (BPS) model, a prominent approach in global mental health, which advocates that (a) biological, (b) psychological, and (c) social factors play a significant role in causes and treatments of disease (Engel, 1992; 2012). However, Engel describes the biopsychosocial model as a medical model for people with MHCs (Engel, 2012; Babalola, Noel and White, 2017).

Furthermore, regardless of the 'parity of esteem' principle which is enshrined in the Health and Social Care Act (2012), and which requires mental health and physical health to be valued equally and receive equal attention and funding (Centre for Mental Health, 2020), there remains a significant difference between the access and availability of treatment between adult mental health and physical health in the UK. This current disparity demonstrates a lack of parity of esteem and limited funding for adult mental health services in general (The King's Fund, 2020). Therefore, even with the best intentions for a paradigm shift towards a social model of care for people with MHCs, but without adequate funding and political interest, it seems that the medical model will continue to dominate mental health care provision offered in the UK. In other words, it could be perceived that a medical model of care is the product of an unaccepting society that sees mental health or disability as an individual's problem that needs to be treated or fixed. That model is easier and far more financially rewarding for the medical establishment than addressing the political, structural and other issues in a society that act as barriers to social and community integration for people with MHCs.

In summary, under the social model of care, the availability of informal CMHS becomes one determinant of mental health that more broadly addresses the social structures that will enable people with MHCs to integrate better into their communities, while encountering less stigma and fewer barriers. Therefore, drawing on Sarah Wheeler's (2015) notion of the social model of care, as a way to bring people with MHCs together in a space where they can socialise and participate, it is imperative to situate informal CMHS within a social model of care framework; a perspective strongly supported by the findings from the reviews in this current study. Such a framework can provide spaces where people with MHCs can meet to develop friendships, otherwise known as 'social connections', and as such enable a limited degree of community integration. Social connections, social networks and relationships are synonymous with social capital.

Social capital

There are several definitions of social capital. The World Bank (1999) defines social capital as institutions, relationships, and norms that shape the quality and quantity of social interaction within groups and societies. There are other definitions of social capital, such as (1) the view by Putnam (1993), which it as a set of linear associations between people for the mutual benefit of the community, and (2) Bourdieu (1986), as the aggregate of a participant's relationships transformed into lasting social connections through the continuous exchange of interactions.

Putnam's view of social capital has been criticised for being too narrow due to its linear perspective, while Bourdieu's view has been acknowledged for converting the notion of social capital into a process used by individuals in social groups to increase their social networks (Carpiano, 2006). The World Bank (1999) further provides a more generalised definition of social capital as not only the total of the institutions, which reinforce communities; but the glue that keeps them together. This definition is robust because it combines Putnam's (1993) view of societal norms with the views offered by Bourdieu and Wacquant (1992) that focus on mutual relationships between individuals and group relationships.

In this case, social capital for people with MHCs, who attended the informal CMHS, represents their cumulative social connections in different spaces and the nature of the social connection that is produced within those spaces (Bourdieu, 1977).

Findings from publications in this literature review indicate that when compared to studies on day centres and ULOs, the prolonged participation in clubhouses was found to achieve several benefits. For example, it reduced isolation, resulting in increased social connections, with clubhouse members being able to obtain and maintain community-based employment as well as access to: (a) education, (b) social housing and (c) other services (Iancu *et al*., 2014; Goram *et al*., 2018). Thus, prolonged activities within the clubhouses resulted in more social contact and increased community integration outside those clubhouses (Mombrary *et al*., 2008; Tang, Ng and Yip, 2010; Pernice-Duca *et al*., 2015; Prince *et al*., 2017; Gumber and Stein, 2018).

More extensive social networks are presumed to be more accessible and diverse, placing less of a burden of care on any one network member. Increasing the size of a person's social network has been shown to reduce loneliness and social isolation (Pernice-Duca, 2008; Harley, Boardman and Craig, 2012; Eklund and Markström, 2014; Hultqvist *et al*., 2016). Studies found that when people with MHCs attend informal CMHS, they report: (a) reduced social isolation, (b) enhanced recovery rates, (c) increased feelings of wellbeing (Carolan, Onaga, Pernice-Duca, and Jimenez, 2011) and (d) improved interpersonal skills; all outcomes which resulted in a positive impact on their family members, as seen in a reduction in the burden of care (Pernice-Duca, 2008; Suro and Weisman de Mamani, 2013). Additional family benefits include increased levels of emotional and physical health outcomes due to their relative attending the clubhouse, rather than remaining in the family home (Pernice-Duca *et al*., 2015). Also, it has been reported that the more times attendees visit a day centre, the larger their social networks become (Caty *et al*., 2005; Eklund and Sandlund, 2016). However, other studies observed that regardless of the benefits of access and participation, people with MHCs report smaller social networks than those possessed by people without MHCs. These smaller networks usually include:

(1) health professionals, family members and others who attend similar mental health services (Hardiman and Segal, 2003; Webb *et al*., 2011),

(2) family members or mental health professionals (Goldberg, Rollins and Lehman, 2003; Harley, Boardman and Craig, 2012),

In this sense, given that clubhouse members socialise and participate for significantly more hours because of the provision of day, evening and weekend activities, they have increased levels of social contact as well as more community integration (Prince *et al*., 2017; Gumber and Stein, 2018). Under those circumstances, when compared to people who attend other informal CMHS, members of clubhouses would have more social contacts due to the frequency and range of the clubhouse opening times. This study will focus Bourdieu's (1977) theory of practice, including habitus, field and social capital in relation to the findings from the ethnography, as detailed in the discussion chapter (see Chapter Five).

To summarise, while it is apparent that the model, theory and concepts drawn from the scoping and narrative reviews above are useful for understanding the findings from the literature review, Bourdieu's (1977) theory of practice, including the three concepts of habitus, field and social capital, captures some aspects of the models and theories discussed above, due to its generic nature and applicability to different social settings where interactions take place (Walther, 2013). However, the generic nature and applicability of Bourdieu's (1977) theory does not create a unified theory of and by itself. Rather, the theory characterises an adaptable theoretical framework that requires the combination of all three concepts, in addition to (a) social capital, (b) choice, (c) agency, (d) power, (e) stigma and (f) doxa (Bourdieu, 1972, 1977, 1987, 1990; Link and Phelan, 2014).

For Bourdieu, social settings are based on the interpersonal communication of socially constructed shared knowledge (Blommaert, 2005; Navarro, 2006; Grenfell 2014). This view of social settings is likened to the views of interpretive ethnography and social construction (Blommaert, 2005; Grenfell 2014; Grenfell and Lebaron, 2014). Bourdieu's (1977, 2000) work emphasises his epistemological and

ontological views of the social world as the "ordering, relational and principled practices within a social process." (Grenfell and Lebaron, 2014, p.1). For the sake of equity, it should be pointed out that Bourdieu's (1977) theory of practice is not without its critics, who dispute his notion of privileged economic capital, cultural and symbolic capital as the source for all social capital. His critics see the theory as embracing a reductionist view that fails to acknowledge the existence of non-class systems (Alexander, 1996; Blatchford, 2010). However, in this case, Bourdieu's (1972) theory of practice is useful because of the highly context-specific nature of the Dragon Café, which requires a detailed description of the relationship between the place, people, and social capital. These three variables are intertwined in a way that enables an understanding of how people engage in the space individually or collectively to co-construct their experiences, a process detailed in the discussion chapter (see Chapter Five), in which Bourdieu's theory of practice is applied to the ethnographic findings.

2.3 The rationale for the doctorate study

Central here is the idea that this study tried to understand What The Dragon Café is, and establish the relationship between the places, people and participation at the café. Findings from the scoping and narrative reviews indicate that research evidence relating to mental health cafés was scarce; although there are ethnographies of commercial cafés in the general mainstream (Kleinman, 2006; Laurier, 2008; Laurier and Philo, 2015) and internet cafés (Soleymani and Farahati, 2014; Underberg-Goode, 2016; Kavanaugh and Maratea, 2019). However, there is little empirical literature addressing the ethnography of community mental health cafés either in the United Kingdom or internationally.

While we know the typologies of the five informal CMHS, their similarities and differences, methodologically there remains a gap in the literature. For example, although there are two ethnographic studies in the literature review on ULOs (Rose *et al*., 2016) and a day centre (Liou and Jarrott, 2018), we do not yet understand what happens in a mental health café, why people attend, and the links between the place, people and participation within the space. In this case, an ethnography of the café would take us

beyond what participants said about their interactions and participation in the space, as noted in previous studies that adopted both ethnographic and non-ethnographic methods.

Mental health cafés are interesting to study because they are distinctively different from the statutory services and other informal community mental health services. Mental health cafés adopt a strictly social model of care, combining the three types of services provided in the mental health day centres; anyone can attend to take part in free activities, volunteer to acquire employment skills, or socially interact without the need for active participation. Also, there is no need for medical assessment, personal budget, or referral from health care providers. This ethos of service provision eliminates access and participation barriers which are common with day centres. However, little is known about the views and experiences of people with mental health challenges who attend a community mental health café after the closures and reconfiguration of day centres in the UK.

Therefore, conducting an ethnography of The Dragon Café will enable the collection of detailed information about the environment itself, how people socially construct their experiences in the space and the meanings that participants attach to their participation in the space. Indeed, it is only by observing such a café that we can more fully understand the phenomenon called 'mental health cafés'. As Mead and Morris (1997) suggest, there is a difference between what people do, what they say they do and what they tell other people that they do. More importantly, while previous studies provided participants views about attending informal CMHS, they did not fully explore the complex dynamics of a mental health café and the value that people give to their experiences in the café, such as why they attend. Therefore, this study will generate empirical literature through an ethnography of a mental health café and contribute to the international literature, using the questions below:

2.3.1 Central research questions

1. What is The Dragon Café?
2. What makes people with mental health challenges attend this informal community mental health service?

2.3.2 Sub-questions

1. How do people with mental health challenges socially construct their experiences at The Dragon Café?
2. What meanings do people with mental health challenges attach to their experiences at The Dragon Café?
3. What is the relationship between the place, people and participation at The Dragon Café?

The next chapter provides an account of the overall research design and processes, including the methodology, philosophical and theoretical frameworks that influenced the choices that guided the methods used to address the research questions outlined above.

CHAPTER THREE METHODOLOGY AND METHODS

3.0 Introduction

The methodology for this study is a constructionist ethnography embedded in the interpretive approach, using observations and informal conversations which were descriptively analysed. Information was also gathered via semi-structured interviews which were thematically analysed. Participant observation in this study was overt or unconcealed, rather than a covert or secret participant observation; a data gathering model which could have raised ethical concerns (Iphofen, 2013). These approaches are detailed in the methods section of this chapter. The use of multiple data collection methods is a key strength of ethnography (O'Reilly, 2008); thus, in this study multiple data gathering methods enabled the collection and interpretation of multiple views from participants' accounts of how they socially construct their experiences in the Dragon Café and the meanings that they attach to those experiences.

This chapter begins with an overview of the research paradigm, epistemology and ontology, followed by the methodology. It is divided into three sections: the first is a brief section on the research paradigm for the study, supported by a visual representation of the overall research process. The next section is the philosophical underpinnings, followed by the methodology for the study in relation to the research aims and overall research question. Next, is an outline of how this study and the researcher's exploration and understanding of the relationship between the place, people and participation were guided by the key principles of qualitative research, including ethical considerations, memoing, data management, rigour and reflexivity.

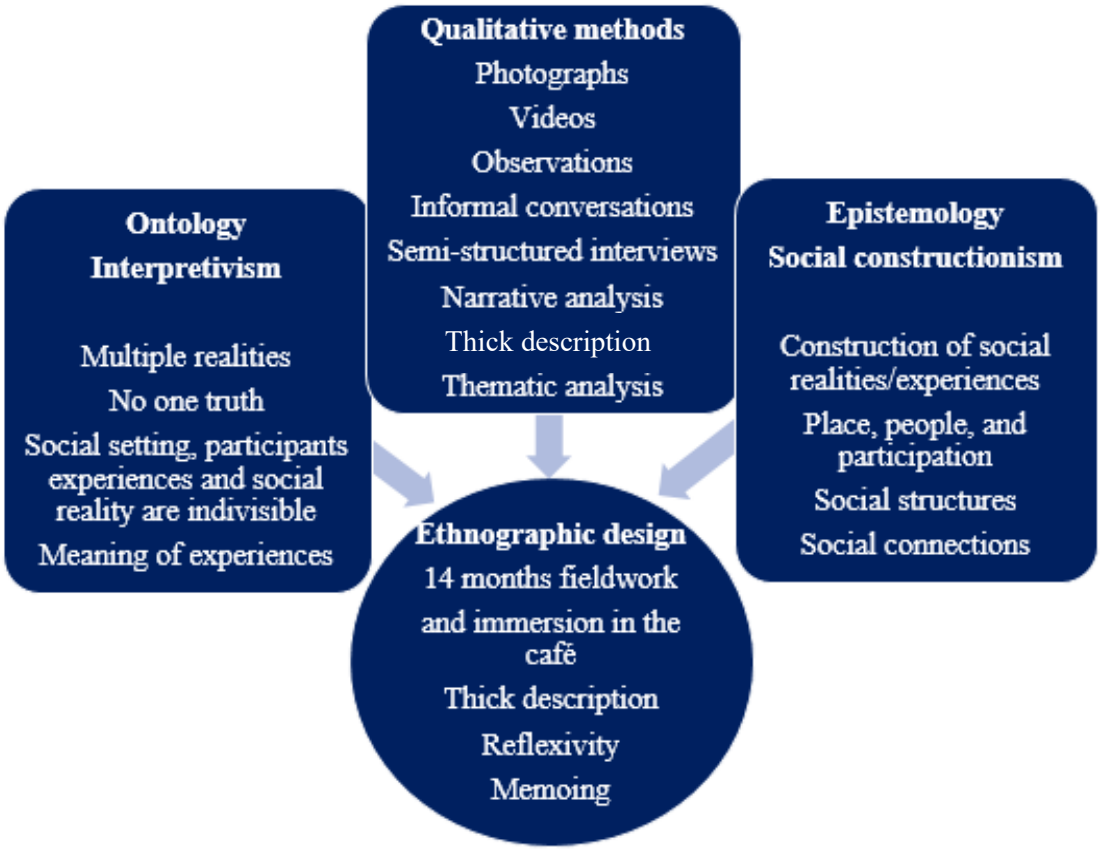
The last section details the methods that were adopted for conducting the ethnography with a description of how the researcher negotiated the initial process of fieldwork with the gatekeepers, how recruitment and sampling took place, how data were collected using observations and semi-structured interviews, and finally, how data were analysed. To begin, the next section details the research paradigms and why qualitative research was chosen as the most suited research design for the study.

3.1 Research paradigm

A research paradigm includes the methodology and research designs, epistemology and ontology, and research methods for conducting research (Bryman, 1984; Lincoln and Guba, 1985; Whitehead, 2006; Hammersley, 2013). There are three main types of research designs, namely: quantitative, qualitative and mixed methods research which involves a combination of qualitative and quantitative research (Bryman, 1984; Creswell, 2007; Sandelowski, 2010). Quantitative research focuses on objective observations and numerical measurements (Creswell, 2007; Johnson *et al.,* 2017) and it involves the use of closed-ended questions to: (1) explain, predict, describe or control variables and (2) establish the cause and effect relationship between two or more variables, such as determining patterns of behaviour in the way people think, act or feel with the use of statistical analysis (Brannen, 2005; Bernard, 2013; Bacon-Shone, 2015).

Quantitative research is often employed to determine patterns of behaviour in the way people think, act or feel via the use of statistical analysis (Brannen, 2005; Bernard, 2013; Bacon-Shone, 2015). On the other hand, qualitative research is an approach usually associated with the social constructivism and interpretivism paradigms, which emphasise the socially constructed nature of reality (Berger and Luckmann, 1967; Given, 2008; Hammersley, 2013; Green and Thorogood, 2014) and how these social realities are interpreted to produce meanings in the data (O'Reilly, 2009, 2011; Parahoo, 2014), as depicted in the research paradigm below. (Figure 3).

Figure 3 Research paradigm



Constructivist ethnography within interpretivism is about recording how participants socially produce their realities. Such data is then analysed in an attempt to uncover the more profound meaning and significance of human behaviour and experience, including contradictory beliefs, practices and emotions (Denzin and Lincoln, 2011; Hammersley, 2013; Parahoo, 2014). For these reasons, this study did not adopt research designs which place emphasis on collecting and analysing quantitative numerical data (Bryman, 2008; O'Reilly, 2012; Parahoo, 2014). Instead, this study sought to obtain rich and complex data on participants collective experiences in order to interpret and produce a view of the place, people and participation at the café (Hammersley, 2007; Bryman, 2008; Sandelowski, 2004; 2010; Denzin and Lincoln, 2011; Chowdhury, 2015). Leading on from this goal focused information, the next section will briefly outline the philosophical framework of social construction and interpretivism, and the methodology, ethnography. I will present these individually, although they are interrelated and inform the methods, aims, objectives and overall research questions for this study: (1) What is The Dragon Café? and

(2) What makes people with mental health challenges attend this informal community mental health service?

3.2 Philosophical underpinning

This study is philosophically underpinned by social construction and interpretivism. Epistemologically, the study draws on social construction to explore how participants socially construct their experiences at the café. Therefore, social constructivism will enable the exploration of how people with MHCs collectively construct meanings from their actions, practices and interactions within the café (Berger and Luckmann, 1967, Benton and Craib, 2011; O'Reilly, 2012).

Ontologically, interpretivism enabled a deeper insight into the processes within the café that drive participant's actions and interactions, through interpretations of the meanings that they attach to those experiences (Hammersley and Atkinson, 2007; Benton and Craib, 2011). Ontology deals with two aspects of philosophy: objectivism and subjectivism (Benton and Craib, 2011; Anderson, 2016). Objectivism is a quantitative position which seeks to provide an explanation that there is only one reality and hence it is possible to obtain objective reality through empirical observations, where social entities are external to the social actors (Anderson, 2016). Ontological subjectivism otherwise known as the qualitative paradigm position is adopted in this study because it is an interpretivist position which maintains that reality is subjective and socially constructed by the actions and experiences of social actors within a society (Lewis-Beck, Bryman and Futing Liao, 2004; Anderson, 2016).

Two of the strongest critics of objective ontology, who are in favour of social constructionists are Berger and Luckmann (1966) who were highly sceptical of the application of scientific processes in the study of different cultures, groups and societies (Benton and Craib, 2011). Berger and Luckmann (1966) attest that language helps societies to develop relationships, which is fundamental to social structure, human relationships and social cohesion. Together, the social constructivist and epistemological views of Berger and Luckmann (1966) suggest that societies have collectively held beliefs that give meaning to things,

people, ideas and categories. Consequently, social researchers attempt to make meaning out of the knowledge that they acquire from observations of social constructs (Denzin and Lincoln, 2011) because it is precisely this knowledge that constitutes the fabric of meaning, without which, no society can exist (Berger and Luckmann, 1966).

3.2.1 Social constructivism

In ethnographic studies that are informed by a social constructionist approach, priority is given to the iterative and inductive description of collective and internally constructed social processes in a setting. This iterative and inductive process enables the presentation of new and revealing methods of understanding the phenomenon under study (Hammersley, 1990). Therefore, in this study, a social constructivist approach enabled an understanding and interpretation of how participants socially construct their interactions in the café, and such enabled the maximum interpretation of the data that elucidated how participants collectively create meanings through their interactions with each other, the space and activities at the café because knowledge is collectively constructed as participants learn from each other (Berger and Luckmann, 1967, 1991; Benton and Craib, 2011).

The social constructionist perspective originated from sociology in relation to the nature of reality, and it is usually combined with the interpretivist approach (Benton and Craib, 2011). However, regardless of the link, social constructionism and interpretivism are distinctively different, but they can be used together to understand how societies are socially constructed, as well as interpret the meanings that people in the society attach to their experiences. For example, one thing that constructionists and interpretivists have in common is the emphasis on the process of producing, negotiating, sustaining and modifying the meanings of social actions (Schwandt, 2003). Thus, while interpretivism is an ontological paradigm that unearths the meaning behind social interactions, social constructionism provided an epistemological perspective that seeks to understand how knowledge and truth are created (Schwandt 2003; Berger and Luckmann, 1991).

Social constructivism refers to the way that people collectively construct meanings from their actions, practices and interactions within a social context (Berger and Luckmann, 1967, O'Reilly, 2012). The concept is complementary to interpretivism which enables insights into the processes within a social setting that motivate participants' actions and interactions (Leitch *et al*., 2009). It is also complementary to ethnographic research due to its approach to aiding in the understanding of the culture and multiple realities among people (Hammersley and Atkinson, 2007; Williamson, 2006).

A social constructionist approach prompts ethnographers to look, listen and understand the rhythms of the day within which participants produce, maintain and attach meanings to their socially constructed experiences in a research setting. Observing and documenting these socially constructed experiences allows the constructionist ethnographer to see, hear, and analyse the processes by which social reality becomes real for the participants (Berger and Luckmann, 1966; Benton and Craib, 2011). Indeed, constructionist ethnography differs in research settings, fieldwork and participants (see, Barth *et al*., 2005; Holstein and Gubrium, 2013), but they are similar in the sense that ethnographic studies occur in the natural setting of the participant. The latter context is arguably the predominant orientation to ethnographic fieldwork (Bulmer, 1984; Emerson, Fretz, and Shaw, 2007; Gubrium and Holstein, 1997; Kaplan, Salzer and Brusilovskiy, 2012; Ladner, 2016). Therefore, it is crucial that the researcher listens actively in order to obtain and write in sufficient detail about the events that happen in the research setting.

The above approach in relation to social construction and ethnographic description provides the collection and of the social realities of the participants' world in a research setting (Geertz, 1973; Holstein and Gubrium, 2013). In the absence of being there, the researcher cannot listen, observe, understand or interpret how participants socially contrast their experiences in the social setting (O'Reilly, 2012). Besides, the processes of getting involved with the participants in the café permeate the ethnographic standpoint (Bulmer, 1984; Emerson, Fretz, and Shaw, 2007; Gubrium and Holstein, 1997; O'Reilly, 2012). Indeed, it was only by getting involved in the processes and participating in a social setting that the researcher can

truly observe how participants socially construct their realities, that he or she can then interpret and thickly describe the meanings that they attach to such experiences (Geertz, 1973; Holstein and Gubrium, 2013).

Having said that, there are limitations to conducting an ethnography through a social constructivist lens, such as: (1) the prolonged period of time in the field and during data analysis (O'Reilly, 2008), (2) lack of ethical considerations when a researcher becomes too immersed in the culture of the group (Hammersley and Atkinson, 2007), (3) the subjectivity of views from different researchers and (4) the lack of generalisability due to the in-depth study of a single culture (Goodson and Vassar, 2011). In addition, there is the challenge of the subjectivity of findings which makes it questionable to use findings to inform policy or practice (Hammersley and Atkinson, 2007). Therefore, the limitations of ethnography could introduce issues that may impact on the entire research process.

Paradoxically, Berger and Luckmann (1966) argue that some form of social constructivism limits the freedom of interpretation that social researchers have. For example, the Diagnostic and Statistical Manual of Mental Disorders (DSMV) that lists mental health categories in detail may limit the way that healthcare professionals diagnose mental health symptoms. The publication of the DSMV can also impact on how service users interpret symptoms or categorise them into languages that can be used to describe the presentation of symptoms. However, when compared with positivist views, Berger and Luckmann (1966) resolved that social constructivism allows for more freedom of speech, thought and interpretation of language, forms and activities than did the positivist paradigm. Therefore, people can only socially and collectively create their realities when they are connected. This view is supported by Edgley *et al.* (2014) who argued that natural sciences should not be viewed as an entity or independent of a community, but part of the community of interest where research is carried out. Notwithstanding, critics of social constructivism point out that it fails to consider the effects of natural phenomena on the society which are not dependent on human speech or action (Bowling, 2014). In defence, Berger and Luckmann (1966) argue that debates about social science inquiry cannot be separated from debates about natural science

because in order to understand how social realities are constructed, research findings must be interpreted wholly.

3.2.2 Interpretivism

Interpretivism which is credited to Max Weber is a philosophical tradition embedded in hermeneutics and phenomenology, and it focuses on the nature of people's behaviour and participation in social settings (Benton and Craib 2011; Lewis-Beck, Bryman and Futing Liao, 2004; Anderson, 2016). Thus, emphasis is placed on the value of developing an understanding of the social world from the subjective view of those being researched (O'Reilly, 2008; Benton and Craib 2011). As such, through this subjective understanding, the researcher can better interpret the diverse meanings given to social phenomena within the context in which they occur. Indeed, the central ontological conviction of interpretivism is that reality is inseparable from social actors and the context in which they exist (Parahoo, 2014). Therefore, the relationship between social actors and the world as dynamic and interactional enables the possibility of understanding how multiple realities exist simultaneously. In addition, interpretivism rejects the positivist and realist notion that knowledge is objectively grounded with concrete explanations of theories and hypothesis (O'Reilly, 2008). Instead, interpretivist approaches seek to understand social reality through the perceptions of the research participants (Benton and Craib 2011; O'Reilly, 2012). The interpretive perspective suggests that people socially construct their knowledge, but this knowledge needs to be interpreted to understand the meanings that actors attach to their experiences (O'Reilly, 2012).

Interpretivism is a Weberian approach to understanding and presenting social settings and actions with a view that people are social actors and so, researchers must seek to understand the social settings alongside the multiple social actions of people in the setting (Scott-Jones and Watt, 2010; Chowdhury, 2014; Parahoo, 2014). Authors (e.g., Holloway and Wheeler, 2002 Parahoo, 2014) suggest that the researcher must interpret the meanings behind the social actions, in what he called 'verstehen', otherwise known as 'understanding'. Thus, interpretation is understanding and vice versa, but the researcher must first seek to

observe what is going on before they can interpret what was seen and heard. In this sense, social construction aligns with interpretivism (Scott-Jones and Watt, 2010). Therefore, in this study, a social constructionist and interpretivist approach enabled an understanding and interpretation of how participants socially constructed their interactions in the café, using the five senses, to hear what was happening in the café, by listening to and listening for what might happen (Holstein and Gubrium, 1995; O'Reilly, 2012; Lavis *et al*., 2015). The use of active listening embodied understanding with the maximum interpretation that elucidated how participants collectively produced their experiences as well as the meanings that the participants attached to those experiences and interactions.

Interpretivism is an epistemological method designed to harness the possibilities of social processes developed in ethnography as the space between social structures, theory and social reality (Benton and Craib 2011; Reed, 2011; Voyer and Trondman, 2016). The authors add that ethnographic studies, underpinned by constructionist and interpretivist views, are important for researching in-depth fieldwork and detailed descriptions of the social interactions of hard-to-reach populations (Voyer and Trondman, 2016). This is pertinent in this current study because people with MHCs are often described as belonging to a hard-to-reach population. As Reed (2011) attests:

> "We have disagreements, that is, not only about how we establish the sheer existence of this or that phenomenon, but also about how we can claim to correctly and effectively explain, criticize, or interpret it." (p.3).

Added to the above, the interpretive paradigm provided the platform for interpreting the findings from the ethnography relating to the 'What', 'When', 'What', 'Who', 'Why' and 'How' questions that are grounded in practices at The Dragon Café (Voyer and Trondman, 2016). In the next section, I will briefly demonstrate how a social constructionist and interpretivist ethnography.

3.3 The methodology of ethnography

Ethnography is a methodology, method and theoretical approach (Atkinson, 2007; Reeves, Kuper and Hodges, 2008; Reeves *et al*., 2013) used by researchers for creating and representing knowledge (Fetterman, 2010; Emerson, Fretz and Shaw, 2011). It is an approach that is based on the ethnographers' experiences of the research setting and the participants (Hammersley, 1992; Fetterman, 2010; Naidoo, 2012). In this study, ethnographic methods helped to facilitate visual and textual data collection methods, including: (a) 3-dimensional (3-D) video, (b) photographs, (c) observations, (d) informal conversations, (e) semi-structured interviews, (f) writing and expanding the fieldnotes, and (g) writing the ethnography (Burgess, 1982; 2016; Hammersley, 1992; Emerson, Fretz and Shaw, 2011; Reeves *et al*., 2013; Gobo and Molle, 2016). These methods enabled the use of a research process that could construct a dependable viewpoint that facilitated an extensive understanding of the place, people and participation at the café (Pope, Ziebland and Mays, 2000; Pope and Mays, 2006; O'Reilly, 2012).

The origin of ethnography can be dated to the fieldwork and participant observations conducted by several social anthropologists, for example, (a) Bronislaw Malinowski, who put forward observation and fieldnotes (Malinowski, 1986; Young, 1981), (b) Margaret Mead, who was acknowledged for her careful observations and note-taking on comparative ethnography (Mead, 1985; 2002), and (c) Franz Boas whose anthropological influence resulted in the understanding of race and cultural constructs (Boas, 1940). Thus, ethnography belongs to the school of thought of cultural and social anthropology (Hammersley, 1992; Hammersley and Atkinson, 2007) used by researchers during fieldwork (Burgess, 1982, 2016; O'Meara *et al.,* 2015; Blommaert and Jie, 2010) to understand unfamiliar settings from the participants' point of view (Ware *et al.,* 1999; Fetterman, 2010).

In previous years social science researchers disregarded the views and perceptions of individuals diagnosed with MHCs (Rogers and Pilgrim, 2001). However, social science researchers have increasingly acknowledged the cultural, social interactions among people with MHCs and this topic has become increasingly recognised in anthropological research (Maso, 2001; Alverson, Carpenter and Drake, 2006;

Vom Lehn and Hitzler, 2015). Also, ethnographers have explored how the culture of social groups influenced the experiences and perceptions of people with MHCs to understand how participants created meaning out of their experiences within groups (Jain and Orr, 2016; Kitchen *et al*., 2017; Ringer, 2017).

Furthermore, researchers have steadily increased their attention to ethnographic studies in mental health (Ware *et al.,* 1999; Jain and Orr, 2016) and health related topics (Ware *et al.*, 1999; Burnard, Naiyapatana and Lloyd, 2006; Goodson and Vassar, 2011). For example, (1) ethnographic studies that used observations, informal conversations, and unstructured interviews, for exploring CMHS (Goodson and Vassar, 2011); (2) ethnographic studies have used semi-structured interviews, observations and fieldnotes (Ware *et al.,* 1999; Burnard, Naiyapatana and Lloyd, 2006; Alverson, Carpenter and Drake 2006; Goodson and Vassar, 2011; Jobling, 2014; Delara, 2016); (3) ethnographic evaluation of mental health policy and an overview of ethnography in health and medical education research (Jobling, 2014); (4) using ethnography to explore mental health experiences among female Muslim immigrants youths (Delara, 2016); and (5) an ethnographic study of job-seeking among people with MHCs by researchers who engaged in intensive participant observation (Alverson, Carpenter and Drake, 2006).

3.3.1 Strengths and limitations of ethnography

The key strength of ethnography is the researcher's ability to be immersed in a social setting over an extended period of time, an approach which results in an in-depth understanding of the social and cultural contexts of the participants (Alkenbrack, 2009; O'Reilly, 2012). A central limitation that is most questionable in ethnography is the dependability of ethnographic studies due to the challenges with the replication of events and findings (Hammersley, 1992; O'Reilly, 2012; Delara, 2016). For example, it may be problematic to reproduce events because participants behave differently in different situations (Crawford *et al*., 2013), so no study can be duplicated accurately (Freshwater, 2010). Nonetheless, LeCompte and Goetz (1982) propose that the limitation of replication can be addressed if a researcher provides a detailed description of the methodology in a way that another researcher can reproduce the

original data analysis strategy; although this possibility may not be available to novice ethnographers (LeCompte and Goetz, 1982; Freshwater, 2010).

However, it has been noted that some circumstances cannot be reproduced accurately, even with the most comprehensive description of methodology and methods from the original researcher (LeCompte and Goetz, 1982; Freshwater, 2010; Delara, 2016). Therefore, there are questions of credibility, dependability, and transferability of research findings, but these were all addressed in this study (see Chapter 3.9). Furthermore, adopting an ethnographic approach has other limitations, such as the prolonged period of time in the field; the time it takes to analyse the huge amount of data from the various information sources (Freshwater, 2010; Okely, 2012; O'Reilly, 2012). There is also the likelihood of diverse subjective views when different researchers provide different interpretations of a single social setting (Hammersley, 1992). Also present is the limitation caused by the acknowledged lack of generalisability in ethnographic research, due to the in-depth study of a specific group of people or society within one context (Goodson and Vassar, 2011; O'Reilly, 2012).

Indeed, ethnography is a universal approach to the in-depth inquiry of social processes from both emic and the etic perspective (Pike, 1967), such that etic data are the researcher's views, and emic data are based on participants' views (Pike, 1967; Spradley, 1979; Agar, 2011). As Pike described:

> "Etic viewpoint studies behaviour as from outside of a particular system," while the "emic viewpoint results from studying behaviour as from inside the system" (p.37).

A researcher adopts a complete emic approach and becomes too immersed in the research setting, sometimes known as "going native" (Madden, 2010, p.77)" and contaminates the data through lack of objectivity. An emic approach, also referred to as the "insider," "inductive," or "bottom-up" (Pike, 1967; Spradley, 1979; O'Reilly, 2009). As described by Lett (1990):

> "Emic constructs are accounts, descriptions, and analyses expressed in terms of the conceptual schemes and categories regarded as meaningful and appropriate by the native members of the culture whose beliefs and behaviours are being studied." (p. 130).

An emic approach, therefore, occurs when a researcher presents data that represents only the participants' views. On the other side is the etic approach which is otherwise referred to as the "outsider," "deductive," or "top-down" research process where the researcher begins with theories, hypotheses, perspectives, and concepts from outside of the participants under study (Pike, 1967; Spradley, 1979; O'Reilly, 2009). Therefore, a completely etic perspective is void of participant's views and experiences, such as in quantitative research (Pike, 1967; Spradley, 1979; Whitehead, 2004; Agar, 2011). As Lett described (1990):

> "Etic constructs are accounts, descriptions, and analyses expressed in terms of the conceptual schemes and categories regarded as meaningful and appropriate by the community of scientific observers." (p.130).

As the above quotation implies, a researcher who takes an existing theory or conceptual framework and conducts research to see if it applies to a new setting or population is taking an etic approach. One of the strengths of the etic approach is that it allows for comparison across contexts and populations, and the development of more general cross-cultural concepts (Pike, 1967; Spradley, 1979; Agar, 2011).

Specifically, ethnography is a universal approach of in-depth inquiry of social settings and people from the emic and the etic perspectives (Whitehead, 2004). Both emic and etic approaches complement each other, but the researcher is viewed as an 'outsider' in an etic approach and as an 'insider' in an emic approach (Pike, 1967; Spradley, 1979, Agar, 2100). The emic approach or 'insider ethnographer' (Wacquant, 2004) is preferred in ethnographic research because the researcher is seen as an insider who immerses themselves in the natural setting of the participants in an attempt to understand the people, place and participation from the view of the participants (Tedlock, 1991; Okely, 2012). Thus, it was decided that for this piece of research, the researcher would be embedded into the café, to combine the initially unfamiliar insider's views with outsider knowledge, in order to observe and document the relationship between the place, people and participation at the café. It is precisely this knowledge that informed the next section to support evidence the methods used in the ethnography.

3.5 Methods

In this section, the methods employed in the ethnography will be presented, highlighting the multiple data collection methods and analysis that enabled the researcher to present the findings in a way that illuminates and intertwines the context of the café with participants' accounts and the researcher's reflections (Fetterman, 2010). This section also demonstrates how integrating the fundamental principles of qualitative research, such as ethics, rigour and being reflexive enabled the researcher to critically engage with the research process.

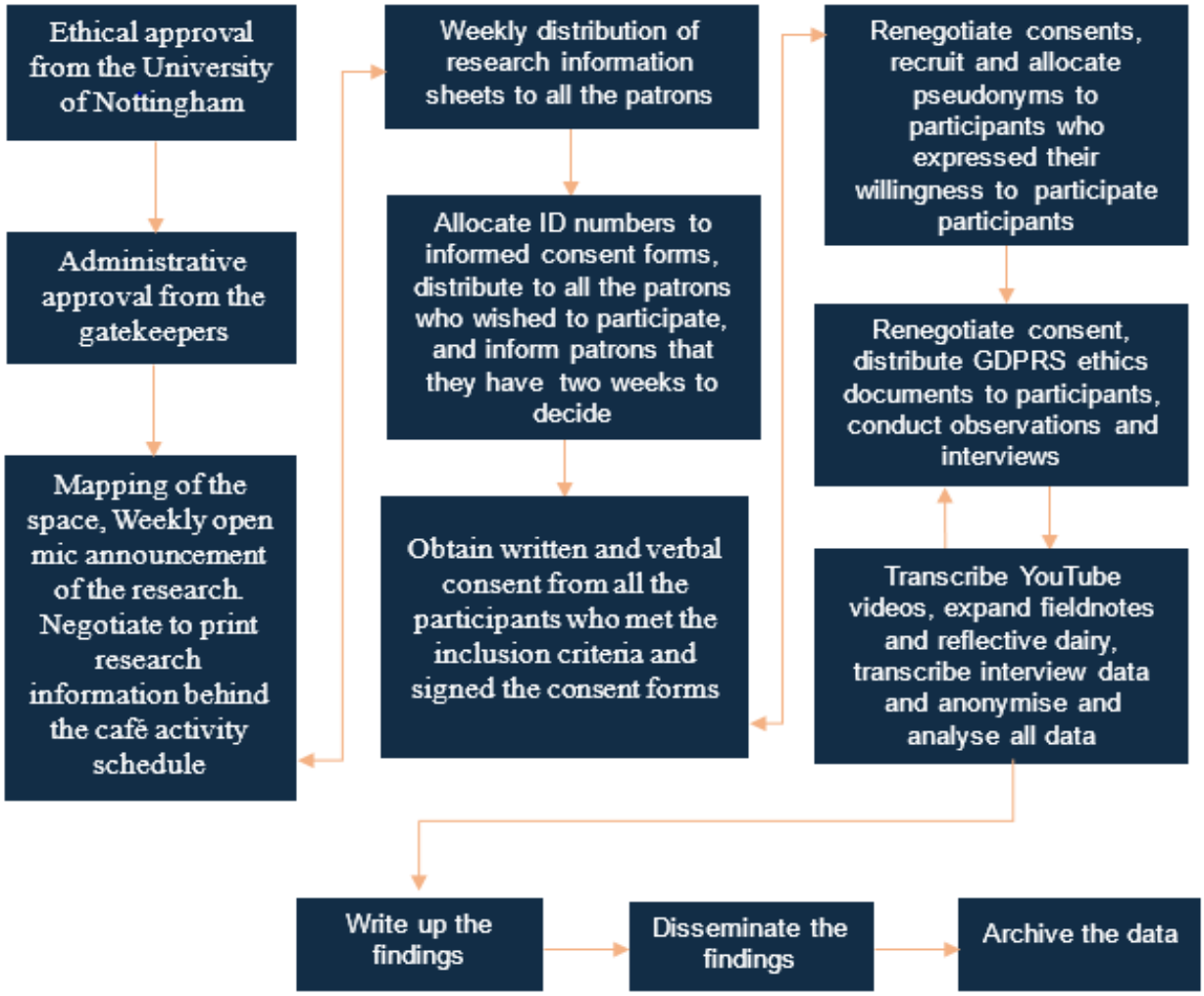
In ethnography, multiple rather than specific data collection methods are adopted through the use of a mixture of techniques that are appropriate to the research situation (Burgess, 1982; 2016; Emerson, Fretz and Shaw, 2007; Atkinson, 2007; Brewer, 2011). Foremost among data collection methods in an ethnographic study is participant observation. However, ethnographic studies also include the use of other data collection techniques, including: (a) focus groups, (b) interviews, (c) photography, (d) video recording, (e) examining documents, and (f) mapping (Fetterman, 2010; Naidoo, 2012). The methods for this study include: (1) purposive sampling (Patton, 1990), (2) observations, (3) informal conversations, (4) fieldnotes (Burgess, 1982) and (5) semi-structured interviews (Ware *et al*., 1999; Tong, Sainsbury and Craig, 2007). Data analysis for the observations and informal conversations was based on thick description, as proposed by Geertz (1973); the semi-structured interviews were thematically analysed (Braun and Clarke, 2006, 2016). A multimodal ethnography was utilised to allow the use of different data collection methods (Dicks, Soyinka and Coffey, 2006) which provided more insights into the phenomena being studied (Denzin, 1978; Carter *et al*., 2014) as well as enhancing the trustworthiness of the study (Polit and Beck, 2012).

3.5.1 Research process flowchart

A flowchart was developed as a guide to provide the order in which to conduct the research; it listed the sequence of activities required to conduct this research (Kothari, 2004). This flowchart enabled the

researcher to know what parts of the research had to be completed; what needed to be done next; when, why and how to prepare for future actions.

Figure 4 Flowchart for the research process



3.5.2 Mapping the study setting

Study settings are significant to observe participants in specific contexts where a group of people who are connected to a specific space socially construct their interactions and experiences (Berger and Luckmann, 1967; Green, Camilli and Elmore, 2006; Reeves, Peller, Goldman and Kitto, 2013). As described in section 1.1, the study setting was a single-site ethnography involving The Dragon Café in the London

Borough of Southwark. A more comprehensive description of each of the three rooms, including the outdoor space, is provided in Findings One (see Chapter 4.1 - 4.1.3.4).

Mapping is a research process that allows measuring and evaluating aspects of spatial experiences, such as perception, movement, interactivity, and even memory; especially where it is challenging to record and analyse such data through quantitative approaches (Mounajjed, Peng and Walker, 2007). Ethnographic mapping is not usually accurate, but it is essential for understanding the social life of participants (Malinowski, 1922; Kuznar and Werner, 2001). Thus, for this study, ethnographic mapping involved the contextual layout representation of café space (Monajjed, Peng and Walker, 2007). As Malinowski (1922) described:

> "The genealogical census of every community study is more in detail, with extensive maps, plans, and diagrams that serves as the more fundamental documents of ethnographic research" (p.13).

Therefore, in the absence of ethnographically mapping of the café space, it would have been difficult to fully appreciate the spatial happenings in the café, the movements and interactions, and how the participant's experienced the physical area of the café. Thus, mapping provided the reader with a stronger view of the space in which participation occurs.

3.5.3 Ethical considerations

In this section, several ethical considerations will be highlighted that were necessary to follow before the beginning of the fieldwork, as well as details of those that were implemented at different stages of the fieldwork. These considerations included the importance of the distribution of the research information sheet Appendix 8), a process designed to ensure that participants' were fully aware of the aims of study before they were given the consent forms to take away, read and sign and return to indicate their willingness to take part or not take part in the research (**Error! Reference source not found.**) (Miller *et*

al., 2012). It is unlawful for a researcher to begin a study involving human participants without first obtaining ethical approval, so I was aware that any data collected before ethical approval was obtained cannot be used (Ghandour, Yasmine and El-Kak, 2013; Iphofen, 2013). In other words, without complete information, a participant cannot be said to be fully consenting or making an informed decision about his willingness to participate in the research. Therefore, in addition to distributing the research information sheet, the full details of the study were disclosed weekly on the open 'mic', via which the researcher spoke openly to all patrons throughout the fieldwork. Full details of the study were also shared with participants when the researcher spoke to café patrons individually during informal conversations and semi-structured interviews., Similarly, the researcher ensured that the ethical concern of autonomy was enforced by respecting the values, rights and decision of participants, by negotiated and renegotiated informed consent throughout the life of the study. Participants were also reminded of their right not to participate or their decision to withdraw, without incurring repercussions at any time during the research process (Miller *et al.,* 2010).

Research ethics are the guiding principles for institutions or individuals who conduct research with human participants (Miller *et al*., 2012), and the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1978) advocated that ethical considerations should protect everyone that is concerned in the research process, including participants, researchers, locations and institutions. Therefore, this study also complies with the Economic and Social Research Council (ESRC) Framework for Research Ethics (FRE) (ESRC, 2017), the Nursing and Midwifery Council (NMC) Code of Professional Conduct (NMC, 2015) and the University of Nottingham (UoN) Medical School Ethics Committee's Guidelines (Dale, 2005; UoN, 2015). Therefore, the ethical considerations that were observed during this study were: (a) informed consent, (b) autonomy, (c) capacity, (d) anonymity and (e) confidentiality. For example, to protect the details of the research and participants, the researcher ensured that both the transcriber and the proofreader involved with this thesis signed the University of Nottingham's non-disclosure agreement.

The ethics application began with seeking permission from the University of Nottingham Medical School Ethics Committee (Appendix 10), followed by seeking administrative/access approval from the gatekeepers at The Dragon Café (Appendix 11). These approvals guided further actions and reactions with regard to paying attention to: (a) the rights of the participants, (b) health and safety issues, (c) privacy and confidentiality, and (d) the measures that were put in place to manage unexpected outcomes or adverse situations (Dale, 2005; UoN, 2015), such as a participant going into crisis during an interview which can count as a significant ethical concern. For example, in order to uphold the ethical standards data collection, before gathering any data it was necessary to liaise with the gatekeepers regarding the different sources, such as working as a volunteer before engaging in informal conversations with those who were attending the café during the fieldwork.

Also, each methodological concern was discussed with the research supervisors to ensure that it complied with and addressed all ethical considerations. In addition to the information sheet and consent forms given to the participants, in July 2018, participants were given the General Data Protection Regulation and the Research Participant Privacy Notice (Appendix 12) and the summarised Data Protection Regulation (Appendix 13). The National Health Service (NHS) ethical approval was not required because the research setting was in the community, so participants were not in a clinical setting. Therefore, the researcher ensured that none of the participants was disrespected and each participant's autonomy was protected. It was also ensured that participants were fully in control of their own decision to take part, or not to take part in the research. Moreover, the researcher attempted to answer all questions that were asked by participants (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1978). For example, reassuring participants that their voice would not be recognised because the tape recordings will be typed so only written words will be used. Participants were also informed that they had been given pseudonyms and participant codes, which were written on the informed consent forms, such as P15 for participant number 15.

Furthermore, there were no incentives for the participants to take part in the study because such a gesture could constitute an ethical concern as incentives can result in or be interpreted as undue influence and coercive action (Castro, 2008; Grant and Sugarman, 2004; Health Research Authority, 2014). In observing the Belmont Principle of Beneficence and Justice, the researcher ensured that no participants were exposed to any harm or discomfort or exploitation during the research (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1978).

Also, the final Principle of Justice was adhered to, by ensuring that all the participants' rights to privacy were respected. This goal was achieved by ensuring that all the patrons were aware of their opportunity to participate in the study, and more importantly (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1978) by safeguarding all the information that participants shared in strict confidence, as described in the section on data management (see Chapter 3.8). Therefore, to ensure confidentiality and privacy involved guarding the identities of the participants by not disclosing their physical characteristics in the conversation to others, or in the thesis, or during the dissemination of the research findings (Duncombe and Jessop, 2002). In other words, all the information provided by the participants is held in strict confidence in the University of Nottingham's secure database. As a result of the above precautions the participants can never be linked to the information that they provided (Duncombe and Jessop, 2002).

Furthermore, the provision of information about the proposed research was vital, as it enabled participants to make an informed decision regarding whether to sign the consent form and participate in the research or not (Miller *et al*., 2012). Voluntary informed consent prevents imposing researcher power (Miller and Dingwall, 1997; Whitehead, 2004) and exploiting participants (Duncombe and Jessop, 2002). Therefore, vulnerable participants, such as people with MHCs, whose decision-making capacity may fluctuate, need to be protected (Amer, 2013). Also, Benitez *et al*. (2002) proposed that the researcher should obtain an audio recorded verbal consent or ask an advocate or witness to sign for the participant, where appropriate. In this case, it was not necessary to audio record verbal consent because only two participants were unable

to read, or write but were able to sign their names, so the consent form was read aloud, and each point was explained to the participants before they signed the forms. In addition, participants were given the consent forms to take away for two weeks to read, and then, return the signed consent forms if they wished to take part in the informal conversations and semi-structured interviews. Thus, each participant had adequate time to read their consent form before they returned it. Also, throughout the data collection process, the researcher continued to negotiate and renegotiate consent, and discussed the research aims with the participants to assist in remembering the nature of the enquiry (Corbin and Morse, 2003; Okely, 2012).

As Upasen (2017) suggests, nurse researchers need to be aware of how their relationships with participants, otherwise known as relational ethics, may influence their research output. Therefore, bearing that in mind throughout the research process, it was necessary for the researcher to develop mutual interpersonal relationships with the participants and all the patrons, so that that the data were not contaminated, and the researcher's position was not undermined (Upasen, 2017); a protocol described in the section on reflexivity (see Chapter 3.10). In addition, all ethical concerns were discussed with the supervision team. One example of such a concern was when the gatekeepers asked for the information leaflet to be printed on A5 size paper instead of A4 because of the connotation that is associated with A4 for people with MHCs, such as missed health check appointments, admission letters and unpaid bills.

Dale (2015) proposes that researchers should be sensitive to vulnerable participants who may show signs of crisis or be uncomfortable with answering a question because it has reminded them of a challenging experience. Therefore, this ethical concern informed my data gathering; for example, when a participant said he was unable to respond to the interview questions because the church office was too quiet. Therefore, the question was posed in the café when there were background distractions but reduced noise levels that did not impact on the recording of the interview. In the next section, the process of recruitment and sampling will be discussed, alongside the criteria prescribing whether to include or exclude participants in the study.

3.5.4 Recruitment and sampling

Within this section, details relating to the processes that were used for recruiting the patrons who signed the voluntary consent forms and who participated in the study will be presented. In combination with the recruitment and sampling strategy, this section provides the inclusion and exclusion criteria that were used to recruit the participants or exclude those who not selected. Before starting data collection, the researcher conducted three visits to the café to make initial observations of the space and meet with the gatekeepers (Lincoln and Guba, 1985; Parr, 2000; Ellis, 2013).

Lincoln and Guba (1985) suggest that this initial observation should be unstructured to facilitate a situation where the researcher can contextualise the research setting and acquire a sense of what is prominent and formative. Conducting an initial observation was pertinent to this study because I was anxious about the sustainability of the café in the absence of Sarah Wheeler, the Founder of The Dragon Café, and therefore, I had to develop new relationships with the gatekeepers. During the initial visits to the café, the recruitment process was discussed with the gatekeepers, and it was agreed that the researcher should begin with the distribution of the research information sheets and announcements of the research aims on the open mic, to ensure that the participants were aware of the aims of the study, the researcher's intentions and position in the café (Corbin and Morse, 2003). However, as with most research, things do not always work out as planned (O'Reilly, 2008). Consequently, the gatekeepers decided that the researcher should begin data collection after three months into fieldwork because the gatekeepers wanted the researcher first to embed themselves into the café space, activities and interactions with the patrons.

The researcher aimed to recruit at between 30-50 participants for the observations, informal conversations and interviews because research evidence suggests that after 30 or so participant interviews, very little additional information is extracted from interview transcripts (Morse, 2000; Green and Thorogood, 2014). 62 patrons signed the consent to take part in the interview, but only 38 took part (Appendix 14). This is evidenced in studies that the number of participants who sign the consent forms does not necessarily

determine or represent the number of participants who will take part in the interviews (Ellis, 2010; Goodson and Vassar, 2011).

Some authors have suggested that key informants are gatekeepers and trustees who can provide in-depth insider views and who are willing to share what they know about the processes within the research setting (Lincoln and Guba, 1985; O'Reilly, 2008; Swain, 2017). Equally, Lincoln and Guba (1985) observe that obtaining information from key informants has its challenges, such as the provision of information that meets an informant's agenda or a gatekeeper recruiting someone as an informant to meet the gatekeeper's agenda. Besides, in this study, any patron who had attended the café for more than two months was considered a key informant, so most of the patrons could be referred to as key informants. These patrons were able to provide diverse and vital information about the place, people and participation at the café. It is also important to note here that it was challenging to recruit patrons who were gatekeepers, trustees and paid staff for the observations and semi-structured interviews during the fieldwork, so this constraint limited access to the views of such patrons.

3.5.5.1 Sampling strategy

The sampling strategy in qualitative research refers to decisions about who to recruit, settings, times, activities, and social processes (Patton, 1990; Shorten and Moorley, 2014). Sampling in this study was purposive, a model which provided an opportunity for the researcher to recruit participants who had attended the café for more than two months, giving more of the patrons the opportunity to participate in the study. As such, the researcher was able to obtain diverse and detailed information about participants' experiences of and in the café (Patton, 1990; Tong, Sainsbury and Craig, 2007; Denzin and Lincoln 2011). In addition to the purposive sampling, snowball sampling happened quickly at the café when patrons invited other patrons to participate in the research and speak to me about their experiences of the café (Shorten and Moorley, 2014).

Further, to demonstrate transparency in the sampling process and reduce sampling bias, attempts to recruit were recorded, and any reasons for non-participation were also recorded (Tong, Sainsbury and Craig, 2007). Participants who were sampled included all the patrons who visited the café to socialise or take part in the creative activities, those who volunteer help, paid staff and the gatekeepers of the service. Thus, to highlight the typology of the patrons (Figure 1), all the participants are referred to as 'patrons', but they are described differently to identify the diverse views from different patrons (see Chapter 4.0). Also, inclusion and exclusion criteria were developed in order to identify and then hopefully recruit patrons who were eligible to participate in the study.

3.5.5.2 Inclusion criteria

Eligibility for participating in the study included English-speaking male and female participants, aged 18 years and above, who: (a) could voluntarily sign the consent form, (b) can give verbal consent to be observed, (c) engage in informal conversations, and (d) had attended The Dragon Café for at least two months before the start of the study. The gatekeepers at the café informed the researcher that anyone who attended the café for less than two months might not be able to provide rich and detailed information about the processes within the café because usually in the first month, patrons may only attend for an hour a day or twice a month.

3.5.5.3 Exclusion criteria

Patrons who did not meet the inclusion criteria were: (a) patrons who were unable to give informed consent, (b) those who signed the consent form but did not take part in the study, (c) those who did not want to be observed or (d) who did not want to take part in informal conversations and (e) those who had attended the café for less than two months before the start of data collection. In addition, there were (f) patrons who withdrew their consent after signing the consent form, thereby excluding themselves from getting involved with the observations and informal conversations.

3.6 Data collection

In this section, I describe the four types of data collection methods that were used in the ethnography. After the distribution of the information sheet and the initial announcements on the open mic, informed consent forms were distributed to 62 patrons who expressed their interest to participate in the informal conversations and interviews.

3.6.1 Data collection process

One consent form was provided for all the patrons (see Appendix 9) and this used for all three data collection methods, including observations, informal conversations and the semi-structured interviews. The patrons were informed that they could take the consent form away for two weeks to think about their decision to take part in the informal conversations and interviews, and to sign and return it to the researcher to indicate that they had decided to take part. The researcher also informed the patrons that they could withdraw their consent after signing and returning the consent forms without giving any reason. This was to reassure the patrons that they were not bound to take part in the observations, information conversations and interviews just because the signed the consent form. Some participants signed and returned the consent forms the same day, others took the form away and returned it after they had signed it, and on average, participants signed and returned their consent forms within two weeks of receiving it. To ensure that patrons were continually reminded: (1) of the research aim, (2) why the researcher was at the café and (3) what she was doing for each day, weekly announcements were made throughout the 14 month fieldwork regarding the observations, informal conversations and interviews.

One fundamental characteristic of the various types of data collection methods used in this study was that they were all employed in the naturally occurring context of the café. Still, they differed in terms of the ways the data were collected and analysed. Also, the combination of diverse data collection methods: which enabled the researcher to highlight ways in which the different types of data generated from the

varied data collection methods helped to better understand the participants' experiences of the café from a range of perspectives (Burgess, 1982, 2016).

Therefore, this study adopted various qualitative methods of data collection, including audiovisual and textual techniques to generate detailed descriptions of the place, people and participation in the café. A combination of these methods resulted in the collection of rich and diverse datasets which strengthened the quality of the data (Hammersley and Atkinson, 2007). Accordingly, the study aligns with a multimodal approach of using more than one data collection method (Dicks, Soyinka and Coffey, 2006), including (a) mapping the study setting, (b) real-time observations, (c) informal conversations, (d) semi-structured interviews, (e) photographs, and (d) a 3-D video, drawing special attention to the spatial environment in a way that enables a visual understanding of the space, and the rhythm of the day at the café (see Chapter 4).

3.6.1.1 Observations

'Participant observation' is the starting point in an ethnographic initiative. The term refers to all formal and informal data collection during fieldwork, providing the context for other data collection methods such as: (a) the interview guide (Spradley, 1980; Hammersley and Atkinson, 2007; Gobo and Molle, 2016). Denzin (1998) and (b) extending the utility of "thick description" (Geertz, 1973) as an anthropological construct used in ethnography, and particularly in participant observation. Therefore, the central source of information for this ethnography was the observation of the place, people and participation at the Dragon Café.

The observation phase of data collection requires the researcher to observe people in a research setting by noticing and writing fieldnotes about what goes on. It has been suggested that researchers should respond to situations as they find them in the field rather than formulating them in advance (Zahle, 2017). However, data collection by way of participant observation raises different ethical issues when it relates to informed consent (Moore and Savage, 2002); particularly in order not to violate participants' privacy (Zahle, 2017).

Similarly, Oeye, Bjelland and Skorpen (2007) propose that participant observation raises ethical concerns, because informed consent is an individual, rather than a collective action, but participant observation is a process of observing people collectively. For these reasons, the gatekeepers and the researcher agreed that the researcher could only observe activities and interactions involving the 'written and verbally consenting' patrons.

Therefore, in this study, the researcher negotiated and renegotiated informed consent for participant observation, by ensuring that before each observation of any activity or space where patrons were present, the researcher, café manager and other paid staff informed the activity coordinator and the patrons about the planned observation, and the researcher explained that the observation was not about individual patrons. Put in another way, the researcher informed the patrons that in writing up the fieldnotes, only the processes of the activities are described rather than any individual actions; therefore, no patron can be recognised by the description of the activity being reported. However, as Oeye, Bjelland and Skorpen (2007) point out, it is not practically possible to avoid observing situations where others, who did not give their consent, were present. As Sieber (1992) put it:

> "One who considers a given research procedure an invasion of privacy can simply decline to participate" (p. 49).

As stated previously, the researcher negotiated and renegotiated consent throughout the data collection process. Therefore, the researcher reassured the participants of what the observation entailed, while the café manager, activity coordinator or paid staff announced that patrons who did not want to be present during observations that involved photographs taken by the gatekeepers to either leave the activity space for less than five minutes or look away so that their faces did not appear in the photographs. In this case, the researcher waited until patrons who did not want their photographs taken had left observation to leave, but rather than leave, patrons usually just looked away.

3.6.1.2 Informal conversations

With informal conversations, the researcher also negotiated and renegotiated consent with patrons before and after interactions with them, informing patrons that their accounts will be written down. The written accounts were then read to the source patron in order for them to confirm that the account was accurate; a protocol described in the section on rigour (see Chapter 3.9). In addition, the researcher asked patrons to sign the consent form to confirm that they were happy for their accounts to be used in the final writing of the thesis. Thus, the researcher only used verbatim quotes from participants who signed the consent forms that their informal conversations could be used.

Due to the nature of informal conversations, where the questions and answers are not predetermined, my interactions with the patrons during the observational phase of the study were spontaneous and random; a part of the ongoing observation which allowed the natural flow of conversations to continue (Minichiello *et al*., 1990; Patton, 2002). Therefore, I negotiated and renegotiated consent as I sought participant responses based on different days, times, activities and scenarios. Consequently, each informal conversation generated unique, different patterns of data and unanticipated answers because there was no preparation or assumptions about what to ask or how to ask it. Therefore, I asked the questions in a way that helped the participants to provide me with answers about their experiences of the café. I followed the narration created from my observations and experiences of the place, people and participation spontaneously in order to generate possible interview questions, which I recorded in my fieldnotes and my reflexive dairy. For example, in the findings chapter (4.1.3) you will see that I did not know that The Dragon Café issued membership cards until I arrived at the café on the first day of fieldwork, so I could not have prepared the question about ‘why membership cards were issued in advance’.

3.6.1.3 Interviews

Interviews are the most frequently used method of data collection in qualitative research; the three main types of this information gathering format being: (a) structured, (b) unstructured and (c) semi-structured

interviews (Gray, 2013; Okely, 2012). Unstructured interviews are flexible, informal conversations, such as the ones that were adopted during the observation phase of the study's fieldwork (see Chapter 3.6.1). This type of interview is based on the researcher's interests, but the participants can speak freely, without an interview guide which is present in semi-structured interviews (Minichiello *et al*., 1990; Patton, 1990; 2015). In other words, in unstructured interviews, the questions are unplanned and generated spontaneously.

In semi-structured interviews, the researcher uses an interview guide containing open-ended questions, follow-up questions and prompts to elicit more answers and in-depth information from the participants (Lewis-Beck, Bryman and Liao, 2004; Okely, 2012). Corbin and Morse (2003) propose that semi-structured interviews are informal but "controlled conversations" (p.2) between the researcher and participants, allowing the participants to ask questions and express their views of the research context without the researcher being in total control of the interview process (Okely, 2012). In this study, semi-structured interviews were informed by an interview guide that was developed from questions collated during the observation phase of the study. Participants answers to the questions provided alternative data that created an optimum understanding of their individual views and experiences of the café.

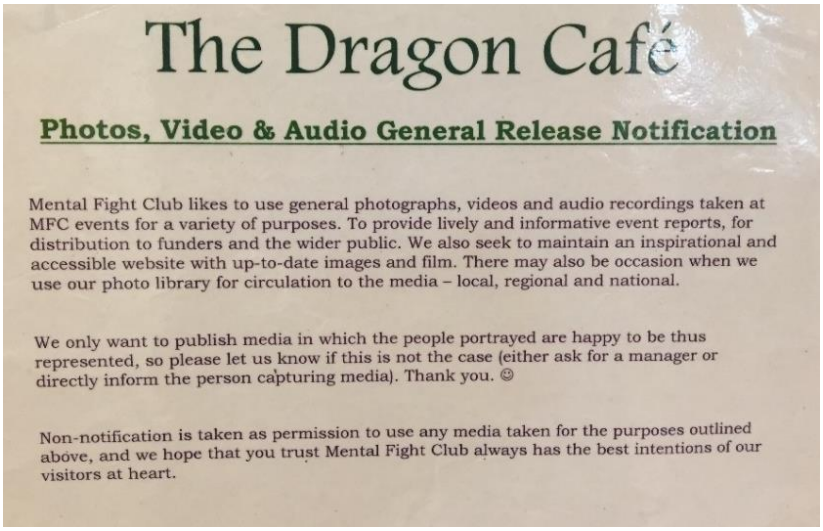
3.6.1.4 Photographs

In ethnography, participants' actions and interactions in their usual setting are not only viewed as pertinent but they are also vital for the insights gained from the research (Atkinson, 2007; Agar, 2011; Iphofen, 2015; Gobo and Molle, 2016). Thus, in addition to the textual data, the researcher decided to draw on the pioneering works of Bateson and Mead (1993) who used photography and film as ethnographic media through their detailed monograph, where images are followed with in-depth descriptions to illustrate the culture of the Balinese people. Therefore, this study adopted an audiovisual presentation of the data. Bateson and Mead (1993) state that "the use of photographs, preserves the wholeness of each piece of behaviour while cross-referencing can be obtained by placing a series of photographs on the same page"

(p.xii). It is precisely this knowledge that informed the observation data collection methods for this study. Photographs were used to translate and communicate the meaning of the context (Geertz, 1973; Denzin, 1989; Denzin and Lincoln, 2011).

I signed a 'License to Use' the photographs on 20th June 2018 (Appendix 15) to access most of the images which were taken by Liz Goman, the café's official photographer, so, while I do not interpret the images in the photographs as part of formal analysis, I use screenshots and visual representations when supporting or contextualising participants' quotes (Brennen, 2017). In addition, before I observed any interactions between patrons, or patrons taking part in activities and participating in the space, the café manager, activity facilitator and/or paid staff informed the patrons and sought their verbal consent to be observed. Other times, before the café manager and activity facilitator took pictures of patrons taking part in the activities, they would inform the activity coordinator and attending patrons in order to obtain their verbal consent. Patrons who did not want their pictures taken were asked to look away or leave the group for a short time and return at the end of the photography. In general, most patrons verbally consented that the café manager and activity facilitator could take their pictures. There is also a general release notification on a wall in the café that informs patrons about photography, video and audio recordings taking place in the café.

Figure 5 Photo, video and audio general release notification


The Dragon Café

Photos, Video & Audio General Release Notification

Mental Fight Club likes to use general photographs, videos and audio recordings taken at MFC events for a variety of purposes. To provide lively and informative event reports, for distribution to funders and the wider public. We also seek to maintain an inspirational and accessible website with up-to-date images and film. There may also be occasion when we use our photo library for circulation to the media – local, regional and national.

We only want to publish media in which the people portrayed are happy to be thus represented, so please let us know if this is not the case (either ask for a manager or directly inform the person capturing media). Thank you. ☺

Non-notification is taken as permission to use any media taken for the purposes outlined above, and we hope that you trust Mental Fight Club always has the best intentions of our visitors at heart.

3.6.1.5 3-Dimensional video

To create a 3-D video, I contacted Joe Foster (President of Design in Mental Health Network), and Alessandro Caruso (Caruso, 2019), a renowned architect, and we co-produced a 3-Dimensional computer-aided design (CAD) video presented as a QR Code (Figure 8) to visually depict the space of the crypt. Intentionally, there is no sound in the 3-D video so that the viewer can observe the café space without the 'real-world' distractions (see Chapter 4.1.4). In order to respect the privacy of the patrons and ensure that ethical considerations are taken into account, the researcher ensured that data collection for developing the 3-D video was carried out when there were no patrons in the space; informed by the following steps:

> **Step 1**. The researcher obtained existing photographs from the café archives after signing a 'License to Use' release form. The photographs were used to create the figures in the 3-D video and some aspects of the crypt space.
>
> **Step 2**. Joe Foster annotated the floor plan of the crypt and this was used as a guide for creating the different spaces within the three rooms.
>
> **Step 3**. The paid staff and volunteers took pictures of the three rooms after setting-up the spaces for the activities, and when there was no patron in the space.
>
> **Step 4**. To obtain a wide angled view of the three rooms when they were empty, the researcher used a bird's-eye view camera lens that was attached to an i-phone.

Although the ethnography involved the use of four data collection methods, the visual methods were used to visually enhance the thick description (Geertz, 1973) of the place, people and participation as demonstrated in the findings section (see Chapter 4.0). Below I present the data collection process for the observation and information conversations, followed by the semi-structured interviews. The fieldwork for this study lasted 14 months (October 2017- November 2018). I participated three times per activity (n=12 activities) excluding football which I observed three times. I completed 432 hours of active participant observations and 1,232 informal conversations with 49 patrons (27 females and 22 males). 32 of the 49 participants took part in the unstructured interviews. In addition, 38 semi-structured interviews were conducted with 21 females and 17 males, all aged between 20 and 80, with an average age of 50. The total duration of audio-recorded interviews was 10 hours and 26 minutes (615.58 minutes) with an

average of 16 minutes per interview. As I indicate in the next sections, the data collection methods differed, as did the data analysis.

3.6.2 Data collection one: 0bservations and informal conversations

> "If prolonged fieldwork provides scope, persistent observation provides depth."
> (Lincoln and Guba, 1985, p.304).

In this section, I present how data were collected from: (a) writing fieldnotes on my observations, (b) engaging in informal conversations with the participants, (c) documenting my experiences in the field, as well as (d) using a reflective diary. I describe specific aspects of the data collection process, including the types of observations that were carried out which influenced the different roles that I filled during fieldwork, and the decisions that informed how data were collected, such as the use of checklists. This section concludes with a list of six questions which I used as the interview guide for the semi-structured interviews.

As suggested by Moffatt, Timmons and Martin (2014) data were collected in a cyclical process of observation, beginning with a broad and panoramic view of the café space. This broad view was then narrowed down to microscopic and selective observations of minute details from participant's accounts, as well as categorising regular and irregular activities, identifying variations in the processes and in participants' behaviour. This detailed information was then used to plan for the focused and selective observations (DeWalt and DeWalt, 2011; Fetterman, 2010; Okely, 2012).

Malinowski (1922) suggests that ethnographers should live among the people being studied to understand their beliefs and custom, know the aims of the study, and record data "in a firm clear outline of the life and behaviour, using an ethnographic diary" (p.23-24). In this study, however, Malinowski's second and last suggestions were possible, but the first was not achievable because the participants at the café did not live in the research setting. Nevertheless, this challenge can be described as unproblematic because I took

time out from observing and taking notes, to join in with the conversations and participate in the activities with the patrons at the café (Malinowski, 1922; Burgess, 1982; Van Maanen, 2011). Similarly, Denzin and Lincoln (2011) posit that researchers should immerse themselves within the setting of the participants and observe what they say, do, and how they interact (Creswell, 2007; Bryman, 2008). Based, on this, I immersed myself in the café, writing detailed fieldnotes and reflective diary, so I was able to describe the place, people and participation at the café comprehensively using thick description (Geertz, 1973; Gobo and Molle, 2016).

In ethnography, studies suggest that the researcher should aim to stay in the field and conduct participant observation for a minimum of six months up to a year (Sanday, 1979; Fetterman, 2010; Van Maanen, 2011). In this study, the fieldwork lasted 14 months from October 2017, with observations from when the café opened at 08.00 am to closing time at 8.30 pm on most days; 11.00 am to 09.30 pm on some and 12.00 pm to 08.30 pm at other times. The timing and planning of the observations enabled the quality of fieldnotes to be optimised and prevented postponing data gathering, forgetting data already gathered or recording inaccurate data (Burgess, 1982; Okely, 2012).

During the fieldwork, the researcher took on several roles that enabled a continuity of interactions and participation in the activities with the patrons (Adler and Adler, 1987). For example, (1) the role of a patron who participated in the activities, (2) a volunteer receptionist wearing the café branded volunteer T-shirt to register new and existing patrons, (3) a volunteer set-up and pack down and (4) a kitchen volunteer who tidied up at the end of the day washing up the dishes and cleaning the kitchen space. These roles enabled full immersion in the café, and the three methods of participant observation were adopted, namely: (a) passive observer, (b) complete participant or participant as an observer and (c) complete observer (Merriam, 1988; Spradley, 1980; DeWalt and DeWalt, 2002, 2011; Jorgensen, 2015). In this case, as a passive observer, I did not particiapte in the activities but I engaged with the patrons by talking to them informally, while observing and writing fieldnotes (Okely, 2012). As a complete participant or observer as participant (Merriam, 1988; Okely, 2012), it was essential to take part in the

creative activities; observations were mentally noted and written down as soon as possible afterwards. As a complete observer, I focused on observations and writing fieldnotes with minimal interaction with the patrons. So that data was recorded as accurately as possible, the mental notes were expanded into descriptive sentences within 24hours of leaving the café.

As Okely (2012) elaborates, the participating observer faces key challenges of time and energy when taking notes, while also participating and observing. Equally, Mack and Woodsong (2005) and DeWalt and DeWalt (2011) show that the prolonged periods required to observe and then write fieldnotes are reliant on the researcher's memory to recall what was observed. This time lapse / delay can result in a likelihood of subjectivity, rather than objectivity when finally writing such notes. Therefore, some of the handwritten observations and informal conversations were expanded after leaving the café due to it being too busy with activities and an average of 200 patrons on any one Monday; a situation making it extremely difficult (impossible in practice) to expand the notes at the research setting.

A key challenge during the initial stage of the fieldwork was the restricted informal conversations. Although informal conversation is a part of observation (Hammersley and Atkinson, 2007), at first, there were very limited interactions with the patrons in the form of informal conversations because the gatekeepers wanted the researcher to interact with the patrons as a volunteer first to get them to know them before asking them questions about their experiences of the café. In a way, this was restrictive, because there were times when it would have been pertinent to ask the patrons questions about something that they said, and although interaction with some patrons did occur, this, such interaction was very limited. Nevertheless, informal conversations are not prearranged (Minichiello *et al*., 1992; Patton, 2002), so despite the restrictions, it was possible to engage with the patrons casually, resulting in the generation of unanticipated conversations that produced rich and detailed information about the participant's experiences of the café as described in Findings One (see Chapter 4.1- 4.1.8). Moreover, being an observer while volunteering provided the opportunity to meet patrons at different times in the different rooms and during different activities (Burgess, 1982; Hammersley and Atkinson, 2007).

The nature of ethnography is iterative (Neale, 2016) and so the role as a volunteer enabled my entrenchment in the processes, thereby facilitating modifications to the data collection and analysis from the beginning to the end of the fieldwork (Madill and Gough, 2008; Curtis and Curtis, 2011). Also, is should be pointed out that the use of a checklist for observation is not always appropriate (Hammersley, 1990; Mark *et al*., 2005), especially in a space, such as The Dragon Café due to the interchangeable schedule of the activities). Initially, a protocol for data collection was not adopted because it could lead to confirmatory bias which can happen when researchers influence research findings to suit the outcome that they were seeking (Galdas, 2017). However, two key limitations of observations are that they are time-consuming, and the information recording often relies on the researcher's memory to recall and then write down as accurately as possible what had been observed (Hammersley, 1990; Mark *et al*., 2005; Hammersley and Atkinson, 2007). Therefore, using a checklist in addition to a reflective diary was a useful prompt to remember what to observe and what had been observed. Thus, to keep a near to accurate log observations, the nine observation dimensions were utilised (Table 6) (Reeves, Kuper and Hodges, 2008).

Table 6 Nine observation dimensions for participant observation

1	Space	The physical layout of the crypt
2	Participants	The diversity of the people who attend the café
3	Activities	The rhythm of the day at the café
4	Objects	The list of items in the space, such as chairs, tables, table covers, coat hanging rail, bean bags etc.
5	Action	How patrons participate in the space
6	Events	The activities that take place at the café
7	Time	The sequencing and timing of the activities, such as in the activity schedule
8	Goal	What patrons are trying to accomplish when they visit the café
9	Feelings	People's expressions and accounts of their experiences of the café

Source: Reeves, Kuper and Hodges (2008)

For example, in the role of volunteer, it was possible to map the physical layout of the crypt and set-up the three rooms from memory after I obtained a floor plan (Figures 7 and 8) from the priest. Also, by

observing without participating in the activities and therefore greatly limiting interaction with the patrons, it was possible to use thick description for documenting and expanding fieldnotes (Geertz, 1973). This opportunity ultimately produced detailed descriptions of the diversity of the patrons, activities, times of events, interactions, and a list of physical items within the space. While the nine dimensions of observations were useful for observing and documenting a thick description as listed above, it was limiting in the description of participants' appearances, actions and interactions in the café's space (Reeves, Kuper and Hodges (2008). Thus, while observing and documenting my observations of the patrons, the checklist of what to observe during participant observation was followed (Mark *et al*. 2005) (Table 7).

Table 7 What to observe during participant observation

Appearance	Clothing, age, gender and physical appearance	Anything that might indicate membership in groups or sub-populations of interest.
Verbal behaviour and interactions	• Who speaks to who? • When and for how long? • Who initiates interaction? • Languages or dialects spoken and the tone of voice	Gender, age, ethnicity, profession or speaker, dynamics of interaction.
Physical behaviour and gesture	• What patrons do • Who does what? • Who interacts with whom? • Who is interacting or not interacting?	• How patrons use their bodies and voices to communicate different emotions. • What individual behaviours indicate about patron's feelings towards each other.
Personal space	How close patrons stand or sit to each other	What individual preferences about personal space suggest about their relationships
Human traffic	How patrons move around in the space	• Where patrons enter and exit. • How long they stay. • Who they are, ethnicity, age, gender. • Whether they are alone or accompanied. • Number of patrons.
Patrons who stand out	Identification of patrons who receive a lot of attention from others	• The characteristics of patrons. • What differentiates them from others? • Why they consult or who approaches them. • Whether they are strangers or well known to the other patrons.

Source: Mark *et al*. (2005)

With the above guide, the participants were focused on 'as a whole' instead of only the space. However, this focus was challenging because it was not possible to observe or describe a participant without describing: (a) the space that they occupied, (b) the people that they interacted with and (c) how they participated in the space. Moreover, with more than 200 patrons in the café space at any given time, it was challenging to observe more than one to three patrons at a time, who were interacting or participating in close proximity to each other. However, the checklist was particularly helpful in achieving the ethnographic intent of establishing the relationship between place, people and participation at the café, especially as it was possible to record the observations timely in the fieldnotes as they occurred (Hammersley and Atkinson, 2007). As evidenced by Ingold (2014):

> "Surely participant observation, if nothing else, is just such a practice. It is one that calls upon the novice anthropologist to attend to what others are doing or saying and to what is going on around and about; to follow along where others go and to do their bidding, whatever this might entail and wherever it might take you…Indeed, waiting upon things is precisely what it means to attend to them" (p.389).

Therefore, I engaged in both non-participant observation and participant observation (Ingold, 2014; Gobo and Molle, 2016). In the former, participation in the activities did not take place, and although interaction with the patrons took place, the fieldnotes were more focused on: (a) observing the people, place and participation, (b) volunteering, (c) documenting observations and informal conversations with the patrons and (d) completing a reflective diary. Mainly, volunteering led to increased interaction through informal conversations and participation in all the activities. . A data participant observations sheet was developed that contained the observation number, researcher's name, setting, date, start and end time (Appendix 16). This was crucial to document times and a sequential holistic view of what happens at the café. Also, in collaboration with the café manager, I developed a plan for fieldwork which details the times that I took part in the different activities at the café, thus enabling a seamless data collection process that aligned with the activities at the café.

As sociologists suggest, what participants say during interviews cannot be taken as a substitute for the observation of their actual actions and interactions with each other in social space because there are

differences between what people do and what they tell others that they do (Mead, 1985; Gieryn, Gilbert and Mulkay, 1985). As described by Gieryn, Gilbert and Mulkay, (1985):

> "Participants' retrospective accounts of action and belief, as obtained for example from interviews, autobiographies, review articles, public lectures, and so on, are highly variable, context-dependent, and therefore unreliable; but it is possible to replace such indirect sources of data with direct observation of social action as it occurs." (p.15).

Indeed, the debate about the dualism between what people do and what they say they do continue with observation seen as an important to counter one of the limitations of interviews. That limitation is that interviews only provide data on what participants say, and not what the researcher sees them do (Green and Thorogood, 2014). In other words, the statements made by social actors during interviews cannot be treated *'*as an appropriate substitute for the observation of actual behaviour' (Mead, 1984: p.236). However, observing participants alone, without interviews to ask about their individual views, may result in the misinterpretation of their actions. Equally, in this study to interview participants without observing them could also lead to a neglect of the multifaceted relationship between place, people and participation at the café (Hammersley, 1990. Therefore, during the observation phase of the fieldwork, 97 possible interview questions were collated and discussed with the supervision team (Appendix 17), which guided the development of six semi-structured interview questions that served as the interview guide (Appendix 18) as listed below:

1. How did you hear about The Dragon Café?
2. How would you describe your experience of the Dragon Café?
3. What is it about The Dragon Café that makes you attend every week?
4. Tell me about your experiences of the workshops.
5. What does that activity mean to you?
6. Is there anything you would like to say or add that we have not discussed?

3.6.3 Data collection two: Semi-structured interviews

Semi-structured interviews are frequently used in prolonged ethnographic fieldwork; they are an inductive, semi-directive method of data collection (Corbin and Morse, 2003) where the participants

answer pre-planned open-ended questions in interview guides, that usually align with the aims, objectives and research question(s) of the study (Creswell, 2007; DiCicco-Bloom and Crabtree, 2006).

Interviews began on the 30th of April 2018. The total number of patrons who initially consented to take part in the interview were 62, including 39 females and 23 males. Of the 62 patrons who initially signed the consent forms, 24 patrons did not take part because: (a) they were either on holiday; (b) they had changed their minds about taking part in the interview without giving any reason, or (c) they were not available at the café to be interviewed. Finally, 38 participants were recruited and interviewed, and 32 patrons who took part in the informal conversations also took part in the interviews.

The majority of the interviewees were White British (n=25), with the remainder identifying as South East Asian (n=4), African (n=4) or Caribbean (n=5). To protect the participant's identities, uphold confidentiality and ensure ethical standards, all the patrons who signed consent forms were initially allocated code numbers, such as P1 for participant number 1. Later, during the data analysis phase, the code numbers were replaced by pseudonyms during the data analysis phase. Of the 38 participants interviewed, 21 were females, and 17 were male, all aged between 20 and 80 with an average age of 50. This was a representative age range for those who attended the café, and similar to the average age of those who took part in the informal conversations (n=36) (Table 8).

Table 8 Characteristics of patrons who took part in the informal conversations and interviews

The age range for all participants	**Patrons who signed the consent form**	**Patrons who took part in the informal conversation by age range**	**Patrons who took part in the interviews by age range**
20-30	6	5	2
30-40	5	3	2
40-50	13	10	11
50-60	13	12	14
60-70	11	5	7
70+	2	1	2
No age recorded	12	0	0
Total	62	36	38

The above table shows that the majority of patrons who took part in the informal conversations also took part in the interviews (n=21), and they were mostly middle-aged. This could indicate a service gap for some people with MHCs outside the middle age range, specifically for those below the age of 30. As previously described, everyone who attends the café is referred to as a patron, but there are different typologies of patrons (Figure 1). Of these, the people that took part in the interviews included patrons, patrons who volunteer, and three gatekeepers who manage the long-term goals of the café. Paid staff and activity facilitators were not interviewed because they did not consent to be interviewed. However, they participated in the observation phase and informal conversations.

The interviews phase lasted four months from April 2018, starting with five pilot interviews that took place in a quiet room upstairs in the church. Pilot interviews are important in qualitative research but more so in ethnographic interviews (Spradley, 1979), because they provide the researcher with a sense of the interview questions, a time to check the timing, and questioning technique, such as listening skills and to make changes where necessary (Creswell, 2007; DiCicco-Bloom and Crabtree, 2006). Interviews are usually iterative in most qualitative research, with data collection and analysis occurring concurrently and this process may require the researcher to make changes to the interview guide by replacing questions and adding different prompts (Walzer, 2017). In this case, the changes that were identified from the interview were more about the space where the interview was conducted, rather than the questions or techniques. For example, one participant said he could not concentrate on the questions because '*the church was too quiet, and it makes the voices louder* (Bolarin).

Evidence suggests that interviews should be conducted in a comfortable space and at a time that is convenient for the participants without distractions and noise, without distractions and / or noise, at a time that is convenient for the participants (Okely, 2012). The interviews took place in summer, and participants wanted to enjoy the sunshine, the church office was not very warm, and sometimes the church was noisy when the pianist and the choir or singing group were practising. Also, when the initial pilot interview audio recordings from the church were listened to, it was noted that they echoed a lot, making it difficult

to hear what the participants said. However, despite the garden being outdoors in front of the café and exposed to the background sounds of sirens and general traffic noise, the audio recordings were clearer than those made within the quiet of the church. Subsequently, the remaining interviews were conducted in the café and café garden.

Audio-recording the interviews was useful to confirm the participant's exact words and comments (Okely, 2012). In addition, prompts were used to obtain more answers from the participants, such as (tell me a little bit about) follow-up questions (what happened then?) and factual questions (dates, times, duration) (Okely, 2012). Equally, evidence suggests that researchers should be aware of any changes in participant's behaviour, tone of voice or actions (Dwyer, Gill and Seertaram, 2012; Green and Thorogood, 2014). Thus, in addition to audio-recording participant's comments, fieldnotes were written on participant's behaviour, including observations of verbal and non-verbal communication (Burgess, 1982; Okely, 2012; Burgess, 2016).

Six open-ended questions were asked in different ways, using, ethnographic interview methods, such as general questions (Tell me about your experience of The Dragon Café?), and focused questions (What have your visits to The Dragon Café been like?). It should be stressed that the questions were not worded in exactly the same way with each participant (Gerrish and Lathlen, 2010). All interviews were audiotaped and fully transcribed verbatim, and for clarification purposes audio interview transcripts were read out to participants who were unable to read, thereby enhancing the integrity of the study (Milne and Oberle, 2005).

In the next section, I detail how the data from the ethnography were analysed differently in order to present participants' experiences of the café. I focused on demonstrating the detailed and stepped process of data analysis as well as establishing the links between the research questions: (1) *What is The Dragon*? and (2) *What makes people with mental health challenges attend this informal community mental health service*? Lastly, I showed the relationships between the basic codes, organising codes and global themes, which form the platform for the findings chapter informed by the interview data.

3.7 Data analysis

Qualitative data analysis (QDA) is an inductive and iterative process (Madill and Gough, 2008; Curtis and Curtis, 2011; Saldana, 2016) that enables the transformation of raw data from interviews, observation or other data collection methods, through the identification of patterns, categories and themes, to provide meaning for an in-depth description and interpretation of participants' accounts (Patton, 2002; Bryman, 2008; Saldana, 2016).

This study aimed to understand what makes people with MHCs attend a community mental health café. The study was informed by the researcher's ethnographic intent to explore the relationships between people, place and participation at the café. Therefore, as previously discussed (see Chapter 3.2), from an epistemological perspective, I sought to understand how participants co-construct their collective experiences and ontologically to interpret the meanings that participants attached to their experiences of the café (Benton and Craib 2011). Thus, the ontological and epistemological influences enabled a data-driven analysis of the individual and collectively shared meanings that participants attached to their experiences of the café, and as such, provided the means for me to examine how these experiences are the participants' perceived social reality in the café, gained through their constant interactions and creation of collective realities (Berger and Luckmann, 1966; Benton and Craib, 2011).

The data analysis for the observations, informal conversations and interviews were carried out using an MS Word document, and a coding template was created on MS Word; data chronologically was organised in the order that data were originally collected, by typing fieldnotes and interviews into two single MS word files from the first observation to the last, as well as from the first to the last interviews (La Pelle, 2004). However, ethnographic research does not only present what the participants do or what they say they do, but also what they make of what they do. The most common method for representing participants' views is through the use of quotations, metaphors, slangs, jokes and frequent used words (Van Maanen, 2011). Therefore, direct quotes from participants were identified and included in the analysis and writing-

up in order to support the transparency and trustworthiness of the descriptions (Becker, 1996; Patton 2002).

3.7.1 Data analysis one: 0bservations and informal conversations

The fieldnotes from the observations and informal conversations were narratively synthesised (Copeland and Creese, 2015) through a thick description of the findings (Geertz, 1973) with photographs and verbatim quotes from participants included: (a) to support the use of thick description and (b) to enhance the interpretation of the findings (Bazeley, 2009). The Dragon Café opens on Mondays from 12.00 pm - 8.00 pm, so data were collected on Mondays, expanded and analysed from Tuesdays to Fridays, enabling an iterative process (Spradley, 1980; Curtis and Curtis, 2011). Fieldnotes from previous observations and interviews were expanded, typed into Microsoft word documents, read and reread, and coded before returning to the field (the café) the next Monday to collect more data. This was useful for developing a systematic data collection method that enabled both the raw and analysed data to be chronologically organised (Miles and Huberman, 1994; Miles, Huberman and Saldaña, 2013; Saldana, 2015).

Initially, all the fieldnotes were typed on MS word in black, but it was soon obvious that this made it difficult to differentiate between the datasets, so individual datasets were colour coded, as follows: (a) participants' accounts were written in purple; (b) the reflective diary was written in green; (c) observations in black; (d) possible interview questions were written in red and (e) theories that were considered to be of relevance were written in turquoise blue. This approach was particularly useful for identifying which dataset and sources were more prevalent on certain days; a point which prompted the researcher's engagement in more informal conversations, when the data from the last observation had less of the purple colour (participants' accounts).

Data analysis in this study involved a combination of descriptive coding (Miles, Huberman and Saldaña, 2013; Saldana, 2015) and NVivo or verbatim coding (Spradley and Shandy, 2005; Bergin, 2011; AlYahmady and Al Abri, 2013) which both align with thick description (Geertz, 1974, 1977) and

interpretivism (Benton and Craib, 2011; O'Reilly, 2012). However, instead of using short sentences or phrases to identify the data, a combination of participants' words, the reflexive diary and descriptive fieldnotes on observations were used. Descriptive coding is a method for documenting rich fieldnotes into concrete datasets of participants' accounts of their experiences on a daily basis or, in this case, per observation day (Miles, Huberman and Saldaña, 2013). It was particularly useful in this study to structure the fieldnotes by (1) observation number, (2) setting, (3) date, (4) start and (5) end time (Hatch, 2002; Saldana, 2013), allowing for logical representation of rhythm of the place, people and participation at the café (Table 9).

Table 9 Patterns to look for in descriptive coding

What to look for	**How it might happen**	**Examples in the dataset**
Similarity	Things happen the same way	Opening times, setting up and packing up.
Difference	They happen in predictably different ways	How some participants behave or interact
Frequency	They happen often or seldom	The café not opening on a Monday.
Correspondence	They happen to other activities or events	Patrons sit around activity set-up before the activity begins.
Sequence	They happen in a specific order	Activities take place in the order that they were printed on the schedule.
Causation	One appears to cause another	When the café door opens at noon, patrons' queue and walk-in one after the other.

Source (Hatch, 2002, p.155)

The use of verbatim coding enabled the sequential organisation of data that highlights a participant's view regarding his/her experiences at the café. Verbatim coding is the use of phrases, quotes, words, and terms spoken by the participants themselves (Bergin, 2011; Saldaña, 2013). Verbatim data from observations have been criticised as questionable due to the inconsistencies that may be associated with the researcher's documentation of the fieldnotes. However, in this study, as indicated in sections on rigour (see Chapter 3.9) and reflexivity (see Chapter 3.10), patrons were shown the fieldnotes after informal conversations, for them to confirm that what was written down was what they actually said, and to prevent any errors being included as valid data. As a result of this process any differences in interpretation could be corrected

(Milne and Oberle, 2005). Fieldnotes were typed and then read line-by-line and sentence-by-sentence so as to identify salient phrases that provided in-depth insights into participants' accounts, (Lofland *et al*., 2005). This process continued until 26th March 2018, the last observation before the interviews began.

In the next section, the approaches that were employed for analysing the semi-structured interview data will be outlined, and the decision to manually analyse the data will be discussed. The next section will also explain how the data was thematically analysed through a systematic coding process, and how this coding process enabled the identification of the basic and organising codes and the themes as visually and narratively presented in the 'Findings Two' part of this thesis. 3.7.2

Data analysis two: Semi-structured interviews

In this section, the overall process that was adopted to analyse the semi-structured interviews will be discussed, beginning with a description of the significance of thematic analysis alongside the process of interpreting the meanings of participants' accounts. A thematic approach to data analysis was adopted to identify and interpret patterns across datasets (Braun and Clarke, 2006; Saldana, 2015), through an inductive approach of: (a) identifying recurring phrases combined as codes, and then (b) as themes in the interview data (Saldana, 2015). Thus, in this study, recurring patterns in the interview data were identified and referred to as basic codes or verbatim records of participant's words. A combination of several basic codes is referred to as 'organising codes' and 'a theme' was the outcome of combined organising codes. Thematic analysis was the approach for the interviews because such a method allowed for an inductive process in which codes and the themes identified were linked to the data (Patton, 1990). As Geertz (1973) suggests, ethnographic data should begin with "an interpretive analysis of the data in search of meaning through established codes, categories and themes that reflect the participants' views" (p.5). Moreover, the thematic approach is compatible with ethnographic research through the researcher's ability to embody the totality of the research process, in order to understand the phenomenon being investigated (Hammersley and Atkinson, 2007).

Thematic analysis has been criticised for leaning towards quantitative data analysis (Braun and Clarke, 2014). Nonetheless, thematic analysis has been widely used in ethnographic studies (Greenhalgh *et al*., 2011; Kitchen *et al*., 2017), and in studies of people living with MHCs (Henderson *et al*., 2014; Crowe, Inder and Porter, 2015; Smith and Macduff, 2017; Tzouvara, Papadopoulos and Randhawa, 2017). Besides, Braun and Clarke (2016) argue that qualitative data analysis is an ongoing, flexible and iterative process, and so is thematic analysis. Moreover, in this study, adopting a thematic approach for analysing the data allowed for the inclusion and description of participants' points of view first, before any interpretations (Roberts and Ilardi, 2003; Braun and Clarke, 2016). This specific procedure resulted in the preservation of participants' accounts, in addition to summarising the data in the context of the research setting, rather than looking for a theory (Green and Thorogood, 2013).

All interviews were transcribed verbatim by a professional transcriber at the University of Nottingham with reference to a standardised transcription protocol. Therefore, the transcriber signed a non-disclosure agreement (19). I listened to the audio recording again of each interview at least once, to clean up the data through a process of de-identification by: (a) editing the transcribed data, (b) correcting transcription errors, and (c) writing what the participants actually said (Curtis and Curtis, 2011). For example, the transcriber wrote Westland hospital instead of Natham (Pseudonym)and although a pseudonym was used to represent the correct name of the hospital, identifying that mistake led to more caution being taken during further listening: as a result of this increased caution level other mistakes were subsequently noted and corrected.

The total duration of the interviews was 615.58 minutes with an average interview time of 16 minutes. There were 38 interviewees in total who yielded very rich and diverse data, even though some interviews lasted for less than 15 minutes. Nonetheless, the duration of interviews (quantity) did not determine the quality of the data collected (Spradley, 1979; DiCicco-Bloom and Crabtree, 2006); rather it is the rigour of the data analysis that is of key importance (Burnard, 1991; Baxter and Eyles, 1997). Initially, data analysis began with NVivo because that programme is useful for both organising and reorganising, coding and recoding the data (Bergin, 2011; AlYahmady and Al Abri, 2013); unfortunately, it was found too

cumbersome to use. As an alternative, although the manual coding was found to be overwhelming, it was easier to analyse the data manually because that option enabled immersion in the data in order to critically analyse and interpret the research findings. Besides, I felt that using manual coding also enhanced the rigour of the study through the use of reflections and memoing; two approaches which were used to document the data collection and analysis process, as well as present the findings (Bryman, 2012).

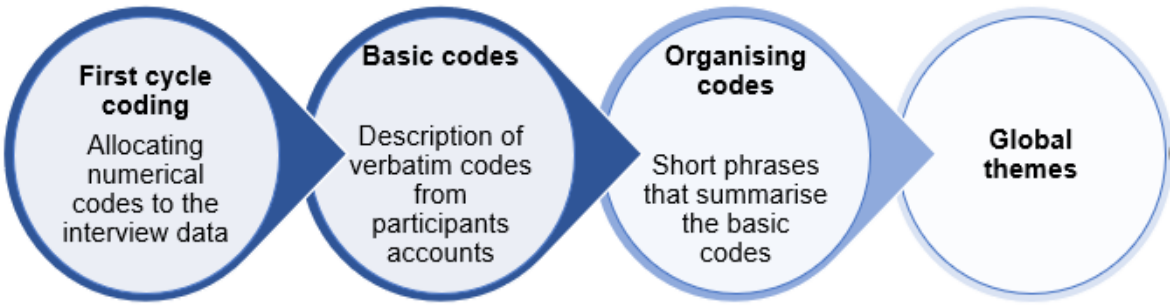
The manual coding began with reading and highlighting initial codes in different colours so that it was possible to code using MS Words files. Each code was allocated a numerical code number in relation to the interview number and recorded inside comments boxes. For example, C1.1 refers to the first code from the first interview and C1.2 is the second code from the first interview. Therefore, it was easy to reread the interview transcript to recode data when a new code was created, or to retain the initial code, as well as search and review the themes. Using MS Word for the analysis had other advantages when it came to the researcher needing to cross-reference codes. For example, while coding interview number 3, code 63 (C3.63), I remembered that they had read something about disclosure and acceptance of mental health symptoms in C2.43 and C2.43, so C3.63 was coded as disclosure of mental health. Therefore, the use of MS Word facilitated a broader identification of the patterns and codes in the analysis from the first to the last interview transcript (Lofland *et al*., 2005).

In this way, when I listened to the tape again, and reread the transcript, it was easy to identify the initial codes in the data and also see the differences and similarities in participants' responses, any changes in my interview techniques over time. Thus, a cyclical data analysis method of reading and rereading each data set not less than three times was adopted, enabling data to be coded, reflected upon with any thoughts for each data recorded by memoing, and keeping a reflective diary. While reading and rereading the data, it became clear that coding does more than identify codes, categories and themes (Braun and Clarke, 2016). In addition, coding allows for the interpretation of the codes in relation to participants' accounts (Lofland *et al*., 2006). Therefore, reading, rereading, and coding the transcript became an embodiment of participants' experiences in a way that allowed me to see through the lens of each participant to answer the research question and address the research aims. Also, I showed the supervisory team the transcripts

and my earlier interpretations of the data for their review and comments. In this study, each data set told a different story but collectively the themes that were identified unified participants' experiences of the café in a way that it has answered the research questions: (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service*?

In presenting the data, basic codes are verbatim from individual participants accounts (see Chapter 4.2) but individually, basic codes highlight very little about the data. To compensate for this deficit the basic codes were grouped into organising codes in order to create topic clusters that represent comparable views in the data. Clusters of organising codes make up the global themes, and global themes are the core themes that capture the overall meaning of the data within the dataset ().

Figure 6 Process of coding and identification of themes



During the process of coding and identification of the themes, 219 basic codes were identified and combined into 57 organising codes which were used to develop a thematic network then linked the research questions (see above) to three global themes and eight organising codes (see Chapter 4.2). While the data analysis process was useful for accounting for how I arrived at the themes, memoing was beneficial for reflecting and writing down thoughts, actions and details of iterative decision-making processes during the data analysis, interpretation, and writing up the ethnography; thus, provided a meticulous paper trail that enhances the transparency of the ethnography account being presented.

3.7.3 Memoing

One key action that facilitated a reflexively rigorous research process, as well as helping this researcher to notice changes over time, was 'memoing'. This research aid is used to record issues of interest or concern involves this researcher manually writing her thoughts about each interview transcript, date of coding and reflections on what she did, did not do, or should have done (Field-Springer, 2019). For example, when I again listened to the audio recorded interviews, I realised that some participants continued to speak after I had switched off the tape recorder; therefore, in subsequent interviews I left the tape recorder on until I was sure that participants had completed what they wanted to say. Only then did I turn it off (Memoing 16.11.18).

Additionally, it became obvious that coding activities were less important than coding the meaning that participants attached to taking part in the activity; it was recognised that there is a difference between experience and meaning (Van Maanen, 2011). For example, I wish: (a) I had prompted P44 about what she meant by "I thoroughly enjoyed singing" (Memoing 29.12.18), (b) I had asked P23 what he meant when he said, "I don't feel frightened to come here" (Memoing 17.12.18), or (c) had asked him to explain what a 'safe space' meant to him. I feel that these prompts would have reminded me to ask other participants about the meaning that they attached to a 'safe space', and this 'depth' or 'thickness' would have added to contextualising participants' perceptions of safety between the café and any other service venues that they may attend. Furthermore, memoing enabled me to adjust my interview questioning techniques after I noted that I asked three prompt questions concurrently instead of one As a result of this observation, in the subsequent interviews I made sure I only asked one question and then waited for the participant to complete their response before asking another question.

Furthermore, coding and rereading my memos also reminded me of where I was in the data analysis process, so enabling an easy paper trail of how the themes addressed the research questions, aims and objectives of the study (Memoing, 15.01.19). Coding and rereading memos, according to Koch (1994; Nowell, Norris, White and Moules, 2017) demonstrates dependability level of a research study. For example, during the observation phase, I recorded the number of consent forms, and this prompted me to

begin the interview: '*At the end of today, the total consent forms signed was 31 and the planned number of participants for the interviews was between 20-30*' (Fieldnote 26.03.19). Besides, memoing was useful for thinking about my experiences of adopting different data collection methods and sources (Memoing, 25.11.18 and 17.12.18).

3.7.3 Summary of data analysis

This data analysis chapter has detailed how the observation and interview data were analysed differently in order to optimally present the participants' experiences at / of the café. More importantly, in this chapter, the significance of thick description for the observation and informal conversations data and the thematic analysis for the interview data were discussed. The focus of this chapter was on demonstrating the detailed and stepped process of data analysis that was implemented to establish the links between the overall processes of data analysis. Lastly, the relationships between the basic codes, organising codes and global themes, which form the platform for the findings chapter on the interview data, were presented. The next three sections detail how data were managed throughout the research project: with particular reference to the critical issues of rigour and reflexivity.

3.8 Data management

Data management is imperative to facilitate responsible conduct throughout a research project's lifecycle as it considers all aspects of: (a) creating, (b) housing, (c) delivering, (d) maintaining, (e) preserving and (f) archiving data (Edinburgh Digital Curation Centre [DCC], 2013; UK Data-archive.ac.uk, 2017). Effective data management enables the researcher to (1) ensure the security of data, (2) ensures the efficiency of accessing and storing data accurately, (3) minimises the risk of losing data, (4) prevents duplication of effort and (5) promotes time management (Gallagher, 2013; CDC, 2013). Data management in qualitative research refers to: (a) how data is created, (b) stored, (c) organised, (d) tracked, (e) processed, (f) accessed by others, (g) discarded, and (h) the software that may be used to support the data analysis (Miles, Huberman and Saldaña, 2013). The data management plan and checklist for such a data

management plan, as suggested by the CDC (2013) and the UoN (2015) were employed in this research. In addition, Online Data Management Training and the data management plan prompt sheet (Appendix 20) at the University of Nottingham were successfully completed.

Lofland *et al*. (2005) suggested that researchers follow a filing and naming system comprising: (1) participant ID number, (2) type of data and type of data collection method, (3) the location of data collection, (4) the interviewer and (5) date of data collection; a system which this study has employed. Following this process, patrons who signed the consent form were assigned a unique identifier and participant code. For example, participant number 2 is P2. Pseudonyms were used for each patron who signed the consent form and took part in the study. In creating the pseudonyms, each participant was assigned theirs according to their nationality, ethnic background, or religion; for example, 'Sharonda Jackson' for a Caribbean participant, and 'Bolarin' for a Nigerian participant. This three-strand filter was employed in order to see if any differences were evident in the responses regarding their experiences at the café between such identified participants; no differences were found.

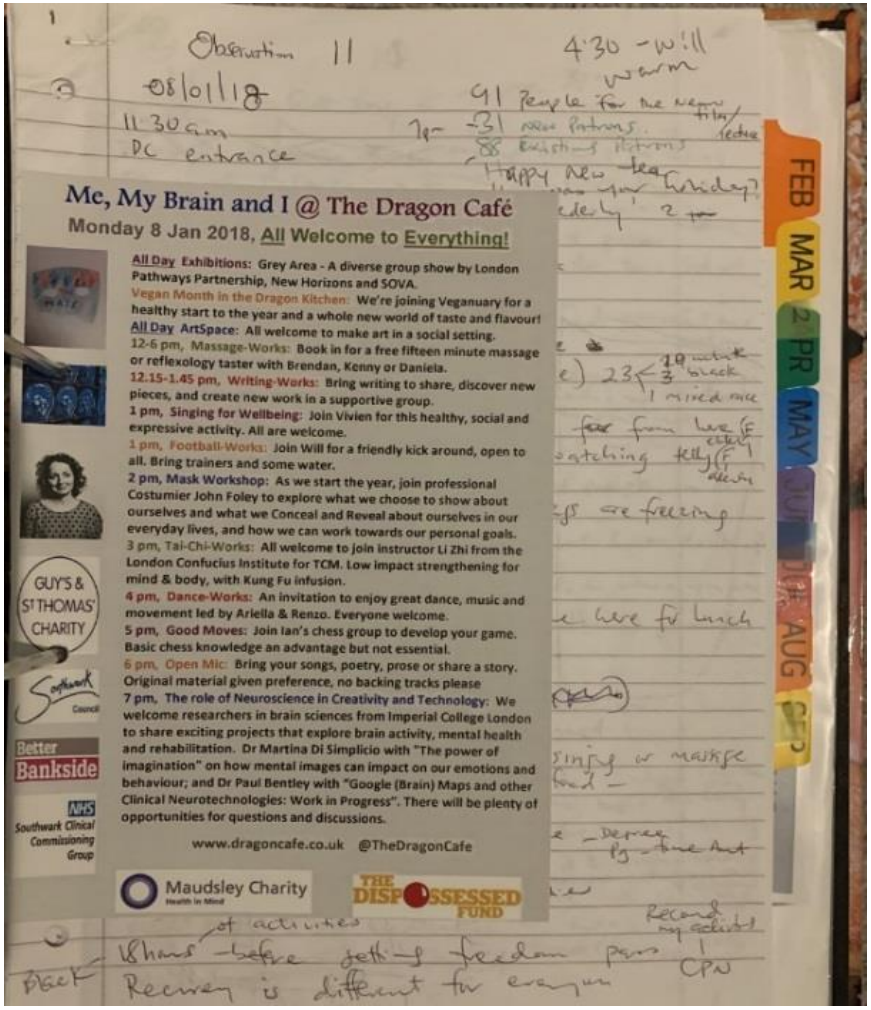
Also, the researcher ensured patrons signed their consent forms separately, rather than together; by employing this method the participants would not know who had what number. The respondents' numbers were allocated randomly as a personal choice (e.g., 22 and 15) rather than consecutively, such as 22, 23, 24. Patrons had a spread of 1- 60 code numbers to choose from, as a way of selecting their preferred identifier for the research. Therefore, patrons who signed the consent form after other patrons had signed, could only choose from any of the remaining numbers, but not the number immediately after the last number. In addition, as suggested by Lofland *et al*. (2005), a folder was created during the observation phase of the fieldwork, and this enabled the separation of each month's dataset (Image 3 Fieldnotes and reflective diary from my fieldwork, thus creating an easy-to-follow audit trail. Also, a copy of the weekly activity schedule was also filed to guide observations and my participations (four per month) and identify any differences in the provision of activities offered in the café on a weekly basis. Moreover, by referring to the past activity schedules, I was able to plan and participated in all the activities, including new

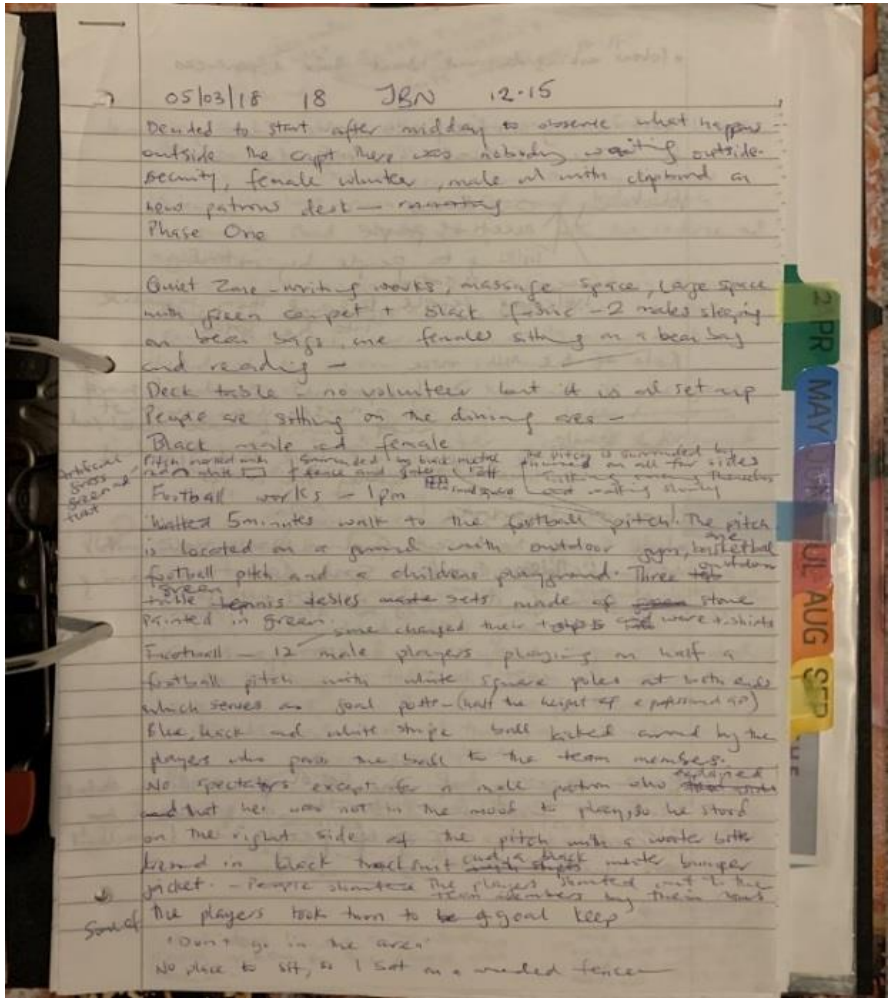
activities that took place quarterly, such as the gong bath; a quiet activity that involves the use of different sizes of brass instruments to make various sounds that creates a relaxing atmosphere (see Chapter 4.1.7.2).

Fieldnotes, observations and informal conversations were filed according to the month, date and time. All raw data were typed weekly, coded using Microsoft Word () and then saved in the University of Nottingham's secure database. This meticulous filing system enabled this researcher to construct a systematic and clear audit trail, which was useful for making connections between participants, activities, location and time in an organised way, which facilitated the writing of the ethnography. An audit trail provided the evidence of the decisions and choices that were made regarding the entire research process, such as the theoretical and methodological issues which required a clear rationale for such decisions (Cutcliffe and McKenna, 2004; Nowell *et al*., 2017). Indeed, study findings can only be audited when another researcher can follow a decision trail using the data collected and theoretical perspective; allowing her or him to arrive at the same comparable, rather than contradictory, conclusions (Koch, 1994; Cutcliffe and McKenna, 2004; Given, 2008).

In the absence of arriving at the same, comparable but not contradictory conclusions, some researchers proposed that irrespective of the type of data collection method, archiving all records of the raw data can provide an audit trail and a yardstick for future data analysis and interpretation (Halpren, 1983; Lincoln and Guba, 1985; Given, 2008). Such a trail can be verified to establish confirmability and as a reference for methodological decision-making and rationale justification (Halpren, 1983; Lincoln and Guba, 1985; Sandelowski, 1986; Cutcliffe and McKenna, 2004; Nowell *et al*., 2017). Thus, developing a systematic audit trail contributed to the credibility of the research process because it was possible to keep records of the raw data, fieldnotes, transcripts, and a reflexive journal. Together, these sources provided a self-critical account of my experiences during the research process and data analysis. For this reason, another researcher can obtain this data for analysis and interpretation because data are open to different interpretations. Therefore, it cannot be predicted whether other researchers will arrive at the same, or even comparable, conclusions.

Image 3 Fieldnotes and reflective diary from my fieldwork





3.9 Rigour

Rigour in qualitative research refers to the: (a) credibility, (b) authenticity, (c) criticality and (d) integrity of the research findings (Sandelowski, 1986; Koch, 1994; Whittemore *et al.,* 2001; Milne and Oberle, 2005; Nowell, Norris, White and Moules, 2017). In ethnography, rigour is important, as different data collection methods can reveal diverse opinions (Patton, 1999; Okely, 2012); such as different participants' views about their experiences of the café. Thus, the findings in this study are presented in a way that reflects the experiences of the participants (Lincoln and Guba, 1985; Milne and Oberle, 2005). Such rich and diverse data, gained from: (a) observations, (b) informal conversations and (c) semi-structured interviews, enabled the data to be compared and checked for accuracy so as to enhance the rigour, credibility and strength of the information collection approach employed in this study (Koch, 1994; Rolfe, 2006; Polit and Beck, 2012; Carter *et al.,* 2014).

Another strategy that was used to enhance the rigour in this ethnographic research initiative was to double-check the interview transcriptions. This desired outcome was achieved by the researcher listening to the audio recordings and comparing the transcript with what was actually heard, by listening to participants' responses and by listening for anything that the transcriber may have missed or misunderstood (Milne and Oberle, 2005). Also, to ensure the transparency of the data collected, patrons were shown the researcher's fieldnotes after informal conversations, to allow the responding patron to double-check the accuracy of their accounts and interpretations (Milne and Oberle, 2005).

Table 10 Strategies for enhancing rigour

Strategies for enhancing rigour	
Authenticity	• I ensured that participants were free to speak. • Sampling was purposeful and flexible. • Participant-driven data collection. • Participants' accounts were used verbatim to show an accurate representation of their experiences of the café. • Data were transcribed accurately and listened to several times to confirm the accuracy of the transcription. • Data transcribed by external sources within the University of Nottingham were also double-checked to ensure accuracy of transcription and any mistakes were corrected.
Credibility	• I captured and portrayed an insider perspective of the place, people and participation at the café.
Criticality	• Using memoing and my reflective diary, I constantly reflected and critically appraised the decisions that I made throughout the research process.
Integrity	• I reflected on possible biases in the research process, such as sampling bias. • I was self-aware of my multiple roles as a PhD student, mental health nurse and interviewer during the fieldwork, data collection, data analysis and writing up. • I engaged with participants to validate the data by showing them the fieldnotes to identify and confirm if I had accurately recorded what they said. • I shared my handwritten fieldnotes and typed fieldnotes with my supervisors as a data peer-review process, in order to confirm that I had accurately expanded my fieldnotes.

Source: Milne and Oberle (2005)

3.10 Reflexivity

> "To be reflexive is to have an ongoing conversation about the experience while simultaneously living in the moment" (Hertz, 1997, p. viii)

Reflexivity in ethnography is the ability of a researcher to think critically and carefully about: (a) how the research was conducted, (b) under what conditions it was conducted, (c) how it was written and by whom,

and (d) what impact these factors might have on the value of the ethnography that was produced (O'Rielly, 2009). Ethnography by nature is research involving a descriptive writing approach that incorporates the analysis of varied experiences of the researcher's positionality and personal experience of attempting to understand a particular group of people in a setting (Hammersley and Atkinson, 2007; Fetterman, 2010; Ellis, Adams and Bochner, 2011; Denzin, 2013; Madison, 2012). As such, ethnographic research is characterised by the documented reflexivity focusing on the researcher's experiences, thoughts and emotions noted during her or his fieldwork (Ellis, Adams and Bochner, 2011; Fitzsimons, 2013).

In this study, reflexivity details my attempts to write myself into my thesis to show how my subjective experiences of entering the field of The Dragon Café impacted on my initial curiosity of finding an alternative to acute mental health wards and statutory CMHS. Also, it sensitised me to be more aware of how to expect the unexpected in any research setting (Dean, 2017; Scott-Jones and Watt, 2019). Indeed, these experiences at the café changed me in ways that made me subdue aspects of my sense of self which included being a Nigerian, a mental health nurse and PhD student, to understand more about the place, people and participation at the café through time, space and interactions with the patrons. As Madden (2017) put it: "The favoured way of making the most of oneself as a tool of ethnography is to do as others do, to have the similar subjective bodily experiences of being in a particular ethnographic place and time" (p.81).

Thus, throughout the fieldwork, I learnt that to understand was to observe the patrons, participate like them and listen to the instructions given by the gatekeepers about what to do, what not to do and how to do what had to be done. As a result, I had to correct myself several times throughout the fieldwork to adapt to the expectations of the processes within the café, the research, the gatekeepers and participants (Finlay, 2002; Denzin, 2013). By implementing those corrections, such as volunteering first before data collection, not wearing the branded café t-shirt when I was acting in the role of a patrons, and helping out with setting up and packing down the spaces, I felt that I was breaking with the orthodoxy of research by doing things different as the place, people and participation guided my field experiences, rather than accepting the

orthodoxy that was presented to me professionally, personally, culturally and academically. For me, reflecting on these mistakes was a learning experience, and I feel that 'reflexivity in this ethnography was more than being aware, rather, it was about being aware of when I was not aware and acknowledging and learning from the consequences of possible oversights. In acknowledging the above realisation, I define my experience of ethnography as:

> "The knowing that you can never know enough about what you seek to know, and even when you think that have understood that which you seek to understand, you would realise that there is much more to learn."

By nature, ethnography is interrelated with the participants, processes and settings that are involved in a specific study; three factors which are the reference points that enable the researcher to articulate her / his experiences (Denzin, 2013). In other words, it was not possible to be reflexive without writing about the participants and the setting, because these are the aspects of the research process that influenced my thoughts, actions and feelings during the fieldwork. For example, by participating in the activities alongside the participants, it was possible to share in their experiences and co-produce those realities with them. Furthermore, thinking reflexively prompted me to embed myself into the social phenomena (ethno) of the study (graphy) (Liggins, Kearns, and Adams, 2013), as well as to co-construct my experiences in the café with the participants. Epistemologically, I was able to co-construct the social realities in the café with the participants, to become embedded through place, people and participation at the café, thereby enabling the collection of rich and diverse data, and the interpretation of participants' accounts (O'Reilly, 2012; Lichterman, 2015).

Limitations of conducting ethnographic research include challenges, such as the one that was addressed through reflexivity. I need to achieve a balance between being an insider and an outsider at the café (Tedlock, 1991) in order for me to not lose my identity and compromise my role as a researcher when I became fully immersed in the café over a one year period (Hammersley and Atkinson, 2007; Emerson, Fretz and Shaw, 2011; Burgess, 2016). Tuckett, (2014) stresses that the constructionist ethnography is a reflexive process that is conscious of the social interactions, and social processes, paying particular

attention to how participants produce these two behaviours in the social setting. Therefore, rather than an outsider's view of participants interactions, my embeddedness enabled the observation, participation, understanding and interpretation of how participants socially constructed their realities when they were in the café.

Ontologically, interpretivism enabled me to better understand and therefore interpret the diverse meanings that participants attached to their experiences (Holloway and Wheeler, 2002; Scott-Jones and Watt, 2019). However, initially, due to assumed knowledge of having experienced the café in the past, I initially commenced fieldwork without being conscious of my subjective stance and how this position might influence the study. For example, after attending the café a few times before the fieldwork, on the first day of fieldwork I was surprised that the rooms that were previously set-up for activities were empty, and I soon found out that the space is set-up every Monday and packed down at the end of the day: *I felt like a fraud with a huge umbrella of imposter syndrome because not too long ago I had my confirmation review and other assessments where I described café as adopting a commercial café style space. However, I also feel relieved that I did not go into the field with a notion of 'Knowing what to expect'. This is a case of catch 22…but the latter is better for helping me to embed myself in this space because I am truly just discovering and experiencing what The Dragon Café is, what it does and for who.* (Reflective note, 16.10.17).

Some authors recommend that researchers enter the field without presumptions, so as to prevent perceived knowledge that may create false perceptions and confirmatory bias about the research setting, people and processes (Hertz, 1997; Dean, 2017; Lichterman, 2015). However, such a constraint is for practical purposes, impossible, because assumptions are inherent in people, researchers included (Burgess, 2016). As Gobo (2010) attests:

> "All of us, therefore, have pre-assumptions, make pre-judgements and harbour prejudices: they are inescapable. However, our reasoning may be more or less influenced by them; we may be biased by them to a greater or lesser extent." (p. 76).

Therefore, I soon realised the challenges that were associated with my previous assumptions about personal knowledge of the café and how my position as a researcher in the field may impact on the research process if these assumptions are not suspended. This revelation occurred whilst becoming embedded in the café research setting, thereby allowing me to *begin* to understand the people, place and participation.

Lichterman (2015) and Reed (2011) suggest that common views of positionality perceive the ethnographer as holding different positions in the hierarchy of social structures within the research. Similarly, Bourdieu and Wacquant (1992) view the ethnographer as the holder of positions that enable them to present a reflexive universal view of the social process that highlights assumptions and the power relations that exist in the field. For this reason, my awareness of my positionality was a highly reflexive narrative of my experiences at the café, with a great emphasis on the profound importance of the several positions that I held as a researcher. Positionality is a concern for qualitative researchers in relation to data collection methods and inter-personal relationships in the field and as such the researcher's positionality influences all aspects of the research process (Kleist, 1999; Bourke, 2014; Cuthill, 2015). The influence of positionality was pertinent in my case as I reflected on what to do with a registered mental health nurse in the UK, a PhD student, Nigerian and Black British female. Moreover, the embodiment of the different roles is informed by my values, otherwise known as 'axiology', in a way that I became more aware that my values are part of the research and cannot be separated from it, and as such guided my judgements throughout the research process (Heron, 1996; Creswell, 2012; Kivunja and Kuyini, 2017).

As described in the motivation for this study (see Chapter 1.2), culturally, in Nigeria, mental health is not a priority in conversations among ethnic groups, in the community or politically. Thus, even though I am a registered mental health nurse in the UK, I am aware of how my previous embedded knowledge and views of mental health, cultural perceptions, and post-modern understanding of mental health may influence my point of view about the place, people and participation variables informing the café and my perception of it. Indeed, my language, cultural beliefs, expectations and my views were embedded into my subconscious from my past experiences, and it is through this lens that I view the world. Thus, my

training as a mental health nurse and additional knowledge and skills that I have developed through education provided me with new knowledge that enabled me to navigate the place, people and participation at the café. As Sultana (2007) attests:

> "It is critical to pay attention to positionality, reflexivity, the production of knowledge and the power relations that are inherent in research processes in order to undertake ethical research" (p. 380).

Therefore, I was very sensitive to these positions as I embedded myself in the research setting because my professional, academic and cultural views influenced: (a) how I interacted with the participants during the observational and interview phases of the fieldwork and (b) how data were collected, transcribed, analysed and interpreted (Kleist, 1999; Cuthill, 2015). For me, interpretive reflexivity enabled me to build an understanding of the overall process of the research, including: (1) how data were collected, (2) how I came up with my interpretations, (3) the mistakes that I made, (4) the things that I should have done, or not done, and (5) how all of these trial and error experiences enabled me to capture the meanings that participants attach to their experiences at the café. This realisation made me more conscious about how those challenges, if they had been left unchecked, could have seriously interfered with the outcome of the study.

Furthermore, interpretive reflexivity broadened my ability to explore meanings, and participants accounts about their experiences of the café (Bourke, 2014; Lichterman, 2015; Voyer and Trondman, 2016). As a novice ethnographer, this experiential inquiry resulted in a deeply felt conscious and inquisitive personal interest to explore the questions and answers about what makes people with MHCs attend the café; and to do so, I had to experience the place, people and participation the way that the attendee patrons experienced it. To achieve this goal, it was necessary to engage in self-dialogue where I entered into a conversation with myself about: (a) what I knew about the café and (b) how I discovered that the café was an unfamiliar phenomenon that, in order to be understood, would require my total immersion through active and prolonged interactions with the place, people and participation.

I tried my upmost to make this journey with limited bias and more open-mindedness in order to actively listen to participants' descriptions of their experiences at the café. An example was when I emailed one of the tutors, who came with students to the café, to confirm what they said to me during the observation phase of the fieldwork. She replied that she said something different and emailed me her comment:

Dear Josephine,

I understand from Basila (Pseudonym) that you are at the writing up stage of your PhD and would like to include something I said at The Dragon Café:

> "*I come here weekly with new sets of students because I want to give the nursing students a different perspective from what they read and study so that they can appreciate other people's way of life and how they socialise*."

To be honest, I don't recall saying this – although I may have – and I don't feel it really reflects the reasons I like my medical students to visit the café. I wondered whether you had perhaps also spoken with someone else who was supervising student visits, as I recall there being nursing students there during our visits? In any case, I am very happy to contribute a quote to your thesis – but how about using the quote below as an alternative?

> "*I bring medical students to The Dragon Café to provide them with an opportunity to interact with its patrons in a non-clinical, social setting; to observe the positive impact such community-based initiatives can have on peoples' well-being and socialisation and to reflect upon the relevance of the experience to their future practice. Visiting The Dragon Café helps students see patients as individuals, rather than conditions. It encourages them to think about whole-person care and to challenge the societally-conditioned stigma and apprehensiveness that exists around mental health*." (Ashley, 22/11/18).

I attach a completed consent form in relation to the new quote I have just given above.
Good luck with your writing!

Best wishes,
Ashley (Pseudonym)

The above may suggest that I misunderstood what Ashley meant, or indeed that I wrote down something different from what she said and any of those could be right. The point here is that in ethnography,

reflexively written fieldnotes are vital but in the presence of so much happening in a research setting, such as the café, at any one time, mistakes are unavoidable (Burgess, 1982, 2016; Lichterman, 2015; Dean, 2017).

Lichterman (2015) considered that reflexivity should encompass a rigorous and critical analysis of a researcher's actions and practices while in the field. Thus, throughout the research process, it was important to be very conscious of: (a) my subjective stance of existing knowledge of the café, (b) the dangers of becoming too immersed in the field and (c) how questions were framed during interactions with the participants (Mead and Morris, 1997; Blommaert and Jie, 2010). There was also a need to be sensitive and perceptive of how my presence influenced participants' action, interactions, and reactions to my presence during observations sessions (Hertz, 1997; Finlay, 2002; Navarro 2006).

Holloway and Freshman (2007) attest that a researcher being reflexively aware of probing their subjective feelings, thoughts and assumptions promotes a rich insight into these influences by probing my subjective responses and interpersonal relationships with the participants, which was highly relevant in my study. For example, at times during the interview, I felt like the interview guide was restrictive and preventing greater use of prompts and flexibility of questioning when there was an opportunity to ask more questions, but it was being blocked. Still, I sometimes depended on the interview guide. Thus, on reflection, when a participant said, '*So I came down to The Dragon Café, participated in the singing group, thoroughly enjoyed it, and I'm never going to stop [laughs] coming back*' (Donna). Following such an enthusiastic response I could / should have explored further with prompts by asking the participant what it was about the singing that she enjoyed. In future, I will think a bit more about the participant's answers so that I can use effective prompts to enable them to provide more in-depth responses.

Reflexivity has been criticised as self-indulgent with the researcher talking about themselves with little or no reference to the participants, processes and settings (Ellis, Adams and Bochner, 2011; Liggins, Kearns and Adams, 2013). However, as an approach, being reflexive enabled me to tell my story through a narrative infused with emotion, vulnerability, and doubt about my identity and capability. As such, having

the experience of fieldwork in the café was particularly crucial for me to explore these emotions. Indeed, the credibility of reflexive research also relates to how factual the researcher presents and interprets participants' accounts (Ellis, Adams and Bochner, 2011). Therefore, to enhance the credibility of this study, I kept a detailed reflexive journal which I used throughout this ethnography to document a detailed account of the entire research process. This reflexive initiative resulted in raised self-awareness levels regarding my identity and the development of ethnographic skills which enhanced my understanding of myself in relation to the place, people and participation at the café (Fetterman, 2010; Madden, 2017).

To summarise, my reflexive intent was to show and tell my experiences of the café while communicating detailed accounts of the place people and participation to an audience outside the research setting, rather than the more usual reporting of what was seen or heard: although of course the latter two issues were addressed. Unintentionally, being reflexive prepared me for the entire research process, such as participant observation, informal conversations and semi-structured interviews; it made me appreciate the significance of actively documenting my feelings as I embedded myself in a research setting so that I was more conscious of how my presence impacted on my feelings and thoughts, the research setting and participants, as I sought to understand a phenomenon called a mental health café.

In the next chapter, the findings from the ethnography will be presented, including a 3-D video, photographs, observations and informal conversations and the use of images which serves to contextualise the thick description of the place, people and participation at the café. Information showing how the participants socially interact, produce and reproduce their experiences at the café will be presented in detail. In discussing the findings from the semi-structured interview, in-depth interpretations of participant's accounts of their individual experiences at the café are clarified. In both analyses, verbatim quotes from participants' accounts are used to show why participants attend the café, and articulate the relationship between the place, people and participation at The Dragon Café.

CHAPTER FOUR FINDINGS FROM THE ETHNOGRAPHY

4.0 Introduction

The last two chapters have provided details of the processes used for analysing the data acquired from the observations, informal conversations and semi-structured interviews. This chapter begins with a description of how data are presented to show a logical sequence of events in relation to the participant's accounts of their experiences. Then the chapter continues to set the scene for the observation phase of the study, which includes a detailed physical description of the underlying structures of the place: (1) where the café is situated, (2) transport links, (3) the local geography of the area, with details of (4) the ownership and administration of the building. This latter issue highlights the terms of use and how the café fits into the various spaces within a building.

In presenting these findings, pseudonyms are used as replacements to represent patrons' identities. Patrons as consenting subjects of the ethnography will be referred to as follows: (a) 'participant' (an attendee not acting as a volunteer or paid staff); (b) 'participant volunteer' (a volunteer or activity facilitator); and (c) 'participant gatekeeper' (a member of the café's management). In describing the place, people and participation within the café in general, all other attendees present in the café who, for whatever reason, declined to be participants in the study are referred to as: (d) patrons, (e) volunteers, (f) activity facilitators and (g) gatekeepers. Participants' responses in this observation chapter are written in italics with double quotation marks at the beginning and the end of each quotation. Associated with these quotes are: (1) the participant's pseudonym, (2) the words 'informal conversation' and (3) the date of the conversation in parentheses; for example: (Basila, informal conversation, 12.07.17). The terms 'people' and 'patrons' are used interchangeably to describe those who attend the café. Lastly, I narrate my final thoughts in the form of a summary of the findings intertwined with my reflections.

I acknowledge that my interpretations of the findings from this ethnography, whilst carefully made, remain subjective and open to alternative or competing perspectives; a proviso that can be applied to any

qualitative data. I have endeavoured to offer credible interpretations but accept that my findings could have other meanings, depending on who is interpreting, describing, and analysing this data (Parahoo, 2014; Scott-Jones and Watt, 2019). It is important to note here that some questions and participants' responses in the findings from the observation and informal conversations may overlap, duplicate, reinforce or extend the findings from the semi-structured interviews. For example, during the informal conversations, participants used words like 'we' and 'us', in a way that their responses were about group experiences which were collectively created, and therefore less about their individual experiences of and in the café. For example, during the informal conversations, participants responded that other kinds of day centres had closed, and they had nowhere else to go other than The Dragon Café. However, during their interviews, participants gave individual and diverse reasons for attending the café, including: (a) a GP referral, (b) seeing a flyer, and (c) recommendation by a health practitioner, thereby addressing the overall question of the study in more depth through diverse and multiple views. Furthermore, there were many distractions during the observations and informal conversations, such as participants leaving to join activities or interact with other patrons, going home because they were tired or not responding because they were passively participating in the activities by watching what was going on. Subsequently, during the semi-structured interviews, it became apparent that participants had more to say about their own individual experiences, with greater use of the pronoun 'I'.

4.1 Findings one: Observations and informal conversations

This section presents thick descriptions of the place and space of the café, and the data gained from the observations and informal conversations. This analysis identifies how participants began to visit the café after a recommendation by health practitioners, family and friends or they saw a leaflet or outdoor banner about the café. The café provides them with somewhere to go, enables them to meet people who share experiential knowledge, and offers a choice of four spaces where they can interact and participate in a variety of free activities including: (a) the outdoors with gardens and (b) the three rooms inside the café. This section also presents data that indicates how participants collectively produce their experiences

through their participation at the café. Thus, the relationships between the place, people and participation are shown as key to the construction of participants' experiences of the café, accurately describing motives and intentions of social actions of thoughts, emotions and social interactions between participants in the café. In the absence of the café, as participants described below (See Chapter 4.1 and 4.2), they would have had nowhere to go. It becomes important therefore, to thickly describe the physical space of the café to enable a broader understanding of the space, and participants accounts of their experiences of the place and space where the café is located. Indeed, without the thick description of the physical spaces within the café, and an explicit explanation on why the physical space of the café is a central part of the ethnography, the reader might not fully understand what the café is and what it is about such an informal CMHS that makes people with mental health challenges attend. Such an approach is designed to allow readers to experience a sense of credibility from the accounts described and why it is.

As Denzin (1998) proposed, credibility or authenticity in thick description is "truthlike statements that produce for readers the feeling that they have experienced or could experience the events being described" (p.83-84). In essence, Denzin extends the utility of "thick description" as an anthropological construct used in ethnography, and particularly in participant observation. Indeed, social structures and the understanding of social structures form the basis of Clifford Geertz's anthropology, which suggests that the ethnographer should describe the context and culture through thick descriptions of various details, concrete structures and meaning (Geertz, 1973). Therefore, this chapter provides a detailed context of the relationships between place, people and participation while addressing the overall research questions: (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service?*

As detailed earlier (Chapter 2.2.4.5) and in the discussion chapter (5.1.2 and 5.1.5), space and time are connected for constructing and developing collective social practices within diverse places and spaces (Miller, 2011; Uitermark, Nicholls and Loopmans, 2012; Campbell, 2016). Thus, it becomes important to explicitly describe and document the physical space of the café as a key aspect of the ethnography, in

order to understand how the internal and external structures of the café space impact the patrons and their participation within the café. In doing so, I present the rhythm of the day at the café in relation to the physical space and why people attend the café; with the different activities that the café offers in different spaces presented sequentially. Also, I describe the various details, concrete structures and meanings that participants attached to their experiences (Geertz, 1973). Further, I have presented the thick descriptions (Geertz, 1973) of the place, people and participation contextualised by how people act, react and interact in the environment in relation to space, other patrons and the activities themselves. Understood in this way, it was central to show the interdependent, dynamic relationship between people's behaviour within the café space and activities to show where one cannot be present without the others (Duff, 2012). Therefore, I thickly describe the findings to present the motives and intentions behind participants' actions, thoughts, emotions, and social interactions, as they individually and collectively produced and communicate their experiences of the café. Presenting the data in this way enables the reader to experience a sense of credibility from the accounts described. As Denzin (1998) put it, credibility in thick description is: "truthlike statements that produce for readers the feeling that they have experienced or could experience the events being described" (p.83-84).

I present selected reflective diary accounts from the fieldnotes to offer my insider and outsider views (Pike, 1967; Oakley 2012). Also presented are my experiences of the place, people and participation at the café, written in *italics* with the words 'fieldnote' and date written in parentheses (Fieldnote, 05.03.18). I use my initials JNB (Josephine NwaAmaka Bardi) to indicate where I asked participants questions, as well as including some questions that I reflected on during the fieldwork in order to show my thinking process and how I internalised questions regarding some of my experiences.

I merged different verbatim quotes from different patrons on different days and times to present a logical sequence of the ethnography. Individual and multiple perspectives from participants' comments, quotations and phrases are covered in the ethnographic narration without necessarily keeping to sequential

dates. Rather, verbatim quotes and accounts from different participants about similar experiences show how they individually and collectively construct their experiences of attending the café.

Further, in answering the research question, "*What is The Dragon* Café?" early differentiation of the café from other kinds of resources emerged from an objection by one participant gatekeeper to the narration in a 2013 YouTube video (Tabase, 2015) where The Dragon Café was described as a pop-up café:

> "*While The Dragon Café was referred to as a pop-up café in its first year when we were uncertain as to whether it would become an enduring project, it is no longer "a pop up". It, however, is an "art and mental health space which pops up every Monday. So, the use of the verb form is correct. We still talk about it "popping up" to signify its weekly spatial resurgence which you capture so beautifully in your work. Pop-ups do tend to be temporary, and to move from one place to the next as space availability dictates.*" (Basila, informal conversation, 26.06.19).

Moreover, from my observations, I cannot describe the café as a 'pop-up', but I can describe the activities as 'pop-up' due to the need to use the same space for two or three activities (Section 3.11.6). From this perspective, it is essential to describe the characteristics of a 'pop-up space' so that the reader can discern why the café is not referred to as a pop-up phenomenon. According to Lefebvre and Nicholson-Smith (1991), pop-up spaces are permanent spaces transformed for temporary use and designed as experiential platforms within social spaces. Equally, other authors have described pop-up stores as not belonging to space where they pop-up (Steven and Ambler, 2010; Harris, 2015; Overdiek, 2017). As Overdiek (2017) maintains "pop-up stores often blur the symbolic order of a shop, mostly, and they are not designed to sell, but to immerse the users in shared experiences which include products*"* (p. 117). In this sense, the café does not fit the definition of a 'pop-up café', but that does not suggest that the term 'pop-up' is only for commercial stores. For example, there is research evidence on non-commercial pop-up cafés, such as: (a) 'death' cafés (Miles and Corr, 2017), (b) 'dementia' cafés (Halley *et al*., 2005) and (c) the 'frazzled' café which pops-up in spaces within different Marks and Spencer stores around the UK (Nursing Standard, 2017).

4.1.2 Setting the scene for the observation phase of the ethnography

I now set the scene for the observational phase of the study. First, I present the floor plan of the crypt, an annotated floor plan, which shows the spatial environment of the spaces within the crypt, and a QR code of a 3-dimensional video of the indoor and outdoor spaces of the café (Figures 7 and 8). The use of an annotated floor plan and a 3-dimensional video further illustrates the space of the café, providing the reader with virtual data that buttresses my point on why it is paramount to describe and how the place and space of the café, and as such, enable further understanding of the relationship between the place, people and participation at the café. Again, my decision to thickly describe the physical space of the café is validated below by how participants describe their experiences in the difference spaces within the café. In other words, without my initial description and visual presentation of the spaces, participants comments regarding the views of the café spaces could be misunderstood. Afterall, ethnography is about showing and telling so that they reader As stated previously (See Chapter 1.0), my ethnographic intent was to understand the relationship between the place, people and participation at the café, so in achieving this, it is crucial that I present not only detailed ethnographic narrative that takes the reader on a journey in and out of The Dragon Café, as though they were present, but also a description of the space where people interact with each other and participate in activities.

Second, I describe my initial experiences of the fieldwork by detailing how I orientated myself to the café environment and its patrons; in particular, how balancing what I knew about the café with my initial interactions with participant gatekeepers, formed the platform for my immersion in the café. I also include pictures alongside verbatim quotes from the patrons to contextualise the thick description of the observed events; as well as thick descriptions of: (1) the place where the café is located, (2) the rhythm of the day at the café, (3) participants' accounts of their experiences of the café space and (4) the activities that the café offers.

Figure 7 The crypt floor plan without set-up

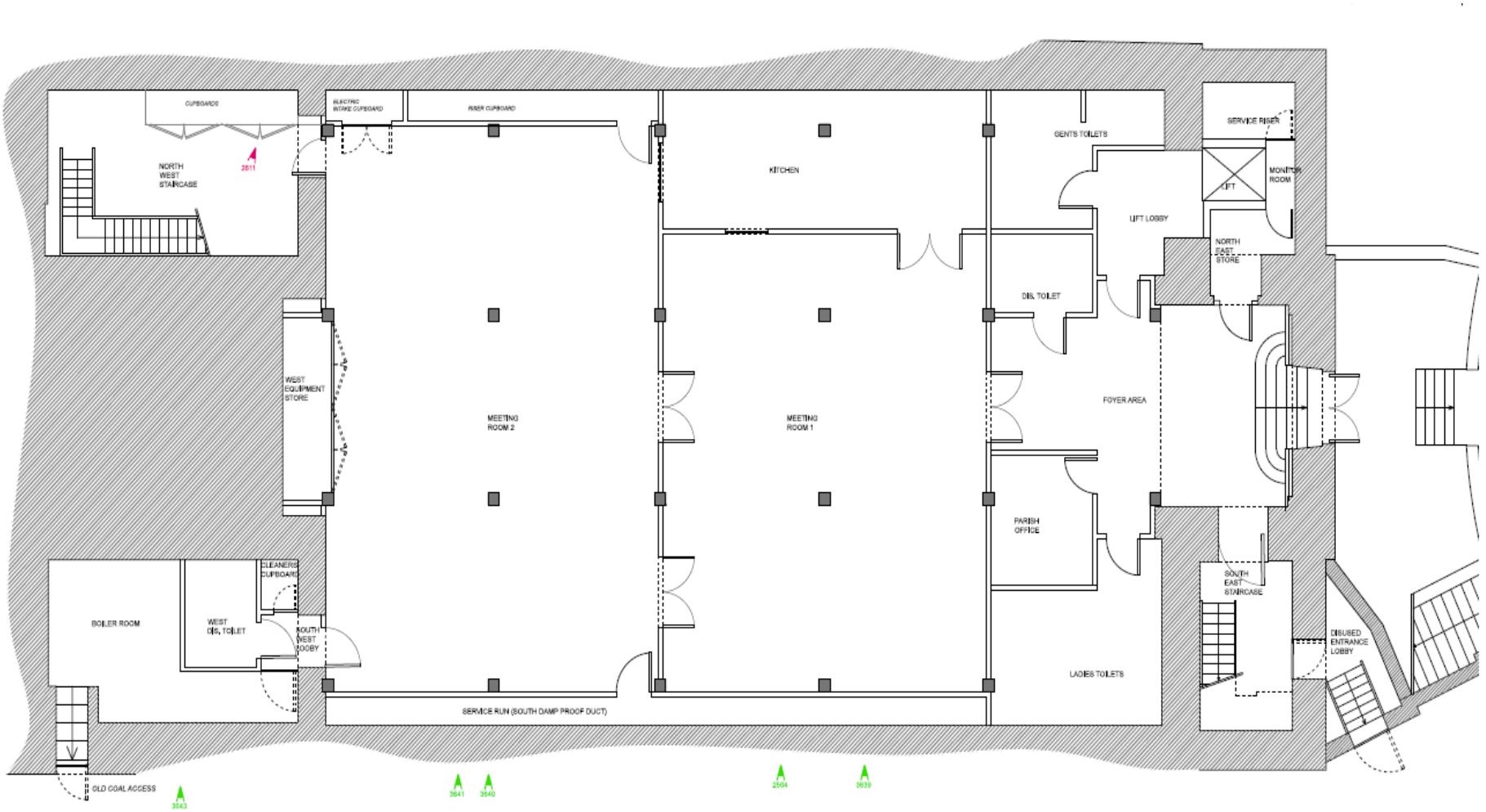
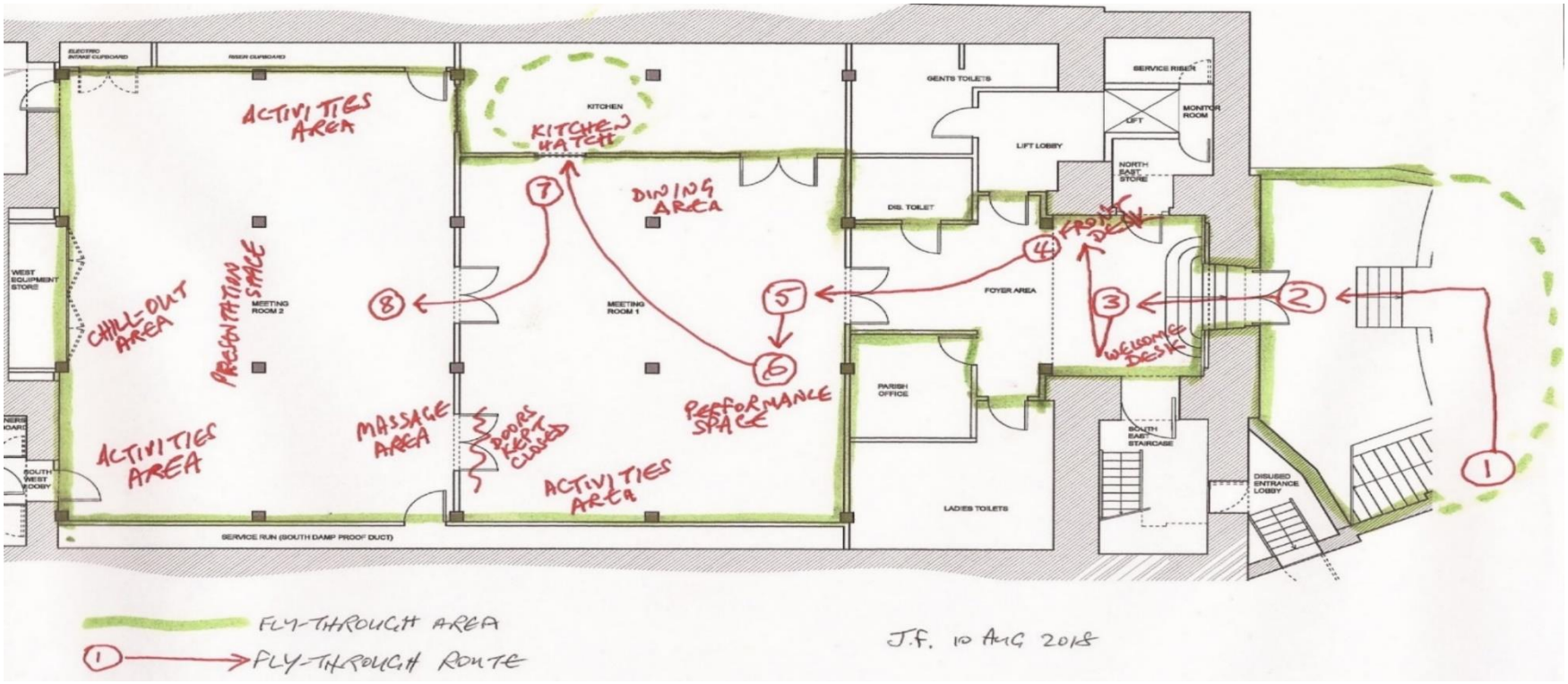


Figure 8 Annotated crypt floor plan and the QR code for the 3-dimensional video



Scan the QR code to access the 3-dimensional video of the outdoor and indoor spaces of where The Dragon Café is located. To download QR code from your mobile phone, open the App Store and search for QR code readers, open the App, and scan.

*It is the first day of fieldwork, and I am feeling nervous, excited and unsure about what to do, what to say and how to act 'right', but most of all, sad. I tried to retain the feeling of excitement, but all I felt was sadness, loss and nostalgia. Today reminded me of the first day that I walked into the crypt and met Sarah Wheeler. The day that I made a promise to study The Dragon Café in my PhD, three years ago in the second semester of my master's study, a time when I did not know how or where to get the money for a PhD or indeed what a PhD was. Today also reminded me the last time that I walked into the crypt for Sarah Wheeler's funeral, the day that I said goodbye. From today onwards, I will spend time with a diverse group of people in an unfamiliar, familiar space, to learn the how, what, why, who and when about the place, people and participation at The Dragon Café. To understand what I do now know that I do not know about The Dragon Café (*Fieldnote, 09.10.17).

I began fieldwork at the café on 9th October 2017, arriving at 11.15 am and quickly observing renovation work going on in the church with metal scaffolding around the building. As I walked towards the crypt at the back of the church, I noticed lots of people (male and female) waiting around the entrance of the crypt in front of two arched, dark blue double doors. Three of the people outside the crypt had black Dragon Café t-shirts on and were sweeping the grounds outside the crypt; others were attaching two outdoor 'Dragon Café' banners and laminated 'No Smoking' and 'No Alcohol and Drugs' signs with black plastic straps to black metal fences that surrounded the crypt.

A man wearing a branded Dragon Café t-shirt was holding a pen and paper with a list of names, and I could hear him telling the people waiting that the café opens at 12.00 pm. I greeted him and tried to enter the crypt, but he asked me to return at 12.00 pm. I thanked him, walked away and sat on a dark brown wooden outdoor chair, from where I could see what was happening at the crypt entrance. More people joined the gathering, and the man with the clipboard spoke to them, ticked something on the paper after talking to some of those waiting, and wrote something down after talking to other individuals. *I could not hear what he was saying to them or their responses, and I could not tell what he was ticking on the piece*

paper (Fieldnote, 09.10.17). Some of those waiting talked among themselves, others stood alone, while some were smoking or sitting on two outdoor wooden chairs.

At 12.00 pm, the people waiting around started to queue in front of the double doors and slowly entered. I waited for everyone to go in, and then I walked over to the man, introduced myself and explained that I had a meeting with a gatekeeper at 1.00 pm. He pointed out where to meet the gatekeeper, but said I had to check-in at the reception desk first. I walked into the crypt and saw three women wearing similar branded Dragon Café t-shirts and seated on the left and right of the Reception Area behind two tables covered with dark purple silk organza fabrics. There were two laminated signs attached to the front of each table. On entry, I could smell pastries (cakes, scones) and other assorted cooked food and hear instrumental music playing in the background. I greeted the women, and as I tried to walk past them, one of them asked if I was a patron. I did not know what a patron meant by the word 'patron', so I said no. She then asked if I had visited the café in the past, and when I said yes, she responded that I was an existing patron and directed me towards the table on the right where a woman checked my name on a laptop, wrote something on a card and gave the card to me.

Image 4 Membership card at the café



I was confused when the female volunteer directed me to the existing patron's desk because I did not know whether I was a patron when I became a patron or what being a patron meant (Fieldnote, 09.10.17). As I walked into the second room, I was thinking of three questions to ask the gatekeeper as soon as I had the opportunity: (1) What is The Dragon Café? (2) Who are The Dragon Café patrons? (3) What is the

membership card for? Although Sarah Wheeler already set out her own individual answer to the question of what the café is, as indicated earlier (See Chapter 1.3), the extracts below are combinations of participants views and of how they define and describe the café.

I met with a participant gatekeeper who asked me about the data collection methods. As I explained that I would conduct observations, informal conversations and semi-structured interviews, the participant gatekeeper immediately said:

> "*You cannot call it observations because it has an inpatient connotation to it. We will call it participation so that it helps you embed better, and we will call interviews, conversations so that you can take your point of reference from the patron's points of views*" (Basila, informal conversation, 09.10.17).

I nodded and agreed with the participant gatekeeper's suggestion because as I mental health nurse, I understood what she meant by 'inpatient connotation' and anyway, I came here to learn, and the best way to learn was to listen, observe and do as I was told (Fieldnote, 09.10.17).

JNB – Who are The Dragon Café patrons?

> *"People are called patrons because The Dragon Café exists through the patronage of attendees, not echoing the NHS system of labelling. There is a sense of belongingness that exist here because patrons are not using a service; they are part of the service.*" (Basila, informal conversation, 09.10.17).

JNB – What is The Dragon Café?

> "*The Dragon Café represents entry-level into the society; it is the first step to leave isolation at home and be at peace, undisturbed.*" (Basila, informal conversation, 09.10.17).
>
> *"In The Dragon Café, we support patrons to achieve whatever goals they want to achieve, and there is a continuity of being in the space because patrons can choose to stay the whole day or come and go as they please throughout the day*." (Basila, informal conversation, 09.10.17)

JNB – What is the membership card for? Is it like clubhouses where members are issued with membership cards?

> *"Yes, we issue membership cards, but there is no onus on people to participate or carry out any task, and people design their roles here in the café because they choose what to do or not to do. This is very different from the clubhouses, which are more employment-focused, and members must take part in the day to day running of the clubhouse."* (Basila, informal conversation, 09.10.17).

> *Even if people are just coming for a coffee, they have to register, so people are given membership cards to help us keep statistics of who visits. It is our evidence of who visits the café.*" (Phillip, informal conversation, 19.03.18).

People have varied views about being registered as a member at the café and having a membership card. For medical students, being a member of the café provided access to socialise with different age groups of people with a varied diagnosis of MHCs in a social, rather than clinical space:

> *"Amazing space with a membership card to attend whenever I like and be a part of something. I can interact with people of all ages. My classmates don't seem to understand the non-clinical view in this space."* (Amina, informal conversation, 12.03.18).

> *"Having a membership card means that we have access to a space where we can meet and interact with people with different diagnoses of mental health problems…at uni, we are only taught diagnosis and treatment, and on the wards, the same people are called patients, and we cannot freely interact and participate in different activities.*" (Tom, informal conversation, 5.3.18).

One patron reported that having a membership card provides them with free access to other services:

> *"I also attend the Bridge, a female-only service where patrons with The Dragon Café membership card can attend and participate in workshops, including the use of the gym and swimming for free.*" (Diqrah, informal conversation, 13.11.17).

Another day, two of the participant gatekeepers joined me at the table and started to talk about why the café was established. I knew the reasons that Sarah gave (see Chapter 1.3), but I was keen to know if the participant gatekeepers had different opinions about why the café was established:

> "*What I realise is that there was the need, and the need came from when they closed down a lot of the day centres. More people are in the community as you know from your own background, and therefore, there is a need for people to find somewhere to go to.*" (Susanna, informal conversation, 27.11.17).

I asked Susanna why the café is called 'The Dragon Café', and she explained that Sarah Wheeler, the founder of the café chose the name:

"*To represent both the name of the church where the café is located and St George who slayed the Dragon, because for Sarah, slaying the dragon is a symbol of dealing with mental health problems*." (Susanna, informal conversation, 27.11.17).

4.1.3 Description of the place where the café is located

As detailed previously, it is important to explicitly explain why the physical space of the café is a key part of the ethnography. This section provides the initial description of the space where they café is located. The Dragon Café uses the crypt of St George the Martyr Church, which is located opposite Borough Station in the London Borough of Southwark (St George the Martyr with St Alphege & St Jude, 2017). The London Borough of Southwark is a densely populated part of inner London that is rated as the 9th most populated local authority in England and Wales (Southwark Annual Public Health Report, 2016). Transport Links to the café is a two to five minutes' walk from public transport links, including bus routes: 21, 35, 40, 47, 78, 133, 381, C10, night bus routes: N21, N133, N199, N343, N381 and the London Underground route on the Northern line.

Image 5 St George the Martyr Church



One the participant gatekeepers informed me about how they rent the crypt from the church and the attitudes of some of the church congregation towards the café:

> "*We hire the crypt space from the management of St George the Martyr with St Alphege & St Jude, Southwark for an annual cost at the rate of £60.00 per hour and £300.00 per day. The rent is renewable annually, and it excludes the foyer but includes the two meeting rooms and the toilet facilities*." (Susanna, informal conversation 13.11.17).

While it is fascinating that the café is in the crypt of a church, there is little evidence to demonstrate that it is connected closely with faith communities; a point made by patrons who expressed different views about the café's location in the crypt of a church:

> "*Well, the church sees us as part of their wider mission, so they are very happy to have us and that actually, if you like, improves their numbers. They see it as part of their service to the community, but there are people in the church who don't want us there.*
> "*A church is calm, a place of sanctuary."* (Teri, informal conversation, 4.12.17).

> *"I suppose a church building can mean a lot of things to people. You know, it is a church, faith, acceptance, security, supporting each other, closeness.*" (Arnold, informal conversation, 20.11.17).

Two of the participant gatekeepers identified space and funding as two issues that may impact on the café remaining open in the crypt.

> "*Funding and space are issues, but maybe if it is spaced out, it might lose the intimate feeling that this space provides.*" (Mohammed, informal conversation, 11.12.17).

> *"Space is a major challenge. We want to be able to host different workshops, and some of them require a lot of space, but we can't host these workshops. Some workshops require a space where they can coordinate noisy workshops, and some are quiet workshops. Both workshops require a different kind of space.*" (Susanna, informal conversation, 13.11.17).

> "*We are open every Monday except for August and some Christmas days like this year because Christmas falls on a Monday. Some people want us to open every day, but they are more worried that we haven't got the funding to continue it. Because what we haven't got, you know, is a million of pounds to keep it going.*" (Susanna, informal conversation, 27.11.17).

Participants echoed what the participant gatekeepers said about opening the café for more than one day and, on the use of the space:

> "*It will be good if The Dragon Café can open more days in winter because it is cold, and people feel low. In summer people can go to the parks and walk around in the beautiful weather*." (Aida, informal conversation, 15.01.18).

In addition, a female patron talked about the flexibility of moving from one room to the other in the café without the restrictions that she described as her experience in another café:

> "*Take it this way right, I was in a café with a friend on Saturday, and we wanted to move, but we were told to stay calm, I hate that word calm. In The Dragon Café, you can move as you like. If I get tired sitting in one place, I can sit on the bean bag, sit there*" (Barbara, informal conversation, 05.02.18).

JNB – What if the café was set up in one large space, instead of the three different rooms?

> "*If the room was flat like a hall, I will not be able to have a quiet time*." (Sharonda, informal conversation, 12.02.18).

> "*The noise will be too much. I attend the chess, but the dancing workshop is too loud, and sometimes they put the dance and the chess workshop at the same time. We cannot endure the noise when they do that, and it affects some patrons who are sensitive to noise because it triggers".* (Austine, informal conversation, 26.02.18).

> *"It is good the way the space is laid out because people act and speak differently in the different rooms and spaces, so people have somewhere else to go in the different rooms*." (Celesta, informal conversation, 01.10.18).

The next section will show the café space that the participants mentioned in the quotes above. The entrance into the crypt is through dark green double doors at the back of St George the Martyr Church, through two black metal gates surrounded by black metal fences and red brick walls on both sides.

Image 6 Outdoor space of the crypt with the metal gates and redbrick walls.



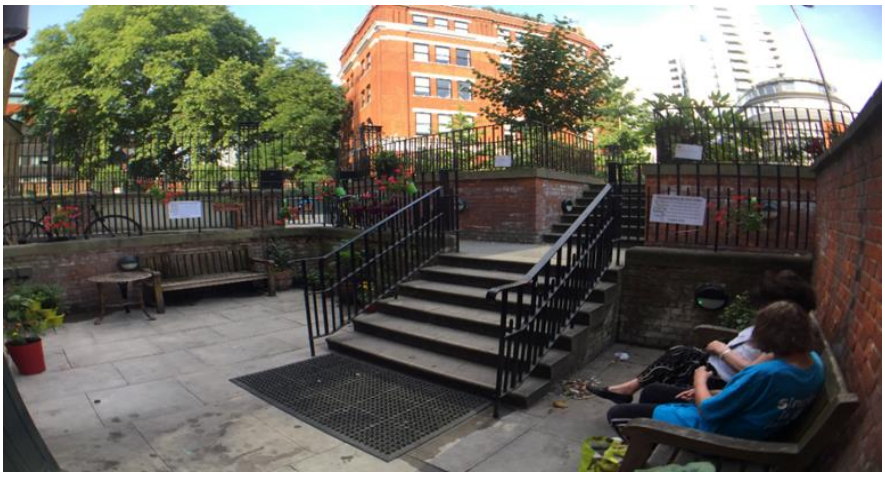
The two metal gates lead into the churchyard on three levels: a raised ground, a landing and a lower ground. The landing holding the two gates is between the raised ground and the lower grounds of the churchyard. The disabled lift door is the dark green door on the right side of the double doors, and the left side of the northeast entrance gate. At the top of a flight of seven steps, there is a raised grass area used by the café patrons as a smoking space. Volunteers place four blue plastic chairs on the grass primarily for the use of the smokers.

Image 7 Smoking area in the raised ground of the garden



The lower ground is accessed via a flight of six steps with black metal railings on both sides, two wooden benches and pots of flowers on the right and left sides of the arched dark green wooden double doors that lead into the crypt foyer, which is used as a Reception Area for the café.

Image 8 Lower grounds of the outdoor space of the crypt



How The Dragon Café fits into the crypt space

To understand the place, people and participation at the café, it is important to describe the different spaces in the café and the activities that takes place in the spaces. There are three large rooms, a kitchen, male, female and disabled toilets, and two storage spaces in the crypt. The ceilings and walls of all the rooms, including the kitchen, are white. The three large rooms have light brown laminate flooring. The kitchen floor is covered with grey vinyl tiles, and the toilet floors and walls are decorated with white tiles. The patrons who are gatekeepers named the three large rooms in the crypt according to the activities that take place in them, not as labelled on the crypt floor plan (Figures 7 and 8). For example, the first room in the crypt is labelled 'Foyer' on the floor plan, but the café patrons use it as a 'Reception Area' to meet and greet new and existing patrons. The second room in the crypt is labelled 'Meeting Room One' on the floor plan, the patrons refer to it as 'Space One'. The third room in the crypt is labelled 'Meeting Room Two', but the patrons call it 'Space Two'. Of the three rooms, Space One is the noisiest and accommodates the majority of existing patrons who sit and talk together. Space One is where loud activities, such as the Singing for Wellbeing, Dance Works, and Open Mic [sic, microphone] take place. Space Two is not as noisy as Space One; it is where activities with limited noise levels take place, such as Yoga and Writing. In contrast, the Reception Area is a busy room because people walk in and out of this space and to from the three toilets and the lift. From now onwards, I will refer to the three rooms as (1) the first room as Reception Area, (2) the second room Space One and the third room as (3) Space Two.

Reception Area

The Reception Area space is the smallest of the three rooms within the crypt, but it is larger than the kitchen and measures 5.85m in length, 3.91m in width and 2.5m in height. It is accessible through arched wooden double doors that are painted green on the outside and blue on the inside. There are six steps with stainless steel handrails on both sides, and a 0.30m in length and 0.15m in width dark grey foot mat on the landing. The church office, male and female toilets, the disabled toilets, and the lift lobby are located on the right and left sides of the Reception Area. There is a round multi-coloured illuminated mother and

baby glass painting, a square black and white framed picture of musicians on the far end right wall, and a table with two comments books beside the disabled toilet.

Space One

The Reception Area opens into Space One through light brown double doors with stainless steel metal handles, and two upright rectangular see-through glass panels on each door. Space One measures 11m in length, 9m in width and 2.5m in height. The crypt kitchen is through the light brown double door on the right of Space One; there is an open hatch where the kitchen volunteers attend to patrons when they purchase food and drinks. The description of the kitchen space is provided without images of the kitchen or the staff and volunteers, as requested by the chef, and the café manager due to food hygiene reasons. However, there are images of people eating or drinking, and of food that are present in the kitchen area as well as in the cooking demonstrations (see Chapter 4.1.7.1). Also, due to hygiene reasons, only the kitchen staff are allowed into the kitchen, so patrons leave their used plates, mugs, plastic cups, trays and cutlery for the kitchen volunteers to collect and return to the kitchen, where they are washed and reused.

Space Two

People enter Space Two through two light brown double doors with two A4 laminated notices which state 'You are entering a Quiet Zone' (referred to as Space Two here). The café manager explained that the sign is there to remind patrons to speak in hushed tones when in this space. Space Two measures 14m in length, 9m in width and 2.5m in height, making it the largest room in the crypt. There is a light brown piano and a unisex toilet on the far left of the room, a storage room opposite the light brown double doors, and a fire exit door with stairs that lead out to the upper chamber of the church and Borough High Street.

Image 9 Doors that lead into Space Two



The beginning of a day at The Dragon Café

A day at the café starts when the operations manager**,** chef and the kitchen staff arrive at 8.00 am. They were all dressed in black short-sleeve branded Dragon Café t-shirts worn with jeans, skirt or cotton trousers. The operations manager unlocks the arched dark green double doors to the crypt. The kitchen staff and chef start preparing different ingredients for vegetarian dishes, cakes and scones, while the operations manager unlocks the two storage cupboards opposite Space Two.

Image 10 Branded café t-shirt



The operations manager unpacks plastic stackable storage containers of various sizes (10 x 84 litres, 5 x 80 litres, six x 5 litres) from the storage cupboard. Each storage container has a strip of white 4" tape with different activities written on them, such as ArtSpace, Massage Works, Good Moves, Reception and Information Table. The operations manager transfers each box to the space where the activities take place, brings out the deck and lighting equipment, three black cardboard wall dividers (1m x 0.6m) for the massage space, and 8 square white plastic top tables. At 9.00am the male and female volunteers, all wearing the branded Dragon Café t-shirts above casual clothes, arrive to set up the three rooms.

To set up the outdoor space, volunteers attach outdoor Dragon Café banners to the black metal fence at the front and back of the church adjacent to Borough Station, and they attach laminated A4 signs on the black metal fence at the back and the arched dark green double doors.

Image 11 Outdoor signs for no drugs/alcohol and no smoking in the yard

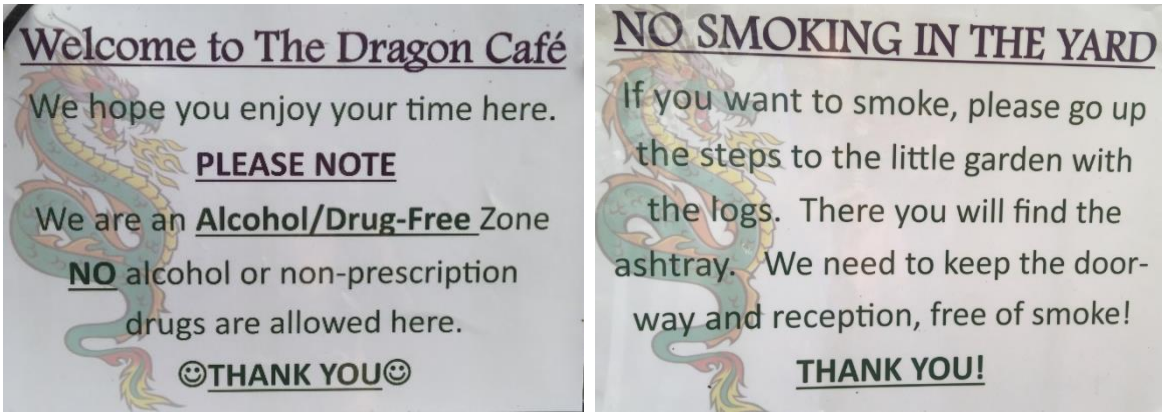


Image 12 Outdoor banner of the café hung on the black metal fence



While some volunteers hang outdoor signs, patrons who have learning disabilities are accompanied by their carers who support them as they volunteer or participate in workshops in the café. During set-up, a participant volunteer allocates certain tasks to participants with learning disabilities as described by a participant gatekeeper:

> "S*ome tasks are set apart for people with disabilities, and they are taught how to perform such tasks under the supervision of their careers.*" (Phillip, informal conversation, 20.11.17).

A participant gatekeeper trains patrons with learning disabilities to perform different tasks, such as covering tables with table covers, plugging in and placing the rechargeable candles and plastic chess pieces

on the tables, and supporting other volunteers to hang the black fabric on the wall behind the large green carpet. The operations manager would explain each step a few times and then, watch as they complete the tasks. Sometimes, the carers would supervise or assist patrons with learning disabilities when they are setting up the space.

Some people visit the café specifically for volunteering roles, and others are existing patrons who offered to become volunteers, for most of them, volunteering means '*giving something back'*:

> "*Volunteering helps me give back to others. I don't do much but doing a little each, we all contribute to making space for something that we can enjoy with others.*" (Victoria, informal conversation,6.11.17).

> "*I used to volunteer at the Crisis Centre, and I fell, so I was unable to continue with volunteering in the Crisis food bank because it was too heavy to lift things. I visited The Dragon Café and liked it but did not want to just participate without giving something back, so I decided to volunteer at the reception because there is no lifting.*" (Janice, informal conversation,13.11.17).

One student volunteer had a different reason for volunteering:

> "*I couldn't work in the UK as an exchange student, so I decided to volunteer, and I have learnt a lot about how to set up and manage the sound deck*." (Sherry, informal conversation, 4.12.17).

While participants had their reasons for volunteering; one participant gatekeeper commented on the importance of volunteers for keeping the café open:

> *"It is not possible to run The Dragon Café without volunteers. You need them to create the space. They are the space. Volunteers are patrons.*" (Mohammed, informal conversation,11.12.17).

Volunteers are refunded their public transport fare, and their meals are free when they present 'a button' token to use as payment for a main meal and dessert. People who volunteer from 8.00 am to 8.30 pm receive four buttons and those who volunteer for shorter times receive two buttons. The number of buttons given and who receives them is recorded. The recipient volunteers' names highlighted to show that they have received the free meals button. In addition to the volunteers, people who visit the café to facilitate activities also receive the buttons tokens for their meals.

Image 13 Button tokens used by volunteers in exchange for free meals



4.1.4 Setting up the three rooms in the crypt

The three rooms in the crypt are empty at 8.00 am before volunteers set-them up for different activities between the hours of 9.00 am to 12.00 pm, and again from 1.00 pm to 6.00 pm. On arrival, volunteers talk amongst themselves, discussing how to set up the spaces, where to put what and how. The three rooms are set-up simultaneously by different volunteers, and each volunteer has a role in setting up the different activity spaces: however, it should be pointed out that the volunteers work as a team to complete the setting up. A black metal trolley with extended base is used to transfer blue plastic chairs and brown cushioned chairs from the storage space under the steps that lead to the upstairs of the church where Space One, Space Two and the Reception Area are located.

Image 14 Storage under the stairs



With the exception of the deck tables, all the tables in Space One and Space Two are protected by plastic polka-dot covers in assorted colours; the volunteers place two plastic chess pieces, one Dragon Café activity flyer in a 10cm x 8.1cm acrylic placeholder and one rechargeable candle in the centre of each table.

Image 15 Items placed on the activity tables

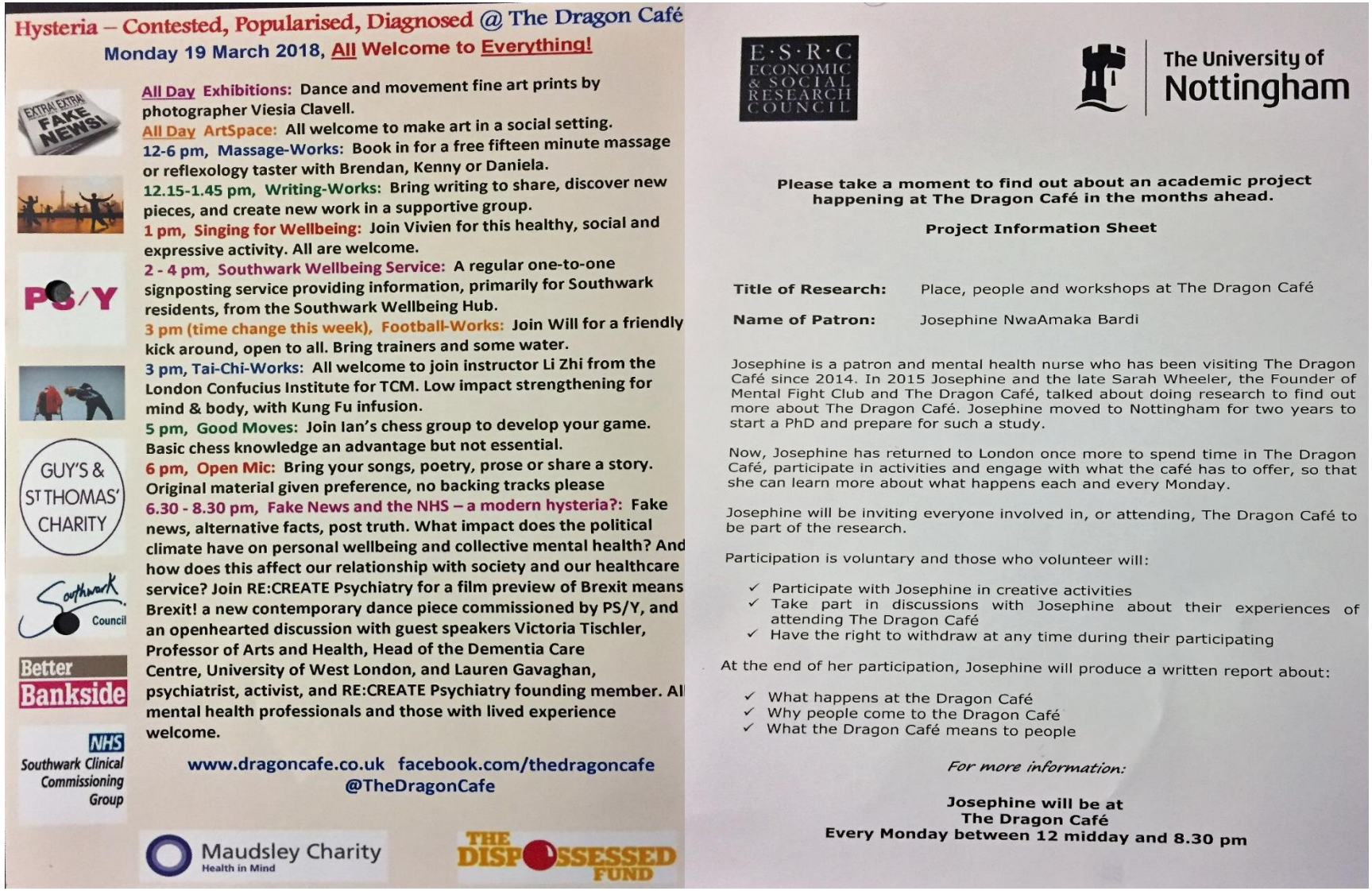


I noticed that there was nothing printed behind the activity schedule, so I decided that I would ask the café manager if it would be okay to print my research information on the back and they agreed that this could be done after I had embedded myself in the café through volunteering, participation in the activities and interactions with the patrons (Fieldnote, 16.10.17). Five months later, I walked into the crypt, and one of the female reception volunteers who hands out the activity schedule excitedly to patrons excitedly said, "see Josephine, your research is behind the flyer" (Informal conversations with Janice, 19-03-18). *That really made my day because Janice said those words in such an enthusiastic way to show that she was happy to see it and wanted me to know. I stood at the Reception Area and watched as she handed the activity schedule to patrons, showed them the back of the activity schedule and explained what the research was about* (Fieldnote, 19.03.18).

Moreover, printing the research information behind the café activity schedule provided the patrons all the information about the research as outlined below:

1. The funding body, the university and researcher supervision details
2. The title of the research
3. The researcher's name, roles and duration relationship to Sarah Wheeler and the café, when and how to contact her
4. What the research will do at the café and how she would interact with the patrons and the space
5. How the patrons were expected to take part or withdraw their decisions to take part
6. How that data would be written up
7. Dissemination of the findings

Image 16 Research information printed behind the café activity schedule



Hysteria – Contested, Popularised, Diagnosed @ The Dragon Café

Monday 19 March 2018, All Welcome to Everything!

PS/Y

GUY'S & ST THOMAS' CHARITY

Southwark Council

Better Bankside

NHS Southwark Clinical Commissioning Group

All Day Exhibitions: Dance and movement fine art prints by photographer Viesia Clavell.

All Day ArtSpace: All welcome to make art in a social setting.

12-6 pm, Massage-Works: Book in for a free fifteen minute massage or reflexology taster with Brendan, Kenny or Daniela.

12.15-1.45 pm, Writing-Works: Bring writing to share, discover new pieces, and create new work in a supportive group.

1 pm, Singing for Wellbeing: Join Vivien for this healthy, social and expressive activity. All are welcome.

2 - 4 pm, Southwark Wellbeing Service: A regular one-to-one signposting service providing information, primarily for Southwark residents, from the Southwark Wellbeing Hub.

3 pm (time change this week), Football-Works: Join Will for a friendly kick around, open to all. Bring trainers and some water.

3 pm, Tai-Chi-Works: All welcome to join instructor Li Zhi from the London Confucius Institute for TCM. Low impact strengthening for mind & body, with Kung Fu infusion.

5 pm, Good Moves: Join Ian's chess group to develop your game. Basic chess knowledge an advantage but not essential.

6 pm, Open Mic: Bring your songs, poetry, prose or share a story. Original material given preference, no backing tracks please

6.30 - 8.30 pm, Fake News and the NHS – a modern hysteria?: Fake news, alternative facts, post truth. What impact does the political climate have on personal wellbeing and collective mental health? And how does this affect our relationship with society and our healthcare service? Join RE:CREATE Psychiatry for a film preview of Brexit means Brexit! a new contemporary dance piece commissioned by PS/Y, and an openhearted discussion with guest speakers Victoria Tischler, Professor of Arts and Health, Head of the Dementia Care Centre, University of West London, and Lauren Gavaghan, psychiatrist, activist, and RE:CREATE Psychiatry founding member. All mental health professionals and those with lived experience welcome.

www.dragoncafe.co.uk facebook.com/thedragoncafe
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Maudsley Charity Health in Mind

THE DISPOSSESSED FUND

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

The University of Nottingham

Please take a moment to find out about an academic project happening at The Dragon Café in the months ahead.

Project Information Sheet

Title of Research: Place, people and workshops at The Dragon Café

Name of Patron: Josephine NwaAmaka Bardi

Josephine is a patron and mental health nurse who has been visiting The Dragon Café since 2014. In 2015 Josephine and the late Sarah Wheeler, the Founder of Mental Fight Club and The Dragon Café, talked about doing research to find out more about The Dragon Café. Josephine moved to Nottingham for two years to start a PhD and prepare for such a study.

Now, Josephine has returned to London once more to spend time in The Dragon Café, participate in activities and engage with what the café has to offer, so that she can learn more about what happens each and every Monday.

Josephine will be inviting everyone involved in, or attending, The Dragon Café to be part of the research.

Participation is voluntary and those who volunteer will:

- ✓ Participate with Josephine in creative activities
- ✓ Take part in discussions with Josephine about their experiences of attending The Dragon Café
- ✓ Have the right to withdraw at any time during their participating

At the end of her participation, Josephine will produce a written report about:

- ✓ What happens at the Dragon Café
- ✓ Why people come to the Dragon Café
- ✓ What the Dragon Café means to people

For more information:

Josephine will be at
The Dragon Café
Every Monday between 12 midday and 8.30 pm

4.1.4.1 Setting up the Reception Area

The Reception Area is empty on arrival until the volunteers set up three tables covered with purple organza fabric and attach two laminated printed signs labelled ‘New Patrons’ and ‘Existing Patrons’ attached with white or black tape to the front of each table.

Image 17 The Reception Area before the set-up



The new patrons’ table is rectangular with two chairs placed behind it. The grey wooden pulpit which occupies part of the floor is covered with purple organza fabric, and a wooden donation box is placed on top. There is a transparent plastic business card case that contains unused Dragon Café membership cards, A5 activity schedules, two clipboards with registration forms and five pens on the table. In addition, there is a notice board with an A3 size Dragon Café activity schedule for the day, a dark and light brown fabric dragon, a purple folder for the completed new patrons’ forms, plastic bowls that contain pens, markers in, staples, pins, stapler and paper hole punch on a square table to the right.

Image 18 The Reception Area after set-up



The existing patrons' table is on the right of the Reception Area, and there is a six-foot black metal clothes rack in front of it.

Image 19 Existing patrons' table



Volunteers place a laptop, a clipboard with a list of exiting patrons, a list of any visiting activity facilitators and a list of existing volunteers on the existing patron's table. There is a table to the left of the disabled toilet with two black, hardcover notebooks marked 'Volunteers Feedback' and Patrons Feedback' in white ink.

Image 20 Exiting patrons table and the feedback notebooks



While some volunteers are setting up the Reception Area, other volunteers are setting up Space One and Space Two, working collectively by simultaneously setting-up the different spaces.

4.1.4.2 Setting up Space One

Space One is also empty on arrival before volunteers begin the setup.

Image 21 Initial set up of Space One



Volunteers also set up blue plastic chairs around a meeting table, deck table, two ArtSpace tables and five square white plastic top tables on the right. The café manager, the chef and other paid staff have their staff meeting at the meeting table, which patrons later when they are eating and interacting while watching the activities in Space One.

Volunteers set up the All Day ArtSpace on two rectangular tables pushed together and covered with white and light blue plastic polka-dot covers, each with eight chairs, eight plain white sheets of paper, glass and plastic bowls containing markers, pencils, pens, and crayons of assorted colours.

Image 22 Before and after the set-up of the ArtSpace



Volunteers set up the condiments table behind the five small tables. The condiments table contains cutlery in a light brown square woven cutlery holder; transparent plastic cups; black trays for serving; one small black tray with jam, butter, marmite, salt, sweetener, honey, pepper, peanut butter and marmalade; and four transparent plastic jugs (two for water and two for milk). Two black menu boards are hung above the condiments table. A small blackboard displays prices of hot and cold drinks, and there is a large board with a vegetarian food menu and prices.

Image 23 The condiments table and menu boards



Image 24 Complete set up of Space One



Image 25 Setting up the multi-use space in Space One



Multi-use space in Space One

From 12.00 pm to 12.45 pm, volunteers set up this space with two microphones and a projector which displays the activities for the day and any cancellations. During the Singing for Wellbeing (with chairs arranged in a circle), Dance Works (no chairs) and Open Mic (with a microphone), volunteers mark off the space for the singing workshop with white or black tape across the floor.

Image 26 Set-up for the singing workshop and announcements



4.1.4.3 Setting up Space Two

Space Two is also empty on arrival except for some tables and the light brown piano.

Image 27 Empty Space Two



Volunteers set up rectangular tables with chairs, including the information table, a massage space, and four tables for dining, meetings and discussions. Volunteers set up four tables with blue plastic chairs on the right side of Space Two, and on the far right, volunteers set up two rectangular tables to make up a table large enough for 11 people as well as two rectangular tables with four chairs.

Image 28 Initial set-up of Space Two



There is also multi-use table formed from three rectangular tables pushed together. Activity facilitators use this space for the Writing Works and Good Moves (chess) activities; after each activity patrons sit at the table to eat, read and interact. Volunteers cover all the tables with the table covers, and in addition they

use metal clips to hang two, 1.82m in width, and 0.30 in length, indoor banners on the wall: one shows the café and the other a large green dragon.

Image 29 Complete set-up of tables, chairs and indoor banners



One table is set up with four chairs for the Southwark Wellbeing team with a laminated A4 sheet that has 'Reserved' written on it placed on top. This table is used for meetings between service providers in Southwark and the patrons.

Image 30 Table reserved for the Southwark wellbeing team



Volunteers set up the information table on the immediate right of Space Two with leaflets, flyers, and booklets which contains information about other services inside and outside the Borough of Southwark. There are two dark blue stackable storage boxes under the information table, and they contain cards and different board games, including Monopoly, Checkers, Scrabble, and Chess. A participant gatekeeper explained how the information table is a mechanism to encourage patrons to attend other services:

> "*The Dragon Café is only open on Mondays, so we have the information table for patrons to know about other services that they can attend on other days.*" (Phillip, informal conversation,16.10.17).

Image 31 Information table with leaflets about other services outside the café

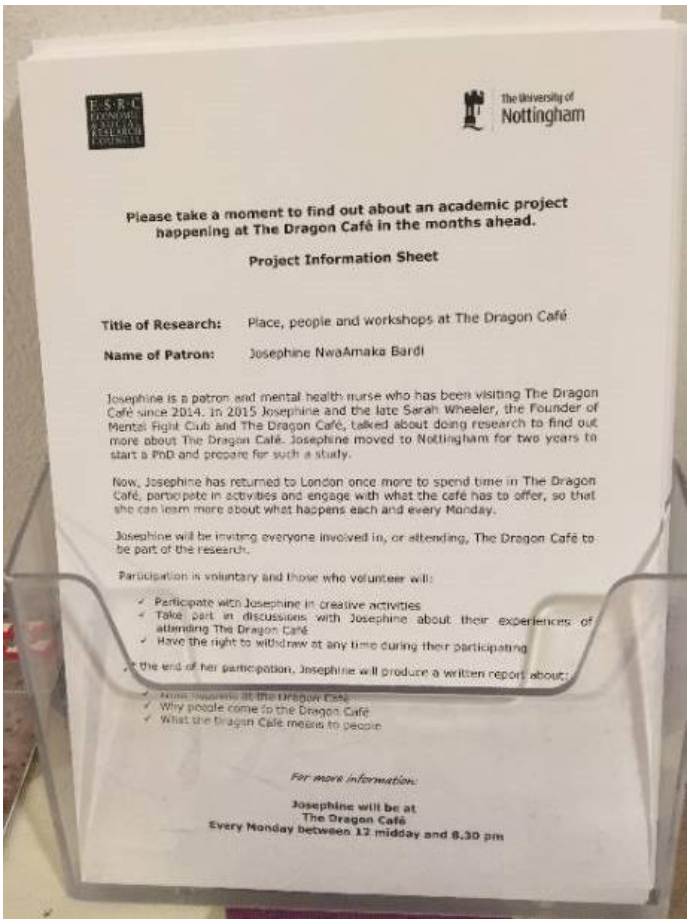


In addition to information about external services, the current study's research information sheet was also displayed on the information table. Although participants were given the full version of the research

information, the information sheet in the acrylic display stand is printed on A5 paper as requested by a participant gatekeeper:

> "*Patrons do not like when official documents are printed on A4 sheets because A4 sheets represent so many negative experiences like the loss of benefits, detention and hospital admissions.*" (Basila, informal conversation,05.02.18).

Image 32 Research information sheet



E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

The University of Nottingham

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Project Information Sheet

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On the right side of the information table, there is a space used for the massage workshop. The massage space is set up on the immediate left side of the information table so that they are both on either side of the light brown double doors in Space Two. Two volunteers set up the space for the massage workshop. They put down a half heart-shaped 2.4m green carpet and hold it in place with white or black tape. Volunteers arrange six brown cushioned chairs in the middle of the green carpet, and the place a massage

chair in the centre. Volunteers mount three (1m width/0.6m length) black wooden room dividers on metal stands around the green carpet so that the massage space is marked off from the rest of the space. They place eleven artificial plants with plastic flowerpots in front of the black wooden boards. The artificial foliage comprises of; six topiary rose trees in red, yellow and pink, and three artificial box tree topiary spirals.

Image 33 Set-up of the massage space





There is a multi-use space where volunteers hang a 3.6m width and 3m length black fabric sheet to cover the storage space doors and tape down a 7.3m long and 7.3m wide green carpet on the floor with white or black tape. A small rectangular multi-coloured rug and six dark blue bean bags are placed on the green carpet. To the right of the green carpet is the deck table with a chair, a blue stackable storage box of deck

equipment, and two lighting equipment spaces marked with white or black tape on the floor. The deck table is set-up without plastic table covers to prevent the equipment from overheating. After setting up Space Two, volunteers dim the lights.

Image 34 Set-up of the multi-use space and deck table



Image 35 Complete set-up of Space Two



4.1.4.4 Summary of the set-up of the three rooms

The multi-use spaces and multi-use tables in Space One and Space Two are altered throughout the day according to the activities. From 9.00 am to 12.45 pm, volunteers set up an image projector which is placed on a small table to project day's activities, including any cancellations and information about other services onto the surface that is adjacent to the ArtSpace. In Space One, volunteers would set up this space before different activities which start at different times; 1.00 pm for the Singing and Wellbeing activity; 3.00 pm for the Cooking Demonstration; 4.00 pm for Dance Works; and 6.00 pm for the Open Mic when patrons perform acts, such as singing, playing the guitar or reading a poem, individually or in pairs. Sometimes, when there is an evening event, such as a discussion panel or screening on mental health topics in Space Two, volunteers would clear the multi-use space and reset it for that activity. Patrons and volunteers move the dark green bean bags to the left the multi-use table in Space Two. At 7.00 pm, volunteers set up chairs and tables for discussion panels and film screenings on mental health topics, such as RE: Create Psychiatry and Psychoanalysis. During discussion panels, volunteers would set up blue plastic chairs and brown chairs with brown cushions around the green carpet with the small rectangular multi-coloured rug.

The next section offers a detailed description of why people visit the café. In this section, informal conversations were used to obtain information about the people who attend the café and why they attend. Therefore, verbatim quotes from participants' accounts are used to contextualise how those who attend the café socially construct their experiences of the café, together with the meanings that they attach to these experiences.

4.1.5 The rhythm of the day at The Dragon Café

The café opens at 12.00 pm, and there is an A4 laminated paper on the arched green double doors informing people of the opening times, but people start arriving outside these doors from 11.30 am (Image 38).

Image 36 Café opening time signage



Some existing and new patrons smoke and talk among themselves; others sit alone on the wooden benches or eat while waiting. New patrons who are not aware of the café sometimes enter the crypt before the opening time, and volunteers ask them to either wait outside the arched double doors or go to the local library which is two minutes' walk away.

The church manager does not allow nails in the walls, so volunteers attach laminated A4 sized papers relaying different information on the walls and double doors with blue tack. During the winter months, volunteers attach a laminated A4 size sign, informing people that the café is open despite the closed doors to retain heat. Between 11.30 am and 12.00 pm, a male volunteer with a clipboard speaks to existing patrons who are waiting, asking their names. He ticks these off to show that they attended the café on that day. They do not then queue for a second time when they enter the Reception Area.

Image 37 Patrons waiting to enter the café



Sometimes, when volunteers who normally set up the space do not arrive in the morning, the café opens between 30 minutes to one hour late. If and when such a delay happens it is likely some patrons will start asking, "*Can we go in*?" During the winter season, some participants would complain about waiting in the cold:

> "*I can't wait any longer because my legs are freezing. Why do they keep us waiting?*" *…I did not come early because I don't want to wait in the cold, but they are still not open, and it is already past 12.*" (Fadiya, informal conversation, 08.01.18).

I knew exactly how Fadiya meant because a few months earlier it was freezing, but I had to wait outside for the café to open, so it was a relief to be leaving the cold, and as I walked into café, I thought about how lonely the wooden chair would be for anyone to sit alone on a cold day (Fieldnote, 06-11-17).

On such days when the café opened late, a participant gatekeeper or a participant volunteer would apologise to patrons and explain the reason for the delay, such as fewer set-up volunteers, and that it is safer to set-up completely before people go in because of health and safety reasons; nobody wants a patron to be injured. Participants' responses about how far they had to travel to attend the café provided two answers: (1) participants were willing to travel that far because of the benefits that they perceived that the café provided and (2) some participants attended the café because there was no service around their areas:

> "*I come early because I live very far from here. I don't want to sit at home watching telly… I live in Leyton, so it takes me two hours to get here*." (Fadiya, informal conversation, 08.01.18).

> *Services around my area are day centres with lots of old people, not age-appropriate, so I cannot interact with them the way I do here*." (Freddie, informal conversation, 05.03.18),

Generally, participants replied in the positive about why they come early and wait outside the crypt., using similar phrases, such as "*to book the massage"* (Bolarin), or "*to get out of the house"*, (Tianna). It is apparent from the above that most patrons are willing to wait outside until the café opens whether it opens on time or much later than noon because, as highlighted above, the café provides a space that addresses their needs as highlighted above. However, some participant volunteers have different opinions about why patrons arrive before the opening time:

> "*Hostel and day centres switch of the central heating early in the morning and they have no heating during the day, so they come here to spend the day because it is warmer*." (Arnold, informal conversation, 11.12.17).

> "*Anybody can come through the door, but other places screen people and screening is a barrier. Here people can pick and choose, socialise, make friends, and it is open for a lengthy period, so it is worthwhile to travel down. Other places open from 10.00 am to 12.00 pm.*" (Janice, informal conversation, 27.11.17).

Once the café is open, participants queue and enter into the crypt in an orderly form, one after the other (Image 40). *While waiting with the patrons, I felt like I was ignoring the patrons who were smoking and talking in the smoking area, but I don't smoke, so it was difficult for me to stand very close to them and engage in informal conversations without inhaling second-hand smoke… I decided to speak to them later* (Fieldnote, 16.11.17).

Image 38 Patrons queuing as they enter the café



Image 39 Membership registration form

Welcome to The Dragon Café! PLEASE COMPLETE CLEARLY AND PRINT YOUR NAME

First Name	Surname	Tel Number	How Did You hear about Us	Patron's Card No.

Where do you live? London borough or other town/city PLUS Postcode please:

Your Email –VERY IMPORTANT – Please use CAPITAL LETTERS and fill in one letter per box in this grid (and don't forget the dots!) – thank you.

Welcome to The Dragon Café! PLEASE COMPLETE CLEARLY AND PRINT YOUR NAME

First Name	Surname	Tel Number	How Did You hear about Us	Patron's Card No.

Where do you live? London borough or other town/city PLUS Postcode please:

Your Email –VERY IMPORTANT – Please use CAPITAL LETTERS and fill in one letter per box in this grid (and don't forget the dots!) – thank you.

Once inside, visitors wishing to become patrons join the queue at the New Patrons table. The reception volunteers' welcome new patrons and show them where to sit to complete the registration form. New

patrons complete the forms by writing their names, home addresses, and telephone numbers, how they heard about the café and their email addresses (Image 41).

On one of those initial days of fieldwork, the café manager asked me to volunteer at the reception to register new patrons. I felt like I was being inducted into The Dragon Café routine, but at the same time, I felt like I may lose some of my other roles in other to fully embrace these new roles that I require for the data collection. These roles include, but are not limited to a volunteer, patron, workshop coordinator, kitchen staff, mental health nurse, PhD student, researcher, or should I say, amateur ethnographer? That sounds better. I smile *(Fieldnote, 16.10.2017). I observed another volunteer for a few minutes, and then, the volunteer manager gave me one of the branded Dragon Café t-shirts (Image 42).* Yahooooo, I thought and smiled, thanked him, and walked into the female toilet where I changed into the t-shirt and walked out like 'I am one of them now'. I felt like an insider…whatever that means for different people who conduct ethnography *(Fieldnote, 13.11.17)*.

As Okely (2012) suggests, the ethnographer cannot know the meaning and culture of a group in advance or from the outside, unless through participating from inside the setting and being and embedding themselves within the group. Embedding myself into the place, people and participation at the café was pertinent in this study because, volunteering as a receptionist at the café was a good for meeting people with very limited informal conversations taking place. Still, it was the best place to meet and greet both new and existing patrons, so spending time at the reception enabled me to meet more patrons and build up a rapport which made informal conversations easier later (Fieldnote, 13.11.17).

Image 40 Josephine happy to be accepted as a volunteer



After my initial experience, I asked a participant gatekeeper if I could continue the reception role until the end of the year on 18th December 2017 (Image 43). She was pleased about this, and she explained that café was short of volunteers from the following week, 20th November 2017 so it will be helpful for me to work as a volunteer receptionist.

Image 41 Josephine volunteering at the reception and registering a new patron



After the registration process, new patrons are given the café membership card with their names and membership numbers; the volunteer receptionist files all the registration forms in a purple folder while the other volunteer shows the new patrons around the Spaces. The volunteer refers to the activity schedule

as they walk around Space One and Two with new patrons. When showing new patrons around, the volunteer receptionist explains that: (a) all the activities are free, (b) what activities take place in each space, and (c) when the activities are due to take place. Sometimes when new patrons arrive as a group, the reception volunteer is required to conduct a group introduction to the spaces and activities. Initially, when patrons arrive in groups they participate in activities, sit and eat together, but after a while, they take part in different activities of their choice, before regrouping and leaving together.

The spaces of the café determine how some patrons behave, who they interact with, where they sit, what they do, and why. Existing patrons who did not have their names ticked off the clipboard before the café opened, queue in front of the existing patrons' volunteer, showing their membership cards or giving their names. The volunteer receptionist highlights their names on the café's Excel spreadsheet to record their attendance. By having their names and membership numbers on the café database, patrons who forgot or misplaced their cards can still gain entrance. Existing patrons who had their names ticked off the clipboard walk past the volunteer receptionist and the majority of them walk straight into Space Two and queue to book the massage (Image 44).

Image 42 Patrons queuing to book for the free massage



One of the participants volunteers positively described the popularity of the massage workshop:

> *"They are booking in for the free 15 minutes massage because it is a very popular workshop."* (Janice, informal conversation,16.10.17).

After booking the massage, some patrons remain in Space Two, some patrons return to Space One where they sit at tables near the kitchen to talk to each other or sit alone, in groups talking, eating, or taking part in the Art Space.

Image 43 Patrons interacting and participating in the art workshop in Space One



Other patrons return to Space One where they either sit at the five small tables near the kitchen to talk to each other, sit alone, or queue to purchase food and drinks which cost from 50 pence for a glass of juice to £5.00 for the main meal (Image 46). When patrons order food or drinks, the volunteer cashier greets each person, takes their orders, informs them of the price, accepts payment, gives change, and gives them their food or drink. Most patrons would put their food and drinks on one of the black trays and sit on a table in Space One or Space Two, while others do not use a tray.

Image 44 Patrons queuing to purchase meals and drinks



In Space Two, patrons sit on the multi-use table opposite the massage space, lie on the beans bags or sit in groups or alone at the tables talking, eating, waiting for the masseuse, reading, or using their phones (Image 47).

Image 45 Patrons interacting in Space Two



There were always differences and variations in when people arrive or leave the café, where they occupied in the spaces and what they did at any point. However, there are broadly regular patterns of patrons' behaviour in the environment, not least regarding how they sit in groups, sit alone or in pairs, and how they participate in certain activities or eat together. The actions and rituals of the 21 existing patrons who arrive before 11 am and earlier than other patrons are similar each week as they congregate around the middle and lower grounds, and they sit on the wooden chairs outside the crypt, smoke together, bring and eat their own food for lunch or eat the vegetarian food on offer. The next sections detail the different types of activities that the café offers, including participants views about their experiences of the café, the benefits that they perceive from participating in the activities and what participation means to them. First, I present the different reasons that participants gave for visiting the café.

4.1.6 Why people visit the café

The people who attend the café are from diverse populations, religions and ethnic groups, including Caribbean, Whites, Blacks and Asians. People visit for different reasons, including to: (a) have lunch, (b) take part in the free activities, (c) facilitate an activity, (d) meet a friend, or (e) meet with participants' gatekeepers. Activity (e) occurs when visitors from outside the UK wish to discuss how to set up a mental health café in their own country. Visitors are mostly aged 25 and above, but sometimes children visit with an adult. When a child or adolescent visits, the accompanying adult is required to complete an under 16's form to confirm that they will be responsible for the child when both the adult and the child are in the café (Appendix 21). On average, more than 200 people visit the café every Monday, and anyone who visits the café is referred to as a patron once they have completed registration and are issued with a membership card with their names and membership numbers are written on it. Some people remain patrons, but others take on other roles as remarked by a participant gatekeeper, a participant and a participant volunteer:

> *"Patrons come, enjoy the space and they might want to become volunteers, so the idea is that The Dragon Café is a user-led service because people who were once using the service as patrons become volunteers, and then, paid staff.*" (Susanna, informal conversation,11.12.17).

> "*I have been here for four years…I came here with a friend who told me about The Dragon Café and decided to volunteer.*" (Janice, informal conversation,13.11.17).

> "*The Dragon Café meets people's needs at different levels. Good company, layback and interact with people around you, make new friends and people can signpost you to other services or share coping strategies with you…Company without pressure, so I can drift in and out of things…, no elements of expectations, coercion or compulsion. No rejection if you are not doing it right and rejection is the root of all problems.*" (Elizabeth, informal conversation, 05.03.18)

While volunteering at the reception and updating the patrons' list; I noted that friends, family members and healthcare providers recommended the café to the majority of the people who visit the café, so I made a note that one of the questions in the semi-structured interviews would be what participants told family members friends about the café. Some visitors come not only from the UK but also other parts of the world to observe how the café works as articulated below by one participant volunteer and a participant gatekeeper:

> "*Looking at the spreadsheet and the countries from the patron's list, I think we did have visitors from Denmark, Australia, France, India, Jamaica, Norway, Portugal, Switzerland and the United States. They wanted to learn about how we manage café.*" (Susanna, informal conversation, 27.11.17).

Among the people who visit the café are university students who attend with their tutors as part of their learning:

> "*I bring medical students to The Dragon Café to provide them with an opportunity to interact with its patrons in a non-clinical, social setting; to observe the positive impact such community-based initiatives can have on peoples' well-being and socialisation and to reflect upon the relevance of the experience to their future practice. Visiting The Dragon Café helps students see patients as individuals, rather than conditions. It encourages them to think about whole-person care and to challenge the societally-conditioned stigma and apprehensiveness that exists around mental health*." (Ashley, 22.11.18).

While volunteering meeting people, and making friends was reported as reasons for visiting the café, safety was a prominent reason given by some patrons:

> *"Lots of people come here because it is a space where they can meet people, chat, eat and socialise. Most of the people live on their own, so coming here helps.*" (Don, informal conversation, 20.11.17).

> "*It is a safe space for people, and they provide a variety of workshops.*" (Janice, informal conversation, 13.11.17).

> "*They feel safe, less judged, commonality, familiarity and trust*." (Gloria, informal conversation, 08.01.18).

In addition to the increasingly limited access to other services, patrons had varied reasons for attending the café, such as to provide evidence for them to obtain a freedom pass (a free travel card in the UK), and to reduce the symptoms of their mental health challenges. In particular, one male patron referred to his healthcare workers expecting his recovery to happen 'speedily':

> "*Yes, you have to do 18 hours of workshops before getting a freedom pass. I record my workshops for my CPN (Community Psychiatry Nurse), and they inform the freedom pass people. They want us to recover fast, but recovery is different for everyone. I can say that I am coping, but I can't say that I am recovering. I am coping, that's all*." (Bolarin, informal conversation, 08.01.18).

> "*Socialising used to make me anxious, but I am not socially anxious anymore. This is the most amazing inclusive space to be accepted. Just chill out with, no rejection.*" (Celesta, informal conversation, 01.10.18).

Other patrons continued to attend the café because it reduces their isolation, helps them integrate and socialise, and meet people who understand because they share similar experiences:

> "*I like coming here because when we are here, we may laugh, talk together, sing and befriend each other. When you are alone at home, you feel down and sad*." (Shade, informal conversation, 09.10.17).

> "*Coming here is getting away from everyday stresses, socialising, people understand, commonality (that word again) of hobbies and problem, relate to others who have the same experience*." (Diqrah, informal conversation, 08.01.18).

> "*To integrate, come out of our shell. When you are at home, you can feel alone and think that you are the only one that feels like that. When you come here, you will feel better to know that other people feel it too*." (Sharonda, informal conversation, 12.02.18).

For other patrons, they attend the café because when they attend other services, they are forced to participate in the activities and some of the other services offer fewer activities, which limits what they can participate in:

> *"In other places, people must participate in the workshops, but in The Dragon Café people can participate in workshops of their choice. There is lots of opportunities to participate in different workshops for free and no discrimination. People can spend only a few hours; some people spend the whole day*." (Fadiya, informal conversation, 26.03.18).

> "*Other places offer only one or two workshops, so when you get bored, there is nothing to turn to. The Dragon Café offers a range of workshops, so if you don't like one activity, you can do something else or nothing*." (Christiana, informal conversation, 15.01.18).

I also became aware of how some participants' decisions to attend the café was based on their perception of people outside the café who they described as '*judgemental*', '*normal*' and '*patronising*', so I explored further to understand what they meant.

JNB – Can you tell me about more about what you mean by people outside here?

> "*I like coming here because The Dragon Café is a place to be, not judged. People outside here are quick to judge.*" (Alex, informal conversation, 09.10.17).

> *"I can't explain it, but in the big outside world, people put their hands on your shoulder and say, 'how are you?' in a patronising way and voice. People are patronising when they see you are vulnerable; in this space, we are all equal with acceptance and togetherness*." (Gerald, informal conversation, 26.03.18).

> "*Outside here, normal people don't understand. We understand ourselves here because we have the same experience*." (Analisa, informal conversation, 19.03.18).

There was also the notion of the café as a space where people could talk to each other, when compared to the outside world:

> "*Have you heard of talking therapy? Talking is very good, people talk freely here, but outside people don't talk to you.*" (Gabriella, informal conversation, 19.03.18).

> "*People are communicating less in the outside world with the era of mobile phones, social media and other technologies, so this kind of place is very useful to help us speak to each other*." (Rikki, informal conversation, 09.10.17).

Generally, there is a culture of politeness here that I rarely see outside this space. People here speak to each other politely, and I wonder if they do the same outside of this space. Patrons joined the conversations and described how they feel about the outside world and how the café provides them with a community

where they feel accepted with a sense of belonging and no expectations or pressure to take part in the activities:

> "*I like coming here because of the community spirit, meeting people. Very low cost and free workshops*. *I live in a residential hostel. It is run like a prison, so I don't really belong there. When I come here, I feel a sense of belonging*." (Usman, informal conversation,08.01.18).

> "*Company without pressure, no elements of expectations, coercion or compulsion with free activities so I can drift in and out of things. You don't have to dress up when you feel lousy, compared to being at work where you have to stay and be there or appear in a certain way.*" (Elizabeth, informal conversation, 05.03.18).

For some patrons, coming to the café allowed them to be themselves in a way that they feel accepted without the need to conform to what society expects from them:

> "*I come here to be myself. Outside here I am very aware that people are staring, so I have to behave myself, but here people have different ill-health, both mental and physical, so it is okay because we are all the same.*" (Jasmine, informal conversation, 4.12.17).

> *"I don't feel judged here, so it is easy to be myself, talk to people, anyone in fact*." (Freddie, informal conversation, 06.11.17).

Conversations about friends and family members outside the café provoked different views, such as patrons who avoid friends and family members who they say do not understand them and are judgemental:

> "*I suffer from anxiety and panic attacks, and I have lost a lot of friends since my diagnosis because they do not understand and what is happening. They say we want to see you as before, and I tell them that I can't be like before, but I can still recover while working. They say no*." (Usman, informal conversation, 19.03.18).

> "*I don't invite my friends to my house anymore. If I laugh, they say it is mental health; if I dance, they say it is mental health. No matter what I do, it is mental health, so when they ring me, I tell them that I am out or busy*." (Shade, informal conversation, 08.01.18).

One patron also reported experiencing stigmatisation and a cultural barrier erected his family members, who viewed his MHCs as a taboo, and his so-called 'friends' who mocked and avoided him:

> *"My brother told me that if I was in Africa, they would tie me up on the bed and beat me because mental health is a taboo. He said it like a threat. I lost all my friends. They were*

> *mocking me. A lot of them when I ring them, they say, I am busy. It doesn't matter because I have my friends here.*" (Bolarin, informal conversation, 08.01.18).

On the topic of friends and family members, I asked some patrons if they would invite their friends to the café, and found similar accounts from patrons who said their friends would be judgemental and how they pretend in front of their friends:

> "*I won't invite my friends. They are nervous enemies. There will be embarrassing silence if they come. They are from the so-called outside world*." (Shade, informal conversation, 12.03.18).

> "*No, I won't because people might feel uncomfortable and my friends may react differently, judgemental and biased. I like being myself, but I will feel like I have to perform in front of my friends*." (Barbara, informal conversation, 12.03.18).

JNB – How about your friendships here and outside the café?

> "*I make new friends here, and we keep in contact outside the café*." (Arnold, informal conversation, 12.03.18).

> "*Five of us met at the mindfulness session in another service, and we have kept in touch. We trust each other, and we keep in touch when we are not in the café.*" (Shade, informal conversation, 12.03.18).

JBN – Is it important to keep in contact here or outside?

> "*Both are important because the café is only once a week. Having this type of relationship is good because I find it hard to open up to other people*." (Chase, informal conversation, 15.01.18).

> "*It is good to have people who know what you are feeling so they can support you. Sometimes when I am not feeling well, I ring one of them and they will say, 'I did this or that when I was not feeling well like you. We ring each other and say, 'there is so and so event, and we attend together.*" (Shade, informal conversation, 12.03.18).

4.1.7 Activities offered at the café

In this section, the activities are presented according to the space where they are hosted, but they are not presented sequentially because, although some activities happened at different times, most of the activities took place concurrently but in different spaces as you will soon read in the sections on Activities in Space

One and activities in Space Two. For example, between 01.00 pm to 02.00 pm, the singing workshop happens in Space One, the writing workshop in Space Two and the football takes place outdoor on the football pitch located in the community park.

All the activities at the café are free and they take place on a weekly basis (unless there is a cancellation), every Monday from 12.00 pm to 7.00 pm. The activities include: (1) the All Day Exhibitions, (2) All Day ArtSpace, (3) Writing, (4) Singing for Wellbeing, (5) Football, (6) Tai Chi, (7) Dance, (8) Chess and (9) Open Mic. The other activities that take place in the café which are not listed on the activity schedule include (10) Yoga, (11) Mindfulness, (12) Gong Bath, (13) Live performances, and film screening on different mental health topics.

Two of the participant gatekeepers described the value that they place on group activities as a facilitator for encouraging social interactions between the patrons:

> "*Always, there are two to three activities happening, so there is always something going on. This place is about involvement*." (Basila, informal conversation, 19.03.18).

> "*Apart from massage, the majority are group work activities, so, you know, 'people getting together', connecting, so they are not doing individual workshops. The idea is to reduce the isolation and people start talking to each other, getting to know each other.*" (Susanna, informal conversation, 20.11.17).

> "*Participating in other activities will nudge patrons out of their comfort zone because when people are unwell, and they come here, there are people all around you. You don't have to interact if you don't want to.*" (Basila, informal conversation, 09.10.17).

People are informed about the weekly activities at the café through emails, social media sites, including Twitter and Facebook, and the café's activity schedule (Image 48), which the volunteer receptionist gives to people when they arrive. Some patrons only take part in certain activities, such as the ArtSpace, writing activity, Singing for Wellbeing and Massage Works. A minority of patrons-only take part in the ArtSpace and massage. Generally, things occur in sequence at the café, and people respond to events as they happen.

The schedule of activities determines how some patrons behave, who they interact with, and when and how they do so. Although people are given the café activity schedule when they arrive, 15 minutes before each activity, the café manager, the ArtSpace facilitator, or the deck manager would announce each activity on the microphone to remind patrons of the time, the Space where the activity will take place, and any cancellations. Patrons take part in the activities for different reasons as described below:

> "*In similar places like user-led, peer networks, community organisations, you must participate in the activities, but in The Dragon Café, you don't have to do anything or participate*." (Dewitt, informal conversation, 11.12.17).

> "*The Dragon Café provides choice of different workshops which helps us connect through shared activities*." (Celesta, informal conversation, 01.10.18).

> "*No rejection if you are not doing it right and rejection is the root of all problems. There is acceptance here, and I can give things a go, experience things and take what you need. The Dragon Café meets people's needs at different levels*." (Elizabeth, informal conversation, 05.03.18).

Image 46 Schedule of activities at the café



Also, there were other predictable patterns of behaviours among groups of patrons who do most things together. For example, a group of three males and one female patron come together, sit in Space Two, and around the same table, take part in the same activities and leave at the same time. These groups of patrons hardly interact with others unless they are taking part in an activity, or when patrons or a volunteer sits at the same table with them. Particularly striking are five patrons (two males and three females) who

individually behave in similar ways when they arrive at the café. They do not take part in any activities, and they sit alone on the same table, observing what is going on. However, my conversations with participants revealed their diverse perceptions of participation:

> *"I do not need to take part to participate. I participate by watching those who take part. Just sitting and watching the workshops is a way of participating*" (Aida, informal conversation, 15.01.18).
>
> "*I do not take part, but when I am at home, I remember some of my interactions and participation here, and they distract the voices*" (Shade, informal conversation, 08.01.18).
>
> "*I just come here to chill out and do not need to participate, and it is better than other centres because it has a variety of workshops*." (Lewis, informal conversation, 23.10.17).

4.1.7.1 Activities in Space One

Space One is the noisiest room in the crypt and all the loud activities, such as singing, dancing and the open mic workshops take place here. The ArtSpace workshop and the cooking demonstration are two quiet activities that also take place in it. Space One is usually quieter during the cooking demonstration, but the All-day ArtSpace workshop takes all day whether the noise levels are low or high.

12.00 pm to 07.00 pm All Day ArtSpace

The ArtSpace is a colourful space with all the chairs occupied by patrons for the majority of the time. There is an unspoken shared behaviour between them. The Art Space is always full of the same patrons and new patrons. Most patrons who attend the Art Space, spend the whole day or half-day sitting on the same seat, either painting or drawing (Image 49). Patrons participate collaboratively in this workshop, sharing and passing the watercolour palette to each other, and sometimes, two or three people would dip their paintbrushes into assorted colours in the colour pallet or rinse their brushes in the same water can without looking up, making eye contact, or saying a word, and other times they spoke or just smiled at each other. Patrons talk about various issues from inpatient admissions, the next workshop that they would

like to attend, their opinions about their Artworks, or something the coordinator said or did, to where, when and where they would meet outside the café.

Image 47 Patrons participating in the ArtSpace



During this activity, I observed there was power dynamics and differentiations between the activity facilitator and the patrons, including myself because the activity coordinator had different rules from the writing workshop activity facilitator who encouraged patrons to eat and drink during the workshop and this inequity made me very conscious of what I did whenever I was in the ArtSpace. *I noticed that the female art coordinator kept looking at my hand to see if I was writing, or I was just being conscious of her thinking that I was writing fieldnotes. The first time I asked to observe the Art workshop, she quickly told me that I could participate/observe the art workshop, but it would be on the condition that I did not write any notes. Therefore, I ensured that I did not write any notes and instead I focused on participating by trying to replicate (without success) the butterfly paintings on the walls while listening to the conversations between patrons who were on the art table. How does the awareness of existing power impact on choice and agency, and increased anxiety about expected display of power*? (Fieldnote, 26.02.18).

Most times the activity facilitator would ask patrons with food to move to a different table because the table was for art works only, and then, she reminded me not to put my water bottle on the art table. This was different from the writing workshop where the coordinators encourage people to eat and drink at the table and this meant that no one leaves the writing workshop to sit somewhere else and eat during the workshop. However, patrons discuss among themselves about their paintings among themselves, as well as the meanings that they attach to each painting:

> "*My watercolour painting is a brain tumour, and it signifies me taking back control because a brain tumour is bad and when I paint it, I am in charge of how I choose how to paint it and what colours to use. Painting a brain tumour on a piece of paper means that I am leaving the brain tumour on that paper*." (Segun, informal conversation, 30.10.17).

> "*I come here for the art because it is escape for me…absorbed in what you are doing like music and art to stop the negative voices and the negative emotions*" (Diqrah, informal conversation, 08.01.18).

Some patrons sit and participate in the ArtSpace all day:

> "*I only take part in the Art Table for three hours and then I go home. Three hours is enough for me, or I get tired*." (Sunday, informal conversation, 4.12.17).

Other patrons drop in and out of the ArtSpace to continue or complete their artwork, (Image 50). Some patrons on the art table hardly speak to each other, rather, they are focused on their artwork; when asked about their reason for attending the art space, patrons reported different reasons:

> "*When you don't have a job, a purpose, it can make you restless, but participating in art and being part of something is important and when I come here, I can be part of something*" (Usman, informal conversation, 11.12.17).

> "*Art allows us not to talk about individual experiences but connecting with other people*." (Sunday, informal conversation, 05.03.18).

Image 48 Patrons taking part ArtSpace One



Sometimes the ArtSpace coordinator would suggest a theme for the day and provide the materials for patrons to produce varied types of artwork that shows processes from the beginning to the end, and these are done individually, in pairs or collectively (Image 51) as shown below:

Image 49 Patrons taking part in themed Art activities



The second ArtSpace is set up with four chairs and various packs of watercolour, assorted sizes of paint brushes, markers, and water in a glass tumbler for rinsing the brushes. This ArtSpace is a drop-in activity which begins when the ArtSpace facilitator puts down a 1m by 1m canvass with pencil marks of different motifs on in it and invites people to join in the group painting to draw or write words on the canvass. A range of artworks are produced through collective participation. These artworks are collectively created, so patrons would sit together, laugh and chat as they paint and draw different motifs and write different words on the canvas (Image 52). There is a sense of community in this space as patrons shared the assorted watercolours, markers, brushes, pencils, and rinse used brushed in a transparent glass container that contains water.

Image 50 Patrons collectively creating an artwork



People laughed and smiled at each other as they talked about the painting, praised, and complimented each other's colouring skills. Some patrons stood by and watched without joining in the group doing the colouring. Once completed, the artworks are hung with metal clips on the walls of Space One or Space Two (Image 53). There was always a sense of satisfaction and pride among the patrons when they see their artworks hanging on the wall.

Image 51 Completed artwork hanging in Space One



Sometimes, people come from in-patient mental health facilities to design artwork for the café. For example, the artwork below was facilitated by an 'Artist in Residence' at Natham hospital (Psuedonym). It is a 'Fabric Art' activity called 'Bedsheet Tapestry' on a used white used Natham hospital bedsheet. The

facilitator drew various designs and wrote the words ‘The Dragon Café’ in pencil (Image 54). When the bedsheet was on display, patrons dropped in and out, painting assorted designs, writing words, and stitching fabric letters that made up the name ‘The Dragon Café’ (Image 54 and 55).

Image 52 The white bedsheet before patrons designed it



Image 53 Patrons decorating the white bedsheet together



This finished work was displayed on the wall in Space One like other completed art pieces (Image 56).

Image 54 Completed artwork hanging in Space One



While patrons attend the all-day art workshop, volunteers set up spaces for the other activities in Space One and Space Two, such as the singing for wellbeing and the writing workshop.

01.00 pm to 02.00 pm Singing for Wellbeing

The Singing for Wellbeing activity is the second most popular activity at the café with more than 25 people attending at any one time. At 1.00 pm, the patrons would sit in a circle and wait for the activity facilitator. This activity begins when the facilitator welcomes patrons to the activity, by giving each of them a high ten (two hands instead of one, as in high five) and distributes A4 paper with a list of the songs. The facilitator would explain the chosen songs for the day and the history of each song, such as the original singer, the country that the song originated from, when it was released, how it helps with wellbeing and how the group should sing it. Following that, the facilitator would ask patrons to make different sounds with their mouths, including wuuuuuuuuuuuu, ahhhhhhhhhhhhhhhh, shhhhhhhhhhhhhhh, siiiiiiiiiiiiiiiiiiiiiiiiiii, mnnnnnnnnnnnnnnnnn.

On one of those times, a female patron held my hand and pulled me to join the singing group. *Sitting among the singing group, I felt like I was being initiated into café activities by the patrons as a way of acceptance. This made me feel very happy because it has been a bit confusing today, especially with people not recognising me in my new hairstyle… I did not want the workshop to end because it was such a collaborative effort to sing together. I wondered if Space Two was entirely quiet as we sang in very high tones* (Fieldnote, 06-11-17). The facilitator sings different songs, and the patrons repeat after her until they can sing it together. Sometimes, the facilitator would ask the patrons on the right and left to sing the different chorus from the same song. Other times, the facilitator would stand in the centre of the circle to demonstrate a dance move which the patrons would repeat after her (Image 57)

Image 55 Patrons taking part in the singing workshop



At the end of the singing activity, the facilitator and patrons thank each other, and volunteers remove all the chairs and place a freestanding microphone with a projector in the middle of the space to project the activities on the wall.

JNB – What does singing mean to you?

> "*Singing is using the body and the brain. Communal, celebratory, brings people together and connecting with people. When I sing, I am comfortable to look at people, make eye contact without being socially anxious*." (Celesta, informal conversation, 01.10.18).

In response to the above question, participants positively described their individual and collective experiences of singing together and how that enabled them to connect with people, and experienced reduced symptoms of mental health challenges:

> "*I like singing because it is uplifting. Singing together creates a sense of belonging, the more I sing, the more confident I become. Since I started attending the singing workshop, I can sing indoors at home. The singing instructor brings different songs from different countries*." (Chase, informal conversation, 12.03.18).

> "*Participating and not talking about the bad things. Absorbed in what you are doing like singing to stop the negative voices and the negative emotions*." (Diqrah, informal conversation, 01.01.18).

In line with the above, participants attached similar and different meanings to their experiences of the singing workshop, but a key observation is how participants highlighted that the singing workshop also helps people with physical health challenges. During the conversations, a female patron with physical health challenges reported how improved ability to speak better, and a participant gatekeeper highlighted the health benefits of the singing workshop:

> "*I was very ill and weak with a physical health problem. After the diagnosis I started attending the singing group and I started speaking again.*" (Kerry, informal conversation, 12.03.18).

> *"So, one of the ladies told me she had COPD (Chronic Obstructive Pulmonary Disease) lung disease, and that is why she comes to the singing group… Singing is very good because it gives people confidence to sing here and they can sing at home because I now know how to sing.*" (Susanna, informal conversation, 12.03.18).

Overall, all the participants positively described their experiences of the singing workshop. Another activity that takes place after the singing workshop is the cooking demo.

02.00 pm to 03.00 pm Cooking Demo

This activity only took place twice during the 14 months fieldwork. The session involves a demonstration of how to cook different vegetarian dishes. The kitchen volunteers set up the space by placing ingredients for the cooking demonstration on a metal table, moving the table to the multi-use space, and a microphone is placed at the side of the metal table. The facilitator starts by introducing herself, the name of the food that they will cook, the ingredients, and the health benefits of the food. As I sat watching the cooking demonstration, I remembered that earlier, one participant gatekeeper had informed me about the type of food served and why the café serves only vegetarian meals:

> "*We serve only vegetarian dishes because it does not exclude anyone. You know, everyone would eat vegetables, but most people these days do not eat meat. This also helps us prevent contamination and food poisoning from raw meat and fish"* (Basila, informal conversation, 09.11.17).

Patrons sit around Space One and listen as the facilitator speaks into the microphone, telling them the ingredients, and explaining the quantity of ingredient to add, when to add them and how to mix them. Patrons ask questions about quantity and substituting ingredients.

Image 56 Cooking demonstration facilitator



As I sat there watching the cooking demo, *I suddenly felt hungry, but I found it difficult to leave as I wanted to observe a bit more, and as if he could hear me, the volunteer manager handed me four different coloured buttons today because I was going to volunteer from 8.30am to 8.30pm. I was very happy with the buttons because the food smells yummy today and they have scones as well…yipeee* (Fieldnote, 23.10.17).

Image 57 Samples of the vegetarian dishes served at the café



Later that day, a female volunteer who joined me for lunch talked about the ingredients used for the cooking:

> "*Did you know that the food here is prepared with free ingredients from Borough Market?*" (Alison, informal conversation, 23.10.17).

JNB – Really? I did not know that.

> "*Yeah, they have been supporting the café for a long time, so we do not need to buy any ingredients.*" (Alison, informal conversation, 23.10.17).

As l listened to the female volunteer, I wondered what would happened without the food donation, but I was unable to ask this because the female volunteer stood up and left the table. At the end of the demonstration, the facilitator shares the recipe for the cooked meal to patrons, patrons taste the food, and the kitchen volunteers transfer the metal table and everything on top of it to the kitchen. Another activity that takes place in Space One is the dance workshop.

04.00 pm to 05.00 pm Dance Works

At 4 pm the Dance Works workshop starts with very loud songs blaring out of the speakers so that we could hear the activity facilitators' voices and the music in all the spaces, including the Reception Area and outdoors. The female volunteer on the existing patron's desk began to dance and I watched her for a while. The dance workshop is the loudest and the third most popular activity in the café, and it is facilitated by two dance instructors. Volunteers would place two jugs of water with several cups on a table beside the deck table, and patrons usually drink the water during the dance. When patrons have gathered in the space, the dance instructors stand in front of them and demonstrate the different dance steps. Patrons repeat dance moves after the activity facilitators, such as raising their hands, singing the songs, and clapping their hands (Images 60 and 61). (Fieldnote, 13.11.17).

I started to move my legs and head to the rhythm of the songs. I wanted to dance so much because I could hear my favourite Brazilian song. I was not sure if I could leave my receptionist duty to dance, but before I knew it, I was on the dance floor. For a minute it felt like all eyes were on me as I danced happily, followed the instructor's dance steps, and danced back to the reception at the end of the music. Ahhhhhhh, now that was fun, and then, I remembered 'going native'. At what point does a researcher go native? (Fieldnote, 13.11.17). Madden (2010) that researchers should go close but not too close to the participants

so as not to avoid “going native" and becomes totally immersed in the culture or group of people that they are studying (pp.77). Thankfully, I did not lose my role as a researcher as I embedded myself in the place, people, and participation at the café. Rather, participation in the activities enabled me to interact and develop mutual relationships with the patrons, and this was very useful for recruiting participants for the study.

Image 58 Josephine taking part in the dance workshop with the patrons



The female dance activity facilitator shouts out moves using the microphone, and a volunteer plays different songs from the deck at a very loud volume. Patrons are dancing, smiling, and moving simultaneously to the male and female activity facilitators’ voices. The dance is energetic, the moves are fast, and the music is loud.

I suddenly felt very emotional and teared up quite a bit as I watched people dancing happily and I believe it was because I remembered how disempowering the acute ward can be when people with MHCs are described and viewed as ‘not capable’ and ‘they have no insight’. As I observed the dance steps, I knew that I could not follow those moves like most of the patrons in the group. I felt guilty for probably being

one of the judgemental nurses who only saw labels, diagnoses, and medication rounds. I could not remember if I was or not, but I do know that culture was one of the main reasons why I decided to look for a community mental health service where people could be themselves without restrictions (Fieldnote, 30.10.17).

Image 59 Patrons repeating the dance moves



Sometimes, the activity facilitators would ask patrons to dance in their own styles, and at other times patrons would choose a song that everyone would dance to. During this workshop, patrons would gather in Space One to watch the dance and sing along, patrons join, leave, and re-join the group, and one or two reception volunteers would join the dance. At the end of the dance workshop, volunteers would set up the space with a microphone and projector which projects the schedule of activities on the wall, and then, just before 6pm they place a chair behind the projector and announce the open mic activity.

Participants positively described their feelings about the dance workshop, but I was keen to know how the activity facilitators taught the patrons to follow the dance steps:

> "*Dance lifts my mood and takes thoughts away without trying. It is both individual, communal so it helps me have confidence in my body. Better body image.*" (Celesta, informal conversation, 01.10.18).

JNB – That was fun. How long have you been teaching dance at the Dragon Café?

> "*Thank you, Josephine. Four years ago, I was approached by the trustees to volunteer, but I couldn't because my mum had just passed away. Two months later, they approached me again, and I thought 'this is what I need to keep my mind off my mum passing'…I haven't turned back since*" (Preethi, informal conversation, 30.10.17).

The activity facilitator explained how she ensures that patrons can remember the dance moves:

> "*I listen to people's vibes and follow that in my choice of songs and moves. I play different songs, introduce different moves which I occasionally change so that people are not bored or feel that they cannot follow the moves. People need to focus their minds on something and learning different moves while dancing is a good way for them to focus.*" (Preethi, informal conversation, 30.10.17).

06.00 pm to 07.00 pm Open Mic

Patrons who wish to perform in this activity write their names down on a paper held by the café manager, a volunteer, or a paid staff member. Before each performance, a staff member would introduce the patron who would perform, and people would clap to welcome them. This activity is when patrons have the opportunity to sing, play musical instruments, read out poems or short stories, and these are performed as individuals, in pairs, or in groups (Image 62). The patrons who participate start each act by introducing their act, the reason they chose the act, and what the act means to them.

At 6 pm I heard a high-pitched operatic voice in Phase One, and I quickly noted that it was time for the Open Mic Workshop. This workshop encourages people to bring their songs, poetry, prose or share a story. I stepped into Space One to see and listen. Space One was full of people, and I was tempted to count them. I am not sure if I am supposed to count or not, but I did anyway. They were 52 people sitting, standing, and listening to a female singer. I stood and listened, but I could not understand a word of what

she was singing. In the end, the singer explained that the song was in Latin and it meant 'Hail Mary'. (Fieldnote, 16.10.17). Other patrons sit and listen to the performances, and sometimes they sing along. *As I listened as patrons participated in this workshop, reading out poems and stories, singing and playing different instruments, I thought, it must take a lot of confidence to stand in front of people and speak, sing, or play an instrument and all I could think of was how service users are seen as not capable on acute mental health wards* (Fieldnote, 17.11.17). At the end of each performance, patrons would applaud the performer, and at the end of the activity, volunteers would remove the chair, and announce the next activity in Space Two.

Image 60 Patrons taking part in the Open Mic workshop



4.1.7.2 Activities in Space Two

Space Two is not as noisy as Space One, and here people sit together in groups, alone or sometimes lie down on the bean bags to sleep, read, or watch other activities. In Space Two, people are expected to read or talk together in hushed tones, but during most sessions, a volunteer or the café manager would remind patrons to speak in lower tones or answer their phones outside Space Two. All the activities in Space Two are conducted quietly, including yoga, mindfulness, tai chi, massage, gong bath, chess and the evening film screening and discussions. The first of these activities is the writing workshop and massage.

12.45 pm to 01.45 pm Writing Works

This workshop takes place at the same as the singing workshop. From 12.00 pm, the multi-use table is set-up by the activity facilitator. She would place two rechargeable candles, several types of writing pens, a magnifying glass, and the café activity schedule on the table (Image 63). The female volunteer places photocopied pages of a book and coloured A4 sheets of paper on the table in front of each empty chair.

Image 61 Writing workshop facilitator setting up the table



Once, when I assisted with setting up the space for the writing group, I asked the male facilitator what made him volunteer to facilitate the workshop and he responded:

> "*To give people who are not able to share their feelings verbally the opportunity to write them down*." (Anthony, informal conversation, 12.02.18).

Except for one or two new people, the same patrons attend the writing activity. Once everyone is seated, they greet each other and introduce themselves. After the introductions, one of the facilitators explains the reading for the day, the reason for the choice of book and a brief background about the author. The facilitator would then ask each person to read a paragraph from the photocopied extract of the chosen book. Sometimes, when a patron is unable to pronounce a word, other patrons would assist by pronouncing the word correctly. At the end of the readings, patrons would collectively discuss different parts of the reading, including phrases, words that they do not understand, and their thoughts about the contents of the reading. After the discussion, the facilitator would set the alarm on her phone and ask everyone to write for twenty minutes on any topic of their choice. The writing part of this activity is done silently with everyone writing without speaking (Image 64). When the alarm goes off, everyone stops writing, and each person reads out what they have written.

Image 62 Patrons taking part in the writing workshop



The others listen, ask questions, allowing the writer to respond, and then they give the writer a round of applause. *I was impressed at how patrons wrote very insightful stories and poems on cue in 20 minutes.*

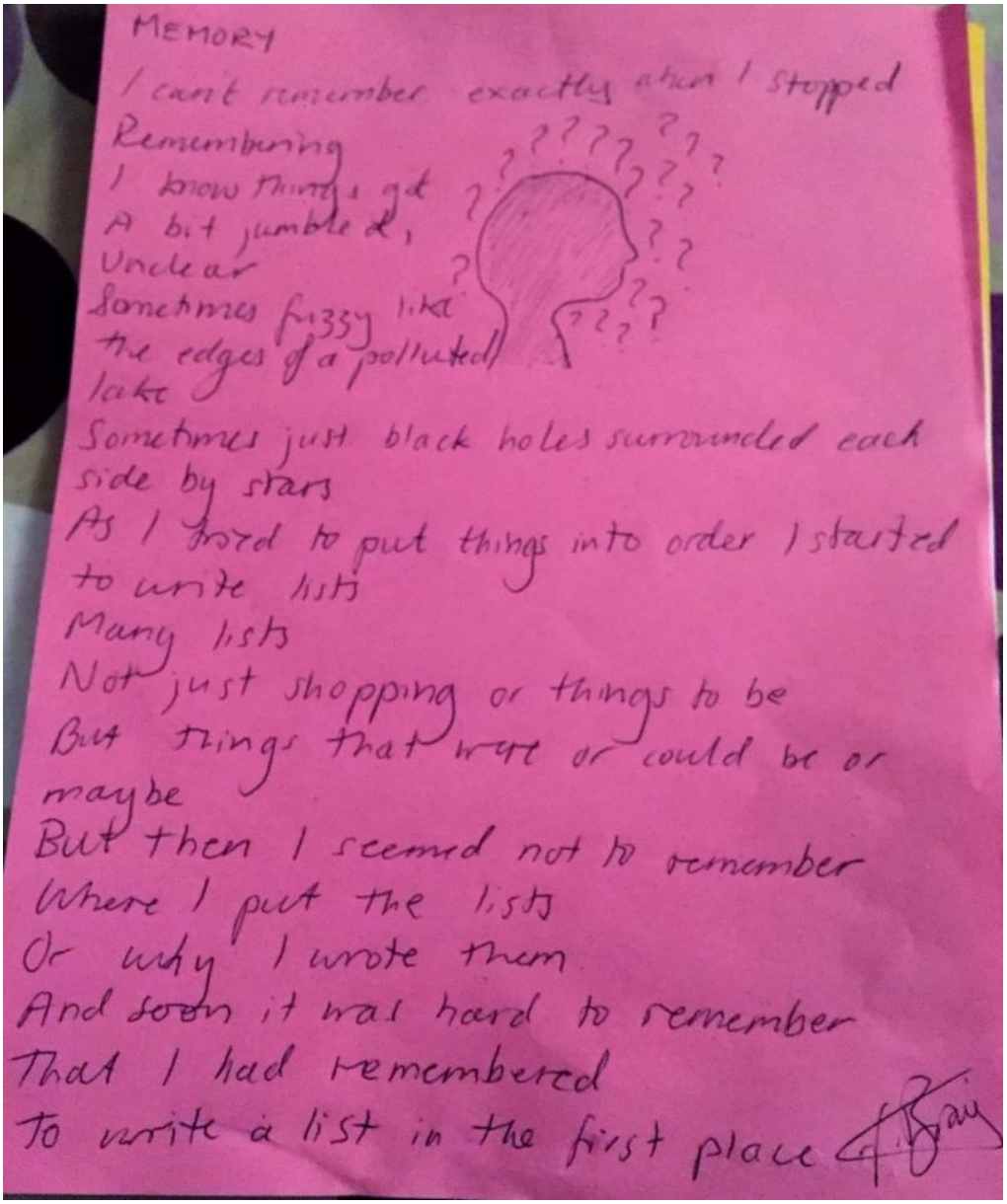
It got me thinking about a lot of things… How this writing workshop makes more sense to me than shup up and write and how some patients on acute wards where most of them only go for smoking breaks, walks, medication, and community meetings. How can we introduce writing workshops on acute mental health wards to support inpatients? (Fieldnote, 22.01.18).

Sometimes the activity facilitators would ask patrons if they would like to donate their written work for publications and displays at a museum in London. Some patrons would sign their written work and give it to the activity facilitator who files them in a folder, explains how and when the works will be published, and which museum it will be displayed in. Patrons occasionally displayed how their decisions to interact was based on trust. On one occasion, a female patron that I had not seen previously attended the writing workshop and asked patrons to file their written work in a folder, with a promise that she would arrange for publication. Nobody responded to her and all the patrons refused to give their poems to her. When I enquired why they ignored the female patron, and male patron linked their decision to trust and familiarity:

> "*We do not know her enough to give her our work, so we cannot trust what she says. She is new you know, so she may not come back*." (Rosen, informal conversation, 05.02.18).

During the writing workshop, I noticed that patrons were patient with each other as they read, and there was a collective participation in the writing and reading out of the poems. At the end of the activity, the facilitators remove everything on the table except for the rechargeable candles, the café activity schedule stand and the two plastic chess pieces. Some of the patrons would remain on the multi-use table to eat and talk among themselves, and other patrons join them while waiting for the masseuse. Three patrons agreed for their work to be included in the thesis, but only one patron signed consent the form and agreed for her poem is shown below (Image 65) with one of my poems which I wrote when I participated in the writing workshop (Image 66).

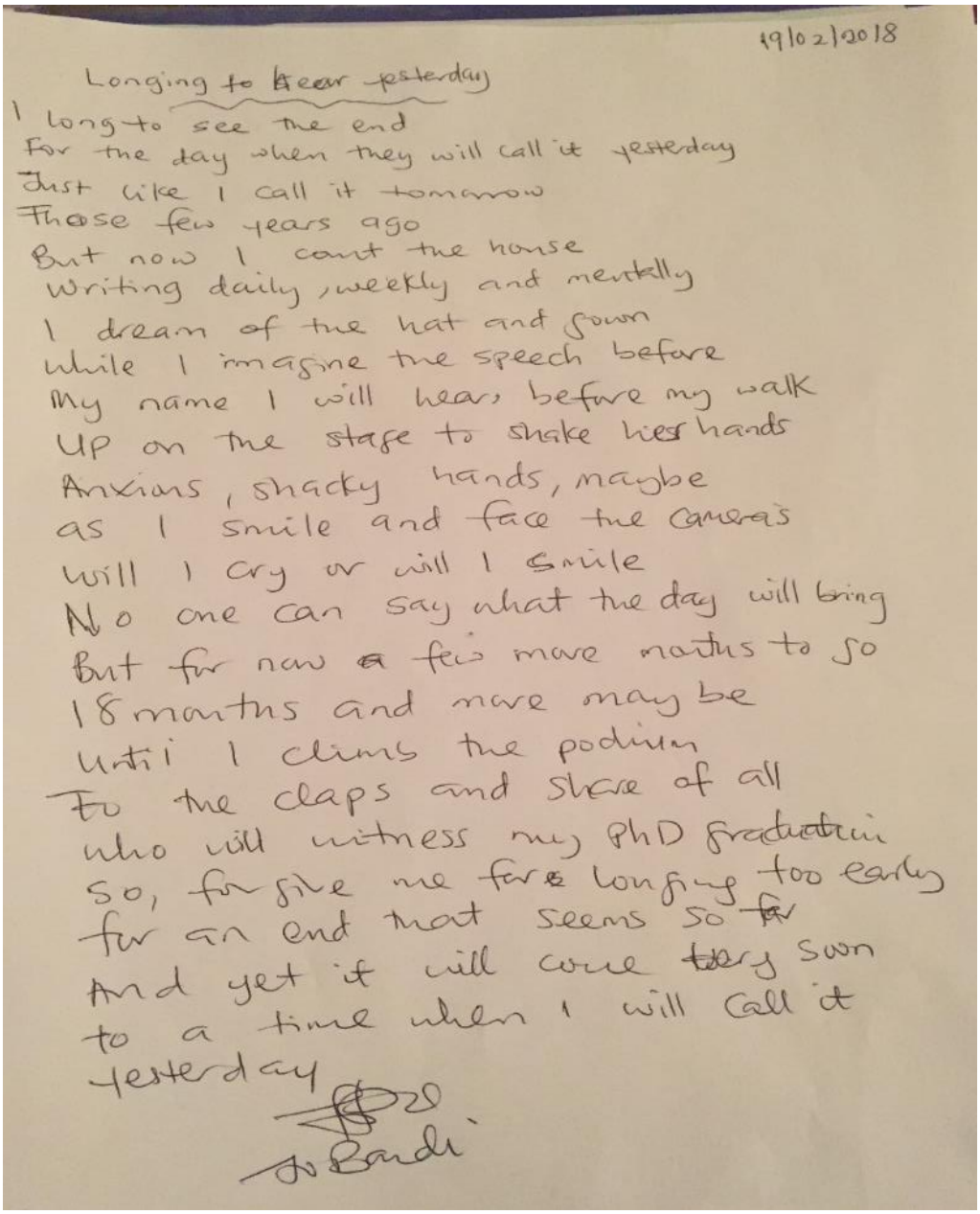
Image 63 Sharonda's poem 19.02.18



When I asked Sharonda the meaning of the poem, she replied:

"*Oh Josephine, that I think is the beginning of dementia for me…I seem to forget a lot these days*." (Sharonda, informal conversation, 19.02.18).

Image 64 Josephine's poem 19.02.18



For me, the poem above describes my feelings about graduation which seems so far, and yet so near (Fieldnote, 19.02.18)

During the writing workshop it is very difficult to observe and write at the same time because I was observing the patrons and the workshops, such as the Southwark Wellbeing and Tai Chi. I must put my mindfulness skills to work so that I can focus on one thing. The plan was to sit with my back turned to the patrons and activities taking place on the multi-use space so that I was not distracted. I smile…because I

remembered that I could not avoid the sounds and smell even with the back turned (Fieldnote, 22.01.18). Another workshop that takes place at the same time as the writing workshop is the football workshop, and although the football activity is an outdoor one, I present it here because it is one of the first activities that begins from 1.00 pm with other activities, including the writing and singing workshops.

01.00 pm to 02.00 pm Football Works

Each time that I observed in the football workshop, I informed the café manager that I was leaving the crypt to observe the players. This activity takes place outdoors, but it begins with the volunteer manager announcing the time in Space Two. It is facilitated by a male volunteer and attended only by male patrons. The football pitch is a five minutes' walk from the café to the far end of a community park with a basketball court, outdoor gym equipment, three outdoor table tennis stands made of stone, two swings and a children's playground. The football pitch is surrounded by a 4 metre high black metal fence. The ground is covered in green artificial grass, there are four white metal goal posts installed horizontally and vertically, white paint in front of each goal post with red half-moon shape in front of the white square markings (Image 67).

Image 65 The football pitch



They are usually about 10 male players in during each game; six patrons and four who do not attend the café. On my first visit, I introduced myself to the players who do not attend the café and ensured that they verbally gave their consent for me to observe the game without taking photographs of them. Before the game starts, patrons change into polyester shirts, do some stretches, the group is divided into two and individuals agree on what role to play in the field, such as the keeper or defender. During the game, the players were breathless, sweaty and they clapped when someone scored a goal. At the end of the game, the two teams shook hands with comments, including "*thank you men*", "*good player*" and "*nice game*". There was limited informal conversation before and after the football activity because they men spoke among themselves, discussing past and future football games as well as that day's game. However, I had a short conversation with the activity facilitator who shared his opinion about the café, and his feelings before and after the game:

> "*Feeling warm in a space that is inclusive for all. When I am in a low mood, I can get anxious that no one will be here to play football when I arrive, or they may not want to attend so I think "what's the point?" I should be doing other things, but I feel motivated after the game.*"
> (Arnold, informal conversation, 05.03.18).

At the end of the game, the players discussed future games as they changed into dry t-shirts and jackets, and we walk back to the café. The next indoor activity that takes place after the football is the Southwark Wellbeing Hub.

02.00 pm to 04.00 pm Southwark Wellbeing

This activity is facilitated by the Southwark Wellbeing Hub, and they provide one to one session on health and wellbeing for patrons who live in the London Borough of Southwark. Patrons go individually to sit with the Wellbeing facilitator, and they talk in hushed tones, and no one can hear what they are saying. I have written very minimally about this activity because it is a one to one session, and for reasons of patrons' confidentiality, I did not ask questions about what participants discussed with the facilitator. While this activity is taking place, the volunteers clear the multi-use space with the green carpet by

removing the bean bags and politely asking patrons to leave the space, so that they can prepare it for the next activity, such as Tai Chi.

03.00 pm to 04.00 pm Tai Chi Works

This activity is attended by 10-15 patrons and facilitated by male and female activity volunteers. It is the only activity that was either cancelled, or the facilitator arrived late, and patrons complained about it:

> "*I am upset that there is no more Tai Chi.*" (Kate, informal conversation, 12.03.18).

JNB – What does Tai Chi mean to you?

> "*Tai Chi helps me relax, so I do that…. It is good for meditation and I might stop coming if there is no Tai Chi*." (Kate, informal conversation, 12.03.18).

> "*I can't connect with people, but I visit The Dragon Café for the Tai Chi because when I am doing Tai Chi, I observe, look and learn the moves. It helps me to focus on something.*" (Mitchell, informal conversation, 06.11.17).

Image 66 Tai Chi facilitator demonstrating a move



Before the activity, the male facilitator asked the patrons if they have any injuries, after which he explains the benefits of Tai Chi, such as for self-defence, breathing and balance. During the activity, the facilitators explain each move in relation to its benefit. The facilitators demonstrate different moves, and patrons repeat the moves. The patrons who had been attending the Tai Chi session regularly and knew the movements, moved before the instructor's demonstration. At the end of the activity, the facilitator would thank the patrons and remind them to keep practising the breathing exercises.

Image 67 Patrons repeating the Tai Chi moves

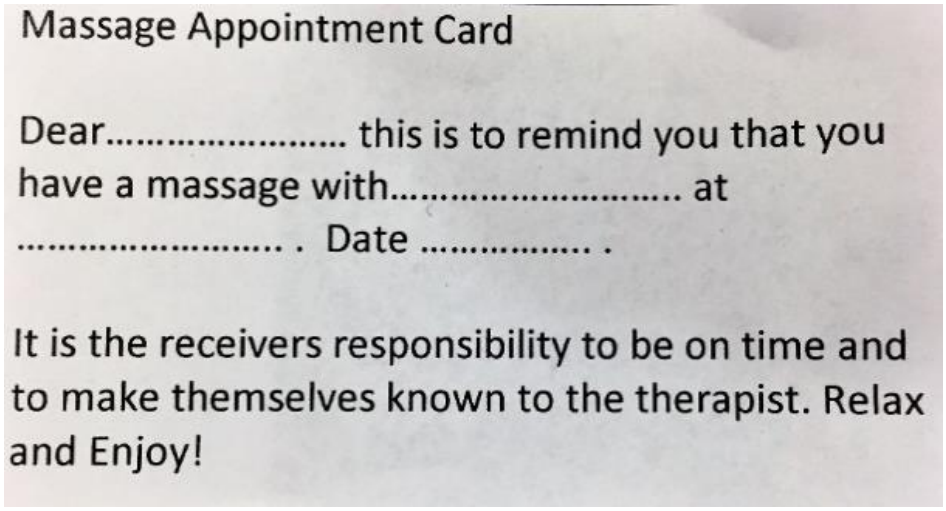


12.00 pm to 06.00 pm Massage Works

There are two male masseurs and one female masseuse. The female masseuse and one male masseur provide upper body massage, including the neck, arms, upper and lower back, and the other male masseur provides foot massages. There is a laminated information sheet attached to the wall with gum tack, and it contains all the information about the massage session. Patrons must book to attend for the massage session, and when they do, they are given the massage appointment card with their name, name of the masseur / masseuse, time and date written on the card.

Image 68 Massage information sheet and the appointment card





When patrons attend the massage sessions, the masseuse would ask if they had any injuries or a preferred part of their upper body or feet that they would like them to massage. During the massage, the masseur or masseuse tells the patrons to relax and ignore the noise in Space Two. After the massage, the masseuse would ask the patron how they are feeling and advise them to avoid coffee, as well as to drink water or herbal tea to flush out toxins from their body.

Image 69 Male and female masseuses massaging patrons



Listening to participants account about how the massage made them feel very relaxed at the end of the session, I decided to speak to a patron soon after they had attended the massage session:

JNB: You look sleepy, do you feel like sleeping?

> *I feel relaxed and I want to sleep* (Bolarin, informal conversation, 09.10.17).

A few months later, I booked and attended the massage because my legs were constantly tired from standing and walking around the café during the observational phase of the fieldwork. *At 2.20 pm, I attended the reflexology session as part of my observer as participant role. I fell asleep during the 15*

minutes foot massage and the masseuse had to wake me up…I was a bit embarrassed, but glad that I have experienced what the patrons were talking about (Fieldnote, 05.02.18).

03.00 pm to 04.00 pm Yoga Works

This activity only took place three times during the fieldwork, and those were the times when Tai Chi was cancelled. As with the other activities, 15 minutes before it starts, the café manager would make an announcement to remind patrons of the time and space. Volunteers would politely ask patrons to move the bean bags away from the large green carpet to the left side of Space Two behind, and around the multi-use table.

Image 70 Yoga mats laid out before the activity



When the green carpet is empty, volunteers would roll up the small rectangular carpet to the side of the deck table. Varied coloured yoga mats are transferred from the storage under the steps that leads to the upper chamber of the church and placed in rows on the large green carpet and on the wooden floor around the green carpet. If the yoga activity took place after 6pm, volunteers would transfer the artificial plants from the packed down massage space and place them behind the yoga mats.

Image 71 Patrons taking part in the activities



The activity facilitator usually wears a long white dress, or white skirt and blouse, and she sits with her both legs wrapped in a yoga pose, otherwise known as the lotus position. During the yoga activity Space Two is quiet and the lights are dimmed with instrumental jazz music playing softly in the background. On arrival for the activity, patrons would take off their shoes and seat on the mats and on the large green carpet. At the beginning of the activity, the facilitator spoke in a very low and calm tone, as she explained the health benefits of yoga and deep breathing.

During the activity, the facilitator described each move and asked patrons to repeat each move as far as they could to avoid injuries. Patrons repeated the moves, including deep breathing, stretching of hands, lying on their back, extending the legs, and kept their eyes closed whilst performing these moves. *I wondered if some mental health nurses who worked on acute wards would believe that inpatients are able to listen, focus and follow such repetitive moves. In my opinion and experience of working on acute mental health wards, most nurses see the incapacity in patients, rather than capacity* (Fieldnote, 22.01.18). At the end the activity, the facilitator thanks everyone for attending and the volunteers pack up and store the yoga mats in the storage area under the steps. Most of the patrons in Space Two who did not take part in

the activity sat quietly on bean bags and around the tables, and they spoke in hushed tones as they watched the activity. Patrons reported different positive perceptions about the yoga activity:

> *"I love this space. I participate in yoga and reflexology because they help with my back and neck pain.* (Abigail, informal conversation, 05.03.18).

At the end of the yoga workshop, I felt relaxed and more focused and aware of my surroundings. I did not like Yoga before today and would not attend a session when I visit the gym, but today's workshop had made me understand the importance of breathing and focusing on my breathing. I am looking forward to the mindfulness workshop, but I am already tired and sleepy from attending two workshops with two more to go. I can now understand why patrons say they are not able to attend more than three workshops a day because they get tired. Also, my tiredness is limiting my ability to write fieldnotes, although I am more observant now. What is the point of observations if the researcher is too tired to write fieldnotes? (Fieldnote, 22.01.18).

05.00 pm to 06.00 pm Good Moves Chess Workshop

At 5 pm the large table beside the massage space is set up for the Good Moves workshop, and 14 people are seated on blue plastic chairs around the table. They are listening to a volunteer who is holding a book and points to a fabric chess board as he describes the basic moves for playing chess. *I do not really like chess, so I am dreading the day that I must participate in that workshop. Perhaps the volunteer instructor can change my mind about chess and make me understand it enough to like it, so I made a note to participate the next chess workshop.* (Fieldnote, 16.10.17).

This activity takes place on the multi-use table. A male volunteer facilitates it, and it is attended by mostly male patrons and sometimes two female patrons. There is no set-up for this activity except for the items that are usually on each table. Before the activity, the male activity facilitators hang a white and black checkered nylon fabric with a white rope attached to metal clips on the wall in front of the multi-use table

(Image 74). Some patrons sit around the table, others sit on the bean bags, and they all look towards the nylon fabric while listening to the facilitator.

Image 72 Chess mat and the facilitator demonstrating the moves



During the activity, the facilitator reads from a chess moves book, points to the checkered fabric, explains different moves, asks patrons to suggest moves, and he moves the chess pieces according to patron's suggestions. Patrons ask the facilitator questions about alternative moves, he answers their questions, and everyone discusses the moves.

Image 73 Patrons listening to the chess activity facilitator



Sometimes when Space Two was noisy during the activity, the chess facilitator would ask the patrons not taking part in the activity to keep the noise down, but on many occasions, did not make any difference to the noise level. One of those days, I had to attend the chess workshop. *I find chess extremely boring, but I had to attend to experience what the patrons were talking about. I felt queasy at the thought of one whole boring hour, but I managed to complete it…no more I thought but I participated in three more because duty called (*Fieldnote, 23.10.17).

At the end of the Good Moves activity, the chairs and tables are removed to the storage under the staircase, and patrons use the space once more for sleeping or sitting on the bean bags. I asked the facilitator what chess meant to him and he replied that "*chess is a game of psychology* (Teri). The patrons also expressed their views about chess:

> *"Chess that is why I come* here." (Mitch, informal conversation, 06.11.17).

JNB – Why chess?

> *The move in chess helps with planning, focus, goals, and strategy. If you don't plan, you fall on your face… chess is good for mental stimulation and it helps us form close ties. It is easy company"* (Mitch, informal conversation, 06.11.17).
>
> *"There are so many different workshops like the chess game which can help them sharpen their brains and getting massages*." (Freddie, informal conversation, 30.10.17).
>
> "*Chess help me focus. Cognitive skills, mental power and memory*." (Celesta, informal conversation, 01.10.18).

05.00 pm to 06.00 pm Mindfulness

This is a popular activity, but it does not take place weekly. To set up the space, volunteers set up chairs on and around the larger green carpet, and they place projector and freestanding microphone in front of the green carpet. A volunteer sits behind the deck table and controls the mindfulness presentation slides and instrumental music. Space Two is usually quiet during this activity and the lights are dimmed.

Most of the people who attended the workshop sit on the blue plastic chairs and the bean bags, while others sit in groups on the chairs in the dining area (Image 76). The facilitator speaks calmly into a microphone as she instructs the patrons to close their eyes, listen to her voice and focus on '*the present*', '*the now'* and '*nothing else*'. She adds that patrons should ignore any interfering noise in Space Two and in their minds, and instead should focus on the different moves that they were making. Most patrons close their eyes during this activity. *I could not focus or close my eyes because I wanted to see what others were doing, but then I heard her say again that we must try to focus on 'the now' and when I looked up, I saw her looking directly at me, so I closed my eyes. I desperately wanted to observe what was happening, but it occurred to me that to participate, was a form of observation and I needed to participate so that I can understand when patrons tell me about the workshops, and so, I closed my eyes and focused on the female instructor's voice and words* (Fieldnote, 22.01.18).

Image 74 Patrons taking part in the mindfulness activity with their eyes closed



The facilitator added that patrons should try to focus on one thing at time and she suggest that focusing on things should include routine activities at home, such as making a cup of tea or thinking of picking up a biscuit. She demonstrated and verbally described a slow movement of picking up an imaginary cup of tea and patrons repeated the move.

Patrons repeated all the moves, including: (a) close your eyes, (b) stand up and roll your shoulders backwards using four different moves and forwards using four different moves, (c) make hula hoops movements of rolling the waist ten times to the left and ten times to the right, and (d) turn your heads in a circle ten times to the right and ten times to the left. Whilst patrons were repeating the moves, the facilitator calmly asked them to slow down their actions, pay attention to each movement, and feel what they were doing by concentrating on their actions.

The facilitator spoke about what she referred to as the three C's: Curious, Courage and Compassion. She asks patrons to be curious about their intentions, have the courage to deal with the mental monkeys and to have compassion on themselves rather than blame. At the end of the workshop, the facilitator informed patrons that mindfulness trains the mind to block outside and interfering thoughts, so that people can focus on what they are doing. She also suggested that patrons should try and walk slowly when others are rushing because it would enable patrons to be more mindful and appreciative of their actions, as well as enabling them to notice the environment. Patrons attached different meanings to mindfulness:

> "*Mindfulness takes me away from thinking about the past and the future. Stay in the moment, breath. It takes thoughts away without trying*." (Celesta, informal conversation, 01.10.18).

> "*Mindfulness is very good. It interrupts the train of thoughts when things are negative*." (Chase, informal conversation, 12.03.18).

> "*Mindfulness has done a lot for me. It makes me calm and I feel in control, instead of agitated. I was in a bad place before I started attending the mindfulness class.*" (Bolarin, informal conversation, 09.10.17).

JNB – What do you mean by a bad place?

> "*The voices talking to me all the time, telling me things to do. The voices made me feel powerful, like I can do anything and be anybody", but "mindfulness makes me feel less agitated*" (Bolarin, informal conversation, 09.10.17).

> "*With mindfulness, the voice is still there, but I can do things. Not every time you can control the monster, so when you have a good day, make use of it. Mindfulness brings peace (He said this with a smile).*" (Bolarin, informal conversation, 08.01.18).

JBN – Who is the monster?

> "*The voices*" (Bolarin, informal conversation, 15.01.18).

In line with Bolarin's comment about 'the voices', Bolarin and Shade positively described how attending the café enables them to deal with the negative symptoms of hearing voices:

> "*Mindfulness and meditation can help, but you can't get rid of the voices. The voices are very convincing, and they say things like 'kill your parents"* (Bolarin, informal conversation, 15.01.18).

> "*When you are in the midst of people, you do not have to listen to them. I get angry at the voices*" (Shade, informal conversation, 15.01.18).

JNB – How do you do you control the anger? *Sometimes asking such question makes me feel sad and as vulnerable at the patrons. I am getting quite upset as I type this because I can almost hear her voice, see her face and how sad she looked when she those words. Maybe it is a good thing that café opens only once a week because I am not sure how I would have had the emotional strength required for me to listen to such sustained sad experiences.* (Fieldnote, 15.01.18). On a positive note, Shade recounts how the memory attending the café helps her deal with 'the voices':

> "*I remember some of my interactions and participation here, and they distract the voices*" (Shade, informal conversation, 15.01.18)

Overall, the patrons articulated positive benefits and diverse meanings which they attached to their experiences of attending the mindfulness workshop. Another workshop that is similar to mindfulness with regards to requiring a quiet space and how the activity is facilitated is the gong bath.

07.00 pm to 08.00 pm Gong Bath

This is a quiet activity that involves the use of different sizes of brass instruments to make various sounds that creates a relaxing atmosphere. In the one year of fieldwork, the gong bath activity took place twice, and a minimum of 45 new people registered as patrons in one evening. On both occasions, the total numbers of attendees were 77 and 91, respectively. This makes the gong bath the most attended activity at the café. The café manager makes announcement several times on the day of the activity to remind patrons about the time of the activity so that the patrons who would normally leave before 7.00 pm can attend if they chose to. At 6.30 pm volunteers would remove the multi-use table and stackable chairs to the storage area and place a large round and flat brass metal gong, seven small brass gongs, a flute, two wooden rain sticks with mesh tops in front of the large black fabric at the back of the green carpet. They hung the large round brass gong on a black metal rail, placed the flute and rain sticks in front of the large round brass gong, and arranged the smaller brass gongs in a semi-circle in front of the large round gong. Yoga mats are placed on the large green carpet, some lights were switched off and others dimmed lower than they do for the yoga and mindfulness activities. This makes it difficult to take pictures during the gong bath activity because Space Two is usually dark, except the pictures are taken before the activity starts.

The facilitator begins the activity by welcoming everyone and explaining that Gong Bath is an ancient therapy used by indigenous people for healing. They ask everyone to either lie down, sit on mats or on a chair and close their eyes. Some people lie down on the yoga mats, some sit, or lie down on the bean bags, and others sat on chairs (Image 77). During this activity, there is usually no space because patrons occupy all the chairs, bean bags and mats. The facilitator taps the large round brass gong and small gongs lightly with rain sticks which have long wooden handles and a round sponge on the end, and she blows on the flute and speaks in hushed tone.

Image 75 Gong bath activity coordinators during a workshop



I could hear the gongs and the very low tuned voice of the facilitator as she asked us to relax, close our eyes and listen to the sounds from the gongs. *I counted 77 patrons and I was not sure if this was something that I should get involved in because I had to close my eyes to participate in this activity… I felt like I should not have participated in this workshop because I could not observe with my eyes closed, but I remembered that ethnographic observations involve smell, touch, sight, and sounds* (Forsey, 2010). *Therefore, this was an opportunity for me to use my sense of sound. While I was still contemplating whether to close my eyes, I woke up 45 minutes later. Is there such thing as blind ethnography or ethnography without sight?* (Fieldnote, 30.10.17).

The next time the activity took place, I made sure to keep my eyes open, difficult as it was, I managed to observe as 91 patrons fell asleep and I could hear snoring. At 7.45 pm, the facilitator hit the brass instruments differently and people started to wake up. At the end of the activity, the facilitator advised that people should drink lots of water for two days to keep hydrated. She added that this was required to flush out toxins from the body. Patrons applauded the facilitator as volunteers switched the lights back on. Some people stayed in Space Two and others left to Space One, while others walked outside the crypt. Most days when there was no gong bath activity, the volunteers would set-up the multi-use space for the evening

screening where patrons and health professionals engage in collective dialogue on different mental health topics.

07.00 pm to 08.00 pm Evening screening film screening and discussions

The evening screenings vary in their contents, medium (video, talk, and drama), space set-up, facilitators, and number of attendees. The usual set-up involves chairs arranged in front and around the large green carpet with one or two freestanding microphones in front and a projector on a small table (Image 78).

Image 76 Set-up of the evening discussion



Of all the activities in the evening, the RE: CREATE Psychiatry sessions was the one that took place most often during the fieldwork (Image 79). Other activities, such as the role of neuroscience in creativity and technology, natural holistic therapy and short films took place once or twice. RE: CREATE Psychiatry is a collaborative user-led exploratory and productive discussion between mental health service users and medical professionals, such as “Let your voice be heard”, and a film about mobile structure entitled “Creativity as a form of resilience”

Image 77 The recreate psychiatry leaflet



'Let Your Voice Be Heard' involves the exchange of audio recordings of mental health experiences between patrons at the café and in-patients on an acute ward. For this activity, volunteers set up the multi-use space so that patrons can sit around two tables with a tape recorder and loudspeakers placed on top. This exchange of experiences requires in-patients, and patrons at the café to speak and record their experiences of mental health service provision (Image 80). To complete the exchange, recordings from each group are sent to the other group. In other words, the recordings from patrons at the café are sent to the people on in-patient acute wards, and recordings from people on in-patient wards are sent to patrons at the café. Individuals from each group would listen to the recordings and record their own responses.

Image 78 Set up of the multi-use space for the evening screening and discussions



Sometimes, when the evening activity is only involved discussions, volunteers would set up chairs around and on the green carpet without a projector. During discussion only sessions, both patrons and doctors would take part, as reported by a participant gatekeeper:

> "*Re: Create Psychiatry was developed in 2013 for young doctors to dialogue through shrink radio. Open, non-hierarchical discussions about power, labelling, medication, unequal relationship between doctors and service users, negative effect of the mental health system on both doctors and service users. Psychiatrist are frustrated by their role, especially when they have to section patients without collaborative thinking, and this creates tension between roles*." (Mohammed, informal conversation, 11.12.17).

One day, I was still sitting at the reception desk and about to go home when suddenly, one of the patrons invited me to join the people seated for the film screening. *I suddenly felt exhausted, because it had been a long day and my back hurt, so I wanted to go home, but instead, I smiled, packed up my backpack, stood up, walked over, and sat down among the people waiting for the film screening to start* (Fieldnote, 23.10.17). The RE: Create Psychiatry volunteer coordinator spoke through a microphone as she welcomed everyone and introduced the four parts of the film screening and everyone sat quietly as we watched the film. The doctors and other health professionals sit on the chairs which were placed on the large green carpet facing the patrons who are seated on the chairs and bean bags around the green carpet (Image 81). At the beginning of the workshop, the RE: Create Psychiatry facilitator welcomed everyone and introduced the film screening and the topic of the day. The 'ground rules' were that everyone can speak about the topic, their experiences in relation to the topic or ask a question; the health practitioner(s) would respond to the comments and questions.

Image 79 Patrons and health practitioners taking part in a discussion session



One of the sessions that I attended was titled 'Films of Natham: Navigating the site of Natham Royal Hospital through moving images.' The screening began with still photographs, and the guest speakers explained the meaning of each still image, including paintings by patients from the 1950s in what they described as 'Psycho-Geography.' The most significant picture for me was the painting of tourists viewing patients in Natham; a popular 'entertainment' activity in the Victorian era. This painting was titled 'Emotional voice: the weight of history'. *I did not know that there was a time when patients were for sight-seeing, so the picture of chained men reminded me of how some people, including children with mental health challenges, are treated in some treatment centres in Nigeria. I have never witnessed any, but I heard that some church in South East Nigeria chain children and adults with learning disability, autism, and mental health challenges* (Fieldnote, 23.10.2017).

At the end of the film screening, people clap, ask more questions, which the activity coordinator and speakers answer, after which the café manager thanks everyone. Once the space is empty, the volunteers pack up the chairs and tables and returned them to the space under that stairs. While the evening activity is taking place, volunteers start packing down the Reception Area and Space One.

06.00 pm to 09.30 pm Packing down the set-up

The evening shift volunteers start arriving from 6pm to pack down the space, they check in at the exiting patrons table where they receive buttons tokens for their free meals. Between 6.00 pm and 7.00 pm, these volunteers start packing down the set-up for the activities that have already taken place, such as the massage space, and the multi-use table. At 6.30 pm, a female volunteer packs down the massage space. She starts by removing the six brown cushioned chairs, folds the green carpet after removing the 4" inch tape used to hold it down; she then removes the black wooden panels from the metal base pushing the wooden panels to the wall. She puts the massage chair on the left in front the set of light brown double doors and packs the artificial flowers chair in front the black wooden panels. Sometimes, volunteers arrange blue plastic and brown cushioned chairs in rows in the empty massage space, so that patrons can sit there for the film screening. Volunteers pack down Space One after the open mic activity. At the end of the open mic, volunteers stack all the chairs together, push the rectangular tables that belong to the church to the side and flat pack the square white tables that belong to the café. The plastic polka dot table covers are folded and stored on a table in the kitchen; art works are removed from the walls and rolled or folded individually into long transparent white storage boxes. The lighting equipment, rechargeable candles, together with the lights are packed into labelled blue or red plastic storage boxes, and the deck equipment is stored in its original box.

From 7.30 pm or when there are no new patrons visiting to attend the evening sessions, the reception volunteers start to pack down the reception space. They begin the pack down from the new patron's table by packing everything on the table, such as unused registration forms and membership cards, together with folded dark purple silk organza fabrics, into a blue or red plastic storage box, As well as dismantling and flattening the tables and stacking the chairs. The volunteers pack down the existing patron's table after updating the new patron's details on the laptop. The wooden donation box and white bin are stored in the kitchen, and they move the donation podium, coats rail, tables, and chairs to Space One. They complete the pack down by unplugging the laptop on the existing patron's table, folding away the silk organza fabric into the plastic storage box, and moving the boxes, tables, and chairs into Space One until after the evening

screening when they move them into Space Two, and into the storage cupboard. Some of the kitchen volunteers continue to serve patrons who purchase a main meal, hot and cold drinks, while the other kitchen volunteers wash and tidy up the kitchen. The condiments baskets with cutleries, jugs, transparent plastic cups, black trays tablecloth are packed and stored in the kitchen. Most of the patrons who do not attend the evening activities in Space Two, help with packing down the Reception Area and Space One. Others stand around and talk to each other or speak with the volunteers and the café manager.

At the end of the evening activity in Space Two, the pack down volunteers and some patrons, transfer all the packed down equipment, chairs, and storage boxes from Space One into Space Two. The only things left in Space One after packing down are the blue rectangular tables that belong to the church, the hand painted butterflies and Sarah Wheeler's pictures on the wall, so that all an observer can see is mainly floorboards, whitewalls, and butterflies. Volunteers stack the blue plastic chairs and cushioned brown chairs and store them in the space under the stairs.

The volunteers pack the rechargeable candles, replica chess pieces and the lighting equipment into the labelled red and blue plastic storage boxes, and then, they fold the green carpet and pack the deck into a deck box. They take down the café banner, the green dragon painting and black fabric from the metal strips with clips by undoing the clips that are used to hold the three items up on the walls and fold them away into the storage room. At 9.15 pm, all the patrons exit the café. The café manager, operations manager and 6.00 pm to 10.00 pm pack down volunteers pack the plastic red and blue storage boxes into the storage space. The pack down volunteers and the kitchen staff exit the crypt, leaving the operations manager and the café manager who both lock up the storage room, the exit door that leads to the storage area under the staircase (Image 82), switch off the lights in all the rooms in the crypt, and finally lock the arched dark green doors.

Image 80 Empty Reception Area, Space One and Space Two when the café closes for the day



I cannot explain what it felt like to watch them switch off the lights and lock the double doors that lead into the Reception Area. There is an uncertainty that surrounds the empty crypt, a former graveyard, a lonely space. A space that just a few hours ago was filled with people participating in the different activities that popped-up from an empty space, but now it had been packed down into emptiness so that it felt like an end to something that no longer exists. This temporary nature of things that exist, and yet do not, makes me imagine a cloud of uncertainty hanging over my PhD which has left me with another question, what would happen if The Dragon Café closed? Somehow, I knew that the café might open next week, but I reflected on the 'what if' and this made me anxious, I don't like the feeling, but I hate to think what it must feel like for the patrons, volunteers, paid staff, and the gatekeepers 'if' the café closed. As I walked out of the crypt, I felt that my observations had reached saturation level because I was seeing and writing fieldnotes about similar events about the place, people, and participation at café,

so it is time to start recruiting participants for the interviews (Fieldnote, 26.03.18).4.1.8 Summary of the observations and informal conversations

Overall, the space of The Dragon Café in the crypt of a church inadvertently shapes the rhythm of the day at the café, including the behaviours, actions and interactions of the patrons, and the events are more or less the same with the regular activities space set up in the morning by volunteers and other spaces set up as, and when required throughout the day. Thus, the majority of the existing patrons followed similar patterns of behaviour, from when they arrived in front of the crypt, how they participated, and when they left. A diverse range of people visit the café from within and outside the UK for several reasons, including: (1) to meet people, (2) socialise, (3) volunteer, and (4) participate and find out about the café, but the central reason that participants gave for attending the café was to escape the social stigma, loneliness, and social isolation that they experienced outside the café into a safe and non-judgmental space where they felt a sense of belonging. These findings are discussed in more detail in the consolidation of the findings (see Chapter 4.3) which is a combination of the findings from the observation, informal conversations, and semi-structured interviews. The next section provides details the findings from the thematic analysis of the semi-structured interview data which adds to the evidence about why people with MHCs attended the café, and further contextualises the evidence regarding the relationship between the place, people and participation at The Dragon Café.

4.2 Findings Two Semi-structured interviews

In this section I present the thematically analysed data from the semi-structured interviews, suggesting that participants attend the café: (a) to escape from the outside world, (b) to meet and make friends with people who share similar experiences and (c) to participate actively or passively in the space without pressure. It is important to reiterate here that some questions and participants' responses in these semi-structured interviews may mirror information attained in ‘findings one’ section of this chapter (observations and informal conversations). This similarity will, in part, be because during the observation

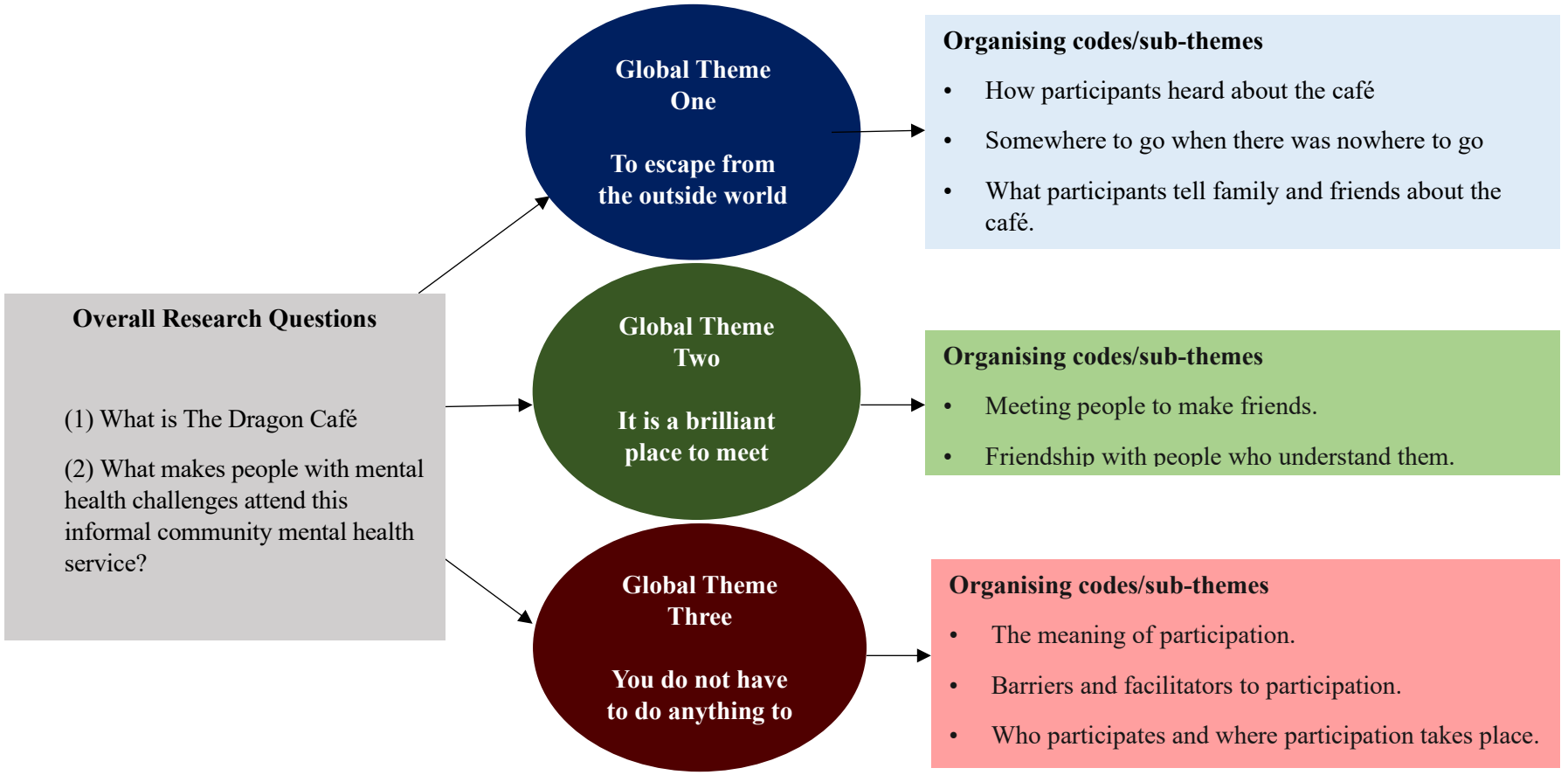
phase of the fieldwork, I was not able to explore some questions in depth. Also, findings from the informal conversations showed that participants used 'we', 'they', 'us' 'you' more than 'I' in most of their responses; as such, their responses were more about collective experiences and less about their individual experiences. Participants' verbatim quotes are written in *italics* with double quotation marks on the endpoints, with their pseudonyms, age and date of interview in parentheses. For example, (Shade, 50-60, 11.06.18).

In addition, there were many distractions during the observations and informal conversations, such as participants leaving to join activities or interact with other patrons, going home because they were tired or not responding because they were passively participating in the activities by watching what was going on. Subsequently, during the semi-structured interviews, I realised that participants had more to say about their individual experiences, although they also talked about collective experiences. For example, during the informal conversations, participants insisted that other day centres had closed, leaving them nowhere to go except The Dragon Café. However, in the interviews, participants gave individual and diverse reasons for attending the café, such as recommendations by health practitioners and friends, so data from the interviews contributed to addressing the research questions, aims and objectives of the study in more depth. In presenting the interview data, participants verbatim quotes are presented with their pseudonyms, age range and the date of the interview, for example, (Shade, 50-60, 11.06.18), but only names are used in the thematic networks.

This section begins with a thematic network; a network of illustrations that consolidates the basic and organising codes into the central themes (Attride-Stirling, 2001). The first thematic network shows the overall research question in relation to three global themes and eight organising codes (**Error! Reference source not found.**). The three global themes include a thematic network used as a representational tool to illustrate the connections between (1) the basic codes, (2) the organising codes, and (3) the global themes which capture the overall meaning of the data within the dataset (, and). Drawing on Braun and Clarke (2016), the basic codes are verbatim from participants' accounts. Individually, basic codes highlight

very little about the data, so I grouped these into organising codes, arranging basic codes into cluster topics that represent comparable views in the data. Clusters of organising codes make up the global themes. The thematic network below shows a summary of participant responses to the overall research questions: (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service*? The thematic network is presented in relation to the three global themes and the eight organising codes/sub-themes with short phrases summarising each theme.

Figure 9 The main thematic network linking the overall research question to the themes



4.2.1 Global Theme One: To escape from the outside world

When referring to this global theme, participants discussed it in the context of three specific sub-themes. These themes were: (1) how participants found about the café, (2) why they continued attending the café, and (3) what they told their friends and family members about the café. Regardless of whether participants had attended the café for years, months or only weeks, they all described the café as: (a) a place that they are happy to attend, (b) a place they looked forward to attending and (c) a place they would continue to attend because it felt safe and welcoming when compared to the outside world, as described below:

> "*I think a lot of people that come here seem to recognise they're on level playing field. I think there's an openness. Because people do feel safer in here, I know I do, it's easier to be here than maybe outside of The Dragon Café*." (Agatha, 50-60, 21.05.18).

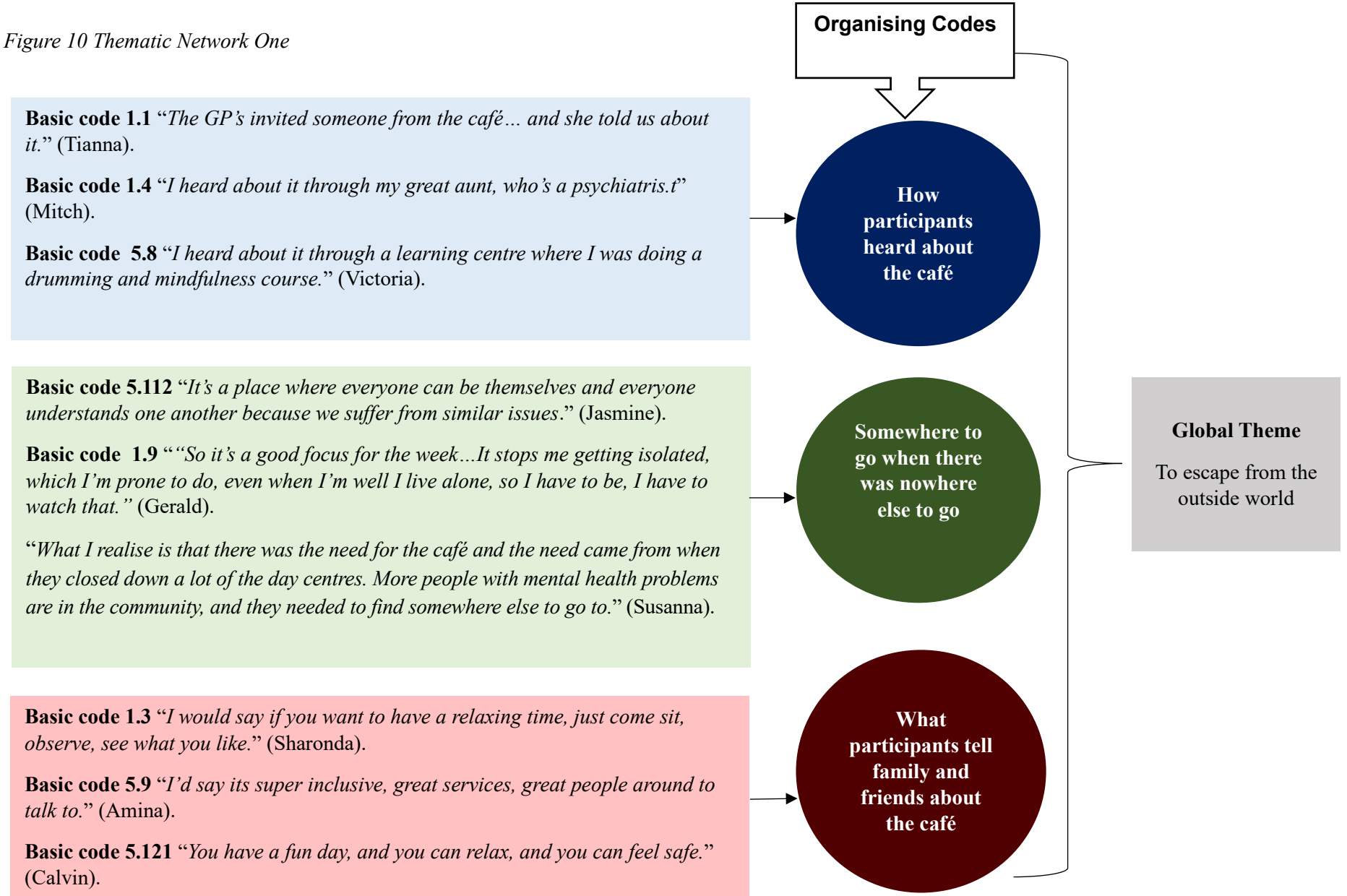
> "*I think it's a place where, you know, where you see some familiar faces again, you see the familiar volunteers and you, when you know people's faces you get to know them, and you kind of feel comfortable with everything, or the environment*." (Rosen, 40-50, 02.07.18)

Individually, participants ascribed multiple meanings to their experiences in the café through time, space and interactions with others. Although some participants decided to attend the café based simply on personal recommendation, the majority reported that their choice was in response to: (a) either the closures of day centres or other services, (b) the type of provision on offer elsewhere, (c) the refusal of services to let people in because they lived in different areas, and (d) their perceived perception of the social stigma that they experience outside the café:

> "*Also, people are not looking at me and judging me in the way that people do outside, or you think that they do*." (Celesta, 50-60, 01.10.18).

> "*Coming to the café…it helps us to calm our self-down. Because when you get agitated, the voices multiply. When you get calmer, you can be able to do things even if the voices are there. So, it relaxes you*." (Bolarin, 50-60, 30.04.18).

Figure 10 Thematic Network One



The thematic network above illustrates how verbatim accounts from participants were used to develop eight basic codes, and how the basic codes were combined into three organising codes that formed the global theme relating to the most common reason given by participants for attending the café; *to escape from the outside world.* To attend the café, participants had to know that it existed, so the global themes begin with how participants heard about the café.

4.2.1.1 How participants heard about the café

To attend the café, people had to know that it existed. One participant reported that there was a lot of advertising about the café in community mental health services:

> "*It was also advertised quite widely… widely through the community mental health teams. I think I saw posters and that kind of thing. It's hard to remember now because it's quite a while ago*." (Analisa, 40-50, 21.05.18).

Most of the participants said that they heard about it from health services or health professionals and probably would not have known about the café without this route to information:

> "*I was introduced to The Dragon Café by my care coordinator, because I'm under a hospital, and they sent me to a crisis team, and she's one of the people who look after me because I have been admitted several times because I have had several breakdowns in the past.*" (Catarina, 60-70, 09.07.18).

> "*Well, my GP surgery was holding an open day. And then we had different speakers, and one of the GP's invited someone from the café to do the singing with us because they knew each other. And so, she told us about it.*" (Tianna, 60-70, 21.05.18).

The quotations above indicate that knowing about the café through a health professional or from a mental health service prompted Catarina and Tianna's attendance. For Amina, she heard about the café when the university she attends offered a course which included volunteering at the café:

> "*My university course offered a course with a chance to help volunteer at The Dragon Café*." (Amina, 20-25, 02.07.18).

From Amina's account, the university she attends had become aware of the importance of volunteering for their medical students, in order to provide them with a social view of mental health through opportunities to interact with people with MHCs in a social setting, in addition to clinical settings. This assumption is made based on the comments below from the lecturer, who visited the café with Amina and other students:

> "*I bring medical students to The Dragon Café to provide them with an opportunity to interact with its patrons in a non-clinical, social setting; to observe the positive impact such community-based initiatives can have on peoples' well-being and socialisation and to reflect upon the relevance of the experience to their future practice. Visiting The Dragon Café helps students see patients as individuals, rather than conditions. It encourages them to think about whole-person care and to challenge the societally-conditioned stigma and apprehensiveness that exists around mental health*." (Ashley, 30-40, 22.11.18).

In relation to Ashley's comment above, Amina commented that attending the café changed her views about people with MHCs:

> "*So, people with mental health issues are heavily stigmatised. People tend to not see them as human; their interactions, or how they function as human is like anyone else who does not have mental health issues. Whereas in The Dragon Café…, people are happy, people are sad, people are going through things...but because it was such a calm environment where everyone's friendly, and there's no hostility, it's a lot easier to unsee that kind of, or unlearn that kind of idea about people*." (Amina, 20-25, 02.07.18).

Some participants stated that they heard about the café from family members or a friend keen to recommend it to them:

> "*Because word of mouth was not coming, it was only when a friend comes from [MIND], our friend. And he told us about this, and that's when we come because we had nowhere else to go after it shut down*." (Dewitt, 60-70, 03.05.18).

> "*I heard about it through my Great Aunt, who's a psychiatrist at one of the hospitals… her friends recommended this place to her"* (Mitch, 20-30, 21.05.18).

Other participants knew about the café through the internet, information flyers about the café, and the outdoor café banner:

> "*I saw the poster on the outside of the building, on the church fence*." (Gerald, 60-70, 11.06.18).

> "*And then I was in the chemist, and I spotted the flyer for it. And I'd never heard of it up until then….*" (Agatha, 50-60, 21.05.18).

Some participants had, in effect, chanced upon or found the café themselves. Interestingly, in the quotes below, Janice and Amina flag up background anxiety about whether 'a criteria' would apply to entering the café and taking part in the activities on offer at the café. This anxiety about criteria was also mentioned by Victoria and Amina, who pointed out that they felt anxious about not being welcome during their first visits to the café because of previous experiences in other spaces:

> "*The first time I came into Dragon Café…I was really nervous – that happens a lot with me when I step into new places, And usually when you step into new places not many people are very welcoming, but I was very welcomed to Dragon Café*" (Victoria, 40-50, 30.04.18).

> *"The first day, I felt like I could just immerse myself in what they had to offer as opposed to feeling like it's a new environment and feeling hostile maybe, or just nervous. I didn't feel as nervous as I thought I would be…"* (Amina, 20-25, 02.07.18).

In addition to the sub-theme of having established how participants heard about the café and what influenced their decision to attend the café, the reason why participants continued to attend the café will now be explored.

4.2.1.2 Somewhere to go when there was nowhere else to go

Once participants had made up their minds to attend the café, they had distinct views about why they continued to attend, including: '*when you get to The Dragon, the stress is gone* (Amina, Chase and Catarina); '*When, when I'm out of this café, when I leave here, I feel less tension*' (Bolarin); and '*the café relax your mind*' (Ugomma, Amina). In general, participants felt that the café was open to all, welcoming, relaxed and a peaceful space that reduced stress, as indicated in the following typical comments:

> "*I felt it was a very peaceful place where everyone was welcome, whether you are young, old. Because I observed there were different age groups there. And was peaceful where you could relax, you could fall asleep, and you could chat with everybody, different people*" (Tianna, 60-70, 21.05.18).

> "*It provides calm in a storm. Because there's life, with all these horrible things that are happening, people can go into there, and it's calm, and it's quiet. Even if you've got people pacing backwards and forwards, you've still got the calmness there*." (Donna, 70-80, 18.06.18).

> "*If you came with stress, by the time you are ready to leave you will forget about all the stress, and it lasts for a good two to three good days… my Mum always says to me you don't take things too seriously now…you have a laugh about it. I said because going to The Dragon Café taught me how to relax. The things that you do here relaxes you*." (Brianna, 07.05.18).

But it also seems that the lack of options for support from other services greatly influenced ongoing attendance at the café. The impact of service closures, structured or compulsory participation and change in service provision had proven mostly negative. However, participants described diverse feelings of loss, including: '*nowhere else to go after other services shut down*' (Dewitt), '*when a previous activity group ended'* (Donna), '*not allowed to attend another service due to changes in funding allocation*' (Rikki) and had experienced forced participation (Calvin). Also, with various service reconfigurations, not least the introduction of Recovery Colleges and the closures or changing status of other services, participants faced several other significant losses, such as established social ties, friendships, networks and places to socialise:

> "*Well, I come from another service, which is a mental ill place and that closed down, and that's when we come because we had nowhere else to go after it shut down and then we heard from a friend of ours about the café, and I've been here five years.*" (Dewitt, 60-70, 03.05.18).

While Dewitt talked about services closing down as the reason why they had nowhere to go and continued to attend the café, the language used around closures differed among participants. Some respondents described situations where attending the café became the only available option as Rikki outlines in the following two comments

> "*Last week, I went to a Recovery College, only to be told that I would not be accepted... I said why? They said well, is the service management had not paid their dues to the recovery college*." (Rikki, 40-50, 18.06.18).

> "*Well currently I'm living in an area, which is in the different borough and my care co-ordinator comes from another borough. And that means that any groups that I want to attend in an area different borough from where I live, I can't because they don't accept your care co-ordinator being outside the area you live in*." (Rikki, 40-50, 18.06.18).

Janice, a participant volunteer at the café, said that she reassures people that they are free to attend the café without any restrictions or criteria, such as place of residence. She identifies anxiety about this in those attending for the first time:

> "*I'm volunteering at reception, so people come for the first time and say, oh I went to this place, the hospital, and they said I should come here and I'm like, that's fine. There are no criteria, everyone is welcome. People say I live in the south of Southwark, am I allowed to come? And I say of course you can, everyone is welcome. There are no criteria where you live*." (Janice, 50-60, 09.07.18).

As such, we can consider the presence of specific service criteria as a chief barrier to access. This conclusion suggests that the opening of the café in 2012 was timely given the closures of mental health day centres and other services in London and the introduction of Recovery Colleges. The reduction in services available locally appeared to result in increased footfall of people attending the café, particularly for specific kinds of activities lost elsewhere:

> "*I was at a singing group in Dulwich that was closing down, and somebody said well why don't you join The Dragon Café singing group? So, I came down to The Dragon Café, participated in the singing group, thoroughly enjoyed it, and I'm never going to stop*." (Donna, 70-80, 18.06.18).

> "*Well, the day centres were closing down in Southwark, and there was a big change around mental health division. And I've always been interested in creative art…so the café seemed like a really good place to come along.*" (Analisa, 40-50, 21.05.18).

Further accounts about Recovery Colleges highlighted the importance of the café opening and remaining open at a time when other services were closing, something that Calvin described as a permanent loss of space '*because they stopped everything else*'. Participants described the collective sense and feeling of loss as a result of the closures and reconfiguration of other services. This was exacerbated by Recovery Colleges introducing services with compulsory participation in new activities, such as computer classes. This narrowing of group activity options resulted in non-attendance at such services, as Calvin outlines in the following two comments:

> "*Yeah, it became a Recovery College, and they became really strict. They used to have food; they used to cook meals. We used to pay £2 and have dinner and dessert. Then they stopped that, they stopped everything else, and before, you could play pool or table tennis and have fun*

> *and talk to people like you do here, and then they didn't want that, they stopped it. And then as soon as they did that no one was turning up*." (Calvin, 50-60, 11.06.18).

> "*Yeah, we used to play games, go to Brighton, play badminton at the sports centre, play table tennis, go to the Olympic Park; we'd do all sorts of things…and then it just all stopped suddenly. It became completely different, and they wanted you to learn about stuff. They had computer classes…and people wouldn't be interested in that, so if you didn't participate in that, you couldn't go*." (Calvin, 50-60, 11.06.18).

This form of barrier could have serious consequences for people who live alone and are isolated from the community, especially if this was the only place where they could have contact with other people. Interestingly, although the participants described negative experiences that followed the closures of day centres and the reconfiguration of some of the services into Recovery Colleges with their compulsory participation, it is important to note that they also reported positive experiences from these services before the closures. Therefore, prior to the closures, service provision in the now closed and reconfigured services may have been comparable to the café, especially as those services were closer to where participants lived, so they did not have to travel far. Furthermore, participants reported that they socialised and participated together in various activities, such as playing pool and singing. Therefore, if the day centres had remained open, some of the participants may not have come to the café. However, findings from this ethnography suggest that very few services have remained open since the café opened: only three participants reported attending other services since they started attending the café.

Stopping such activities and the introduction of compulsory participation in other specific activities has created an access barrier for some participants. However, there were other barriers, such as people not being allowed into services that were open because they did not live in the area. With people being unable to meet up at day centres and other services, they lost contact with each other. As Calvin reported, the closure of day centres also led to the loss of contacts with friends who used to attend with him. In describing the different types of loss, it is important to recognise that loss can mean different things to different participants depending on their age and experiences of previous services, relationships and participation.

There were differences in the way a sense of loss of friendship was described by a 50-60-year-old who is married, a 60-70-year-old retiree and an 80-90-year-old who lives alone. In this context, not having someone to talk to for a 40-50 year old and the loss of somewhere to attend and interact with people for an 80-90-year-old man is different, but similarly palpable in the comments of Calvin and Kent respectively:

> "*We all used to go to the same day centre, and then, that stopped. We used to go there to socialise and see our friends and things. We couldn't go there anymore. A lot of people we lost touch with.*" (Calvin, 50-60, 11.06.18).

> "*The service was a good group, the afternoon group. The bloke who runs it…was very good at his job, very good. And I got to know him, and he used to phone me up and arrange for me to go out and we used to go out and have a meal, then he retired, the gardening group packed up, and they never replaced anybody*." (Kent, 80-90, 11.06.18).

This loss can be particularly difficult for someone with a mental health condition, especially if they live alone, as Kent further comments:

> "*As I say, I'm a bit of a lonely person, you know, I live on my own and that, but now, I come down to The Dragon, have a cup of tea, I've got to know a fella, about 70-odd… and we get on, then go to the singing which I enjoy, then have a meal and a massage. Just a good three or four hours*." (Kent, 80-90, 11.06.18).

Losing contact with a workshop facilitator must have been a significant loss for Kent who probably had no one else to phone him up or go out with him. However, in light of the above quotation, it seems that Kent's loss of contact was short-lived when he started attending the café. Likewise, other participants reported that the closure of other services or the end of certain activities created an opportunity for them to attend the café where they met new people and developed new friendships, as well as re-engaging in friendships with people that they used to attend other services with:

> "*I knew about the café from another service where we used to attend mindfulness but that stopped so we came here. By coming here our bonds do get stronger, we keep that relationship, you know. Without The Dragon Café, we would not have been able to do that*." (Bolarin, 50-60, 30.04.18).

In essence, participants heard about the café from different sources, and they started attending because of diverse reasons, most tellingly the main reason appears to be the closures and changes in service provision. According to some participants, the café was not only for people with MHCs, but it was also about people with physical health challenges. Brianna and Susanna talk about how anyone can attend regardless of their health status:

> "*They treat everybody the same, you don't know special, everything is open to you, and you can enjoy whatever The Dragons Café have. It doesn't matter if you have cancer; if you have diabetes, here is for mental health. Even if you don't have mental health, you're being treated the same way as everyone at The Dragons Café*" (Brianna, 50-60, 07.05.18).

> "*So, the café is not only about people with mental health problems. Anybody can come. You have other people coming who have other health conditions. Some of them have got other long-term health conditions.*" (Susanna, 50-60, 27.11.17).

One participant, who was retired, continued to attend the café because she viewed it as a place to go and have something to do rather than specifically addressing mental or physical health challenges:

> "*It's a good place for pensioners because when I first retired, you know you're looking for something or somewhere to go or to do. And there's no advice, nothing there, no-one prepares you for retirement. You might think you are prepared because you make plans, but when you retire initially, you don't know what to do. You get up early first time around. You get up as usual, and then you just go low. You just… because there's no-one to tell you, do this*" (Tianna, 60-70, 21.05.18).

Tianna wished that there was somewhere for pensioners to go because she felt that when she visited the general practitioner (GP) about low mood and sleeplessness, all they did was prescribe sleeping pills instead of recommending a space, such as the café:

> "*You get up as usual, and then you just feel low…and the GP's… you go quick to tell them you get up early or you don't sleep too good. What they will do is give you medication, tablets to make you sleep. And you don't want that. What you would want is like someone to tell you, oh there's such and such a place, why don't you go*?" (Tianna, 60-70, 21.05.18).

Another thing that the café offered the participants was a feeling of order, routine episodic support and the predictability of being in the café every Monday without intrusions. From this point of view, there is a contradiction between imposed and personal structures. For example, in the interview narrative, participants did not attend the Recovery Colleges because they did not like being told what to do, but on

the other hand, they reported that they liked the structure of attending the café on Mondays and knowing what to expect. Similarly, some participants stated that they continued to attend the café because it is open on Mondays, and this provided them with a '*good focus for the week'* (Gerald, 60-70, 11.06.18). Therefore, the café opening on a Monday benefitted participants of all ages as evidenced in the comments of Amina and Gerald:

> "*So yeah, just being able to like have lots of fun on a Monday…Monday of all days... when everyone's all wound up, and I used to be wound up. But it feels good to know that I have somewhere on a Monday that I could come and relax and go back out and enjoy the rest of my day/evening really*." (Amina, 20-25, 02.07.18).

> "*So, it's a good focus for the week, a good start to the week*.". *I've got some friends here. I've made friends. It stops me getting isolated, which I'm prone to do, even when I'm well I live alone, so I have to be, I have to watch that*." (Gerald, 60-70, 11.06.18).

While the participants above described Monday as a good focus for the week and Gerald commented specifically about how attending the café stopped him '*from getting isolated'*, a participant gatekeeper, Susanna, recounted that the decision to open the café on Mondays was intentional. According to Susanna, opening the café on Mondays addressed a specific need of loneliness which people with MHCs might experience over the weekend. Therefore, the café provided people with a space that helped to reduce isolation and increase interaction with others:

> "*It was specifically set up that it was on a Monday, after the weekend. Monday's not a very good day for people who've got mental ill health. They often feel down after the weekend. They might have had a very lonely weekend…. So, the idea is to support people on a Monday to come to do something they will enjoy. To have a group of people they can come and chat to and then… go and do other things in the community.*" (Susanna, 50-60, 02.07.18).

> "*Well, part of it's to reduce isolation. So, the idea of people coming here is they can join in, they can do as little or as much as they like, and they feel part of the group* (Susanna, 50-60, 02.07.18).

As Gerald and Janice note succinctly, isolation is much more likely when living alone and requires attention:

> "*It stops me getting isolated, which I'm prone to do, even when I'm well I live alone, so I have to be, I have to watch that*." (Gerald, 60-70, 11.06.18).

> "*It's getting us out the house and then socialising because a lot of people are isolated because you've got to remember that a lot of people that come here live on their own, they're single people aren't they, you know*" (Janice, 50-60, 09.07.18).

It is telling that participants feel the need to disclose their mental health status, despite the non-medical context of The Dragon Café. Those participants disclosing their mental health status positively reported that they continued to attend the café because it helped them to manage specific symptoms or even avoid taking medication. For example, mixing with other people was a '*big achievement*' for Bolarin, who said the attending the café helped him to deal with '*the* voices' (L8362). Gerald said that he stopped taking medications after he started attending the café, and Analisa considered the safety of the space as helpful in reducing anxiety:

> "*To mix with other people similar, that's a big, big achievement. I would not have done that if I didn't come to The Dragon Café. I'd be sitting down in the house, taken over by the voices*" (Bolarin, 50-60, 30.04.18).

> "*The Dragon Café has helped me. It's helped me, you know...I have not been taking medication since I started attending. I used to take medication years ago, so, so it's helped me*." (Gerald, 60-70, 11.06.18).

> "*And it took me mind off my anxiety as well, but it took me quite a while to settle into the group and feel confident*." (Analisa, 40-50, 21.05.18).

This focus on safe space and mental health is further indicated in the comment by Rosen:

> "*Maybe The Dragon is just like a safe environment for people that feel like if they feel a bit sensitive or they've been through mental health things…there's an awareness down there, and people are supportive about that I think*." (Rosen, 40-50, 02.07.18).

It is obvious, therefore, that although the café adopts a non-medical model, participants felt the need to disclose their mental health status, but in a way that enabled them to describe a reduction in symptoms:

> "*It's like with mental health, we're all in the same boat, but everyone has a different passenger seat… the boat is the mental health, and the passenger seat is the different types of sicknesses. We kind of understand that we are going through issues, so we are able to sympathise more, and I guess that's probably one of the reasons why I attend The Dragon Café*." (Victoria, 40-50, 30.04.18).

The interviews provided similar accounts about how the café helped participants to manage the symptoms of their MHCs. For example, Analisa described how she was able to manage the symptoms of anxiety because she felt safe in the space:

> "*Also, it's a really safe space, I think. That is what's important about here for me. … if I am feeling anxious, I can be anxious*." (Analisa, 40-50, 21.05.18).

One participant gatekeeper, Susanna emphasises this aspect of the café:

> "*The strength of the café is, the environment that it's created, and it's to do with being a safe and nurturing and an open-hearted environment.*" (Susanna, 50-60, 02.07.18).

Although the comments from some participants suggest that this is largely the case, it is not the experience of every participant. One participant who had attended the café for more than five years reported uncertainty regarding the safety of the space by stating that the café did not feel as safe as it used to be:

> "*Well, recently it hasn't been safe because two people had their mobiles and things were stolen. You know, Martin and Diana had their mobiles stolen suddenly - like this kind of thing has never happened before. So, it was a big shock because everybody who comes here is normally very trustworthy, but maybe in recent times people are not just as trustworthy, but for that to happen theft is not a thing for downstairs, so I was very surprised*." (Calvin, 50-60, 11.06.18).

Calvin expanded his views about the shift in safety in the café, before and now:

> "*Up until then, you kind of feel that you're not in danger of anything down here. But of course, now I'm more aware…and I think a lot of them come there as they feel it's safe, but some say it's not quite as safe as it used to be*." (Calvin, 50-60, 11.06.18).

So, for Calvin, his sense of security in terms of personal possessions is compromised. That said, the comments of participants remain predominantly focused on the positive contribution the café space makes for those who live alone and those with MHCs:

> "*It's relaxing, it's peaceful, and it's time out from the outside world…because people outside here can be very scornful when it comes to mental health…when you talk to them about your health issues*." (Victoria, 40-50, 30.04.18).

> "*I think it's a fantastic place and I tell everyone about it because it's so welcoming and you know, I think it's a great social space for people, especially people living on their own who've*

got no friends or family. They can come and socialise or just sit and watch things going on." (Esther, 30-40, 16.07.18).

4.2.1.3 What participants tell family and friends about the café

There is much to learn about the value of the café for participants, from their comments about how they discussed the service with family and friends. It appears that the café is a talking point for participants, resulting in additional participation by family and friends.

"*I've often told people about coming here and said to them that it's just a great place, lots of different activities, you can do art, singing, you can have a nice meal. It's a place to socialise*." (Esther, 30-40, 16.07.18).

"*I brought my partner who has depression, and also my daughter. We did the Tai Chi together. So, it's helped my daughter and me*." (Esther 30-40, 16.07.18).

I told my friends to come here to meet people who become like friends and family." (Ugomma, 40-50, 30.04.18).

Tianna invited her son along to the café, but he decided not to attend. Even so, it is significant that participants, such as Tianna wish to suggest the facility to others in need. She also appears to view her attendance as a positive influence on her son's mood:

"*I wouldn't say I am mentally ill, but we have mental issues in my family. And coming to the café helped me mentally learn how to manage myself, because I've got a son who's bipolar, I've been trying to get him to come, but his pride won't let him, but my son says to me, I'm more calm in myself, he tells me...*" (Tianna, 60-70, 21.05.18).

The patrons show a particular sensitivity to just how daunting it can be to attend a new space when inviting family and friends along, as is clearly shown in the comments of Agatha and Ugomma:

"*I said there's nothing to worry; there are other people who feel like you, you won't have to feel like you're outside of that. And even if you do, it is a space where you could feel like that. And if you feel like it's too much, you can get up and go. It's not; it's nothing, it's not bound*." (Agatha, 50-60, 21.05.18).

"*They say what we mean by Dragon Café, I said, don't worry, when you come here, you enjoy the singing, the drawing, the writing, and you meet other people like you.*" (Ugomma, 40-50, 30.04.18).

Such quotes bring to the foreground the dual view held by the patrons of the world outside and the world of the café, with its range of unstructured opportunities, facilities, and freedom to choose and also the notion that there is nowhere else to go. Participants pointed out how they would feel if the café closed down:

> "*Then you would have to think where else I could go if there wasn't a Dragon? I would be upset; I'd be devastated if there wasn't a Dragon, I've got to think about what would happen and where would I go?"* (Francesco, 50-60, 02.09.18).

> "*What would I do, where would I go? I would have to think about something else to do. If it had closed today, I would probably be in my house alone and lonely, thinking oh, I'm missing The Dragon Café*." (Sharonda, 50-60, 09.07.18).

Francesco and Sharonda's accounts echo the view of most of the participants (n=15) who used words to substantiate what it would mean to them if the café closed; '*I'd be devastated*' (Francesco), '*I'd be sad because I would miss the friendship*' (Catarina), '*it will be a tragedy'* (Dewitt), '*I will miss it terribly*' (Sharonda). For one participant, Rikki, the closure of the café could mean that he would have nowhere to go due to his previous report about living in a different area from other services that he would like to attend:

> "*I'd have to spend too much money on cafés and sitting in the library. You can only sit in one particular library for so long*." (Rikki, 40-50, 18.06.18).

Rikki's comment, seems to indicate a limit to the time that people can spend in a commercial café, but I wanted to know if there were other differences between visiting a library, a commercial café, and coming to the café:

> "*They've got free Wi-fi, that's about it. You can speak to people here that come from the same background. They have all had a mental health issue, and they know you*." (Rikki, 40-50, 18.06.18).

One participant, who self-disclosed their mental health status, said if the café closed, people with specific MHCs might find it difficult:

> "*Well, if they close The Dragon Café, a lot of people will find it difficult because they come here to relax…I'm talking for the people that hear voices*." (Bolarin, 50-60, 30.04.18).

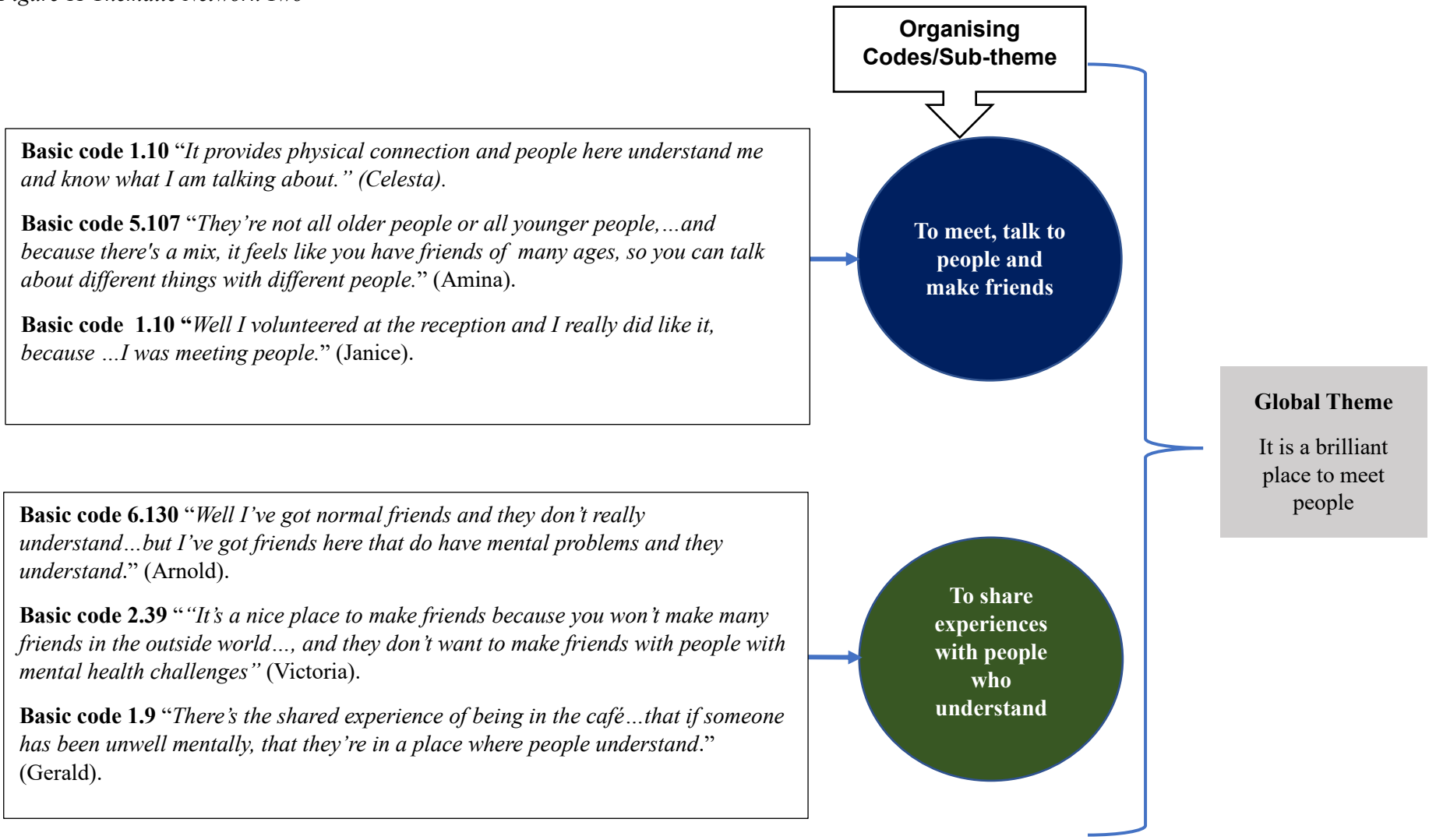
In essence, knowing about the café was not enough for participants to continue attending the café, but once participants had attended, they reported diverse experiences that prompted them to continue attending the café. Of all the experiences accounted for in the theme above, people and meeting people was important to the participants. The word 'people' as in family or friends was prominent in most of the quotes above, and this meaning continues in the next theme below.

4.2.2 Global Theme Two: It is a brilliant place to meet people

This theme comprises of two sub-themes: (1) to meet, talk to people and make friends, and (2) to share experiences with people who understand. Meeting people was a focal point for the participants (n=15), and it was closely related to the theme of '*Escape from the outside world'* as participants commented about the difficulties that they experienced with making friends outside of the café. Here are some examples of participants' views, "*People outside here can be very scornful when it comes to mental health*." (Victoria), "*If you come here, you gather, you meet people, you make friends*." (Francesco) and "*It's a brilliant place to meet people*." (Mitch).

In essence, it was easier for participants to make friends at the café than it was outside, and Victoria identified attitudes towards people with a mental health condition as the key barrier to developing friendships with people outside the café.

Figure 11 Thematic Network Two



The thematic network above, highlights the importance that participants attach to meeting people and making friends with people who understand them through shared experiences, and those that they can relate with inside and outside the café. The theme of escape from the outside world is reflected here with the view that people in the outside world would not form friendships with people with have MHCs. From that point of view, participants partition their friendships into two categories, 1). '*My normal friends do not understand because they do not have mental health conditions'*, and 2) '*friends who understand because they share similar experiences*'. Thus, participants favoured the latter because they could share experiences with them without a feeling of being misunderstood, rejected or stigmatised.

In general, participants discussed how meeting people at the café enabled them to make friends:

> "*Meeting people means a lot. You're socialising, aren't you? If you are, say, in the house and there is nobody there you're not communicating with anybody, so the café opened a door for me to meet and socialise with other people*." (Janice, 50-60, 09.07.18).

> "*It's a nice place to make friends because you won't make many friends outside, in the outside world because a lot of people are too stuck up, and they don't want to make friends with people with mental health*." (Victoria, 40-50, 30.04.18).

4.2.2.1 To meet, talk to people and make friends

Meeting people was synonymous with talking to other people, and this was an important part of what participants did at the café. However, it meant different things to different participants: '*friendship here is more like a bond'* (Dewitt); '*without this friendship, I cannot do things because of the voices*' (Bolarin); '*I've got something in common with my friends at the café because we all have mental health conditions*' (Arnold); '*well friendship for me means not being on my own'* (Francesco) and '*meeting friends from here outside the café almost felt like we're all a family'* (Agatha). These descriptions of friendship are not strictly what everyone might see as friendship, but this was how participants described the meanings that they attached to their friendships made at the café:

> "*I think that's what The Dragon Café symbolises is if you come here, you gather, you meet people, and you make friends*." (Francesco, 50-60, 02.07.18).

Collectively, participants described the café as a space where they could meet and talk to people because of the challenges and social stigma that they had previously experienced with meeting and talking to people outside of the café, as Victoria and Celesta elucidated:

> "*If it were somewhere else, like in the outside world, they would look at you as if you were some kinds of dirty tramp, or they would scorn you. They would look at you differently, very judgmental*." (Victoria, 40-50, 30.04.18).

> "*The Dragon Café is much more than that because I don't have to wear a mask with my friends here, but I have to wear a kind of mask with my friends outside here because I'm worried about rejection and I can't afford to lose my friends*." (Alison, 50-60, 01.10.18).

Although Victoria's comment does not represent the views of all the participants, the perception of the attitudes of people outside the café towards people with MHCs was dominant among the participants (n=8) who described the café as a non-judgmental space:

> "*It's nice to find people where they take you as you are, you know. Where they don't judge you too tough and try to treat each other nicely, you know. Realising people might have mental health conditions, learning difficulties, or they might be different from you*." (Paulette, 50-60, 02.07.18).

> "*You know, like you are the person you are within the café and you're sort of, you're not judged for sort of how helpful you are or how friendly you are there*." (Mitch, 20-30, 21.05.18)

Another important point relating to participants meeting people and making friends, was the ease of talking to people in the café compared with the barriers to talking to people outside the café:

> "*Because if I'm outside, I have to check myself consciously often. But while I'm here, it's sort of like, I can just sit down and be quiet or talk to anyone, or they talk to me. Which I find sort of like, okay*." (Jasmine, 60-70, 18.06.18).

> "*Well, it's easy to come and to spend time here… I can talk to anyone here you know … it's very inclusive and welcoming*." (Gaye, 40-50, 11.06.18).

> "*Some days you'd be lucky if you find somebody to smile back at you in London…It's like if you're sitting on the bus or tube or whatever if you want anybody to speak to you, they look at you as if you're an alien.*" (Rikki, 40-50, 18.06.18).

Although some participants described difficulties with developing friendships and talking to people outside of the café, other participants attested to how talking to people at the café helped them to relate better with their family members and other people outside the café:

> "*Before I started coming here, I never wanted to go anywhere because I always felt that people wouldn't accept me for what I am… I always feel that I'm not a part of the family, but by sitting with people and socialising with friends at The Dragon Café, when I go home, I now sit with my family and have a good laugh*." (Brianna, 50-60, 07.05.18).

> "*When I'm out of this café when I leave here, I feel less tension, less stress. I go home and talk to my wife…because I was not mixing with anybody before, I was not talking to nobody, but now I integrate with people, you know, I'll talk to people.*" (Bolarin, 50-60, 30.04.18).

Interestingly, in the quotes above both participants talk about how attending the café improved their interactions with family members and other people, with Bolarin comments on reduced stress and tension after attending the café. In the light of participant's perceived reduction in stress levels, a number of interviewees' (n=7) shared similar views, (Amina), (Janice), (Chase), (Brianna), (Paulette), (Catarina) and "*When you are stressed, erm, just to come out of your home and relax your mind, spend time together with people and have friends*." (Ugomma).

In addition to meeting people and talking to other people, Sharonda discussed how talking to people was also about talking about other activities that they engaged in outside the café. In essence, this exchange of additional information increased the topics in their conversations, enabling patrons to talk about what they did both inside and outside the café:

> "*We also don't just talk about the café, we talk of other things we do outside of the café, so we sort of bring that into the café to share. I've just come back from holidays, so I shared my holidays with them…and someone else talked about their holidays, so it's like a group of friends*." (Sharonda, 50-60, 09.07.18).

The focus on talking to other people is further elucidated by Arnold and Rikki who commented on how patrons, who live on their own or in a hostel, may only talk to people when they visit the café:

> "*Well, just meeting my friends and having a good time. Getting away from my mind for a few hours. If I've got no friends, then my mind becomes my friend, and that's not a very good friend.*" (Arnold, 30-40, 21.05.18).

> "*It's a good place to come and talk to people. I mean if you're in a hostel, and you don't get on with anybody in the hostel… This might be the only people you talk to in a week when you come to The Dragon Café*." (Rikki, 40-50, 18.06.18).

The above reflects how lonely some settings, such as hostels can be. Consequently, it was not surprising that two participants described a situation where some people with MHCs were keen to remain in hospitals because it was the only place where they could meet and talk to other people:

> "*And you can see why people often look forward to going back to hospital…I mean it seems a weird concept, but all the time that they're in acute mental health hospital, they want to get out. But when they get out all they want to do is return to the hospital, because they are in the environment of knowing somebody, things being done for them, and people talking to them…*" (Rikki, 40-50, 18.06.18).

> "*I loved being in the hospital, which is ridiculous. I'd have been isolated had I been at home…But because I was in a whole ward of people, I was not isolated…I just absolutely love being with other people*." (Donna, 70-80, 18.06.18).

Donna and Rikki both present similar views of how some in-patients prefer to remain in hospital where they can talk and spend time with other people, rather than return to the community where they are isolated. However, Donna contradicts that view by saying that patients want to escape from the hospital because they were bored:

> "*Give them something else to think about apart from being stuck in hospital because all anyone wants to do is escape*" (Donna, 70-80, 18.06.18).

In addition, Donna suggested that the café idea should be introduced in mental health hospitals so that patients can engage in activities to stimulate their minds, instead of sitting around and doing nothing:

> "*Yeah, they should have The Dragon Café everywhere, and even in mental health hospitals, they should have more activities because you can see how good it is for people. Why do they not*

> *have this in hospitals...why would you leave people with mental health difficulties and illnesses sitting around hospitals doing nothing when you could give them things to stimulate them?*" (Donna, 70-80, 18.06.18).

Donna presents a point of view which unwittingly highlights the importance of engaging in activities for people with MHCs and how the absence of activities in some in-patient hospital wards might be detrimental to people's health. In contrast, Rikki pointed out how patients intentionally jeopardise their discharge to prolong their hospital stay.

> "*I've seen people in the hospital getting near to the stage of being released, only to mess it up, so they stay longer*." (Rikki, 40-50, 18.06.18).

Significantly, Rikki referred to the café as a replacement for acute mental health hospitals because the same people who were inpatients also attend the café:

> "*The Dragon Café is an extension of a hospital where you see the same people and the same characters that you would see in a hospital, but they've got different names*." (Rikki, 40-50, 18.06.18).

The café being perceived as an extension of hospitals, is an important finding for understanding the usefulness of such services for people with MHCs. This perception is particularly significant as it hints at how the absence of spaces, such as the café in the community results in some in-patients, with little or no social links in the community, to intentionally jeopardise their discharge from hospital. This means that some people with MHCs are staying longer than necessary in the hospital and occupying the already limited hospital bed spaces. On a positive note, participants (n=8) cast a new light on how they feel a sense of belonging because the café provides a community, as evidenced below:

> "*I think it's that thing of belonging though, more than anything else; you belong to something. You have a feeling of belonging. I think that's important to have, this feeling of community, being part of a community in something, and then that gives a sense of belonging*" (Rosen, 40-50, 02.07.18).

> *"Well, my experience is I left a place of isolation and came into a community setting, and there were no barriers, right. I was welcomed with open arms and that extended through friendship outside of that café."* (Janice, 50-60, 09.07.18).

To be with and to socialise with others while participating in activities, was important to participants in the sense that participants were doing things together. It is telling, therefore, that participants feel that they have escaped from the loneliness and isolation of the outside world into a community where they feel accepted:

> "*A group of people who share interests, a group of people who all share a location you know… I know everyone's from all over the place, but on a Monday here, it's a collection of people who are coming together as a community for a particular reason or interest or just to be together really*." (Analisa, 40-50, 21.05.18).

> "*It seemed a really good thing for the community as well…to blend in the community is really important because people just get lost. Even living and working in London, you could just totally get lost here*." (Rosen, 40-50, 02.07.18).

The comments above reflect Susanna's earlier point about why the café opens on Mondays only (see Chapter 1.3 **Setting the scene for this research study**). Esther acknowledged that the café is only open once a week but stresses the positive impact that one day of attendance makes in people's lives. Broadly speaking Esther's emphasis on the impact of loneliness, together with Rosen's accounts, aligns with Sarah Wheeler's intentions when she opened the café as a way to combat people's loneliness:

> "*People are lonely, and they get ill, and loneliness is one of the biggest killers. You can die from loneliness. People die from loneliness, so this is a place where people don't have to be lonely. OK, it's only once a week, but it's like a lifeline for probably a lot of people*." (Esther, 30-40, 16.07.18).

This finding supports earlier notions from participants about escaping from the outside world. From this standpoint, participants associate attending the café with belonging to a community. The perception that the café replaces the hospitals, suggests some participants may not seek out other services and will therefore unintentionally limit their choices of where to attend. Alternatively, it could simply mean that with participants reporting stigma, rejection, loss and isolation due to the reconfiguration of other services outside of the café, it is unlikely that they will seek to attend other services:

> "*And I think a lot of people that come here seem to recognise that they're on a level playing field. I think there is an openness here. Because, people do feel safer in here, and they feel more of themselves, I know I do, it's easier to…be open here than maybe outside of The Dragon Café.*" (Agatha, 50-60, 21.05.18).

> "*So, you know, people greet you when you come in and you sit down, and you chat with them… and you feel like, you're talking like you've known each other for 20 years. In a sense, you don't feel out of place*." (Paulette, 50-60, 02.07.18).

Having a place to go, to meet people and socialise was important to participants as indicated in the findings above. However, participants also highlighted how social stigma, isolation and loneliness meant that without attending the café, they may not have anyone to interact with; a reason which prompted dependency on the café and reluctance to accept their hospital discharge. Meeting people at the café precipitated participants' accounts about friendships with people who shared experiential knowledge.

4.2.2.2 To share experiences with people who understand

In this second sub-theme, participants discussed the importance of friendships within and outside of the café with people who had similar mental health experiences; creating the narrative that some participants would probably not have any friends with MHCs if they had not attended the café. It seems, therefore, that the café remaining open is almost a catalyst for some people with MHCs to have a space where they can go to meet other people with related challenges. Indeed, a majority of the participants (n=19) talked about how friendships with people who had experiences of MHCs were beneficial because there was a shared understanding. For example, Esther pointed out how attending the café was an opportunity to mix with other people, which made her feel that she was not alone.

Arnold described having a mental health challenges as *'isolating'* and how he gained relief from meeting people at the café with similar experiences. These comments indicate that friendship in the café was not only about relating to other people in general; more specifically it was about relating to people with similar experiences who were able to understand:

> "*It helps you I suppose to realise that maybe…your troubles are not as bad. Other people have got conditions as well, and it's not often you get the opportunity to mix with people who've got similar or different mental health difficulties….*" (Esther, 30-40, 16.07.18).

> "*Yeah, I've made friends with people in my predicament, they have conditions like I do, and I never really had friends that had depression or that have mental conditions like I do, so I had to get along without knowing people like that, but now I do know people like that…so I've got good friends, and they know I've got mental conditions, I know they've got mental conditions and that's a different sort of friendship really.*" (Arnold, 30-40, 21.05.18).

Overall, Esther's and Arnold's views are consistent with the views of most of the participants (n=17) who highlighted the importance of friendship with people who understood because of shared experiences. However, Arnold goes further by categorising his friends into two groups; '*different*' and '*normal*' as he stated:

> "*Well, I've got normal friends and they don't understand; I don't talk to them about mental conditions, but I've got friends here that do have conditions, and they know me – it's just a bit different, that's all*." (Arnold, 30-40, 21.05.18).

Although he did not explicitly say this, Arnold's comment establishes that he views people with MHCs as 'abnormal'. However, this view was not specific to Arnold. A similar description was used by Rikki who defined '*normal*' as the absence of '*violent outburst or silly behaviours*' among people with MHCs. Thus, there seemed to be an expectation that people in the space would behave in a certain way to be described as '*normal*':

> "*It's a nice environment to do things, do creative things. People are generally quite normal. It is what you see, really. I've not seen any violent outbursts or silly behaviour. So yeah, it's quite nice*." (Rikki, 40-50, 18.06.18).

For one participant, attending the café enables him to meet people and make new friends. This was significant for him because, from his account, he would have no friends if he had not attended that café. In other words, his attendance was not about making friends with people with MHCs; it was about having friends to reduce the isolation that he would have suffered if he had not attended the café:

> "*Yeah, sometimes, instead of having the friends that you've got…I've got a lot of new friends from here. I wouldn't have had friends if I was just hanging about in town.*" (Calvin, 50-60, 11.06.18).

Similar to Calvin's view, friendship for some participants was about being able to make friends and interact with people from all age groups. This is a significant finding because, as previously discussed, a majority of the interview participants were middle-aged with fewer participants over the age of 70 and below the age of 30 (n=13). Notwithstanding, there seemed to be an acceptance among participants in the 70+ and younger than 30 age groups about how different age ranges are not significant to forming or maintaining friendships at the café; once there, it fostered friendships and enabled diverse conversations. For example, Amina a 20-25-year-old, and Kent an 80-90-year-old participant both described how being different ages did not limit their relationships with the other people who attended the café:

> "*There is also the range of people here. Because I thought it'd be like all the same age but not. They're not all like older people or all younger people, but there's like a mix. And because there's a mix, it feels like you have friends. Obviously of like many ages, sort of like you can talk about loads of different things with different people*." (Amina, 20-25, 02.07.18).

> "*Oh yeah…Bolarin has always been friendly. Bit different age group but as I say, we get on. He likes a bit of sport, likes snooker which I like, so we've always got something to talk about; yeah, we don't sit there in silence*." (Kent, 80-90, 11.06.18).

As shown in the quotes above, participants placed value on being able to make friends with people of different age groups who they could socialise and participate with in the café. Participants also accounted for how they sustained these friendships by meeting and socialising outside the café:

> "*I do meet them outside the café too, so we are friends. We go singing and meet for food as well. Do other things and activities outside the café. It's very important. I mean if I never had any friends and my life would be very dull, so I need friends to make life easier*" (Arnold, 30-40, 21.05.18).

> "*Oh, I've developed friendships with quite a few people. I mean you cannot be pally with, well everybody, but I seem to have a relationship with quite a number of the patrons that's here. We chat well, and you know, and I think it's nice that people can… I wouldn't say I extend it to my home, because I'm a very private person, but you know activities like if they're going for tea or coffee anything like that….*" (Tianna, 60-70, 21.05.18).

This example of friendship can be considered as another way that attending the café helps people to socialise outside the café and reduce experiences of loneliness, because some participants may not have other friends outside the café. Some participants did, however, comment on how they only related to patrons when they visit the café. For example, some participants have friends and family members who they can relate to outside the café:

> "*Yeah, I guess I've made friends, probably not friends that I see outside of the Café because I've got a fair number of friends already, so… but they feel like friends, and I ask how they are, and sometimes we've spoken about mental health issues, about music, about, you know, how the person is doing, how their week has been*" (Gerald, 60-70, 11.06.18).

> "*I'd rather just be here and take part and talk about what we're doing now other than outside… I've got friends outside that I go to, and my mum…to talk about deep stuff*." (Analisa, 40-50, 21.05.18).

The statements above point to situations where some participants, who live alone with no friends outside the café, may experience further isolation if they make friends with patrons who do not wish to extend their friendship outside the café. It also means that if they shared some of their experiences with people who do not want to extend the friendship outside of the café, they would have to wait until the next Monday to continue their conversation:

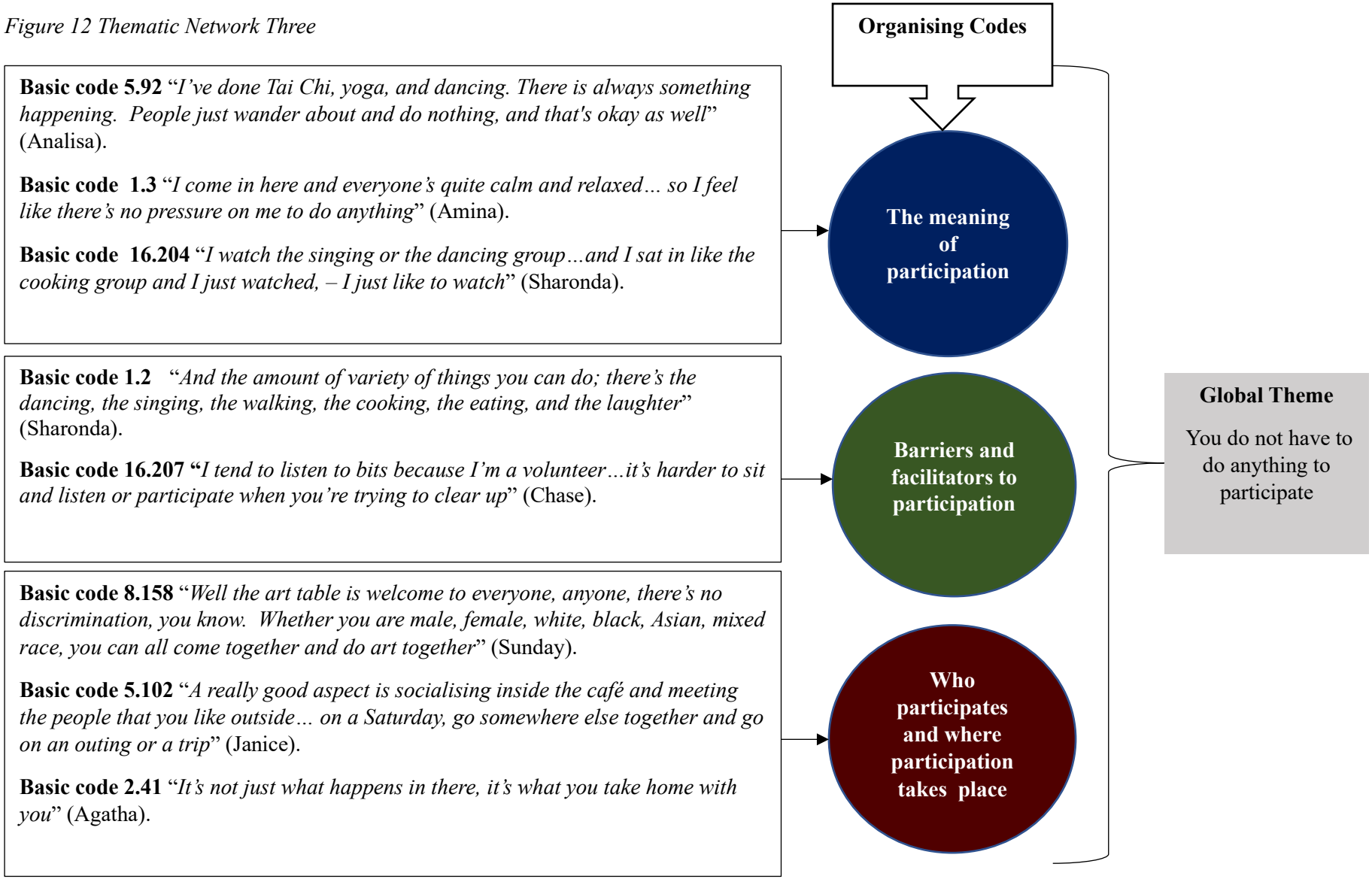
> "*You only meet on Monday's, and then you meet next Monday, and you continue the conversation*." (Gaye, 40-50, 11.06.18).

Regarding participants' perceptions of continuing their friendships outside the café, their views were mostly positive, with all but three of the participants reporting the benefits of being able to connect with the same friends from the café when outside the café. For example, meeting outside the café enabled them to organise and participate in different activities, such as going out and attending events. In summary, friendships within and outside the café are embedded in participants positively described experienced of socialising with each other.

4.2.3 Global Theme Three: You do not have to do anything to participate

This theme is defined as 'all the activities that participants took part or did not take part in at the café and the meanings that they attached to participation'. Participation without pressure was a central theme for all of the participants, and it closely evolved inside and outside the café. As was discussed in Findings One (4.1.7), the café provides a variety of free activities including: (a) open mic, (b) singing, (c) dancing, (d) yoga, (e) mindfulness, (f) football, (g) chess, (h) ArtSpace, (i) tai chi, (j) writing, (k) massage, (l) gong bath and (m) evening sessions relating to different mental health topics. Therefore, to avoid repetition of the activities, it is only the activities that were not described Findings One (see Chapter 4.1-4.1.8) that are discussed here. In the thematic network below, verbatim quotes from participants are used to show participants' perceptions of participation, and how these combines into organising codes that highlight: (1) the meaning the participants attached to participation, (2) why and how they participate or do not participate and (3) where participation takes place.

Figure 12 Thematic Network Three



4.2.3.1 The meaning of participation at the café

One of the key points that participants highlighted was the importance of unstructured participation without compulsion. But more than that, participants perceived participation in relation to friendship, describing the act of taking part in group activities with others as a form of friendship because they believed that people have to be friends to participate together:

> "*I think participating in groups and like being part of something in the community. It really helps with the mental health… and if you have certain sensitivities with your mental health, it's good to be involved in something like this café community.*" (Rosen, 40-50, 02.07.19).

However, the focal point for 14 out of the 38 participants was '*no pressure'*, or the freedom to do what they liked, when and with whom. Here are some of the descriptions from the participants:

- '*freedom of being able to choose what you want to do for as little or more, as less, as you want, as we feel in ourselves'* (Francesco, Chase, Agatha, Catarina, Dewitt and Analisa),
- '*no pressure to do anything*' (Chase, Gerald, Rikki, Paulette and Susanna),
- '*no one hassles you; nobody is hassling you and telling you what to do'* (Dewitt and Catarina), *'chill out*' (Dewitt, Janice and Calvin),
- '*you can zone out'* (Rosen),
- '*I can just be myself and you just be yourself'* (Dewitt, Sharonda, Analisa, Rikki and Jasmine),
- '*nobody interferes with you*' (Kent) and
- '*free to come and go as you wish'* (Donna).

Undoubtedly, being able to make decisions about what to do, or not to do at the café was important for participants. As a result, participants perceived the non-compulsory participation at the café as a form of freedom:

> "*The café fundamentally changes the way of life, and it changes the way of people's expectations about what is it I want to do, not what they want you to do, but about what I want to do*." (Francesco, 50-60, 02.07.18)

> "*It's just the atmosphere. It's just so peaceful when you come in; nobody's bothering you, you can do whatever you want, you can go wherever you want, join in anything, sit down, it's just so calming space you know. You don't have people come over and ask you what you're doing or interrupting you…you just be, however, whatever you want to be*." (Esther, 30-40, 16.07.18).

Aside from the freedom described above, participation seems to be the theme that shows how participants interacted with the space, activities and people, within and outside the café. Several things count as participation at the café, including: (a) observing others, (b) doing nothing, (c) doing anything, (d) staying the whole day, (e) arriving and leaving at will, (f) not attending but remembering the experience of attending, (g) meeting and participating with friends from the café, (h) friends from outside the café and (i) family members outside of the café. For some respondents, participation started before they arrived at the café. Amina and Esther described situations where they planned, in advance, what to do at the café. For example, before leaving the university to attend the café, Amina commented on how she would feel after attending, while Esther reported that she specifically came for the dancing because she would have paid if she had gone somewhere else:

> "*With The Dragon Café like, it feels like… especially because it's so close to my uni that I can just… if I'm feeling maybe overwhelmed on a Monday, I could always like just come down and defuse and calm down and relax and enjoy myself*." (Amina, 20-25, 02.07.18).

> *"I wanted to do something for myself today, so I came here because I want to do some dancing, I want to feel better about myself and things in general, so that's why I came; and where else can you go for that …there is nowhere else, unless you want to pay…but you don't have to pay here*." (Esther, 30-40, 16.07.18).

One participant also pointed out how they would have to pay to take part in activities outside of the café. This seemed to highlight that paying to take part in activities could be another barrier to participation in other services:

> "*Because of all these things, if I went and did them myself, I'd have to pay a lot, especially the massage with the mobility issue I've talked about. I've paid £70 for a massage, you know; it's free here*." (Janice, 50-60, 09.07.18).

Thus, it is fair to assume that some participants would not have attended the café if they had to pay to access the activities on offer. Consequently, in addition to the perceived freedom to participate or not participate, the café, directly and indirectly encourages attendance and participation by offering the activities for free:

> "*I've got a garden, and it needs a lot of looking after, so obviously they were giving me tips and things to do to help maintain it. And it does not cost me anything. If I were to enrol to do a gardening course it would cost me money, so again, it's there, and it's free. "I've participated, and it's given me know lots of tips for my garden without costing me anything*." (Janice, 50-60, 09.07.18).

According to one of the participants, the activities that the café offers help people through life because they can use different activities to express how they are feeling, such as in the writing workshop. This interviewee pointed out that participating at the café was more than just being there; it was also about letting go of feelings, such as anger:

> "*Well, because The Dragon Café is there to help people through life through the activities that it provides. So, if somebody wants to come and do some painting and they are feeling angry and cross, just stuff the pain on the paper and scream and yell, and they can do the same with writing. They can write how they feel. And you can do the same with singing; you can do the same with dance as well*." (Donna, 70-80, 18.06.18).

To know about the activities and timings at the café, one participant pointed out how volunteers gave them the café activity flyer and showed them around the space while describing the different activities:

> "*I remember one of the workers sorts of took me around and introduced me, showed me like different groups and what they were doing and what the place, you know what The Dragon Café has to offer*." (Sharonda, 50-60, 09.07.18).

> "*When you come here and you are new, they give you membership card and introduce everything to us*." (Shade, 60-70, 07.05.18).

This demonstrates how participants are introduced to the variety of activities at the café, but in the same context, it can also act as an indirect way of encouraging people to engage with the activities: a point reported by Sharonda:

> "*People want you to participate, they'll not force you to do it, but they tell you what is available, and that is encouraging. You are there, it's your own time, you do what you want to do, but they encourage you, it's good to be encouraged*." (Sharonda, 50-60, 09.07.18).

Also, such a view might indicate that telling attendees about what the café has to offer reassured them that the café meets the needs of different people through the provision of a range of activities. One of these relates to people who live on their own:

> "*Oh, it's good because people can choose what they want…if there was just one thing someone might not like reading, someone might not like dancing, I mean if you don't like the things, you can just go and sit down and relax. I think you need the variety because people have got different hobbies, different mindsets, you know. You might not like reading, but you might like dancing; someone might not like dancing, but they might like drawing; you know, someone might not like drawing, but they might like walking, so you need the variety because everyone's different*." (Sharonda, 50-60, 09.07.18).

> "*So, a lot of these people are out there, living on their own in the community and coming to somewhere like that is very helpful. And to them… even if they just come and do a bit of painting or drawing or reading or writing or taking part in the cooking*" (Tianna, 21.05.18).

For others, the café represented a space which they related to as an activity centre where they could take part or do nothing. The language used around participation differed among participants however there were repeated references by all participants, forming the dominant view that '*doing nothing*' and '*taking part in the activities*' both count as participation:

> "*It's non-judgmental, there's so much going on, I mean it's busy. I've done Tai Chi… and the Yoga, and I've done a bit of the dancing, and there's always something happening. Or people just wander about and do nothing, and that's okay as well*." (Analisa, 40-50, 21.05.18).

> "*It was almost like an activity centre, and I liked football, I liked the dancing, I like socialising, and I like sitting around doing nothing as well*." (Arnold, 30-40, 21.05.18).

In this context, the café provided Analisa with a space where she could take part in creative art, which suited her creative personality. Equally, other participants (n=6) talked about how their creativity was enhanced because they attended the café and took part in creative activities:

> "*And I had some job stress, so coming to The Dragon was helping me with the creative side because I felt like I was missing out on the creative things in my life. And that was causing me some depression, I think*." (Rosen, 40-50, 02.07.18).

The importance of group activities, rather than individual activities, was also highlighted and favoured by participants who talked about how it:

- *'enabled interactions with other patrons'* (Victoria),
- '*the singing group is about making friends and having a laugh together'* (Susanna), and
- '*I know a group of people that don't actually do the activities, they come there to socialise'* (Janice).

For example, Tianna also added that GPs sometimes refer pensioners to the gym and swimming classes, but these are activities that individuals do on their own as opposed to the group exercises that the café offers which encourage participants to participate and socialise; an opinion that was also echoed by Susanna:

> "*Okay the GPs give you the leaflet, go and do exercises, go and do gym, but you have to have the motivation……when you come to somewhere like the café, you get the motivation and even if you go swimming, you go by yourself, and swimming is not a group exercise although there are other people in the swimming pool, you're not doing the same thing together*." (Tianna, 60-70, 21.05.18).

> "*Apart from massage, majority are group work workshops, so, you know, 'people getting together', connecting, so they are not doing individual workshops…so the idea is that group participation helps to reduce isolation and people start talking to each other, getting to know each other*." (Susanna, 50-60, 02.07.18).

Tianna's comment above, reflects opinions about the non-beneficial aspects of some social prescription pathways which are geared towards individual rather than group activities, with the latter category creating cohesion and interaction. She further explains:

> "*I mean the group I'm in outside the café, we go on outings, and we go on walks. You know, we go to the theatre and museums. But singing, the dancing, the activities like you know, different things to participate and get in to talk to people on a one-to-one and different people different times, you don't get that in the other group*." (Tianna, 60-70, 21.05.18).

To be with others and do things collectively was seen in the café as socialising. For example, Sunday pointed out that he continued to attend the café because it provided an environment where he could socialise with others in groups:

> "*I liked it so much because it was somewhere unusual for me. I've never been in that kind of environment, you know, where therapy users come together, become friends and socialise, and do things together as well, like games, like monopoly, chess, reading, reading groups, you know*." (Sunday, 40-50, 21.05.18).

4.2.3.2 Barriers and facilitators to participation at the café

This sub-theme discusses what motivates participants to take part in the activities and what might hinder or limit their participation. Participants perceived choice, autonomy and the flexible approach at the café as enabling them to engage with the activities that the café offers. For two participants, the freedom to choose what to do or not do held strong motivation for them:

> "*Freedom of choice, you can be involved as much as you want to, or as little as you want to. Whatever you choose to do. You don't have to do anything, and that's what I like…*" (Chase, 50-60, 28.05.18).

> "*Being able to choose what you want to do for as little or more, as less, as you want, as we so feel in ourselves. And I think that's what The Dragon Café symbolises and that's what it means to me to… freedom, independence, choice and variations*." (Francesco, 50-60, 02.07.18).

It was important to participants that there was no pressure to take part in the activities in the café, and this was also a key motivator for participation across all age groups:

> "*It is freedom for me. You know, it feels nice, like I spread my wings and I can do what I want to do – nobody's hassling me, you know – just there, it's peaceful you know*." (Catarina, 60-70, 09.07.18).

> "*Here, you can choose to sit down, relax and chat with people, or get on with the Tai Chi, the chess, the dance, whatever, you know. Your choice to get involved or not, sit on the side lines and watch. No pressure*." (Chase, 50-60, 28.05.18).

University student, Amina highlights the importance of an environment without the pressure to participate:

> "*I enjoy it, and it's a distinct difference…because I usually come in from my uni and then from such as a fast-paced environment, high pressure where everyone's striving for something. And then I come in here, and everyone's just taking time to relax, process the week before as well as getting ready to step into the next week. So, because everyone's quite calm and relaxed and trying to enjoy themselves, I feel like there's no pressure on me to do anything at that time*." (Amina, 20-25, 02.07.18).

Participants' comments above align with the notion that just being in the space was regarded as participation. This differentiates the café from other services because it provides access to participation without it being compulsory, which participants reported as the key barrier to attending other services:

> "*Here, you can just turn up; it's up to you whether you want to do something or not. You know, just being there is good enough sometimes*." (Calvin, 50-60, 11.06.184).

> "*I mean some of the other places like Blackfriars, when you go there, it's very structured. You have to do something at a certain time…they may have only four activities, but they are structured at a certain time, and if you're not there if you don't turn up on time it's finished*." (Janice, 50-60, 09.07.18).

Even though participants felt that they had a choice about what to do in the café, some participants highlighted noise levels, the uniformed security officer at the entrance, the timing of activities and volunteering as additional barriers to participation:

> "*The only negative thing I've got about, it's not negative, because when you talk about something like this you've got to talk about positive and negative and things like that; sometimes in my group, the surrounding noise can a little bit disturbing…I don't really spend much time in the first room because it gets a little bit noisy. I'm always in the quiet room*" (Sharonda, 50-60, 09.07.18).

Donna, who left a different singing group that closed down in Dulwich and had only attended the café for four weeks before her interview date, commented that the noise levels at the café have no bearing on participation when compared to the service that she used to attend:

> "*But it was so different because, with all the noise in the café, everything just carries on. Now the guy that took us to singing for better breathing at another service couldn't have coped with all that noise. He was always telling people to be quiet*." (Donna, 70-80, 18.06.18).

From Donna's account, the noise was not a barrier to attending the café, but it is significant to note how noise can be a barrier to participation at the café, as Sharonda pointed out. In this case, the impact of noise in spaces, such as the café could limit attendance and the time that some patrons spend in the café's different spaces. The implications of this are that some patrons are not able to spend time in Space One or take part in observing the activities with higher noise levels.

For some participants, participation begins before they arrive at the café, and for others, it begins while they are still waiting to enter the café. Thus, the presence of a uniformed security man standing at the double doors that lead into the café was a barrier to participating. For example, Dewitt confirmed that some patrons would not approach the café because of the uniformed security man:

> "*Because before, it was a massive uniform, security uniform… I know someone said to me, why are you going in? I said, why not. He said that security bloke. I said it's alright; it doesn't bother me. Yeah, but he looks like a copper or something you know…I think when you see someone there in uniform, and you've come from like a ward…It was a shock at first, a lot of people went there but wouldn't pass or enter, even though they were that a lot of people there… he's still security but different now because he is wearing the Dragon T-shirt.*" (Dewitt, 60-70, 03.05.18).

The text above reflects how the presence of a uniformed security officer represented authority and ignited memories of being on acute mental health wards where people's movements were restricted by the uniformed security men at the entrance. This implies that memories of the negative impact of previous experiences with authority might influence their decision to access any setting. Also, taking part in the activity of their choice was important to some participants. However, unfortunately the timing of some

activities, such as the writing and walking groups coincided and this prevented participants from being able to attend their preferred activities, and also forced them to choose between two activities. For example, Sharonda talked about a situation when she was unable to take part in the walking group because it was at the same time as the writing group:

> *"The thing is there are so many things going on. I like walking as well, but the walking group is the same time as my writing group so that you can do one or the other, so I go to the writing group…, I would like to go to the walking group, but they overlap so you can't do the two…I have to choose just one, so I choose the writing group because they know me and I know them, and we get on so well, it's like a family type of thing*." (Sharonda, 50-60, 09.07.18).

Gerald perceived the lack of variation in the timing of the activities as an additional barrier to participation for people who worked during the day, who are only able to attend the evening sessions, so they miss the activities that take place during the day:

> "*So, I guess people that are working, they only attend the open mic and…the curated event at the end of the day, they would miss out on the massage and the other groups that are run during the day. So maybe if it was on more often, the timetable of things could be changed, but I think if every area had a Dragon Café, it would be brilliant*." (Gerald, 60-70, 11.06.18).

Obviously, there are participants who are missing out on activities that they would like to attend, such as volunteering and trying to participate in the activities; an issue which permeated conversations among participant volunteers at the café. For example, Chase and Janice pointed out two barriers to participation: (a) trying to combine volunteering and participating in the activities and (b) feeling guilty for participating:

> "*And the evening session…I tend to listen to bits because I'm a volunteer in the evenings now, I'm not quite so involved with sitting through…it's harder to sit and listen to the whole thing when you're trying to clear up because if you don't start clearing up, you're going to be late getting home at the end of the day*." (Chase, 50-60, 28.05.18).

> "*Yeah, I've done the yoga and the dancing and the massage. I've done that you know. But I don't want to take something, a massage or something from a patron you know what I mean. I'm a volunteer; I don't want to do that.*" (Janice, 50-60, 09.07.18).

This semblance of mild stress is probably because volunteers at the café are offered free food and drinks, and their travel costs are refunded, so taking part in the activities induced mild guilt feelings for some volunteers. From what the participants said about the barriers to participation, many of them would prefer more cafés in other boroughs and more opening days at the café; to enable them to take part in different activities at different times and on different days. Without this option, barriers to participation at the café may be likened to barriers to participation at the other services. However, unlike the other services, where participation was compulsory, participation at the café was more than just taking part, it was about being there.

4.2.3.3 Who participates and where participation takes place

There is an understanding among the interviewees that their participation takes place when they are in the space without the need to take part in the activities or interact with anyone. For example, for the participants who did not physically take part in the activities, watching others take part and just being in the space counted as participation:

> "*Oh, well when I come, I always hear the singing, I see the people interacting with other people, I see activities going on…it makes me feel like life goes on you know, just makes you forget about the bad feelings in your head and makes me feel happy….*" (Catarina, 60-70, 09.07.18).

Victoria notes additional benefits of watching the patrons who take part in the activities and in doing so, she refers again to the attitudes of people outside the café as a barrier to participation outside the café. As far as Victoria is concerned, watching those who took part in the activities enabled her to see how people with MHCs are confident to showcase their talents in front of an audience; an act which she is doubtful would be possible outside the café:

> "*I've done a bit of the art…I'm not really good at art, but I like sitting there to watch and talking to the people that do the art… I've watched the dance and the open mic…I enjoy that because you are able to see the confidence in people because I don't think they would do it in other places because of how other people would probably look at them…They're more likely to*

> *feel comfortable doing it in a space like this…it's nice to see those with many talents with mental health doing things like that, and to embrace their talents*." (Victoria, 40-50, 30.04.18),

Given the above quotation, to assume that those who did not physically take part in the activities did not participate, may undermine the meaning that participants attach to participation at the café. Indeed, for some participants who only watch what goes on, it was enough for them to learn something that they can take away with them, as described by Sharonda and Agatha:

> "*If I watch the singing or the dancing group, I'm relaxed…and it's fun to watch. Like sometimes, people come to the writing group and sort of look over our shoulders to just curious at what we are doing, – I just like to watch it. Like one week I went, and I sat in the cooking group, and I just watched, and I think oh, I could do that when I get home. And what I do is take The Dragon Café home with me*." (Sharonda, 50-60, 09.07.18).

> "*But see, it's not just what happens in there, it's what you take home with you. I always feel like I take something home with from the café*." (Agatha, 50-60, 21.05.18).

Taken together, it is apparent from the quotes above that participants re-live their experiences of attending the café. Compared with the other services where participants stopped attending as a result of negative experiences, this finding suggests that reliving positive experiences might serve as a motivating factor for them to continue attending the café. Participation outside the café in many accounts (n=25) involved participants meeting outside the café and taking part in activities they had organised for themselves. Overall, there was an understanding among participants that keeping in touch with other patrons outside the café was important for socialising. In other words, as indicated earlier, without meeting café friends outside the café, some participants may experience loneliness and isolation:

> "*It was fantastic. It was great. And it was really good, because it's the first time I'd been out, and few other people as well, it was the first time we'd been out as a group, outside the Café. And it was, it was great. It was so good to go out, outside of the café*" (Agatha, 50-60, 21.05.18).

> "*So that's a really good aspect, socialising inside the café and meeting the people that you like outside…to meet up somewhere else, they might meet on a Saturday and go somewhere else together and go on an outing or a trip*." (Janice, 50-60, 09.07.18)

The comments above demonstrate that most of the participants perceive socialising inside and outside the café as beneficial for them to maintain their friendships with other people from the café. With that in mind, it was pertinent to explore participants' views about what they would do if the café did not exist or if it closed down:

> "*Then you would have to think where else I could go if there wasn't a Dragon? I would be upset; I'd be devastated if there wasn't a Dragon, I've got to think about what would happen and where would I go?"* (Francesco, 50-60, 02.09.18).

> "*What would I do, where would I go? I would have to think about something else to do. If it had closed today, I would probably be in my house thinking oh, I'm missing The Dragon Café*." (Sharonda, 50-60, 09.07.18).

From Francesco's and Sharonda's responses, somewhere to go would be a crucial challenge, so I specifically asked Rikki what it would mean for him if the café did not exist. I posed this question because, for the participants who talked about having nowhere to go, it was about participation barriers such as: (a) structured and compulsory participation and (b) changes in service provision. However, for participants like Rikki, the option was limited because they may be refused entry into other services due to their care coordinators living in different areas from the services that they would like to attend. Rikki noted that he would indeed have nowhere to go, but he added that he might spend time at commercial cafés and libraries:

> "*I'd have to spend too much money on cafés and sitting in the library. You can only sit in one particular library for so long… They've got free Wi-Fi, that's about it…You can speak to people here that come from the same background. They have all had a mental health issue, and they know you*." (Rikki, 40-50, 18.06.18).

Bolarin, who self-disclosed his mental health status, described a situation where people who hear voices might experience increased symptoms if the café closed:

> "*Well, if they close The Dragon Café, a lot of people will find it difficult because they come here to relax. I come here to learn different things, about the technique you use against, I'm talking for the people that hear voices*." (Bolarin, 50-60, 30.04.18).

Bolarin's comment, in part, reflects his views of the challenges that people who hear voices might face if the café did not exist. Collectively, participants' remarks about what they might do if the café closed, point

to the possibility of a situation where some participants facing similar situations of loneliness, isolation, and loss, may have nowhere; thereby reverting to the situation that existed for the patrons before the started to attend the café.

4.2.4 Summary of the semi-structured interviews

Generally, the majority of participants heard about the café from different sources, including friends, family members and health professionals, but the main reason they sought out a place to go was due to the closure and configuration of mental health day centre which created the diverse loss of somewhere to go (place), friendships (people) and activities (participation). However, once participants started to attend the café, the continued to attend the café is open to all, with no access and participation criteria, and it stopped them from getting isolated because it provided them with somewhere to go when they had nowhere else to go, and in a way replaced their replenished their place, people and participation. Once participants were happy with the services at the café, they shared these experiences with their friends and family members who they also invited to the café. Participants' responses were similar and different according to the typology of the participants, how they participated and the meanings that they attached to the experiences of their participation, including the activities that they took part in, how they socialised, who they socialised with and where socialisation took place. In the next section, I present a synthesis of the findings from the ethnography, including the observations, informal conversations and interviews.

4.3 Consolidation of the findings from the ethnography

I now conclude this findings chapter by consolidating and summarising the key findings from the observations, informal conversations and semi-structured interviews. This study has attempted to answer the research questions, (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service?* with an ethnographic intent to establish

the relationships between the place, people and participation in the café. The study had five objectives, three of which I address in this section:

(1) to understand what makes people with mental health challenges attend The Dragon Café.

(2) to describe how people with mental health challenges socially construct their individual and collective experiences at The Dragon Café; and

(3) to interpret the meanings that participants attach to their experiences at the café.

The fourth and fifth objectives are address in the next chapter (see Chapter Five).

Firstly, it is necessary: (a) to discuss details of how data were presented, (b) to discuss the relevance of the use of images, videos, and verbatim quotes from participants as well as (c) the reflective diary created from the fieldnotes. Further, a thick description of the place where the café is located was presented, contextualising: (1) different aspects of the spaces where activities take place, (2) how volunteers set up the 'reception area', 'space one' and 'space two' and (3) how these set-ups create a dynamic atmosphere that shapes the rhythm of the day. The components of that day include: (a) the people, (b) activities and (c) participation at the café, and hence address the central questions (as above). Further, a thick description of the observations and informal conversations' data in relation to café space and activities was presented, using images to show who attends the café, and why, as well as how participants socialise and participate in the space. Thus, the second and third objectives of this study were addressed: (2) what makes participants attend The Dragon Café? and (3) how do people with mental health challenges socially construct their experiences at the café. There was also a section on the thematically analysed data from the semi-structured interviews using thematic maps to first illustrate the link between the overall research question, three core themes, and eight sub-themes. The data gathered were then narratively analysed in order to establish the meanings that participants attached to their experiences of attending the café, and as such the third objective of the study was addressed.

As stated in the chapter on setting the scene for the study (see Chapter 1.3) The Dragon Café is located under the crypt of St George the Martyr Church in London. The café is open every Monday from noon

to 08.30 pm (20.30 hours) for new and existing patrons; except during the public holidays and in August when it closes for the month. It is managed by paid staff and more than 50 volunteers working shift patterns from 8.00 am to 9.30 pm. There is a consistent rhythm to the day when the café opens, due to: (a) the routine nature of setting up and packing down the space, (b) the similar patterns of people's behaviour and (c) the established activities, most of which are available every Monday. These routines shape how those who attend behave, interact and participate in the café's spaces.

The participant gatekeepers also provided some key information, some of which includes: (1) why the café was established, (2) how the café fits into the crypt space in terms of cost and the use of space, (3) the reason for the membership cards and (4) why people who visit and register with the café are referred to as 'patrons'. Also, participant gatekeepers manage the key processes in the café, such as: (a) membership and the use of a membership card, (b) titles in the case of referring to people as 'patrons', 'volunteers' or 'activity coordinators'. They also determine how decisions are made, who makes the decisions and how these decisions are enforced, such as the decision to serve only vegetarian dishes. Other decisions related to: (1) activity types and timings, (2) allocation of space for the different activities and (3) how patrons behave in different spaces; for example, speaking quietly in space two. Participant volunteers, such as the café manager and activity coordinators, manage the decisions about the running of the café, while the patrons decide on: (a) when to attend and / or when to leave the café, (b) how to participate in the space and (c) who they participate with. In other words, patrons are not involved in the decisions about the long and short term goals of the café, so their actions and interactions are guided by the predetermined decisions of the participant gatekeepers and participant volunteers, as well as the paid staff and activity facilitators.

Generally, participants heard about the café from different sources, including friends, health professionals, and family members, as well as through flyers and the café's outdoor banner. However, the main reason for attending came from a shared sense of loss felt by most participants, who started to attend the café after: (1) the closure and configuration of mental health day centres which resulted in the loss of places and spaces for them to visit, (2) the loss of friendships and (3) the loss of activities to participate in; as

well as (4) the access barriers and structured participation criteria in Recovery Colleges, which also meant that some participants were not allowed to enter and other who attended were forced to take part in activities that they were not interested in. However, as stated in chapter one, the café is open to all so different people from within and outside the UK can attend the café, including students and their lecturers, and people with learning and physical disabilities. Participants provided different reasons for attending the café, including: (a) wanting to know more about the café, as in the case of visitors from outside the UK, (b) to provide students with a social model of mental health, as indicated by the lecturer who visited with medical students to see the patrons as 'people', rather than 'conditions', (c) to have lunch and meetings and (d) to meet people, socialise and participate.

Five core topics were identified across the ethnographic data sources:

(1) somewhere to go when there was nowhere to go,

(2) friendships with people who understand through shared experiences,

(3) autonomy and choice of how to participate in the space,

(4) funding as a determinant for sustaining mental health cafés, and

(5) dependence upon a space as a result of experiences of societal stigma referred to as '*the outside world*'.

The majority of the participants described positive experiences as the reasons why they continued to attend the café after their first visit. However, initially they spoke about their sense of a loss of space and place, loss of friendships and loss of activities due to the closure of the day centres; and then they narrated their need to escape from the outside world in which they felt stigmatised. They also spoke about the access and participation barriers associated with attending other services, including structured activities and compulsory participation. These requirements prompted them to seek out other spaces, such as the café, where they could socialise and befriend people of different age groups who shared similar mental health related experiences. Participants also valued the availability of various free creative activities, and the freedom to participate as much as or little as they wished. Among the participants were medical students

who articulated similar benefits as the other participants but added how the café provided access a space where they could meet and socialise with people living with a diverse range of MHCs, but without the medical model of diagnosis and treatment which dominates their academic learning experience. Their experience at the café provided them with a social view of learning which was also echoed by their accompanying lecturer. This opinion from the university students can be likened to them being presented with, and / or having to deal with a social model of mental health care (Beresford, Perring, Nettle and Wallcraft, 2016); which is what their lecturer enabled them to acquire by bringing them to the café to interact and socialise with the patrons.

For the participant volunteers, two positive core reasons were identified as their motivation for attending the café: (1) the opportunity to give back to the community and (2) being 'the face' of the café to reassure new patrons that the café is free for all, without access or participation criteria. Participant gatekeepers, on the other hand, provided responses that described the aim of the café's existence. The start of The Dragon Café coincided with the beginning of the closures of the mental health day centres, and as such was seen as crucial for people with MHCs who are living on their own and who have difficult or challenging weekends. Therefore, the café brings people together to socialise and participate in its space; by providing that option, it helps to alleviate the loneliness and social isolation being experienced by the patrons when they are not at the café.

In addition to the positive experiences participants, participant volunteers and participant gatekeepers identified some challenges relating to their attendance of the café. A minority of the participants highlighted three issues as barriers to access and participation: (1) the noise levels in 'space two', (2) overcrowding and (3) the timing of the activities. Findings showed that the noise levels associated with the singing and dancing workshops prevented some participants from spending time in space one or only participating passively by watching those who are taking part. Participants also identified overcrowding at the café due to the increasing number of new patrons, which they found limited their usual entitlement to space; routine-based interaction participation, such as sitting on the same table or having a space on an activity table was now not always available. The timing of the activities was also found to limit the number

of activities that some participants could take part in, due to some activities occurring at the same time; for example, the singing and writing workshop. Echoing the participants' responses about the timing of the activities, participant volunteers identified the schedule and timing of the activities as a barrier to participating, because they were unable to volunteer as well as participate at the same time. As a result, participants and participant volunteers expressed their wish that the café could open on more days during the week and had more branches around London and the UK.

Whilst participants and participant volunteers highlighted challenges associated with their experiences of noise, overcrowding and timing of the activities, the participant gatekeepers were more concerned about three issues that could affect keeping the café staying open in the long term. Firstly, the participant gatekeepers talked about the need for a space where they could facilitate different activities. Ideally there would be a separate space for activities with lower noise levels and another for activities with higher noise levels; but with the noise contained so that it would not prevent noise-sensitive patrons from attending the café. Thus, having enough funding to acquire more space could potentially eliminate the first barrier to participation as identified by the participants. Secondly, participant gatekeepers identified funding as a central issue for keeping the café open in the long term; and thirdly, they identified the importance of the volunteers as paramount for sustaining the café's existence. Thus, even with the right space and adequate funding without volunteers, the café would inevitably close.

To be precise, these findings are summarised into three core headings that addressed the aim, objectives of the study and the research questions, as follows:

(1) access to a safe place to go when there was nowhere else to go,

(2) meeting and socialising with people who share similar experiences, and

(3) the freedom to be in a space without the pressure to participate.

These core issues will now be discussed to show the relationships between the place, people and participation; relating to how participants socially construct their experiences at the café, and the meanings that they attach to their experiences within and outside the café. These issues will be discussed in more

detail in the next chapter to show the significance of the findings from the ethnographic findings in relation to the wider literature.

The first core issue was that the café provided the participants with a place to go when they had nowhere else to go, after the closure and reconfiguration of other services. Participants associated the closure and reconfiguration of services as a negative outcome that led to varied experiences of loss; including: (a) the loss of somewhere to go, (b) the loss of a space to meet other people who share similar experiences, (c) the loss of friendship, and (d) the loss of activities that encouraged participation and socialisation. The provision of the café space also provided participants with entry into a non-judgmental space and environment without access criteria, which they described as 'safe space' where they could be themselves without the social stigma that they experienced outside the café; as such, they felt the café gave them a sense of 'belonging'. In this case, the loss that participants experienced after the closures can be summarised as the loss of: (1) place and space (mental health day centres), (2) people (friendships) and (3) participation (activities), Therefore, the availability of The Dragon Café enabled the participants to rebalance their lives by compensating for their losses, reduce their social isolation and restore their positive views of informal CMHS, which they previously held about mental health day centres before the closures. Such responses are set out in detail, as narrated in the semi-structured interview chapter.

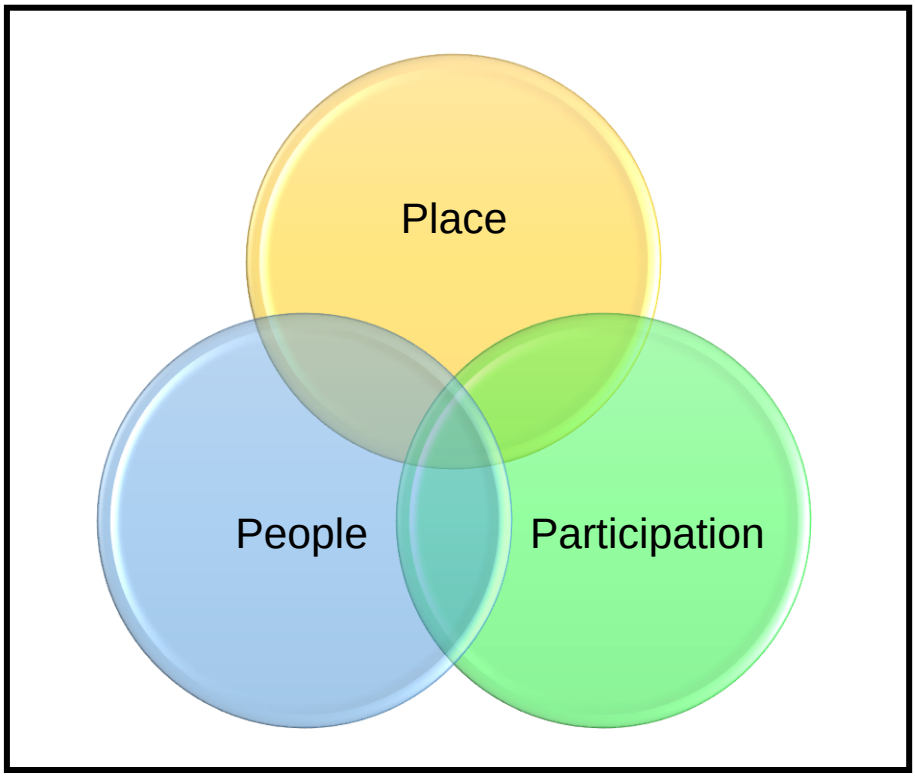
The second core issue was that the café provided participants with a space where they could meet, make friends and socialise within, and outside, the café with people who share similar experiences. This core issue highlights why it was important to document the physical space of the café as a key part of the ethnography because as the participants descried in chapter 4.1 and 4.2, the physical space of the café provided them with somewhere to go, meet and participate with others who share similar experiences. As such, the café space became a meeting point for developing friendships and extending these friendships from the café to outside the café means that patrons were able to meet outside the café to socialise and take part in other activities not located in or organised by The Dragon Café. Therefore, such experiences reduced loneliness and isolation. Also, meeting and socialising with other patrons within and outside the café was crucial for participants who expressed that most of them live alone. From the findings, it was

clear that for some participants, their social networks were limited to family members, health professionals and friends from the café. Therefore, participants placed a lot of emphasis on maintaining friendships and socialising outside the café; even though they might not be face-to-face friendships, because some participants kept in contact through telephone calls. Thus, in the absence of the physical space of the café where they met and developed friendships, some participants may have no-one to interact or socialise with, and so they may become socially isolated.

The third core issue was that the café provided a diverse range of creative activities, offering participants a range of choices without the structured and compulsory participation criteria which are common with the other MH services, such as the Recovery Colleges. Again, without the availability of the physical space of the café where the activities are hosted, participants may not have experience the freedom that they expressed regarding how they engage in the space. Thus, the dominant reason for continued participant attendance at the café was their perceived freedom to 'be themselves' and utilise the space as they wished; a context encapsulated by such phrases as '*doing nothing*' and '*no pressure*'. Participants also highlighted how recalling their experiences at the café, when they were there, encouraged and sustained attendance and participation.

Overall, these findings indicate that participants visited the café because: (1) the café provided most of them with somewhere to go when there was nowhere else for them to go, (2) it alleviated their sense of loss, (3) it is accessible to anyone, and (4) they can meet people and participate passively, actively or through socialising with other patrons. As such, the three concepts of place, people and participation are intertwined and interrelated. With that relationship in mind, a novel conceptual model has been created to summarise the findings from the ethnography, as well as to establish the relationship between the place, people and participation at The Dragon Café (Figure 13).

Figure 13 The conceptual model of the place, people and participation at The Dragon Café



The three domains of the novel conceptual model illustrate how the place, people and participation at The Dragon Café are intertwined in a way that we cannot fully understand without appreciating that one cannot exist without the other two. For example, although some patrons do not actively participate in the activities when they visit the café, they cannot visit without 'passively participating' in the activities by watching those who are taking part and observing what is going on around them. Similarly, patrons cannot attend without interaction with at least three patrons because interaction with others begins at the outdoor space when patrons are waiting to enter the crypt. Indeed, as the participants themselves attest, without the place, they could not meet others to participate. This is also pertinent in highlighting why documenting the physical space of the café was such a central aspect of the ethnography.

The three domains of place, people and participation in the conceptual model are further described below:

1. *Place*: The overall environment the café uses in the church, including the outdoor space, the reception Area, Space One and Space Two, where people meet and socialise with a feeling of belongingness and acceptance. Place also includes spaces outside the café where participants may or may not spend time, such as participants' homes, other services and the community at large.

2. *People*: Anyone who visits the café, registers, and is issued a membership card, is referred to as a *'patron'* and is likely to continue attending the café. People also include family, friends, and others who those with MHCs interact with, such as carers. Non-specific groups of people from diverse backgrounds, difference age groups and from different settings.

3. *Participation*: This domain is defined by passive and active participation by people with MHCs, including doing nothing, or as little or as much as they choose to commit to the activities.

From the above point of view, I suggest that understanding place and space is crucial in this study because it is precisely what prompts participants decisions to attend a service or not. For example, in the ethnographic context, the church is the place and the rooms within crypt where the café facilitates the activities are the spaces. Therefore, by developing this novel conceptual model through a thick description (Geertz, 1973) of: (a) the place, people and participation, (b) the rhythm of the day and (c) the activities at the café, this ethnography answered the central research questions:

(1) *What is The Dragon Café*?

(2) *What makes people with mental health challenges attend this informal community mental health service*?

and the sub-question:

(3) *What is the relationship between the place, people and participation at The Dragon Café?*

Therefore, this study raises the argument that the three domains of the conceptual model: place, people and participation are not chronological, and so they do not exist one after the other. Therefore, to

understand the relationships between place, people and participation at the café, there is a need to view these domains as intertwined because they are not distinguishable from each other. Only by adopting this conceptual framework can we sense how the whole is co-dependent, as further discussed in the next chapter (see Chapter 5.1.5).

In the next chapter the significance of the findings from the ethnography will be outlined followed by discussions of the five original contributions to knowledge that this study makes to the international literature on informal CMHS in general and mental health cafés in particular. The chapter continues with the application of theoretical lens to the findings from the ethnography and concludes with a discussion on the extension of theory for understanding the external factors that might facilitate or hinder social integration for people with MHCs.

CHAPTER FIVE DISCUSSION

5.0 Introduction

The current study aimed to answer the questions, (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service*? and to establish the relationship between the place, people and participation in the café. This aim would be achieved by using the ethnographic information gathering methods of observations, informal conversations and semi-structured interviews. To achieve this aim and answer the question, the study had five objectives:

1. To understand what makes people with mental health challenges attend The Dragon Café.
2. To describe how people with mental health challenges socially construct their individual and collective experiences at The Dragon Café.
3. To interpret the meaning that people who attend The Dragon Café attach to their experiences at the café.
4. To generate empirical research and contribute to the international debate and literature on informal community mental health services in general, but more specifically on mental health cafés.
5. To explore theoretical perspectives on the mental health café phenomenon.

The previous chapter included a descriptive section on the observations, informal conversations, and the thematically analysed data from the semi-structured interviews; thereby providing deeper, richer and narrative data that enhanced the credibility of the ethnography. In that chapter, the research questions (as above) were answered, and I established the relationship between the place, people and participation at the café. In addition, I addressed the first three objectives of the research, as presented above, with the three key findings identified from the ethnography listed below:

(1) access to a safe place to go when there was nowhere else to go

(2) meeting and socialising with people who share similar experiences

(3) the freedom to be in a space without the pressure to participate.

In summary, the central reason that the majority of the participants gave for attending the café was 'the varied sense of loss which they felt after the closures and reconfiguration of mental health day centres'; closures which resulted in them attempting to attend Recovery Colleges. However, that option was often not possible due to structured access and participation criteria; so, they became socially isolated until they heard about The Dragon Café. Participants continued to attend the café because they felt that it provided them with access to a safe space where they met other people and had the opportunity to participate as they wished. The findings chapter also addressed the relationship between the place, people and participation concluding with the development of a novel conceptual model that shows that the three domains are intertwined and, for the purposes of ethnography should not be separated from each other. I argued that the three interrelated concepts are integral to the context of the café because they happen concurrently, enabling a robust understanding of the mental health café in this study.

This current chapter is divided into two sections that focus on the last two objectives (4 and 5). The first section addresses the fourth objective of this study, while the second section focus on the fifth objective. The first section is a critical discussion of the significance of findings from the ethnography in relation to the findings from the scoping and narrative reviews, debating whether to accept, question or challenge the research findings from the existing literature. The second section presents a detailed discussion that shows how the findings from this study could be better understood through the theoretical lens of Bourdieu's (1977) theory of practice. Applying theory to the findings from the ethnography is to illuminate the understanding of the mental health café phenomenon in social spaces, such as The Dragon Café. The application of theory is followed with a discussion on the extension of Bourdieu's (1977) theory of practice for further exploration of possible barriers and facilitators to community integration for people with MHCs, also known in the findings as *'the outside world*'.

This thesis has five new and significant findings from the current study that contribute additional research evidence which can help to understand mental health cafés; findings that to the best of my knowledge have not been reported previously:

(1) The differences between why informal CMHS were established.

(2) Methodological differences and the thick description the research setting and activities.

(3) How agency, structure and power influence interactions at The Dragon Café.

(4) The sense of loss experienced by participants after the closures of mental health day centres.

(5) A novel conceptual model of the place, people and participation at The Dragon Café.

5.1 Five original findings and contributions to knowledge on informal CMHS

This study has compared the current models of informal CMHS and highlighted the strengths of the service model that is utilised at The Dragon Café. In situating The Dragon Café among other informal CMHS, part of the findings from this study mirrors those from previous studies, in their provision of what participants described as safe spaces (Morrissey, 2006; Peters, 2007; Elstad and Eide, 2009; Argentzell, Håkansson and Eklund, 2010; Bryant, Tibbs and Clark, 2011; McFadden and Koll, 2014; Caplan and Cordero, 2015; Sutton, Bejerholm and Eklund, 2019) that foster vocation, psychological (Iancu *et al*., 2014; Tjörnstrand, Bejerholm and Eklund, 2015; Longden, Read and Dillon, 2017; Chen and Oh, 2018), social benefits of meeting and interacting with people who understand through shared experiences (Bryant, Tibbs and Clark, 2011; Dow *et al.*, 2010; Campbell *et al*., 2011; McFadden and Koll, 2014; Pernice-Duca *et al*., 2015; Wilson and Kent, 2015 Longden, Read and Dillon, 2017) , power disparity between healthcare providers and user-led organisation members (Hodge, 2005; Beresford *et al.,* 2011), and power differentials between gatekeepers and attendees' in clubhouse members (2010) and day centres (Liou and Jarrott, 2018). The next section discusses the original contribution to knowledge that this study makes to the international literature on informal CMHS in general and mental health cafés in particular.

5.1.1 The differences between why the five informal CMHS were established

As discussed in the scoping and narrative literature review, informal CMHS were established for specific populations, diagnosis and activities (McDonald, 2010; Campbell *et al*., 2011; Travis *et al*., 2012). For

example, (a) they were intended to provide a peer support space for Jewish survivors of concentration camps (Fried and Waxman, 1988), (b) offer a social learning space for people living with dementia (Jubb *et al*., 2003; Halley *et al*., 2005; Morrissey, 2006; Dow *et al*., 2010; Halse, 2014; McFadden and Koll, 2014), and (c) support to family members and carers of people living with dementia (Mather, 2006; Peters, 2007). Also, previous literature shows that clubhouses were established to provide a work-oriented space for people with MHCs (Mowbray *et al*., 2008; Tang, Ng and Yip, 2010; Wong, 2010; Pernice-Duca *et al*., 2015; Hultqvist *et al.*, 2016; Prince *et al*., 2017; Chen and Oh, 2018; Gumber and Stein, 2018; Gorman *et al*., 2018).

As demonstrated in the review of the literature, previous studies indicated that user-led organisations were established to bring people with shared similar experiences of health status or social care together, towards achieving a common goal (Brown, 2009; Elstad and Eide, 2009; Argentzell, Håkansson and Eklund, 2010; Boyce *et al*., 2010; Wilson and Kent, 2015; Rose *et al*., 2016). Distinctively, previous studies maintain that faith communities were established primarily as a place of worship, but they also serve as a safe space that is open to all, regardless of attendees health status, including people with MHCs who can attend to have an open dialogue about mental health (Sullivan *et al*., 2013; Caplan and Cordero, 2015; Chiu *et al*., 2017; Connolly and Granfield, 2017).

Findings from this study resonate with some of the reasons in the early literature regarding why these informal CMHS were established. For example, in the case of creating open-to-all access, findings from this study are similar to those from some faith communities (Bryant *et al*., 2013; Connolly and Granfield, 2017). This study also echoed the provision of a safe space which was also reported by previous studies as a reason for establishing the informal CMHS (Argentzell, Håkansson and Eklund, 2010; Phutane *et al*., 2012; Bryant *et al*., 2013; Caplan and Cordero, 2015; Eklund and Sandlund, 2016; Liou and Jarrott, 2018). However, this current study found something new and different. The Dragon Café was established to reduce isolation and loneliness after the founder, Sarah Wheeler decided to set up a café as a safe, multi-dimensional and creative space that is open to all: a space where people with a broader range of MHCs can visit to connect with each other, through participating in creative activities and socialising. Therefore,

the reason for establishing The Dragon Café is quite different from sites investigated in previous studies, in that more value is placed on reducing the social problem of loneliness and isolation as the outcome for those who attend.

5.1.2 Methodological differences and thick description of the research setting and activities

Methodologically, the majority of the previous research on CMHS adopted qualitative and quantitative studies that used cross-sectional studies (Mowbray *et al.*, 2008), surveys and questionnaires (Halley *et al.*, 2005; Rogers and Stanford, 2015; Hultqvist *et al*., 2016; Gumber and Stein, 2018), focus group discussions (Bryant *et al*., 2013; Prince *et al*., 2017; Liou and Jarrott, 2018), interviews (Brown, 2009; Wong, 2010; Caplan and Cordero, 2015; Pernice-Duca *et al*., 2015; Virdee *et al*., 2016; Connolly and Granfield, 2017), observations and informal conversations (Sullivan *et al*., 2013; Chen and Oh; 2018), programme evaluation (Fried and Waxman, 1988; Mather, 2006; Chiu *et al*., 2017), audit (Peters, 2007) and report (Halse, 2014; McFadden and Koll, 2014).

There have been few previous ethnographic studies of informal CMHS, including Rose *et al*. (2016) and Liou and Jarrott (2018). Equally, earlier literature on mental health cafés focused more on dementia cafés (Jubb *et al*., 2003; Pratt *et al*., 2005; Mather; 2006; Dow *et al.*, 2010; Halse., 2014) with limited studies on other types of mental health cafés (Fried and Waxman, 1988; Campbell *et al*., 2011). This study is the first ethnography of a mental health café that has taken place in the UK. Prior to this study, people with a broader range of MHCs who attended a mental health café did not feature in research investigations; it is fair to conclude that such people were infrequently studied and were therefore under-represented in existing published research literature. As such, the findings from this ethnography provide new and novel information, which was not previously available, regarding mental health cafés.

To an extent, the data collection methods of some previous studies mirror those used in this study; as in an ethnographic study by Rose *et al*. (2016) of two user-led organisations, and the use of photographs in the action research of a day centre by Bryant, Tibbs and Clark (2011). However, the study conducted here

is the first of its kind in offering an ethnographic study of a mental health café as an example of an informal CMHS. Therefore, the current study contributes to the international literature and extends the understanding of mental health cafés beyond what was previously available. Importantly, to understand what makes people with MHCs attend a mental health café, and to explore how they socially construct their experiences at the café, this study has achieved a novel, sustained observation. That observation approach was complemented and strengthened by: (a) informal conversations, (b) semi-structured interviews, (c) fieldnotes, (d) reflective diaries, and (e) visual options of photographs and videos. Thus, this study has established the need to document the place, people and participations in a research setting comprehensively, using visual and textual data, as well as employing thick description (Geertz, 1973), in order to present the environment where the café is located in a way that enables a deeper understanding of the space.

Previous studies mentioned their settings by describing the services in terms of their particular provision, such as: (a) supported housing (Peloso and Valentini, 2016), (b) NHS Foundation Trust (Rose *et al*., 2016), (c) church building or faith-based setting (Caplan, 2019; Hardison-Moody and Yao, 2019) and (d) day-care psychiatric rehabilitation centre (Brown, 2009; Phutane *et al*., 2012). Other studies in the earlier literature provided a description of the local area where the research setting is located (Travis *et al*., 2012; Virdee *et al*., 2016). These locations were not analysed architecturally or visually; however, one study (Bryant, Tibbs and Clark, 2011) used visual methods, including a map of the day centre area and used photographs of the people with MHCs who attended the day centre. However, the map was not detailed enough to show the space in a way that could enable an understanding of how the space is laid out in relation to the other parts of the environment, the physical structure of the space, and the behaviours of those who attended in that space.

This current study highlights the need to meticulously document the spatial environment of a mental health café, to show how participants navigate the space (or spaces) and activities in the café, and how the set-up of the space enables interaction and participation in the space. As noted in the findings from the ethnography (see Chapter 4.1.3) the availability of the outdoor space, the reception area, space one and

space two determined where different activities were hosted. For example, noisy activities such as the singing and dancing workshops in space one and quiet activities, such as the yoga and mindfulness in space two (the quiet room), enabling participants to choose where to spend time in the café, based on their preferred activities and tolerance to noise levels, Therefore, for the first time, this current study of the phenomena called a mental health café, presents a unique and full description of the physical details of a case of this kind of facility, namely The Dragon Café, including details of the surrounding area of the research setting, transport links and distance to the café, its environment and its resources inside and outside the crypt, and measurement of its three rooms. Furthermore, this study thickly described and documented what previous studies had not done; the way The Dragon Café's spaces are set-up for different activities in separate rooms (space one and space two) and how these set-ups create a dynamic rhythm of that day that shapes how people behave in the café in relation to the activities offered, as discussed below.

In terms of the activities provided by informal CMHS, this study agrees in part with previous studies on the provision of activities, such as: (1) work-oriented activities (Tang, Ng and Yip, 2010; Pernice-Duca *et al*., 2015), (2) day and evening activities (Boyce *et al*., 2010; Prince *et al*., 2017), (3) activities within the space (Elstad and Eide, 2009) and (4) outside the service space (Nordström *et al*., 2009; Bryant, Tibbs and Clark, 2011; Iancu *et al*., 2014; Wilson and Kent, 2015; Sutton, Bejerholm and Eklund, 2019; Gumber and Stein, 2018). However, in the previous studies, it was not clear: (a) how many activities were being offered, (b) what were the schedules and sequencing of activities, (c) the specific locations and formats in which the activities took place or indeed (d) the participation habits of those who attended.

Findings from this research show that while previous studies provided some details of activities and those who participated, research evidence did not present thick description (Geertz, 1973) in this regard. Due to the absence of thick description in previous studies it was not possible to obtain a finely detailed sense of the space where activities were hosted or to capture a substantial percentage of the actions of those who participated actively or passively in those informal CMHS. However, this current study does exactly that, using thick description (Geertz, 1973) of visual and textual data to meticulously depict the 13 free activities that The Dragon Café offers from 12.00 pm to 8.30 pm: showing the sequence of events that

guide the rhythm of the day at the café, even beyond its opening and closing times; the café opens to volunteers for setting up at 08.30 am and finally shuts down at about 9.30 pm after the packing up and putting away has been completed. This study goes further and identifies: (1) the activities by name, space and processes, (2) the timing and scheduling of the activities, (3) the rooms (space one and space two) where activities take place and (4) how those who attend participate in the activities.

Evidently, there has not previously been a visual description of a mental health café or cafés. The wherewithal of these facilities has not been featured in a substantive way in the literature. There have been few actual descriptions of this kind of planned environment among informal CMHS; although studies on mental health cafés do exist, they fail: (a) to describe the café space in detail, (b) to show the characteristics of the space or (c) how those who attend such a café relate and interact in the space provided. The current study fills this knowledge gap and while limited to the single case of The Dragon Café in London, a detailed ethnographic description of such a café is presented for the first time. As such, this thesis amounts to both the first description of an informal CMHS and of a mental health café.

The substantial findings in this thesis allow a further understanding of how activities in a CMHS (The Dragon Café) were scheduled, to enable active and passive participation. Previous researchers did not do this in their presentations of the activities that the informal CMHS services provided. Therefore, this current study underpins a view that this mental health café is distinctively different to CMHS provision in general, because of its provision of distinctive resources. The findings from this study contribute to the existing literature in a way that enables a deeper understanding of the mechanisms within a mental health café that make people with MHCs want to attend. The findings provide us with new insights into: (1) a footprint of what this mental health café looks like, (2) what it offers those who attend, (3) how it offers what it offers and (4) how these factors all account, to a greater or lesser degree, for how people behave in the café's space.

Importantly, this detailed study of The Dragon Café offers a significant benchmark for comparative examination of other mental health cafés. This study offers a robust account that makes an explicit

connection between the place, people and participation at the café that, in turn, achieves a deeper and fuller understanding of the research setting (Lincoln and Guba, 1985; Polit and Beck, 2010). While the goal of this study was not to generalise the findings, it has provided a rich, detailed and contextual understanding of the place, people and participation at one mental health café located in London. As such, it provides other researchers and readers with a detailed description of the café space and activities to make possible the transferability of judgements and the opportunity of replicating and evaluating the café space and activities elsewhere. As discussed in the findings (see Chapter 4) and consolidation of findings from the ethnography (see Chapter 4, Section 4.3), the replication of the café was a prominent wish that participants in this study highlighted, as a possible solution to the access and participation barriers that they had clearly identified and discussed. Regardless of the access and participation barriers, participants continued to attend the café, so the next section details a discussion on the diverse sense of loss that participants experienced after the closures of the mental health day centres and before they started attending The Dragon Café.

5.1.3 Diverse sense of loss after the closures and reconfiguration of mental health day centres

This study has examined the loss that was experienced by people with MHCs after the closure and configuration of the mental health day centres, they had been attending. For people with MHCs, primary loss includes the decline of mental and emotional wellbeing at the beginning of the illness (Wittmann and Keshavan, 2007). This downturn can lead to a loss of functioning resulting in various secondary losses that will be very likely to negatively impact the individual's life (Doka, 1989). Mental functioning is interconnected with physical and social functioning, as well as health outcomes (World Health Organisation, 2003). Therefore, a decline in or loss of mental functioning will negatively affect other areas of the lives of people with MHCs.

Generally, studies have reported losses experienced by people with MHCs, including but not limited to: (a) the loss of existing friendships among people with MHCs, (b) loss of earnings, (c) homelessness (Desjarlais, 1997; Payne, 2012), (d) loss of power in clinical settings such as inpatients wards (Lally *et*

al., 2017), (e) loss work or earnings due to time off sick (WHO, 2003; Lorant *et al*., 2007), (f) loss of place in society (WHO, 2001), (g) reduced social interaction and social skills (Elliott, 2016; Velentza, 2016), (h) loss of life with death up to 10-20 years sooner than the general population (Hjorthøj *et al*., 2017) equivalent to more than three times more than the overall population. (Saxena, 2018; Plana-Ripoll *et al*., 2019).

Other studies identified the loss of benefits, such as a person's 'disability living allowance' (DLA) (Pybus *et al*., 2019; Lacobucci, 2019). Pybus *et al*. (2019) suggest that despite the existence of parity of esteem for equitable healthcare provision between physical and mental health, (The King's Fund, 2017) people with MHCs continue to be disadvantaged in some aspects of care. For example, 32% of the 148,700 people with a psychiatric condition in the study had their DLA taken away. This was double the 16.4% of the 178,300 with diabetes or a neurological or musculoskeletal condition who experienced that DLA loss (Pybus *et al*., (2019). Therefore, authors proposed an extension to the 'parity of esteem' to include welfare systems for equality purposes, in order to prevent the further marginalisation of people with MHCs. In this case, the loss of DLA for people with MHCs could mean the inability to pay rent and bills which, in turn, could result in: (a) eviction, (b) homelessness, (c) poorer mental health, (d) relapse and readmission (e) increased loss of social skills, (f) social connections and (g) identity; ultimately involving greater costs for community and society. Findings from the review of the literature reported participants experiences of loss as below:

- loss of memory for people living with dementia (Halley *et al*., 2005),
- loss of friendships after diagnosis of dementia (Jubb *et al*., 2003; Ansberry, 2019; Alzheimer Scotland, 2019),
- loss of social status, loss of status (Chiu *et al*., 2017)
- loss of confidence and loss of control (Halse 2014; Mather, 2006)

That said, the current study provides us with new and empirical findings regarding narratives from diverse experiences of loss among people with MHCs, following the closure and/or reconfiguration

of mental health day centres. In the ethnography participants reported different experiences of loss as listed below:

- loss of somewhere to go when there was nowhere else to go (Dewitt, Bolarin, Calvin, Susanna)
- Loss of friendships (Calvin, Kent, Bolarin)
- Loss of activities (Kent, Donna, Analisa)
- Loss of benefits (Basila)
- Loss of memory as also demonstrated in findings from the ethnography in Sharonda's poem (see Chapter 4.1.7.2 - Writing Works).

As discussed in the consolidation of the findings from the ethnography chapter (see Chapter 4.3) I developed a novel conceptual model that established the relationship between the place, people and participation at The Dragon Café. More importantly, in relation the novel conceptual model, this original finding on the sense of loss experienced by the participants in this study is crucial because it alerts us to the severity and magnitude of the participants' reported losses which I have categorised as: (1) the place (mental health day centres), (2) people (friendships or social interactions), and (3) participation (activities) in the lives of people with MHCs who had nowhere to go after the closure and reconfiguration of mental health day centres. The loss of friendships must have been challenging for participants, especially as research shows that people with MHCs have significantly smaller social networks than those people without MHCs (Elstad and Eide, 2009; Pernice *et al*., 2017). It is reasonable to conclude that to lose some of that already limited network with people who they socialised and participated with must have been very isolating, as Calvin narrates below:

> "*Yeah, it became a recovery college, and they became really strict. They used to have food; they used to cook meals. We used to pay £2 and have dinner and dessert. Then they stopped that, they stopped everything else, and before, you could play pool or table tennis and have fun and talk to people like you do here, and then they didn't want that, they stopped it. And then as soon as they did that no one was turning up*." (Calvin, 50-60, 11.06.18).

Furthermore, as described in the findings from the ethnography, participants did not find The Dragon Café as soon the closure of the mental health day centres began; it is not clear from the data how many weeks or months it took them to hear about the café. Therefore, it is fair to assume that the sense of loss that the participants experienced individually and collectively over the period when they lost place, people and participation after the closures of mental health day centres was the first phase of loss. The second phase of loss was when some of them attempted to attend the Recovery Colleges, where they experienced additional sense of loss from the rejection that some of them felt due to the access and participation criteria. For example, one participant was not allowed access to the college because his care-coordinator lived in a different borough. All in all, one thing remains true for the majority of the participants' narratives; the closures and reconfiguration of mental health day centres resulted in the loss of place, people and participation, leading to increased social isolation because they had nowhere to go until they started attending The Dragon Café. However, as indicated in the summary of the semi-structured interviews presented in Chapter 4, participants might indeed have nowhere to go if the café were to close in future, due to a lack of funding, resulting in yet another possibility of those with MHCs experiencing the threat and challenge of loss of place, people and participation.

5.1.4 How agency, structure and power influence interactions at The Dragon Café

The overall research question for this study was: *"What is he Dragon Café?"* In other words, what is it about The Dragon Café that people with MHCs are attracted to? In answering this question, using the case of The Dragon Café, this section will discuss the reasons set out in previous literature as to why participants attend informal CMHS, alongside participants' reasons for attending the café under study. In doing that, other prominent issues of this study are discussed, including agency, structure and power as barriers or facilitators to participation.

5.1.4.1 Agency and structure at The Dragon Café

There is a strong interplay between: (a) agency and structure (Lister, 2004; Avison, McLeod and Pescosolido, 2007; Conner, 2013; Mooney, 2016) and (b) agency and participation (Lister, 2004), as well as (c) participation and structure (Hoggett, 2001). Agency may be operationally defined as 'an individual's capacity and right to make their own decisions' (Richmond, 2011). However, a person's agency can be restricted by several factors, including, structure, political agenda (Hoggett, 2001), and health status. Such is the case of vulnerable populations whose lack of agency has become part of their life from childhood onwards (Svindseth and Crawford, 2019). Also, as detailed in the review of the literature, social stigma can impact on the agency of people with MHCs due to their internalised self-stigma, which in turn makes them avoid social spaces where they feel discriminated against by people who are not having to deal with mental health challenges.

In this study, it seems that the closure and reconfiguration of some services are part of contemporary policies that underplay the barriers to social integration for people with MHCs, while at the same time placing demands on them to achieve social integration in their communities. For example, participants in this study experienced reduced agency when they had been refused entry into the Recovery Colleges after they had declined computer lessons. Others were prevented from accessing some informal CMHS because they lived in a different postcode area:

> "*Last week, I went to a recovery college, only to be told that I would not be accepted... I said, why? They said well because the service management had not paid their dues to the recovery college*." (Rikki, 40-50, 18.06.18).

The above scenarios reveal how some participants considered their agency and participation as restricted. These perspectives mark institutional pathways and structures as dominant, which made participants feel disempowered when using other informal CMHS that had imposed structured and compulsory approaches upon those wishing to use of their resources. The WHO (2001) define participation restrictions as: *"*problems an individual may experience in involvement in life situations." (p.14). In other words, not

accessing some informal CMHS could mean a reduction in activities that may result in a lack of community integration and reduced social involvement for people with MHCs.

As stated in the review of the literature, access and participation barriers or participation restrictions were also observed in previous studies with:

- members of user-led organisations (Brown, 2009; Elstad and Eide, 2009; Boyce *et al*., 2010; Wilson and Kent, 2015; Rose *et al*., 2016; Longden, Read and Dillon, 2017),
- dementia cafés (Jubb *et al*., 2003; Pratt *et al*., 2005; McFadden and Koll, 2014),
- an Alzheimer's café (Halley *et al*., 2005; Morrissey, 2006),
- one faith community that requires attendees to have the diagnosis of mental health (Rogers and Stanford, 2015),
- day centres that ask for a health assessment (Eklund and Markström, 2014), and
- The Serenity Café for people recovering from addiction (Campbell *et al*., 2011).

Furthermore, findings from the review of the literature indicated that informal CMHS with diagnosis-based facilities, such dementia and Alzheimer's cafés, or the work-oriented service provision in clubhouses, could exclude some people with MHCs who do not meet that resource's acceptable population criteria; one particular cohort being participants who prefer flexible access and participation, such as those in this study. Similarly, it is possible that even with an open-door policy operated by faith communities, some people with MHCs who are not religious may not attend faith communities where prayer is viewed as: (a) an intervention through God's power (Bryant *et al*., 2013, Sullivan *et al*., 2013), (b) a source of healing and a protective factor (Caplan and Cordero, 2015), and where (c) the lack of prayer is perceived as a lack of faith (Caplan, 2019). In other words, by name, access and participation criteria, it can be assumed that participants in the current study would be reluctant to attend some of the services described in the earlier literature. In addition, this current study has shown how restricted social involvement and social stigma is amplified directly and indirectly in some informal CMHS.

Additionally, there is evidence to suggest that the anticipation of rejection, due to the acquired status of stigma and loss of status, pertains to people with health challenges (Chiu *et al*., 2017). As such, this self-perception can potentially result in low self-esteem and avoidance of or withdrawal from interactions, situations and broader social spaces. For example, some people with MHCs avoid public spaces (Boardman, 2011) due to (a) social sigma (Link and Phelan, 2014) and (b) discrimination and exclusion (Hatzenbuehler, Phelan and Link, 2013; Niedzwiedz, 2019). Thus, even in the absence of being stigmatised, the existence of discrimination and the awareness that there is social stigma in a community can result in such an affected individual developing self-stigma and an altered identity. In this study, such negative issues are evident as the main reasons why the participants were reluctant to engage with other services and people outside the café; an entity they referred to as '*the outside world*'. In addition to societal stigma, participants self-stigmatised based on the way they described people outside the café as '*normal people*'. Thus, participants embodied the two types of stigma that negatively impacted their identity and willingness to socialise outside the café, resulting in reduced community integration by those individuals with MHC.

In line with the above, findings from this study in some way correspond with earlier literature regarding why participants attended the informal CMHS. For example, anyone can attend The Dragon Café, they do not require assessment, and although they register on the first visit and are issued a membership card, this procedure is only to know the number of people who attend the café. Those who attend can participate or not; can, if they wish, acquire different skills from volunteering and taking part in the activities, and they can attend the church, if they wish. However, the findings from this study extend beyond other studies and offer new and substantial evidence and knowledge relating to the reasons why participants attended and continued to attend the café. As such, this study highlights the complexities that surround efforts towards social integration for the participants who attended the café. Thus, it is probable that in the absence of the café, some of the participants may experience the feelings of loss, loneliness and social isolation, as well as increased symptoms of mental health that were often highlighted by participants:

> "*What would I do, where would I go? I would have to think about something else to do. If it had closed today, I would probably be in my house alone and lonely, thinking, oh, I'm missing The Dragon Café*." (Sharonda, 50-60, 09.07.18).

> "*Well, I come from another service, which is a mental ill place and that closed down, and that's when we came because we had nowhere else to go after it shut down and then we heard from a friend of ours about the café, and I've been here five years.*" (Dewitt, 60-70, 03.05.18).

As has been previously suggested, the availability of informal CMHS does not necessarily equal access. As detailed in the review of the literature, some services are tightly regulated and monitored by funding bodies with agendas that do not align with the potential participants' agendas (Jubb *et al*., 2003; Halley *et al*., 2005; Brown, 2009; Boyce *et al*., 2010; Dow *et al*., 2010). Also, in earlier literature, without adequate funding to sustain informal CMHSs, people with MHCs may experience: (1) increased feelings of loneliness and isolation (Prince *et al*., 2017), (2) increased symptoms of mental health (Wong, 2010; Argentzell, Håkansson and Eklund, 2010; Phutane *et al*., 2012), due to (3) the loss of social networks, relapse and hospitalisation (Harley, Boardman and Craig, 2012). These earlier findings are supported by the findings from this study, emphasising the importance of less restricted facilities for people with MHCs, as epitomised by The Dragon Café:

> "*The Dragon Café has helped me. It's helped me, you know...I have not been taking medication since I started attending. I used to take medication years ago, so, so it's helped me*." (Gerald, 60-70, 11.06.18).

As indicated above, and confirmed by Hoggett (2001), a person's agency and perceived control over their life and environment promotes better health outcomes. However, people can regain their agency through interpersonal relationships and the awareness of the ongoing social structure that constrains them (Conner, 2013). This possibility is pertinent to this study when participants refused to attend services with structured and compulsory participation in activities. However, this point in no way suggests that The Dragon Café is perfect or that the absence of structure and routine in the café guarantees access.

Findings from the observations detailed in this study highlight the presence of power differentials between the participants and those who manage the long term and short-term goals of the café, such as the

gatekeepers, activity facilitators and paid staff. Such findings are in the earlier literature (Boyce *et al*., 2010; Chiu *et al*., 2017), but this study is different in that it specifically identifies or pinpoints the complex power differential that inevitably occurs in this type of environment. For example, it was observed that participants in this study were subject to access and participation controls, such as the opening times of the café, timings of the café and how patrons conduct themselves in Space Two and during some activities. Although such structures had to be in place, in order to prevent chaos from people rushing in or speaking to loud during quiet activities such as yoga and mindfulness. Regardless of some of these issues related to the timing of activities, such as asking patrons to move from the writing table so that volunteers could set it up for the chess game, it is important to note how such instructionist power (Pitsoe and Letseka, 2013) coexists between those in power (those who give the instructions) and the patrons (those who follow the instructions from those who are in power).

Despite these instructionist restrictions, participants at The Dragon Café mostly reported a flexible pattern of service provision and 'the freedom to choose how they participate' as the key reasons why they attended the café. Indeed, it was found that there is a continuity of being in the space, in the sense that the patrons can come and go as they like, and participants attest that they could design their own roles by choosing what to do or not do. These findings are distinctively different from other informal CMHS because previous studies did not provide such information. From this study, we now know that people who attend The Dragon Café consider this freedom of participation and choice of how to use the space as extremely important. Nevertheless, findings from the study also show that participants are not entirely free to choose, finding themselves bound into the rules of the café, despite the rhetoric of freedom or perception of inclusion that patrons are part of the organisation, although as noted in the last paragraph, some of the rules are required to keep the café running smoothly.

In fact, patrons are more-or-less told what they can or cannot do and where they can do these things in the space. In my opinion the café could function without such prescriptive constraints if they had more funding and more space as one of the gatekeepers reported in the findings from the ethnography (see Chapter Four) because with very limited space and so many activities that include noisy and quiet ones, it seems that

rules have to exist so that all the activities can be facilitated to meets the needs of as many patrons as possible. With that in mind, it is now clear why the thick description of the café space was a key focus in the ethnography, without which it would have been difficult for the reader to visualise the different spaces in the café in relation to the activities, and more importantly how the use of the already limited space impacts on patrons freedom within the spaces.

This issue of power and freedom will feature in any social spaces service, organised resource or set of activities (Bourdieu, 1989), After all, rules apply to the use of resources in communities in general. However, the findings from this study alert us to the need to consider critically and carefully the balance that is to be had between rules, power dynamics and advancing autonomy and respectful inclusion in any CMHS, not least in mental health cafés.

5.1.4.2 Power dynamics at The Dragon Café

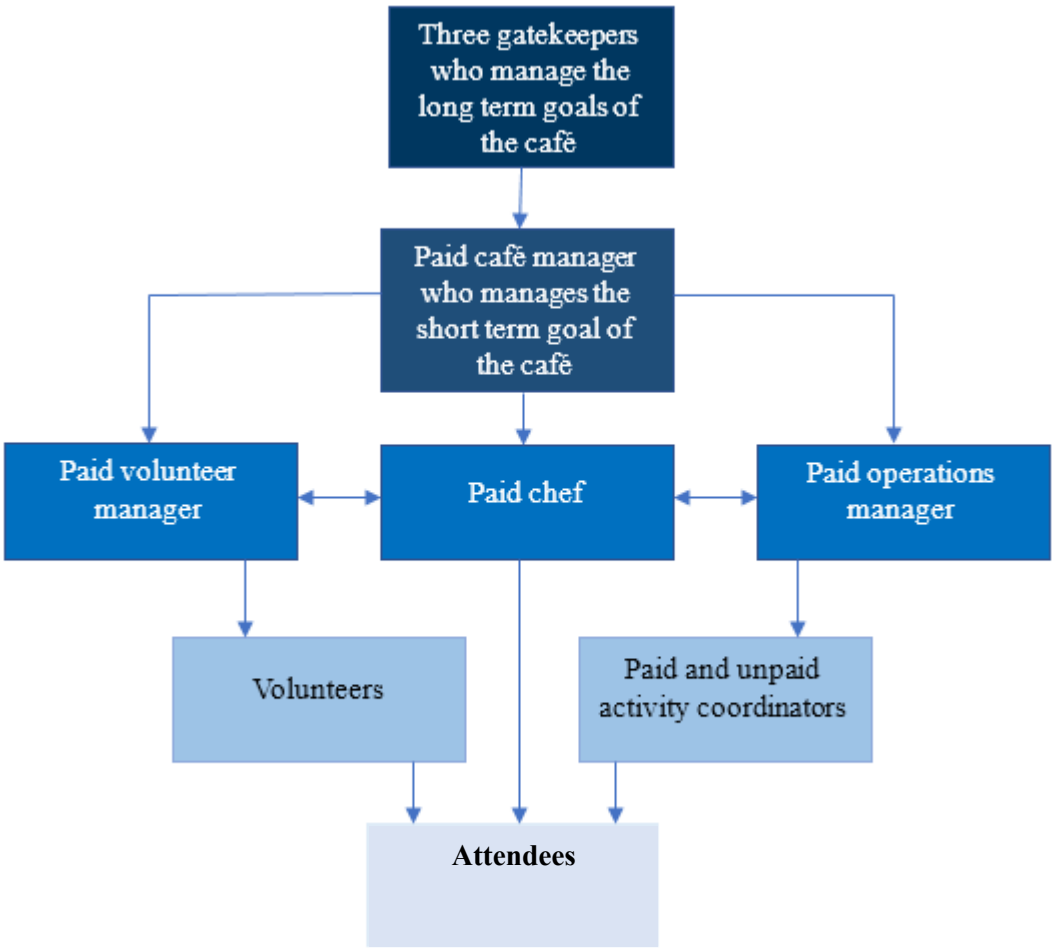
As discussed in the review of the literature, power exists within social spaces (Foucault, 1972), such as informal CMHS, and that power determines how people with MHCs interact in those spaces (Brown *et al*., 2007; Foreman *et al*., 2018; Gorman *et al*., 2018). Previous studies noted that power dynamics influenced participants' autonomy and choice, as well as reducing their levels of empowerment (Brown, 2009; Eklund and Markström, 2014; Sutton, Bejerholm and Eklund, 2019). For example, the gatekeepers and service managers who make decisions on behalf of the people who attend day centres (Liou and Jarrott, 2018) and clubhouses (Wong, 2010). Also, previous studies have reported that the ability to make decisions was associated with recovery for people with MHCs and, as such, the absence of autonomy reduced experiences of recovery.

Similar to previous studies (Eklund and Markström, 2014; Sutton, Bejerholm and Eklund, 2019), findings from the ethnography suggest that in The Dragon Café the gatekeepers, managers, paid staff and activity coordinators sustain the existence of power in different spaces, in addition to the effective functioning of the café, through people's obedience to authority that may stem from habits developed from culture, family orientation, and institutionalisation; for example, on acute mental health wards. However, for the

first time, this study presents original findings regarding how the presence of power in a mental health café influences how participants interact in the space. This is not to say, however, that power dominates the interactions between people in the café because it does not. Thus, relating power to agency and structure seamlessly interlinks with the place, people and participation in the café, demonstrating how power is reinforced through a top-down system and a chain of relationships that determine the orders and conditions in the café. For example, in my role as a patron, activity coordinators and managers sometimes told me where to sit, place my water bottle and how to interact with other patrons during some workshops.

As subtle as these power relations may sound, they soon became multiple superimposed instructions that guided my decisions as a patron and limited my agency and choices (Pitsoe and Letseka, 2013). On the other hand, in my role as a volunteer and researcher, when I was wearing the branded café t-shirt, the issue of power was non-existent, so it felt like these roles restored my agency, and I was able to make different choices and decisions in different spaces at the café within the boundaries of the spoken and unspoken rules by the gatekeepers and some activity facilitators. This point suggests that although power is present at the café, it is dependent on the individuals in authority at a particular time and space, and during a specific workshop; as well as how the participants perceive, or do not perceive or respond to, that so-called power. Thus, in the café, power is not constant and does not impact all the choices that participants make; however, due to the structure of the hierarchy 'sustained' power soon becomes 'dominating' power which limits the agency of the patrons. In reality, therefore, power in the café passes through communication channels ambiguously, and collectively until it is transmitted as sustained wider rules and orders within the café, so allowing the café to function as effectively as it does.

Figure 14 Hierarchy of communication at the café



Berger and Luckmann (1991) maintain that social change is determined by human action in the sense that although reality is socially constructed, it is the people within the social settings that define the production of reality. However, Burr (1995) posits that people may be agents in creating social realities, but their level of agency determines their level of contribution in how those social realities are constructed. This view, according to Burr (1995), is a weakness of social construction in that it ignores the role of agency and autonomy where those in power socially construct realities. These opinions apply to this study because, although participants in the café collectively produce their social reality, I observed that it was the dominant actions of the gatekeepers, paid staff and others in authority that define the scope within which realities are created.

Consequently, it is questionable if the notions of '*no pressure*' and '*no expectations*' can actually exist in the café. Therefore, the presence of power differentials in this study is a significant finding because previous studies did not describe or account for this *inequity* in mental health cafés. This study does exactly that: it reveals the power between the patrons and those who make decisions about how the café is managed. Obviously, we need rules for social spaces to function in order (Desjarlais, 1997). My point is that some rules do more than create order, they condition those without power to submission. This is relatable to literature around power in social spaces as discussed earlier in the review of the literature (see Chapter 2.2.5), which suggests that those who are in power control interactions between people, and in so doing control the identity of people in a given social space (Bourdieu, 1989; Pitsoe and Letseka, 2013). Therefore, power is highly relevant to how social settings evolve, not least in the case of The Dragon Café.

5.1.5 The novel conceptual model of place, people and participation

Social setting and space were identified in all the studies in the scoping and narrative reviews, and in the ethnography as paramount for people with MHCs to access in order for them to meet people, socialise and participate in the activities offered by the informal CMHS. In previous research on informal CMHS in general, the level of observed reality and description of what the space looks like and what is going on in that space is very limited. Therefore, there is only partial information about the environment before such research was actually conducted, as detailed in all the studies in the reviews. This study by no means claims to be the most comprehensive detail of a space, but it does provide the first research that takes the space and place of a mental health café seriously. Indeed, my embodiment of the place, people and participation at the café enabled me to understand, interpret and develop a novel conceptual model to show that the three concepts are intertwined and interrelated.

In developing the novel conceptual model of place, people and participation, I want to begin by highlighting that this study answered the sub-research question: *What is the relationship between the*

place, people and participant at The Dragon Café? As detailed in chapter 5.1.4, structure, agency and power influence participants experiences of the place and space at the café. In other words, structure is the place, agency relates to people's ability to participate as they wish in the café, and power links to how the gatekeepers and those higher in the authority hierarchy at the café utilise the three concepts of place, people and participation in expressing and creating the rules that guide behaviours at the café.

It is also important to reiterate that the three concepts in the conceptual model represents not just spaces within the café, but other social spaces where participants visit or stay, such as other informal CMHS (See Chapter 2), and acute mental health wards which participants also referred to (See Chapter 4). To elaborate, the conceptual model in relation to power and social capital can be related to acute mental health ward, where the place is (acute mental health ward), people (other patients and the multi-disciplinary team) and participation (activities within the ward, including but not limited to medication, ward rounds, tribunals, smoking break etc). As detailed in my motivation for this study (See Chapter 1.2), in my experience as a mental health student nurse, and later as a registered mental health nurse, I found acute mental health wards to be a place where patients had very little autonomy, and as the participants highlighted (See Chapter 4), the opportunity to relate to other patients and staff members on the ward provided them with the social connection that prompted some patients to jeopardise their discharge as these two extracts from the findings chapter elucidate:

> "*And you can see why people often look forward to going back to hospital…I mean it seems a weird concept, but all the time that they're in acute mental health hospital, they want to get out. But when they get out all they want to do is return to the hospital, because they are in the environment of knowing somebody, things being done for them, and people talking to them…*" (Rikki, 40-50, 18.06.18).

> "*I loved being in the hospital, which is ridiculous. I'd have been isolated had I been at home…But because I was in a whole ward of people, I was not isolated…I just absolutely love being with other people*." (Donna, 70-80, 18.06.18).

Therefore, although the presence of power could limit the agency and autonomy of patrons at the Dragon Café, and patients on acute wards, the opportunity to relate and participate with others within social spaces, such as acute mental health wards, is a great motivator for continued visit and, or reluctance to remain in

the space. As such, when considering social spaces where people with MHCs attend, I argue that the novel conceptual model of place, people and participation provides a footprint for us to understand how informal CMHS work and how to set up one.

Further, as described in the previous chapter (for example, Chapter 4), I feel that it is obligatory to contribute to the international discourse on place and space because without place, people and participation would not take place. For example, in the review of the literature, the availability of a church hall (place) provided a space which was transformed into a café style atmosphere for people living with dementia to attend socialise (Halley *et al*., 2005), clubhouses operated in spaces within places, such as community health centres, health centres, government and other agency buildings (Gorman *et al*., 2018) and faith communities function from spaces within religious building (place) (Allen, Davey and Davey, 2010). In this ethnography, it was the availability of the church (place) and the crypt that provided the gatekeepers at The Dragon Café the spaces where they welcome patrons, set-up and facilitated different the creative activities.

> "Places are socially constructed by the people who use them and know them; they are politicised, culturally relative, historically specific, local and multiple constructions" (Rodman, 1992, P.203).

To understand the relationship between place and space, it is important to understand the relationship between health geography, human geography, and health because of their interactions (Lefebvre and Nicholson-Smith, 1991; Dummer, 2008). Health geography is a part of human geography, also known as how people interact with their environment (Rodman, 1992; Tunstall, Shaw and Dorling, 2004; Thrift, 2009; Miller, 2011). Health geography views health from a holistic point of view, including: (a) the society and space, (b) the role of place, (c) location and geography in health, (d) place, wellbeing and disease (Dummer, 2008). Evidently, geography and health are intrinsically linked because where we are born, live, study and work directly impact in combination or separately on our health outcomes (Dummer, 2008).

Therefore, an explanation of why the physical space of the café is such a key part of the ethnography helps us to understand what different spaces mean to people with mental health challenges who attend information community mental health services. Participants in the studies included in the review of the literature described the place and space of the informal CMHS that they attended as: (a) inclusive community (Mather, 2006; Campbell *et al.,* 2011; Liou and Jarrott, 2018), (b) educational and learning environment (Jenn *et al*., 2003; Halley *et al*., 2005; Dow *et al*., 2010; Hultqvist *et al*., 2016; Prince *et al*., 2017), (c) non-judgmental space (status (Virdee *et al*., 2016; Prince *et al*., 2017), and (d) safe space (Wong, 2010; Travis *et al*., 2012; Bryant *et al*., 2013). In this study, Sarah Wheeler, founder of The Dragon Café described it as a multidimensional space (see Chapter 1.3), and then, in the ethnography, participants described the café space as: (a) no pressure to do anything (Dewitt, Chase, Paulette, Amina), (b) a level playing field (Agatha, Brianna), (c) familiar and welcoming (Rosen, Janice), (d) somewhere to relax and calm down (Bolarin, Amina, Donna, Tianna), (e) safe and inclusive community (Susanna, Gaye, Rikki, Kent, Mitch), (f) somewhere to meet people and socialise (Esther, Ugomma, Arnold), (g) non-judgmental (Alison, Paulette, Jasmine, Victoria). In other words, by understanding what participants' favour in terms of the place and space of informal CMHS, we can begin to understand how to develop services that address the needs of people with MHCs who attend such facilities.

Indeed, embodiment and transformation of space to create meaning and metaphorical language in anthropology has been studied (Rodman, 1992; Low, 2009; Miller, 2011). Also, studies have considered narrative phenomenology and how participants construct their experiences and perceptions of places and spaces as crucial for understanding areas of research focused on (a) space and place (Parr, 2000; Pinfold, 2000; Tunstall, Shaw and Dorling, 2004; Thrift, 2009; Miller, 2011), and (b) place-making and identity construction (Low and Lawrence-Zúñiga, 2003; Bryant, Tibbs and Clark, 2011). In this case, the activities at The Dragon Café, such as the dancing and singing that take place within space one and, yoga and writing that takes place in space two create opportunities for collection actions that are socially constructed by the patrons who have developed relationships overtime. It goes without saying, that my thick description of the space occupied by The Dragon Café (Chapter 4), which included details of the stairways, measurements of the spaces, outdoor and indoor spaces addressed important elements of the café space in

such a way that the descriptions match the contemporary hermeneutic approach and discourses of place and space (Low, 2009; Janz, 2017).

5.2 Theoretical perspectives on the mental health café phenomenon.

In this study, the applicability of social theory has been detailed in the review of the literature (see Chapter 2.2.5) where: (a) the social movement theory, (b) the socio-ecological model, (c) stigma, (d) power, (e) the social model of care, (f) the recovery approach and (g) social capital were discussed. Of all these concepts, recovery is the one that ethnographic sources mentioned twice, so it seems relevant to mention the recovery approach here in relation to the findings from the ethnography. Such repetition will be used to further elaborate participants' opinions, and also support a recommendation for future research (see Chapter 6.2.4).

Principle 1 in the National Institute for Mental Health in England (2004) addressing the issue of guiding the recovery process in mental health care states that *"*The user of services decides if and when to begin the recovery process and directs it; therefore, service user direction is essential throughout the process.*"* (p.4). Also, the concept of recovery is firmly situated in mental health care with a consensus on four dimensions used as measures in recovery-oriented service provision: (1) individualised/person-centred, (2) empowerment, (3) purpose and (4) hope (Ellison *et al*., 2016). Similarly, previous studies reported recovery as an indicator of a positive health outcome for participants who attend clubhouses (Prince *et al*., 2017; Chen and Oh, 2018; Gorman *et al*., 2018), day centres (Peloso and Valentini, 2016; Sutton, Bejerholm and Eklund, 2019) and faith communities (Travis *et al*., 2012; Bryant *et al*., 2013; Virdee *et al*., 2016). However, findings from this study suggest negative experiences of Recovery Colleges according to the research participants' accounts.

In this study, recovery was not prominent, and the two times when it was mentioned (see Chapter 4.1.6), the participants perceived it as a prescribed intervention that expected everyone to recover at the same rate. Therefore, it is reasonable to state that for the participants who attend the café, recovery was not

the dominant factor of their perceived benefits from their attending. Overall, the present study found that when compared to other services, such as Recovery Colleges, participants reported a higher level of agency in the café, where they could make decisions about how much or how little they participated in the space, an example of their power and agency. Thus, for participants who refused to conform to the structured and compulsory participation at the Recovery Colleges, it can be said that they retained their agency. Research shows that by conforming to the expectations of the gatekeepers, people with MHCs give up their agency as well as their power to make decisions (Wong, 2010). On that basis, the next section is a discussion of how Bourdieu's (1977) theory of practice was applied in relation the place, people and participation at The Dragon Café.

5.2.1 Applying Bourdieu's (1977) theory of practice

This chapter begins with an exploration of Bourdieu's (1977) theoretical perspectives of *habitus, field* and *social capital* to best illuminate and inform an understanding of the place, people and participation at The Dragon Café informed by the findings from the ethnography. The chapter concludes with the suggestion that extending and amalgamating Bourdieu's (1977) theory of practice with the socio-ecological model (Bronfenbrenner, 1977) (Appendix 22) can advance our understanding of the external factors that may influence the process and degree of social integration for people with MHCs.

In applying Bourdieu's (1977) theory of practice, I am not concerned with proving or disproving the theory, but rather in putting his idea to work for the interpretation of the findings from this study. Thus, drawing on Bourdieu's (1977) theory of practice, *habitus* is discussed here in relation to how participants' past experiences in different spaces shaped their decisions to attend, and continue attending the café. The *field* here is used to discuss the spaces available in the café where participants interact and co-construct their experiences, and *social capital* in this context is discussed to shed light on participants' social connections within and outside the café.

5.2.1 Habitus

Habitus refers to the socialised norms or tendencies that guide behaviour and thinking (Bourdieu, 1977, 1990). For people with MHCs, *habitus* represents the societal norms derived from life experiences and those structures that have the tendencies to impact on *"*the ways that they think, feel and act in determinant ways, which then guide them*"* (Wacquant 2005, p.316; Navarro 2006). In other words, for participants in this study their *habitus* developed through a social disposition, rather than individual process, leading to patterns that are enduring and transferrable over time from one field to another. For example, the *habitus* of participants in this study may be influenced by their ingrained negative experiences of rejection and social stigma (Goffman, 1961). Influences could also include being denied access to, or participation in, other *fields* or their positive experiences at the Dragon Café where they felt a sense of belonging and autonomy. Thus, due to the structure, access and participation criteria in other *fields*, such as Recovery Colleges, participants developed a *habitus* that informed their reluctance to attend other *fields* with rigid access and participation. As a result of such experiences, decisions to attend *fields* with flexible access and participation service ethos, such as the café, increased.

Just as creative activities provided in the mental health café are interchangeable at different times and days, Bourdieu suggests that *habitus* is not fixed but changes in different situations (Wacquant, 2005; Bourdieu, 1977). *Habitus* shifts in relation to specific contexts, adapting to different situations as transferable skills are acquired and internalised over a long period (Bourdieu, 1977, 2000; Navarro 2006). In other words, as participants attend informal CMHS, such as the café, they develop a group identity and acquire similar *habitus* through their shared experiences and co-constructing their collective realities, and as such, some participants think or act in similar ways at The Dragon Café. As Bourdieu (1990) stated: "*Habitus* is society written into the body, into the biological individual" (p. 63).

Essentially, therefore, the way that the participants internalise the place, people and participation at the café, enables a sustained socialisation process through which patrons share the same *habitus*, by creating an established, prolonged manner of acting, seeing and making sense of the café space and activities.

That said, these experiences are influenced by the decisions of gatekeepers and others who make long-term and short-term decisions about the café. *Habitus* occurs within the boundaries of particular *fields* (Bourdieu, 1989), in this case, the *field* of The Dragon Café. The presence or absence of power forms part of the *habitus* of people with MHCs, although this situational perception may differ according to the field that they are in, such as whether they are outside or inside the café.

5.2.2 Field

The *field* provides the structure or space where the process of *habitus* and *social capital* takes place (Bourdieu and Wacquant 1992). The *field* of The Dragon Café is the structure in which participants express and reproduce their experiences, and where they compete for the distribution of interactions and participation that take place in the café. Authors (e.g., Dreher, 2016; Gaventa, 2003) suggest that people often experience power differently, depending on the *field* that they inhabit. Indeed, according to Bourdieu (1984, 1989), power is continuously created and instituted in a social setting through the normalisation of social processes that guide how people behave or think. Thus, the presence of power in the *field*, as suggested by Bourdieu (1984), resonates with the earlier discussion of power differentiation at The Dragon Café (see Chapter 5.1.4.2).

There are different *sub-fields* within the *field* of the café, including: (a) the outdoor space, (b) the reception area, (c) space one and (d) space two. How participants behave in each of these spaces is legitimised through the positioning of patrons, activity facilitators, gatekeepers and managers. This behaviour occurs through socialised norms (activities, timings and schedule of activities and how to behave in different spaces) that either increase or decrease the agency of those who take instructions. Behaviour and thinking are guided from when patrons first arrive at the café and that process continues over time. For example, I observed that patrons are instructed to smoke on the upper grounds of the outdoor space, and when the café opens later than noon, volunteers, managers, or paid staff at the café ask patrons to wait outside until whenever they decide they can enter the facility, no matter what or how bad the weather condition.

Similarly, patrons can only attend the activities provided at the café and at the time that each activity is scheduled. To this end, participant relationships in the café are determined by the power within the *field* of the café, which determines: (a) access to *sub-fields*, (b) the degree and nature of their autonomy in these *sub-fields* and (c) how opposing powers might enhance or limit their agency. As such, the independence of people with MHCs in different *fields* of informal MCHS depends on their: (1) power, (2) position, (3) quality, (4) quantity and (5) form of their social connection that they have accumulated in any particular *field*.

5.2.3 Social capital

In this study, participants reported positive experiences relating to their social connections within and outside The Dragon Café. These connections were usually with their friends from the café, family members and health professionals. Whilst modest perhaps, compared with more socially advantaged individuals, by becoming a member of the café and developing and maintaining friendships with others who become their social networks, participants increased their *social capital* (Almedom, 2005; Verdouw and Flanagan, 2019). Authors (e.g., Cattell, 2001; Whitley and McKenzie, 2005) suggest that for an individual to feel capable and socially inclusive, they need to connect with other people to acquire *social capital* which will provide them with social identity and increased social networks. Equally, Kido *et al*. (2012) suggest that the higher the *social capital* in a society, the lower the stigma, but in the presence of stigma, *social capital* is reduced (Verdouw and Flanagan, 2019). Social stigma is especially the case among vulnerable populations (Johnson *et al*., 2017), such as in people with MHCs who tend to have comparatively small social networks (De Silva *et al*., 2005; McKenzie, Whitely and Weich, 2006; Harley, Boardman and Craig, 2012; Kido *et al*., 2012). Indeed, people with MHCs have been reported to have fewer networks; a situation which determines their reduced opportunities for social integration (Pinfold, 2002)

For people with MHCs, the combined negative situations of social stigma, reduced social support, and inadequate community resources, result in: (a) increased psychological distress (Corrigan, 1998), (b)

increased loneliness and isolation, and (c) even smaller social networks (Pernice-Duca, 2008; Elstad and Eide, 2009; Pernice *et al*., 2017). Evidently, the link between social connection and reduced isolation has been reported as a lifeline that provides opportunities for increased *social capital* (Argentzell, Håkansson and Eklund, 2012); a point also shared by one of the participants:

> "*People are lonely, and they get ill, and loneliness is one of the biggest killers. You can die from loneliness. People die from loneliness, so this is a place where people don't have to be lonely. It's only once a week, but it's like a lifeline for probably a lot of people*." (Esther, 30-40, 16.07.18).

Previous research also attests that increased social connection leads to improved interpersonal and communication skills (Morrissey, 2006; Peters, 2007; Iancu *et al*., 2014; Pernice-Duca *et al*., 2015), a sense of belonging and attachment to a social group or community, resulting in community integration (Carolan, Onaga, Pernice-Duca and Jimenez, 2011). Therefore, increased social connections enable positive health outcomes for people with MHCs. Indeed, Bourdieu's (1977) theory of practice provides a useful theoretical framework for the findings from this study but can only take us so far in understanding the *habitus*, *field*, and *social capital* of any population. His theory does not explain the mental health café phenomenon very well regarding issues around identity or exploring external factors that might hinder or enable social integration for people with MHCs. As Bourdieu himself said:

> To understand interactions between people, explain an event or social phenomenon, it is not sufficient to look at what was said or what happened, rather it is necessary to examine the social space where interactions and events occur," (Bourdieu, 2005, p.148).

Consequently, findings from this study showed that central reason that participants gave for depending on informal CMHS is their resistance to '*the outside space*'. Therefore, it makes sense then to extend or combine Bourdieu's (1977) theory of practice with a theory that will enable us to find out why people with MHCs are reluctant to engage with the '*outside world*'.

5.2.4 Thinking beyond Bourdieu's (1977) theory of practice

In writing this section, I am going to refer to Bourdieu's (1977) *habitus*, *field* and *social capital* in relation to the socio-ecological model. By *habitus* I mean experiences of people with MHCs; for *fields* I mean informal CMHS, or specifically The Dragon Café, and *social capital* means friendships.

I suggest an extension of Bourdieu's (1977) theory of practice with the socio-ecological model; a multilevel approach that examines the relationship between the individual through their: (a) intrapersonal factors, (b) interpersonal processes, (c) institutional factors, (d) community factors, and (e) public policy (Bronfenbrenner, 1977, 2009; McLeroy *et al*., 1988; Eriksson, Ghazinour and Hammarström, 2018). There are two rationales for why I am suggesting an extension to Bourdieu's 1977 theory: (1) this study did not explore the factors outside of a mental health café that may impact on the social and community integration for people with MHCs; which was the main reason participants reported for not engaging with '*the outside world'*. This aspect was beyond the overall research questions of this study: (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service*? The findings in this study suggest increased dependency on informal CMHS and reduced community integration, due to participants' reluctance to attend other services, is leading to overcrowding in spaces, such as The Dragon Café.

In relation to the conceptual model, and drawing on Bourdieu's (1977) theory of practice participants' acquired their primary habitus from their family members in the field of their homes and their initial social capital of their immediate family members (place, people and participation), when I encountered them, they were adults who have acquired their ongoing secondary habitus from different fields (places) and encountered different people who they made friends with (social capital = people). Before they heard about The Dragon Café, they experienced the loss of place, people and participation, in this case, also known as the loss of habitus, field and social capita. Therefore, it is essential to consider what else is outside the café and other informal CMHS that might hinder or facilitate participants' willingness to attend other services and increase their social integration.

It is important to note here that this study in no way implies that only one model is suitable for extending Bourdieu's (1977) theory of practice or that the research findings dispel the need for a biopsychosocial model of care for people with MHCs, which will include the continued use of medication while attending informal CMHS (Babalola, Noel and White, 2017). Indeed, people with MHCs may transit from a state of positive health status to a status of crisis, which may require medical intervention, such as the use of medication or an inpatient admission (Rogers and Pilgrim, 2001; Pilgrim, 2012; Gilburt *et al*., 2014). However, The Dragon Café operates a social model of care (Wheeler, 2015), so I am more inclined to suggest the use of the socio-ecological model to extend Bourdieu's theory of practice, as detailed in chapter on 2.2.5, as well as to offer certain recommendations (see Chapter 6.2.4).

Habitus is neither linear nor constant; hence individuals' experiences of habitus are influenced by two fields: (1) primary habitus from our parents and family members and (2) secondary habitus that is deposited in us from education and other social interactions (Bourdieu, 1986). According to Bourdieu (1977), habitus shapes the fields, and the fields shape habitus, so enabling individuals to cope with unforeseen and ever-changing life situations. In this sense, habitus acts as the human strategy for navigating social fields, based on the amount of capital that people have acquired in certain fields. We already know that people with MHCs have smaller amounts of social capital (Pinfold, 2002; Whitely and Weich, 2006; Harley, Boardman and Craig, 2012); therefore, as a result of that constraint their freedom or autonomy to navigate certain social spaces may be restricted.

Also, habitus is strongly linked to the field, and how people act in the field is based on: (a) their position in a particular field and (b) the rules of the field, otherwise known as *doxa*. *Doxa* refers to the unspoken rules, social boundaries and limits in any given field (Bourdieu, 1990; Reed-Danahay, 2005). Therefore, people with MHCs may act "intentionally without intention" (Bourdieu, 1990, p.12) when visiting certain fields according to their position in that field and the rules (*doxa*) that govern the field (Vandebroeck, 2018); besides, fields are autonomous with no universe rule or rules guiding them (Futrell and Simi, 2004; Wacquant, 2011; Vandebroeck, 2018). However, the autonomy within fields is

relative because the fields are dependent on wider social structures and influences, such as politics, religion, and most recently pandemics.

Notwithstanding, the rules and boundaries within each field determine how people with MHCs engage in that field. Therefore, in this case, it is no wonder that when compared to Recovery Colleges, participants in this study preferred to visit the Dragon Café where they felt that they had positions of relative autonomy due to the lack of both access and participation criteria and participants' perceived power to choose how little or how much to participate, with who and when. However, as discussed in the review of the literature, choices are guided by structures (fields) (Vandebroeck, 2018). For example, the name 'dementia café' might create an access barrier for someone with a broader range of MHCs. Also, mental health day centres offering only work activities might act as barriers for people with MHCs who wish to attend day centres in order to socialise. Similarly, clubhouses might create barriers for anyone with a broader range of MHCs who does not wish, or is unable, to engage in work related activities.

Therefore, for people with MHCs it can be assumed that different fields, otherwise known in this study as *'informal CMHS'* could deposit different experiences (habitus) that can be triggered in particular fields. As such, habitus is activated based on the field that people with MHCs are in and how much social capital they have in that field. This conclusion also depends on the quality of their capital in that space. For people with MHCs, research evidence suggests that they have very small social networks when compared to the general population (Pernice-Duca, 2008; (Elstad and Eide, 2009; Pernice *et al*., 2017); social networks that normally comprise of, or are limited to, their family members, healthcare providers and other people with MHCs (Pinfold, 2000). However, when participants who attend The Dragon Café are actually in the café, they can be said to have increased their social capital within and outside the café because they extend their friendships with others from outside their café (field). Thus, they can activate the habitus that they acquired from the café because this was deposited in them previously and aligns with their experiences of that field and how they participate and interact with other people in that field. In other words, if people with MHCs feel that their habitus fits with a certain

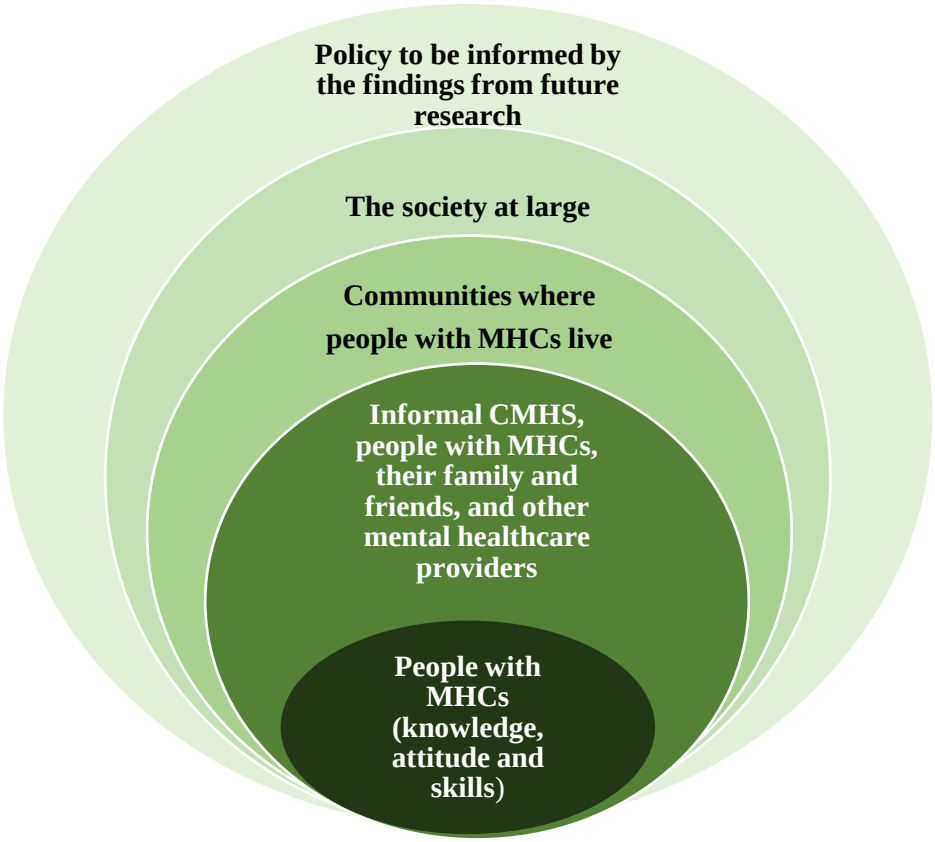
informal CMHS, such as The Dragon Café, and they can learn to adapt to that space with a sense of belonging, they will continue to attend the same field rather than attending a space where they will feel stigmatised.

This conclusion also applies to people who are visiting the café for the first time. They may walk in and decide that the habitus in the space aligns with, or does not align with, their expected outcome for an informal CMHS. If there is no alignment they may leave and may or may not activate whatever habitus was deposited in them from that one visit. Similarly, the same can be said about some of the participants in this study who attended Recovery Colleges where the habitus that was 'deposited in them' did not align with their preferred choice of informal CMHS. Therefore, when they activated their memories of the habitus from Recovery Colleges, they used those memories as the reasons why they would not return. Therefore, three things determine if people with MHCs will return to a field (informal CMHS): (1) the number of habitus that they retain from the habitus that was deposited in them in different fields, (2) how much social capital they acquire and with who and (3) the perceptions and the meanings that they attach to their interactions, participation and experiences in particular fields. As a result, people with MHCs are more likely to continue attending the café where they acquire habitus that aligns with their expected outcomes; an environment (field) where they feel that they can meet people with shared experiences and participate as little or as much as they like. However, as reported in previous studies this ideal outcome can result in dependency on space (Desjarlais, 1997; Boyce *et al*., 2010; Tjörnstrand, Bejerholm and Eklund, 2015) and the lack of community integration among people with MHCs (Virdee *et al*., 2016; Phutane *et al*., 2019).

For people with MHCs therefore, dependency on a space meets one of their central needs; to engage and socialise with other people, especially as they are coming from a place of isolation (Desjarlais, 1997). For example, participants in the study are seeking an informal CMHS where they can meet their need to acquire, retain and maintain social capital in the form of friendships within and outside the café with the same people. By doing so they are able to increase their social capital within and outside the café without the fear of social stigma, because they are associating with the same people outside the

café and also taking part in other activities. In other words, people with MHCs are not asking for symbolic (e.g., academia, honour, publications, reputation), cultural (e.g., educational qualifications, strong cultural capital possessed in a family, a collection of expensive paintings), or economic capital (fortune and revenues, asserts that exchangeable into money) (Bourdieu, 1986). It is possible that by not overtly acknowledging this point the Recovery Colleges may be getting it wrong by asking some people with MHCs to attend structured computer lessons.

Therefore, by extending Bourdieu's theory with the socio-ecological model, future research can explore the barriers and facilitators outside of The Dragon Café and other informal CMHS mentioned in the review of the literature that is making people with MHCs reluctant to engage with community integration; otherwise known as "*the outside world*". Once that exploration is completed the findings can be used to shape policy regarding informal CMHS. In other words, the socio-ecological model will allow us to focus on understanding the views and perceptions of people with MHCs regarding their relationships. By investigating their social spatial network, future researcher can understand the "*outside world*" of those people.



Adapted from: Bronfenbrenner (1979)

The socio-ecological model also aligns with the social model of care (Beresford *et al*., 2010), while the conceptual model of Dahlgren and Whitehead's (1991) suggests wider determinants of health (as detailed in chapter 2.2.5) for understanding how best to address the needs of people with MHCs. In relation to this study, the conceptual model: (a) 'the place' is informal CMHS where the people with MHCs visit, (b) people refer to their 'social connections' with others that they encounter within informal CMHS, and (c) 'participation' refers to passive and active participation within the informal CMHS. The next chapter concludes this thesis, followed with the recommendations, references and the appendices.

CHAPTER SIX CONCLUSIONS AND RECOMMENDATIONSS

6.0 Introduction

This closing chapter demonstrates how I addressed the aims and objectives of this study and answered the research questions. It also details the limitations of the study, recommendations and plans for dissemination of the information gathered. This study achieved eight significant findings. Of the eight, three addressed the aims of the study, two objectives of the study and the research questions (see Chapter 4.3). The three findings from the ethnography that demonstrate the importance of the café to people with MHCs include: (1) access to a safe place to go when there was nowhere else to go, (2) meeting and socialising with people who share similar experiences, and (3) the freedom to be in a space without the pressure to participate.

The remaining five findings contribute new and original knowledge to the existing empirical body of the international literature and extend our understanding of informal CMHS in general, and mental health cafés in particular. These five findings relate to: (1) the differences between why informal CMHS were established, (2) methodological differences and the thick description the research setting and activities, (3) how agency, structure and power influence interactions at The Dragon Café, (4) the diverse sense of loss experienced by participants after the closures of mental health day centres, and (5) a novel conceptual model of the place, people and participation at the café. These new findings addressed the aims of the study's fourth objective and the research question (see Chapter 5.1.1-5.1.5). The fifth objective was answered with the application of Bourdieu's (1977) theory of practice to the findings from the ethnography and the extension of Bourdieu's theory with the socio-ecological model to further explore the barriers and facilitators of community integration for people with MHCs.

This study answered the central research questions: (1) *What is The Dragon Café*? and (2) *What makes people with mental health challenges attend this informal community mental health service*? It also established the relationships between the place, people and participation through the original findings, developed a novel conceptual model, and addressed the aims and objective that it set out to achieve, including:

1. To understand what makes people with mental health challenges attend The Dragon Café.
2. To describe how people with mental health challenges socially construct their individual and collective experiences at The Dragon Café.
3. To interpret the meaning that people who attend The Dragon Café attach to their experiences at the café.
4. To generate empirical research and contribute to the international debate and literature on informal community mental health services in general, but more specifically on mental health cafés.
5. To explore the theoretical perspectives on the mental health café phenomenon.

To build a base of empirical findings from this study, which will provide a robust understanding of informal CMHS in general, several methods of data collection were used. Specifically, this study provides a deeper understanding of the notion of a mental health café as a 'space'; where people with MHCs can attend to meet people, make friends and socialise with others who share similar experiences. The café also offers a diverse range of creative activities and more choice without the structured and compulsory participation criteria a clear example of the exercise of power in an asymmetrical distribution which are common in other services, such as Recovery Colleges.

The thesis began with an introduction and details relating to the structure of the thesis, which provided summaries of individual chapters, including the policy of the transition of mental health service provision in the UK from the closure of the asylums to the establishment of inpatient and community mental health services (see Chapter 1.1). Further, I described what motivated me to study informal CMHS with details of how and why I decided to research The Dragon Café (see Chapter 1.2). The scene of the research study was set , including what the café offers and who attends, beginning with a narrative from a transcribed YouTube video that features Sarah Wheeler talking about her experiences of MHCs as the antecedent for setting up The Dragon Café (see Chapter 1.3).

The introduction chapter continued with a scoping study that sought to determine the scope, size and characteristics of the research evidence on mental health cafés. A narrative review of five informal

CMHS, including mental health cafés, was presented which explored the fundamental mechanisms within such services for those who attend them.

Empirically, findings from the review of the literature showed that while there are several studies on dementia cafés, studies on a broader range of MHCs were scarce with the last published in 2011. Also, four key issues relating to the five informal CMHS were identified from the review of the literature. These key issues were: 1) access to an inclusive, safe space, which provided a sense of belonging; 2) how group participation improves interpersonal relationships and social connection; 3) the role of autonomy and choice for empowerment and recovery and 4) the importance of maintaining funding in order to sustain informal CMHS. Importantly, the findings highlighted barriers to some of the services due to access and participation criteria; such criteria can exclude some people without specific mental health status from attending some informal CMHS and present a barrier to community integration due to dependency on some informal CMHS.

Notwithstanding the importance of funding, autonomy and the ability to make decisions contribute to people's feeling of safety in the space and these were highlighted as crucial for access, participation and recovery (Bryant, Tibbs and Clark, 2011). Thus, barriers to access and participation could reduce the feelings of autonomy and choice and disempower people with MHCs who may be refused access to the informal CMHS that they may wish to attend. If 'autonomy' and 'choice' are prerequisites to empowerment and recovery (Bryant, Tibbs and Clark, 2011), it is questionable to assume that people with MHCs can be empowered to experience recovery in the absence of autonomy. In addition, the reviews aided the consideration of theoretical frameworks for this study, as well as the identification of methodological and empirical gaps in the current knowledge on informal CMHS. Ultimately the reviews enabled the development of the research questions and the justification for the 14 months constructivist and interpretive ethnographic fieldwork.

The ethnographic study was a diligent accumulation of a large amount of audiovisual and textual data sources, including a floor plan, a 3-dimensional video, photographs, extensive and prolonged real-time observations alongside informal conversations and substantial semi-structured interviews. Thus, priority was given to the iterative and the inductive description of the collectively constructed social processes in the café; so, presenting new and revealing methods of understanding the phenomena under study (Hammersley, 1990; Fetterman, 2010). Further, the interpretive approach was useful as data were manually analysed, so allowing this researcher to immerse herself thoroughly in the data, coding, interpreting and analysing systematically through the use of thick description (Geertz, 1973) and writing of the ethnography (Emerson, Fretz and Shaw, 2007). The combination of social construction and interpretive paradigms enabled a smooth process of data collection and interpretation (Holstein and Gubrium, 2013; Voyer and Trondman, 2016), providing a deeper understanding of how participants created their shared experiences in the café and the interpretation of the meaning that they attached to their experiences at the café.

With this robust understanding of the activities, events, people and processes within a single setting (Merriam, 2001; Alkenbrack, 2009), a conceptual framework was developed and used to describe how the relationship between the place, people and participation in the café is unified in a way that one cannot happen without the others. Thus, the use of thick description in this study, enabled an understanding of more than what patrons were doing, going beyond mere details and superficial accounts, to present comprehensive and contextual details that connect the place, people and participation together (Geertz, 1973). As such, the study demonstrates the complex networks of interactions regarding how participants socially construct their experiences at the café (Berger and Luckmann, 1967; Benton and Craib, 2011). Thus, adopting thick description, interpretive and social constructivist paradigms, evoked: (a) the establishment of the significance of space and place, (b) the sequence of events, (c) participants' shared experiences and accounts of their feelings, actions, and (d) the meanings that they attach to their interactions at the café (Geertz, 1973; Denzin, 1989).

Furthermore, the findings from the ethnography illustrate that the closure and reconfiguration of mental health day centres, from flexible spaces that enabled participatory autonomy and choice in structured spaces with compulsory participation, reduced access to support in the community. According to the study's participants, this change led to increased experiences of loss, social isolation and loneliness, reduced independence and choice of where to go and what to do in such spaces. Importantly, this limitation in the nature and reconfiguration of mental health day centres increased dependency on spaces, such as The Dragon Café, resulting in overcrowding in such spaces and increasing the cost of sustaining such facilities. Therefore, in addressing the key mechanisms in the café that influenced participants to attend, the findings indicate that the café compensated for losses that participants experienced with the closure and reconfiguration of other informal CMHS.

Whilst participants in this study were keen to continue attending The Dragon Café due to the benefits they associated with their experiences of the café, the gatekeepers identified the threat of closure due to limited funding. Thus, the sustainability or longevity of the café remains a real concern because the café is free for all to attend, and the creative activities are also provided free of charge. In many ways, The Dragon Café represents what participants described as their 'ideal space', an oasis and a place of belonging. However, all of those benefits may not be possible without the availability of funding; *in* summary 'no funds, no café'. In other words, this study observes the conflict between participants' expectations and funders' expectations in the form of tension which is rooted in their political agendas, as detailed in the scoping and narrative reviews. Consequently, more informal CMHS may close or reduce the frequency of their opening hours, and this might result in considerable costs to the NHS and increased burden of care for family members. Similarly, it could mean an increase in the issues that were identified in the introduction to this thesis, such as homelessness among people with MCHs and an increase in the use of police stations as a place of safety (see Chapter 1.0).

For the foreseeable future, The Dragon Café is a social space where an average of 200 people with MHCs can visit every Monday to participate in the activities on offer, or not to participate, as they wish. However, with the continuing closure and reconfigurations of day centres, the café represents just a

fraction of informal CMHS for people with MHCs in the UK. Also, mental health services in the UK are highly polarised and nowhere is that clearer than the funding divide between physical and mental health (Gilburt, 2014). Thus, for people with MHCs who have access to spaces, such as the café, it is an opportunity to socialise and participate with people who understand through similar shared experiences. However, for others who cannot access a mental health café, or indeed are not aware that informal CMHS exist, life may become a lonely and isolated experience with possible relapse, hospitalisation and homelessness.

Finally, this study suggests that the UK's community mental health service provision cannot carry on without adequate informal CMHS for people with MHCs. There have to be checks to identify these resources, where they are located and the services that they provide; complemented by more research into the benefits and challenges of mental health cafés. Ultimately, funding seems to be the sustaining factor for informal CMHS, and with funding cuts on mental health services, together with the lack of parity between physical health and mental health in terms of facilities and funding (Gilburt, 2014), it might be a while before mental health cafés receive the attention that they may require and merit to meet the needs of those who attend.

In conclusion, this study has shown that the availability of informal CMHS, such as The Dragon Café, offers people with MHCs more control over their choices of social support and activity, as well as protection from experiencing social isolation, increased mental health symptoms and loneliness. It was the latter which, according to Sarah Wheeler, was the reason she set up The Dragon Café, "*to reduce the loneliness and isolation that is endemic in the world that we live in*" (Wheeler, 2015).

6.1 Limitations of the study

A limitation of this study was that the majority of the patrons at the café take part in group activities, so alongside individual interviews, it may have proved helpful to include focus group discussions as part of the data collection methods; however, this form of information gathering was not initiated. Focus groups

could have increased the diversity of views and collectively constructed perspectives on the different activities provided in the café. This *approach* would also have complemented the data from the observations and informal conversations, and the individual interviews. A second limitation was the lack of document analysis. This method of information gathering was not explicitly included in the study design and could have provided comparative written data in determining participants' expressions of their experiences; not least as these issues feature in two 'comment notebooks' for patrons' views and opinions about the facility. A third limitation of the study was that it explored only one mental health café. Although the specific focus on The Dragon Café led to a deep analysis of this particular informal CMHS or community resource, an investigation across other mental health cafés could have obtained more detailed, comparative information on why participants seek out or attend particular kinds of facilities. Finally, a fourth limitation of the study was that it did not explore the barriers and facilitators outside The Dragon Café that may prevent those who attend from engaging with what participants refer to as '*the outside world*'.

6.2 Recommendations and implications for future research and policy decisions

All the recommendations suggested in this study emerge from the review of the literature and the ethnography; this section also includes recommendations that emerged from practice implications. Empirically, more research and theoretical development is needed to fully understand the phenomenon of mental health cafés and how these facilities or resources are differentiated from other, alternative CMHS. I acknowledge that this review and ethnography has only provided a starting point, albeit a substantial and original one, from which further enquiries can be developed.

6.2.1 Methodological implications

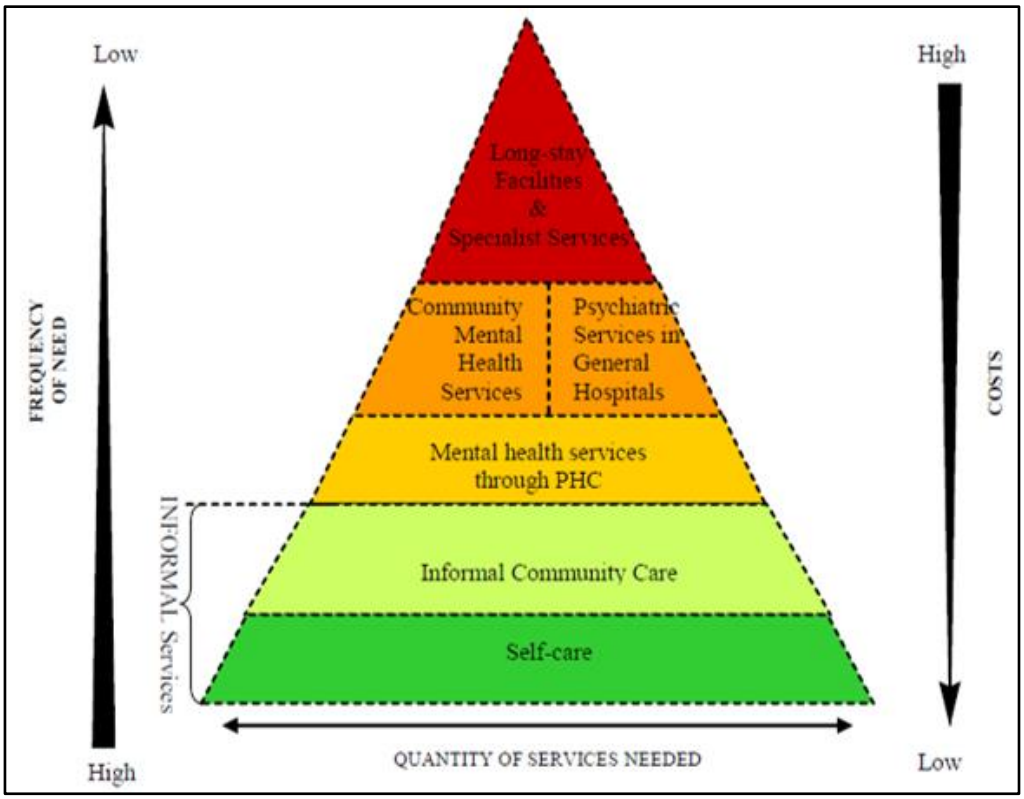
Findings from this study indicate the scarcity of specific research methodology and methods relating to mental health cafés, in particular, and informal CMHS in general. Therefore, future research may consider:

1). Adopting ethnographic methods of visual and textual data collection methods, documenting the place, people and participation with comprehensive information on the spatial environment of informal CMHS in general, or specifically, mental health cafés which are under-researched (Appendix 23). This research orientation may usefully include focus group discussions and documentary analysis.

2). With very little research existing on people with a broad range of mental health challenges, it has been argued that the variance in the understanding and practice of recovery-oriented practice might improve if mental health practice was informed by multiple ethnographic investigations (Pilgrim, 2009). Therefore, to determine how, and under what circumstances, local places support recovery, future research may consider multiple case study ethnographic research of Recovery Colleges to explore what recovery means to people with MHCs who attend such community resources.

3). Conducting a quantitative investigation to measure the cost-effectiveness of The Dragon Café in comparison with the cost of alternative CMHS and/or hospital admissions as suggested by the WHO (2007b) Optimal Mix of Services (Figure 15 The World Health Organisation Optimal Mix of Services). The WHO clearly shows that informal CMHS are much cheaper than long stay facilities, such as hospitals. The proposed study will also seek to examine GP records to determine if the participants' claims in the current study about reduced symptoms of mental health, reduced hospitalisation and reduced medication can be supported by formal evidence and, if so, then use those findings to support the cost-effectiveness of mental health cafés. Findings from a cost-effectiveness research could assist policymakers in considering increasing availability and access to such services, as a way to reduce the cost of mental health service provision in the UK.

Figure 15 The World Health Organisation Optimal Mix of Services



Source: World Health Organisation (2007b)

4). Similarly, the issue of societal stigma (Goffman, 1961) was highlighted in this study, so future research could consider the issue of stigma in more detail through a randomised controlled trial (RCT) to measure stigma in a structured service, when compared to unstructured service or resource environment, for people with MHCs in community settings.

6.2.2 Practical implications

A further recommendation from this current study is that the mental health nursing curriculum should include key information and learning around informal CMHS and the allocation of students on nursing placement to such services. This suggested curriculum alignment from theory to practice in the learning of mental health student nurses is particularly important in order to create a familiarity between the nursing students and people with MHCs because they may have already encountered each other in other inpatient

and statutory or formal community mental health service contexts. Also, suggested is the inclusion of informal CMHS, such as The Dragon Café in the list of services for social prescribing; a community-based personalised service that gives people a choice and control over the plan and delivery of their care (Bickerdike *et al*., 2017; NHS England, 2019). In addition, this study recommends the revaluation of the admission and discharge assessment documentation to include questions about informal CMHS that people with MHCs attend in the community.

6.2.3 Policy implications

Politically, this study recommends a re-evaluation of the National Institute for Health and Clinical Excellence (NICE) guidelines in order for the Institute to include informal CMHS as a community treatment option for people with MHCs. This *addition* should be aligned with the availability of evidence-based research on CMHS and their funding, without which there will not be adequate informal CMHS available to those who need them. Therefore, whilst it is doubtful if the findings from this ethnography can be generalised to other settings, there is the possibility that mental health cafés may be replicated in other geographical areas, with The Dragon Café as a provisional model, to provide a safe space for people with MHCs. The current ethnography of The Dragon Café provides a footprint for how to replicate some, if not all, aspects of its environment, activities and processes. Importantly, The Dragon Café passes what is called 'the family test' (The Centre for Social Justice, 2016) in that participants attending the café recommend its space to family and friends. The Centre for Social Justice (2011, 2014, 2016) suggests that policy initiatives should: (a) recognise the impact of social policies on friends and family relationships, (b) consider the perspectives of friends and family and (c) their roles in society. In this case, The Dragon Café has provided a service which attendees confirm has enabled them to relate better to and communicate with their friends and family members.

6.2.4 Theoretical implications

Given the level of the power differential identified in this ethnography, more research needs to be conducted into the power aspect of these environments. Also, as discussed in the review of the literature and in the discussion chapter, people with MHCs are reluctant to engage with people and spaces outside informal CMHS. Therefore, bearing this disparity in mind, future research may extend Bourdieu's (1977) theory of practice and the socio-ecological model (Bronfenbrenner, 1977), to widen the theoretical lens to enable an exploration of the relationship between people with MHCs and the world outside of such safe spaces as The Dragon Café.

As Pilgrim (2009) argues, there is an absence of adequate ethnographic research on Recovery Colleges. It is therefore far from clear how closely Recovery College environments and practices follow their own framework. This point is particularly important because of the concerns about Recovery Colleges raised by participants from this study with regard to: (1) a lack of creative activities in those facilities, (2) restricted access and participation criteria, and (3) compromised autonomy and decision making. For these reasons, ethnographic research into Recovery Colleges is needed to best explore this issue and compare findings with those resulting from this study. Comparative ethnographic studies of the current study and future ethnographic studies on Recovery Colleges is important because the earlier discussion from this study showed significant advantages of The Dragon Café compared to Recovery Colleges. In the meantime, Recovery Colleges may find this current study of value in reviewing the appropriateness of their own service development.

The study proposes that the novel conceptual model of place, people and participation is a multidimensional fit for understanding the three domains that define interactions between people with MHCs who attend a mental health café. As such, researchers should consider the importance of the relationship between the three domains of place, people and participation when developing informal CMHS; specifically, by adopting the conceptual model alongside the detailed ethnographic description

of the outdoor and indoor physical environments associated with one particular mental health café located in London.

In summary, regarding empirical, practical and policy implications, this study argues that a multi-disciplinary working partnership between educational institutions, health care providers and policymakers is required, in order to increase the awareness of what informal CMHS, such as a mental health café, may or may not offer to people with MHCs. In terms of methodological and theoretical implications, this study suggests collaborative working relationships between people with MHCs, mental health care service providers, national and international academic and non-academic institutions to co-produce evidence-based research that will guide the development of informal CMHS so that such services can meet and satisfy the diverse needs of people with MHCs.

6.3 Plans for dissemination

There are ethical considerations to dissemination that need to be taken into account by an author or authors, such as ownership of data, publication and dissemination of research findings (DH, 2011; Miller *et al*., 2012; Iphofen, 2013). Two major ethical considerations came up in this study. The first was how to disseminate the research findings to the participants and patrons. The second was how to disseminate the findings transparently in a contextualised way that will prompt a change in practice and policy without bias, by not reporting both the benefits and non-benefits of the café to those who attend, as well as highlighting the challenges faced by the gatekeepers. To mitigate both ethical considerations, I discussed each dissemination of findings with my university supervision team, including poster and oral presentations at 19 conferences, in addition to an oral presentation to the patrons at The Dragon Café (Appendix 24). For future dissemination plans, the supervision team has agreed that further disseminations will begin after the end of the final thesis submission. These initiatives will include sharing the findings with the patrons at the café, publications in relevant peer-reviewed academic journals, oral and poster presentations at subject-specific conferences, seminars, and at the ESRC Festival of Social Science.

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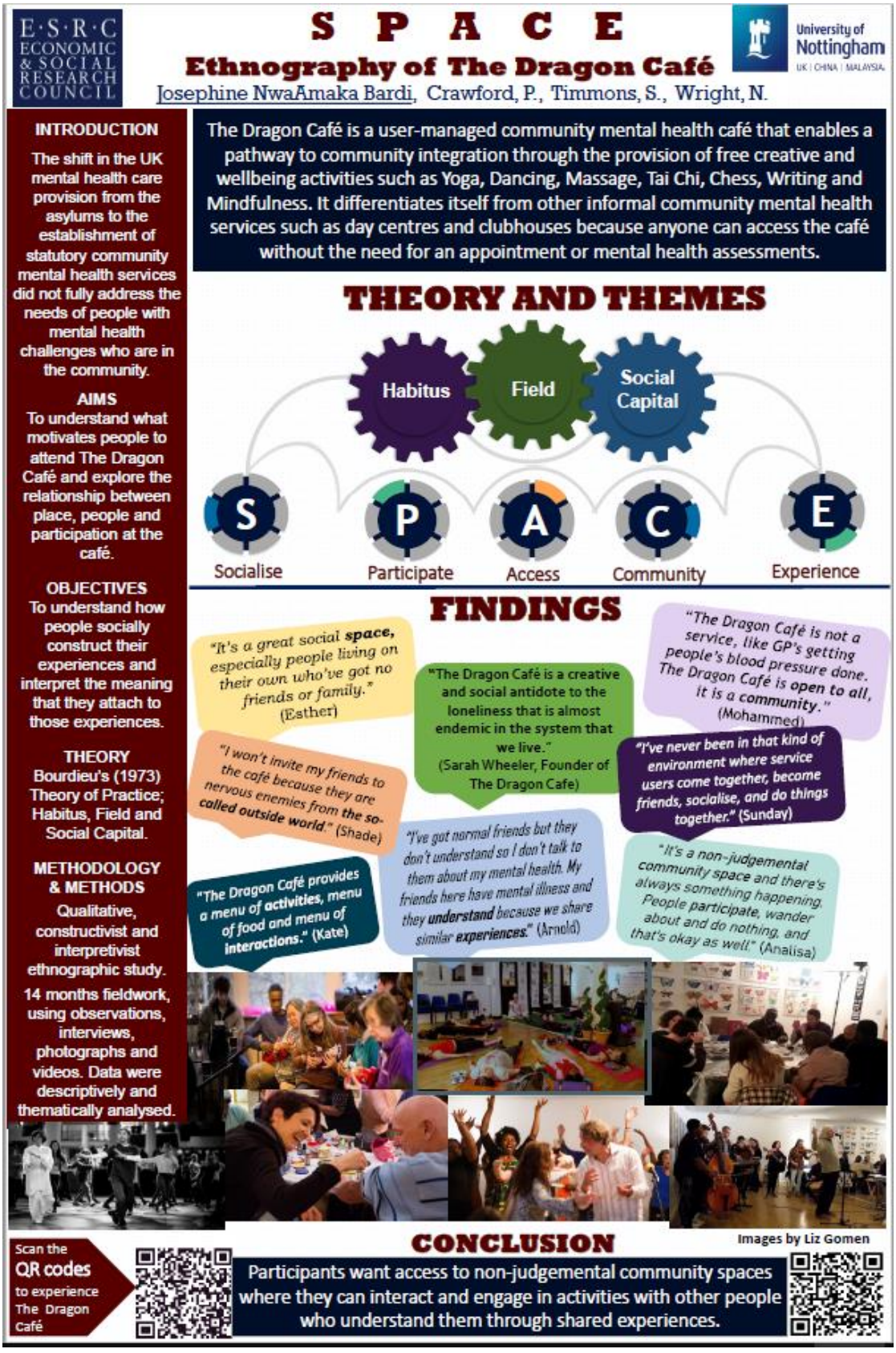
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Appendix 1 SPACE poster



Appendix 2 Consent form written and signed by Sarah Wheeler

Project title: Sarah Elizabeth Wheeler's Story

Researcher's name: Josephine NwaAmaka Bardi

I am fully aware of the nature and purpose of the research project and this has been explained to me. I understand and agree to take part.

- I understand the purpose of the research project and my involvement in it is to tell my story from childhood to date.
- I understand that I may withdraw from the research project at any stage and this will not affect my status now or in the future.
- I understand that information gained during the study will be published and I will be identified.
- I understand that I will be photographed, audiotaped / videotaped during the interview.
- I understand that data will be stored securely by Josephine NwaAmaka Bardi.
- I understand that my photographs, interview transcripts and video recordings will be used for publicity and fund raising in the following ways: book publication, journal article publication, newspaper publications, DC events, University of East London events (the funders of Sarah's Story), University of Nottingham events (the University where Josephine NwaAmaka Bardi is studying for her my PhD), events organised by Economic and Social Research Council (ESRC – Josephine NwaAmaka Bardi's PhD funder's), and any other media avenue that will help to promote Sarah's story and raise awareness for the DC and Mental Fight Club.
- I understand that my childhood, teenage and adult photographs which I will provide for the research, will be used to support all publications and events.
- I understand that I may contact the researcher if I require further information about the research.

Signed S E Wheeler (research participant)

Print name SARAH ELIZABETH WHEELER

Contact details

Researcher: Josephine NwaAmaka Bard

j.bardi@uel.ac.uk; llxjnb@nottingham.ac.uk; josephine.bardi@yahoo.co.uk

ESRC DTC PhD Student, University of Nottingham, School of Health Sciences, NG7 2HA

Qualitative Research Consultant, School of Health, Sport and Bioscience, University of East London, Stratford, E15 4LZ.

Appendix 3 Search terms for the scoping review

S1. ethnolog* OR stories OR “content analysis” OR ethnograph* OR audio* OR video tap* or videotap* or video record* or videorecord* OR “observational methods” OR “participant observation” OR narrat* OR discourse* OR “repertory grid” OR “Behavioural research” OR “behavioural research” OR qualitative OR “thematic analysis” OR “thematic analyses” OR phenomenol* OR “grounded theory” OR “grounded studies” OR “grounded research” OR “constant comparative” OR “constant comparison” OR “purposive sample” OR “purposive samples” OR “purposive sampling” OR “fieldnote” OR “fieldnotes” OR “field study” OR “field studies” OR fieldwork OR “field work” OR “field research” OR key informant* OR “biographical method” OR “biographical methods” OR “theoretical sampling” OR “theoretical sample” OR “theoretical samples” OR "life world" OR life-world OR “conversation analysis” OR “conversation analyses” OR “theoretical saturation” OR "thematic analyses" OR snowball OR “case studies” OR “case study” or transcrib* or transcript* or ("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth or "face-to-face" or structured or guide) and (interview* or discussion* or questionnaire*)

S2 Observation OR focus groups OR interviews OR narrative OR qualitative research OR ethnography OR anthropology

S3 mental AND health OR mental AND illness OR mental AND ill-health OR psychiatric AND disorder OR dementia AND Alzheimer’s

S4 mental AND health AND café OR mental AND illness AND café OR mental AND ill health AND café OR psychiatric AND disorder AND café

S6 dementia AND café OR Alzheimer’s AND café OR memory AND lane AND café

S7 depression AND café OR anxiety AND café OR anxiety disorder AND café OR bipolar disorder AND café OR psychosis AND café OR addiction AND café OR schizophrenia AND café OR substance abuse AND café OR personality disorder AND café OR post-traumatic disorder AND café OR panic attack AND café OR panic disorder AND café OR eating disorder AND café OR alcohol abuse AND café OR drug abuse AND café

Appendix 4 Summary of studies included in the scoping review

	Name of author(s) and dates of publication	Aim of the study	Setting	Study population	Methodology and methods of data collection	Key findings
1.	McDonald (2010)	Florence Nightingale at first hand Inkerman Café	Turkey	Soldiers and their family members	Qualitative Narrative	1. A Sober café established in 1855 by Florence Nightingale during the Crimean war for soldiers 2. Large recreation room and coffeehouse with reading rooms' with cards and magazines when alcohol was the only option 3. A welcoming space where soldiers and their family members could socialise 4. Soldiers could attend and get hot chocolate without the need to drink alcohol 5.
2.	Fried and Waxman (1988)	Stockholm's Café 84: a unique day program for Jewish survivors of concentration camps	Stockholm Sweden	Jews in the Stockholm area who had suffered persecution during the Second World War with lived experiences of	Programme Evaluation	6. Café 84 opens on Friday nights for the Jewish Kabbalat Shabbat ceremony. 7. Also opens on weekdays for regular informal activities such as coffee, music, and Jewish films, and study groups for those who attend.

				Post-Traumatic Stress Disorder (PTSD)		8. Provides a space with a sense of community, warm, friendly and family atmosphere where attendees can have coffee as they socialise through small talks, jokes and exchange food recipes. 9. Social network was with those who attended the café, family members and friends. 10. Reduced feelings of isolation
3.	Campbell *et al.* (2011)	Serenity Cafe with people recovering from addiction	United Kingdom	9 Interviews 10 focus group 97, 171 and 14 survey responses	Qualitative Action research In-depth interviews Focus group Surveys Observations	1. Recovery focused and user-managed with rules of no drugs or alcohol on the premises. 2. Attendees report experiences stigma, social isolation and exclusion from other social spaces. 3. Participation is critical for the attendees to develop social skills and social networks, sense of belonging and community integration. 4. Helpful relationships between people who understand through shared-experiences – compassion, empathy 5. Also provides alcohol nightclub referred to as 'sober night' club (p.134).

						6. Prescribed expectations of recovery. 7. Provides a positive and empowering space for attendees to engage in volunteering, traineeships and employment.
4.	Dow *et al.* (2010)	Evaluation of the Memory Lane Café service in	Victoria, Australia	People living dementia, their carers and family members	Focus group discussions Surveys Semi-structured interviews with open-ended questions Observation	1. Provide a social and educational service. Some participants want education and information, but others prefer socialising. 2. Promotes social inclusion, reduce isolation and improves emotional and social wellbeing for some attendees. Looking forward to attending because some people live on their own. 3. Opening times depend on the availability of space and funding, so they open every four to eight weeks. 4. Spending time with people who share similar experiences, acceptance and tolerance. Socialising outside the café going out and holidaying together. 'You are on a level playing field' (p.249). 5. Autonomy to choose whether to participate or not. 6. Culturally and linguistically relevant cafés and to monitor the impact of

						the cafés from the point of view of those who attend.
5.	Jubb *et al*. (2003)	The Coffee Shop. Developing services for younger people with dementia	Doncaster United Kingdom	Service provision for people with Dementia	Qualitative audit Semi-structured interviews	1. An information resource centre that provides attendees with information through books, internet, leaflets and creative writing with a focus on history 2. Attendees meet regularly to plan social activities, social events and holidays. 3. Reduced feelings of isolation and increased confidence, autonomy, decision making and empowerment 4. Funding and funders impact of service provision
6.	Pratt *et al*. (2005)	The 'Talking About Memory Coffee Group: A new model of support for people with early-stage dementia and their families	Toronto Canada Community	People with early-stage dementia and their families	Early Intervention Programme Qualitative inquiry	1. User-led intervention that provides psychosocial interventions for attendees. 2. Promotes autonomy and choice through an open membership where 3. attendees can join and leave the group at any time 4. Activities in the café provide forums for attendees to discuss, share experiences and learn from each other. 5. Reduced feelings of isolation and increased self-esteem.

7.	Halley *et al.* (2005)	A multi-agency approach to developing an Alzheimer Café	Wandsworth United Kingdom Community	People with dementia and their carers	Survey	1. The Poppy Café provides an informal, supportive environment for people at all stages of dementia and their carers to share positive social experience from stigma. 2. The first point of contact into other services, a place where people form supportive friendships, relax together and socialise. It is also a source of information and advice. 3. Reduced social isolation 4. Lack of funding might impact of keeping the café open
8.	Mather (2006)	Memory Lane Café: Follow-up support for people with early-stage dementia, their families and carers	Melbourne Australia	People in the early stages of dementia	Programme Evaluation	1. A space that creates a sense of belonging. 2. An opportunity to catch up with others to share coping strategies, share information and ideas. 3. A space that encourages a self-reliant and self-help environment which empowers attendees to participate in decision making about what their needs are and how to meet those needs.
9.	Peters (2007)	Café Society	Barnstable	16 and 25 people with dementia and their carers meet at the	Audit	1. Inclusive, safe space where persons with dementia, family members and carers are comfortable to express their emotions

			United Kingdom	Castle Café once a month for two hours.		2. Increased social interaction, so people exchange experiences and discuss challenges that are associated with living with dementia. 3. Emphasis is on communication skills, education and support for couples
10.	Halse (2014)	Schools in at the Memory Café	Report	Those recently diagnosed with dementia	Report	1. A space for intergenerational engagement between 50 students aged from 8-11 years, who are known as 'Dementia Ambassadors' (p.10), and attendees who are living with dementia and their carers, in a social and exciting way. 2. Attendees participate in a variety of focused and reminiscence activities including craft, exercise classes and dance.
11.	Morrissey (2006)	Alzheimer's Café for people with and affected by dementia	Canterbury United Kingdom	Newly diagnosed adults living with dementia and their partners	Personal reflective account based on the Gibbs 1988 reflective cycle.	1. Inclusive, safe space where persons with dementia are comfortable to express their emotions, exchange experiences and discuss challenges that are associated with living with dementia. 2. The emphasis is on developing interpersonal and communication

						skills, education and support for couples. 3. The relaxed atmosphere promotes feelings of acceptance, belonging and recognition among the attendees.
12.	McFadden and Koll (2014)	Dementia Café	United States	People living with Dementia and their carers	Report	1. Safe space where people can share similar experiences. 2. Non-judgemental space where people with dementia can socialise through interactions and participation in creative activities. 3. Volunteers greet participants and give them name badges, show them around and introduce them to other people. 4. Group outings

Appendix 5 Identification of themes from the scoping review, pages 1-2

Combined into single phrases, meanings and interpretations	Studies included in the scoping review												Themes identified and the total number of times that they appeared in the included studies	
	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12		
Café	x	x	x	x	x	x	x	x	x	x	x	x	Drinking coffee together in the coffeehouses and cafés	9
Learning	x			x				x					Study groups	3
Participation													Working in groups	
Informal	x	x	x										Informal activities	3
Safe space	x					x	x	x					Friendly and relaxed family atmosphere	4
Social inclusion	x	x	x	x			x	x	x				Socialise with social networks through small talks and jokes	7
Social inclusion	x		x	x	x	x							Share and exchange experiences	5
Empowerment				x									Increased self-esteem	1
Empowerment							x						focus on their strengths, rather than their diagnosis	1
Social inclusion					x								Opportunity to catch up with others	1
Participation	x	x	x	x	x		x	x	x				Participate in creative and social activities such as events, craft, music and holidays	8
Safes space	x				x	x	x	x	x				Safe social space	6
Social inclusion	x	x	x	x	x	x	x	x	x				Reduced feeling of isolation, networking, a sense of belonging and companionship	9
Empowerment		x											Increased confidence	1
Social inclusion			x	x		x	x						Sharing positive experiences	4
				x				x					User-led intervention	2
Empowerment				x									Promotion of autonomy	1

Social inclusion				x									Open membership	1
Community	x						x						recovery community	2
Social inclusion			x				x	x					Recovery-oriented friendships	3
Empowerment				x	x								Self-reliant and self-help	2
Social inclusion			x			x	x						Relax together and Socialise	3
Learning	x	x	x	x	x	x	x						Source of information and advice through books, internet, leaflets	7
Safe space			x	x	x	x		x					Informal supportive environment	5
Social inclusion			x					x					Sharing positive social experience	2
Learning		x											Creative writing	1
Empowerment				x		x							Forums for discussing challenges and coping strategies	2
Social inclusion					x	x							Sense of belonging and recognition	2
Empowerment					x			x					Decision making	2
					x		x						Empowerment	2
Learning				x									Using technology as a learning tool	1
Safe space						x	x						Safe space	2
Participation									x				Exercise when participating in activities	1
Learning							x						Traineeship, volunteering and employment	1

Appendix 6 Search terms for the narrative literature review, pages 1-3

Boolean phrase and SmartText for search terms

S1 `mental health café' AND `community mental health services' AND `informal community mental health services' AND `mental health support services' AND `faith community' AND `day centre' AND `drop-in centre' AND `community hub' AND `clubhouse' AND `dementia café' AND `place' AND `space' AND `environment'

S2 `mental AND illness' OR `mental AND health' OR `psychiatric AND disorders', AND `mental AND health AND café' OR dementia AND café AND `community AND mental AND health AND services' OR `mental AND health AND support AND services' OR day AND centre OR clubhouse AND church OR faith communities AND `place' OR `space' OR `environment'.

S3 Search terms for mental health problems and mental health café

Depression AND mental health café OR anxiety AND mental health café OR anxiety disorder AND mental health café OR bipolar disorder AND mental health café OR psychosis AND mental health café OR addiction AND mental health café OR schizophrenia AND mental health café OR substance abuse AND mental health café OR personality disorder AND mental health café OR post traumatic disorder AND mental health café OR panic attack AND mental health café OR panic disorder AND mental health café OR eating disorder AND mental health café OR alcohol abuse AND mental health café OR drug abuse AND mental health café.

S4 Search terms for mental health problems and clubhouse

Depression AND clubhouse OR anxiety AND clubhouse OR anxiety disorder AND clubhouse OR bipolar disorder AND clubhouse OR psychosis AND clubhouse OR addiction AND clubhouse OR schizophrenia AND clubhouse OR substance abuse AND clubhouse OR personality disorder AND clubhouse OR post traumatic disorder AND clubhouse OR panic attack AND clubhouse OR panic disorder AND clubhouse OR eating disorder AND clubhouse OR alcohol abuse AND clubhouse OR drug abuse AND clubhouse.

S5 Search terms for mental health problems and day centre

Depression AND day centre OR anxiety AND day centre OR anxiety disorder AND day centre OR bipolar disorder AND day centre OR psychosis AND day centre OR addiction AND day centre OR schizophrenia AND day centre OR substance abuse AND day centre OR personality disorder AND day centre OR post traumatic disorder AND day centre OR panic attack AND day centre OR panic disorder AND day centre OR eating disorder AND day centre OR alcohol abuse AND day centre OR drug abuse AND day centre.

S6 Search terms for mental health problems and drop-in centres

Depression AND drop-in centre OR anxiety AND drop-in centre OR anxiety disorder AND drop-in centre OR bipolar disorder AND drop-in centre OR psychosis AND drop-in centre OR addiction AND drop-in centre OR schizophrenia AND drop-in centre OR substance abuse AND drop-in centre OR personality disorder AND drop-in centre OR post traumatic disorder AND drop-in centre OR panic attack AND drop-in centre OR panic disorder AND drop-in centre OR eating disorder AND drop-in centre OR alcohol abuse AND drop-in centre OR drug abuse AND drop-in centre.

S7 Search terms for mental health problems and community hubs

Depression AND community hubs OR anxiety AND community hubs OR anxiety disorder AND community hubs OR bipolar disorder AND community hubs OR psychosis AND community hubs OR addiction AND community hubs OR schizophrenia AND community hubs OR substance abuse AND community hubs OR personality disorder AND community hubs OR post traumatic disorder AND community hubs OR panic attack AND community hubs OR panic disorder AND community hubs OR eating disorder AND community hubs OR alcohol abuse AND community hubs OR drug abuse AND community hubs.

S8 Search terms for mental health problems and user-led organisations

Depression AND user-led organisations OR anxiety AND user-led organisations OR anxiety disorder AND user-led organisations OR bipolar disorder AND user-led organisations OR psychosis AND user-led organisations OR addiction AND user-led organisations OR

schizophrenia AND user-led organisations OR substance abuse AND user-led organisations OR personality disorder AND user-led organisations OR post traumatic disorder AND user-led organisations OR panic attack AND user-led organisations OR panic disorder AND user-led organisations OR eating disorder AND user-led organisations OR alcohol abuse AND user-led organisations OR drug abuse AND user-led organisations.

S9 Search terms for mental health problems and faith communities

Depression AND faith communities OR anxiety AND faith communities OR anxiety disorder AND faith communities OR bipolar disorder AND faith communities OR psychosis AND faith communities OR addiction AND faith communities OR schizophrenia AND faith communities OR substance abuse AND faith communities OR personality disorder AND faith communities OR post traumatic disorder AND faith communities OR panic attack AND faith communities OR panic disorder AND faith communities OR eating disorder AND faith communities OR alcohol abuse AND faith communities OR drug abuse AND faith communities.

S10 . ethnolog* OR stories OR "content analysis" OR ethnograph* OR audio* OR video tap* or videotap* or video record* or videorecord* OR "observational methods" OR "participant observation" OR narrat* OR discourse* OR "repertory grid" OR "behavioral research" OR "behavioural research" OR qualitative OR "thematic analysis" OR "thematic analyses" OR phenomenol* OR "grounded theory" OR "grounded studies" OR "grounded research" OR "constant comparative" OR "constant comparison" OR "purposive sample" OR "purposive samples" OR "purposive sampling" OR "field notes" OR "field study" OR "field studies" OR fieldwork OR "field work" OR "field research" OR key informant* OR "biographical method" OR "biographical methods" OR "theoretical sampling" OR "theoretical sample" OR "theoretical samples" OR "life world" OR life-world OR "conversation analysis" OR "conversation analyses" OR "theoretical saturation" OR "thematic analyses" OR snowball OR "case studies" OR "case study" or transcrib* or transcript* or ("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth or "face-to-face" or structured or guide) and (interview* or discussion* or questionnaire*)

S11 S1 AND S2 AND S3 AND S4 AND S5 AND S6 AND S7 AND S8 AND S9 AND S10

Appendix 7 Summary of studies included in the narrative review

	Details of Author(s) and Dates	Aim of the Study	Location	Study population and Sample Size	Methodology and Date Collection	Key findings
1.	Caplan and Cordero (2015)	To describe the process of creating a faith-based mental health literacy intervention	Caribbean	12	Qualitative Community-based participatory research Individual and group interviews	1. Religion is a coping mechanism. 2. Faith communities and religion are barriers to treatment and diagnosis because of existing beliefs such as '*My grace is sufficient for you; my strength is made perfect in your weakness.*' (p205) '*I can do all things through Christ who strengthens me.*' And '*Let the weak say I am strong.*' Therefore, they may encourage discrimination and exclusion of members with mental health challenges 3. Members use prayer to maintain faith when experiencing psychological distress as a source of healing and recovery. 4. Health professionals as barriers to treatment and diagnosis

						because patients may be reluctant to share their religious beliefs with health professionals for fear of being viewed as having delusions. 5. Faith community members with mental health challenges stop attending or stop seeking support from the community because members without mental health challenges display stigmatising behaviour such as hostile stares, comments, and moving away from those with mental health challenges. 6. A safe space which facilitates open discussion about mental health
2.	Chiu *et al.* (2017)	Evaluation of a support programme for faith community residents with depressive symptoms	Hong Kong	121 psychiatric outpatients 46 volunteers	Quantitative Programme evaluation	1. Faith communities support recovery. 2. Helpful in some cases, but it limits the relationship between health professionals and service users due to power dynamics. 3. New social circle due to friendships.

						4. Stigma can lead to social isolation and reduce community integration.
3.	Connolly and Granfield (2017)	Exploring the concept of recovery capital within faith a community for people with substance misuse	United States	23 African Americans	Qualitative Case study In-depth interviews	1. Recovery capital: the number of resources such as social networks, work, health, religion and relationships that an individual has access to that will enable them to maintain their recovery 2. Accessible and open-door policy which encourages people with mental health challenges and others to attend or join faith communities. 3. You do not have to belong to a faith community to attend. 4. Sense of belonging, inclusivity and acceptance.
4.	Bryant *et al*. (2013)	To explore how a rural faith community will address depression among its members and the community	United States	24	Qualitative descriptive study Community-based participatory research Focus group discussions	1. The role of the church to provide holistic support, provide information and referral services to relevant services. 2. Prayer as an intervention through the use of God's power 3. Religious beliefs of church leaders are barriers to mental health interventions, so they need training because some

						church leaders preach about faith only. 4. An accessible and open-door policy which encourages people with mental health challenges and others to attend or join faith communities that support recovery 5. Provide information and signpost people to other services. 6. Non-judgemental spaces where they can talk to church leaders without being judged. 7. Different support groups within faith communities different support groups in the café.
5.	Sullivan *et al*. (2013)	Understanding the relationship between faith communities and mental health	United States	Four rural communities in	Qualitative case study Informal conversations Survey Observations	1. Seek to provide emotional wellbeing and promote the importance of relationships for their members. 2. Long-standing relationship between religion and psychiatry. 3. Prayer as an intervention through the use of God's power.

						4. Religious beliefs of church leaders are barriers to mental health interventions, so they need training because some church leaders preach about faith only 5. Faith community leaders provide emotional and psychological support for their members. 6. Participant's religious beliefs might conflict with mental health treatment options, prompting the individual to choose one or other, rather than both. 7. Health professionals may not recognise or understand how an individual's religious belief may impact on their health outcomes. 8. Mental health professionals and faith leaders need to collaborate to limit the barriers to treatment. A major barrier is the lack of relationship between faith leaders and mental health practitioners.

						9. Stigma is a visible or invisible 'mark' that disqualifies a person or group from full acceptance 10. The mutual relationship between faith leaders and mental health professionals leads to referrals to and from faith leaders, increased trust and understanding and decreased stigma 11. Face to face contact was identified as a way to reduce stigma.
6.	Travis *et al*. (2012)	Faith community's intention and preparedness to address and support recovery from substance use disorders	United States	45 faith communities 3,649 members	Secondary data analysis 24-item Congregational Readiness Questionnaire	1. More studies about faith communities are on substance misuse and depressions. 2. Develop culturally appropriate means of working with faith communities and faith leaders. 3. An environment where members support each other to enable recovery from substance misuse
7.	Caplan (2019)	To explore beliefs about mental illness among Latino faith-based communities.	United States	64	Qualitative descriptive design Open-ended questions	1. People with mental health challenges are dangerous and out of control. 2. Mental health is an incurable disease, so people with mental health challenges are rejected and ostracised.

						3. Families do not accept that mental health exists until an individual is in crisis. 4. Prayer, faith and religious beliefs are seen as protective factors, so mental health is caused by a lack of faith, demons, sin and lack of prayer and recovery. 5. The church is seen as a resource for social, spiritual and educational needs. 6. Culture is both a hindrance and enables stigmatisation. 7. Stigma from people without mental health challenges towards those with.
8.	Hardison-Moody and Yao (2019)	To examine the inherent wisdom and indigenous assets that faith communities possess in their religious life and communities. Faith Community	United States	941	Faith community assessment	1. Globally, faith communities are being recognised as an important resource for community health. 2. They meet the social, emotional and health needs of their members. 3. The socio-ecological model which examines the relationship between the

						individual, family members and relationships, the society.
9.	Virdee *et al*. (2016)	Explored the construction of community through faith spaces, religion, and spirituality for persons with psychosis. Faith Community	Canada	31	In-depth qualitative analysis Semi-structured, in-depth interviews Grounded Theory	1. Faith communities provide spaces that accept people regardless of their health status 2. Enhancing social and spiritual capitals. 3. People with schizophrenia are viewed as 'included', but not in the community. Therefore, this may encourage discrimination and exclusion of some members with mental health challenges 4. Community participation as a platform for recovery-oriented service 5. People with mental health challenges, avoid places with stigmatised identities and visit places that support their recovery such as faith communities 6. Faith communities can also perpetuate stigma, which can lead to discrimination and exclusion of people with mental health challenges.

						7. Collaboration between faith communities and mental health services for better support of people with psychosis. 8. Access to faith communities and spaces enables social connections. 9. Behavioural symptoms of mental health resulted in self-stigma and increase the barrier to community integration.
10.	Rogers and Stanford (2015)	To describe the outcomes for individuals in a peer-led church group intervention for mental illness. Faith Community	United States	78	Quantitative Survey	1. Living Grace Group is a user-managed, so its leaders are people who recovered from mental health challenges, has a family or friend with mental health challenges or is a mental health advocate. 2. Religion and spirituality provide support and coping strategies for people with mental health challenges in recovery. 3. Faith communities provide recovery-oriented support. 4. The focus is on the recovery model, emphasising support, empowerment, teaching and learning practical skills.

						5. Members must have a mental health diagnosis similar to membership criteria in clubhouses. However, members have a variety of mental health challenges similar to the members at the café. 6. Reduced mental health symptoms 7. Connection and support from others with experiential knowledge.
11.	Tang, Ng and Yip (2010)	To investigate the effects of the 'clubhouse' model of rehabilitation on various psychosocial issues for Chinese patients with schizophrenia living in the community	Hong Kong	92	Quantitative A longitudinal, case-controlled and naturalistic design	1. Significant improvements in positive and negative scales, general psychopathology, and total scores after attending the clubhouse for six months. 2. Improved employment rates and social integration. 4. Attendees must become members and participate in the work-oriented activities
12.	Mowbray *et al.* (2008)	Are there significant differences in the characteristics and outcomes of members of clubhouses versus Consumer-run	United States	31 geographically matched pairs of clubhouses and CRDIs involving more than 1,800	Quantitative Cross-sectional data Questionnaires Interviews	1. Membership is compulsory. 2. Members were more likely to report their mental health status, so self-reporting is a significantly higher quality of life than those in Drop-in Centres.

		Drop-in Centres (CRDIs)				4. More engaged with mental health services and are more likely to be referred to the clubhouse because they have a more psychiatric history and admission rates. 5. Reduced hospitalisation and saves in-patient costs. 6. Drop-in Centres attendees were more likely to have substance misuse, which may exclude them from mainstream mental health services. 6. People who attend Drop-in Centres feel constrained by the structured routine in clubhouses.
13.	Gumber and Stein (2018)	To examine the factors associated with community integration experiences of adults with serious mental illness who were members of psychosocial rehabilitation clubhouses in New York City	United States	92	Quantitative Online Survey	1. Higher social integration with people in the clubhouse compared to outside the clubhouse with people without mental health challenges. 2. Increased self-esteem towards employment outside the clubhouse. 3. Better relationships with family members within and outside the clubhouse. 4. Attendees must become members and participate in the work-oriented activities

14.	Chen and Oh (2018)	Staff views on member participation in a mental health clubhouse	United States	38	Qualitative Observations and interviews	1. Membership is compulsory with participation in the work-oriented activities. 2. Clubhouses enable recovery in a way that recovery journeys and psychiatric symptoms are discussed openly. 3. Clubhouses adopt an 'understaffed' principle by not hiring enough paid staff, giving a genuine shortage of staff so that members can engage in work. 4. Participating in work programmes enables the development of transferable work skills. 5. Participation takes members' minds off their problems when they felt down and negative. 6. Staff members encourage autonomy, so members have autonomy and choice of what work project to join and which staff members to work with.
15.	Pernice-Duca *et al*. (2015)	The perceived impact of the clubhouse on families.	United States	35	Qualitative	1. Attendees must become members and participate in the work-oriented activities.

					Semi-structured interviews	2. Family members and caregivers experience a significant amount of the burden of care, such as financial, emotional and social for their relatives with SMI, but this reduced when their family members start to attend clubhouses. 3. Clubhouses indirectly support families of people with mental health challenges. 4. Users are members who share similar experiences in relation to their mental health status and this results in a sense of belonging. 5. Respite from caring for family members and feeling of reduced stress and calmer in themselves. 6. Participants willingness to talk to family members resulted in better communication and relationship with family members. 7. Talking about the activities that they took part in, rather than symptoms and management of symptoms.

						8. Engaging with others outside of family and friends.
16.	Hultqvist *et al.* (2016)	To compare users of community-based mental health day centres (DCs) and clubhouses in Sweden regard reported social networks and social interaction	Sweden	185	Self-reported questionnaires	1. Attendees must become members and participate in the work-oriented activities 2. Members share their innermost thoughts with health professionals. 3. Access to enabling social environments 4. Dependency on the space could result in a reluctance to community integration. 5. Shared decision making between staff and members and this promotes rehabilitation 6. Clubhouse attendees have more social contacts than day centre attendees. 7. The more attendees visit a centre, the larger their social networks
17.	Wong (2010)	Exploring mental health nurses' perception of the clubhouse programme	Hong Kong	8	Qualitative Unstructured interviews	1. Attendees must become members and get involved in the work-ordered day

						2. Recovery for those who attend meant not taking medication and having a stable job. 3. Being able to choose leads to increased control, empowerment and ability to manage their own lives and interactions outside of the informal space. 4. Members do not have autonomy or choice to make some decisions due to the paternalistic attitude in clubhouses which results in long-term dependency relationships. 5. Feelings of acceptance due to the non-hierarchical relationship between members and staff patrons, volunteers and paid staff.
18.	Gorman *et al.* (2018)	Examined potential determinants of sustainability for clubhouse programs	United States	7 qualitative	Mixed method Retrospective multi-site study Semi-structured one-to-one telephone interviews Survey	1. Recovery centres that help people with mental health challenges to obtain and maintain community-based employment. 2. Enable people with mental health challenges to obtain and maintain community-based employment, education,

				282 quantitative		housing social integration and other services. 3. Funders main goal is to increase the number of clients lack of space in the café due to reduced funding to expand this a challenge and results in overcrowding in the café. 4. No creative activities
19.	Prince *et al*. (2017)	To explore how clubhouses, foster closeness for people with mental health conditions	United States	6-8 group members per group 250 took part in the follow-up study	20 Focus group discussions	1. Reduces social isolation and promotes recovery and wellbeing for those who attend. 2. Maximise the potential for interpersonal relationships through the promotion of togetherness. 3. Consistent interaction with other people promotes connection with others. 4. Friendships reduce the feeling of loneliness and isolation which otherwise would result in relapse, increase in symptoms of mental health. 5. Non-judgemental space, acceptance and tolerance of others.

						6. Day, evening and weekend activities which enhance social interaction. 7. Outreach to members by staff during a period of absence.
20.	Boyce *et al.* (2010)	To explore the innovatory features and challenges facing mental health-specific ULOs in England	United Kingdom	48 service users and staff	In-depth qualitative interview	1. ULO such as mental health, learning disability and cancer. 2. Individuals who get involved benefit more with increased social connections. 3. ULO project promotes and improves the capacity and capability of generic pan-disability ULOs. 4. Funders agenda are different from users agendas resulting in limited access due to funders expectations. 5. Individual and collective shared experiences of health status or social care and familiarity with other attendees. Paid staff may also share similar experiences of health and social care. 6. Attending only one group may result in group isolation and reduced community integration.

						7. High tolerance and acceptance through shared understanding and experiences with increased empathy. 8. No pressure to attend when people are unwell and cannot attend. 9. No hierarchy of power, but there is a hierarchy of responsibility which may introduce the issue of power. 10. Evening activities which provide an opportunity for attendees and health professional to engage in a collective dialogue about. 11. User-managed, not user-led because the critical decisions are made by the gatekeepers and managers. 12. You cannot ask everyone's (more than 200 patrons) opinion about what to do in the café. 13. 'Normal people' do the same as we do; they go out together for meals and other activities.

						14. Fear of expansion, which may change the user-led ethos such as the loss of informality and retaining the flexible service provision v the introduction of political and medical structures. 15. Too many people, too little space
21.	Brown (2009)	To develop a comprehensive theoretical understanding of how members benefit from mental health consumer-run organisations (CROs)	United States	194	Interviews Open-ended questions	1. Consumer-run organisations are operated by people with mental health challenges. 2. Began in the 1970s by ex-patients who challenged institutionalisation and dependency roles that give the health professional all the power. 3. Safe and non-judgemental space that provides members with a safe haven when there is nowhere else to go. 4. Anyone without a mental health condition is excluded from decision making within the organisations. 5. Managed by people with mental health challenges through collective support that is based on the helper role.

						6. Promotes acceptance, sense of belonging, inner strength, empowerment and collective support through the provision of social interaction in work-ordered days that promote exaltation participation between staff and members. 7. Socialising with others who shared experiential knowledge enables the development of friend identity and friendship roles which promotes recovery, increases self-esteem and confidence, and interpersonal relationships within and outside the user-led space. Increases community integration. 8. Funding is required for the sustainability of the service, but must caution must be taken to avoid compromising the ethos of the association to meet the agenda of the funders
22.	Rose *et al.* (2016)	To explore mental health service user-led organisation (ULOs) in England	United Kingdom	Two user-led organisations	Qualitative Ethnography Observation, field notes, reflective diaries and interviews	1. Theoretical framework, a social movement where service users seek to change to the service provider that they are offered when users felt disempowered and oppressed led to collective action in response to injustice.

					Exploratory multi-case study design Interviews with key informants	2. The new movements of ex-service users for service users 3. Established because some health professionals interpret the expressions of emotions and symptoms of mental health challenges are interpreted as bad manners 4. Collective planning and action are viewed as a safe space where people could air their views
23.	Elstad and Eide (2009)	To add to our understanding of user participation by exploring the experiences of users and professionals within a community mental health service	Norway	10	Qualitative Interviews	1. Users have the right to choose to participate or not participate. 2. Participants take part in creative activities within the space, but there is limited participation outside the space which results in reduced community integration. 3. Autonomy and individual choice about the activities to take part in is vital for user participation. 4. A safe space where people could share their thoughts towards a common goal
24.	Longden, Read and Dillon (2017)	Systematic assessment of the impact and effectiveness of the	United Kingdom	101 adult members of the Hearing	Self-reported questionnaire	1. Improved social, emotional and clinical outcomes.

		hearing voices network self-help groups		Voices Network		2. Safe and non-judgemental communal space to meet people who accept each other and share similar experiences such as voice-hearing 3. People who provided the support that was unavailable outside the group. 4. Talk about experiences and coping strategies without being judged.
25.	Wilson and Kent, (2015)	To explore a mental health service, user-led art group	United Kingdom	6	Semi-structured interview	1. User-led organisations are also mutual-aid groups, peer-support groups, self-help groups of individuals who share similar experiences. 2. Group participation with people who understand because they share similar experiences 3. Increased participation in social activities resulted in reduced social isolation and loneliness 4. Sense of belonging and community. 5. Increased feeling of self-worth and personal pride from creating artwork or writing a poem in the writing group.

						6. Attending the day centres helps people to take their minds off experiences of mental health challenges.
26.	Sutton, Bejerholm and Eklund (2019)	To explore perceived empowerment and change over time, among Swedish day centre users	Sweden	14	Longitudinal study	1. Participants are empowered through an increase in control, autonomy to act on their choices. 2. Day centres offer a range of meaningful services, safe space, drop-in, peer support, education, vocations, and social activities. 3. Day centres may encourage segregation due to participants depending on the space and reluctance to attend other services. 4. Internalised self-stigma increases internalised negative stereotypes about mental health challenges, and social stigma contributes to the experience of self-stigma of attending a day centre. 5. Creates pathways to greater participation, socialising, and a sense of safety within the space.

						6. Recovery from learning to cope with symptoms of mental health after attending a centre for a long time... Participants know what helps them recover or helps them manage the symptoms. 7. Community integration can increase through participation in society outside the day centre.
27.	Tjörnstrand, Bejerholm and Eklund (2015)	To understand the occupation engagement among day centre attendees	Sweden	88	Qualitative Time-use diary to record their occupational engagement at a day centre	1. Work oriented participation through the provision of empowering occupational skills and spaces for social engagements as a rehabilitation intervention. 2. Financial implications of dependency on a single social space with an increasing number of attendees. 3. Togetherness, a sense of belonging, support and social networking that bridged the gap between the community, health and social care 4. Experiences of varied losses as a result of having a mental health challenge

						5. Social isolation without informal spaces to attend, you do not have to sit at home alone because you have a place to go. 6. Reduced stress levels when at the centre. 7. Social anxiety when changing context which may discourage the attendance of unfamiliar spaces. Alienated from the outside world due to the feeling of safety in the space and perception of rejection from people outside the café. 8. Being there and watching others participating. 9. Day centres may create a dependency on a space and may reduce the participant's willingness to engage in other spaces and in the community, which might minimise community integration 10. Need to bridge the gap between feeling safe in the space and participating in society.

28.	Harley, Boardman and Craig (2012)	To explore quantitative and qualitative aspects of friendship with people with schizophrenia who attend a day centre	United Kingdom	137	Mixed methods Semi-structured interviews Survey	1. Loss of social role and networks due to relapse, symptoms of mental health, prolonged or repeated hospital admissions. These can result in social isolation. 2. Small networks of friends compared to the general population. Friendship is usually with other service users from clinical settings or other informal services. 3. Participants are happy with their mutual support in their friendships regardless of the number of friends. People attend to spend time with their friends. Friends fulfil different roles. 4. The perceived stigma which results in social isolation and actively removing themselves from engaging with people outside the informal setting. 5. Attending helps with reducing social isolation for all but especially for those who live alone. 6. A meeting place orientation where people can come and go

						as they wish with no expectations to fulfil any duties
29.	Bryant, Tibbs and Clark (2011)	Exploration of perception of people who use mental health day services	United Kingdom	Not known	Action research Photography	1. Outsiders have a limited understanding of what happens in such spaces. 2. A place of shelter, social contact, structure for the day and therapeutic benefits such as forming social networks and participating, but networks were usually with people from the day service and family members. 3. Safe space with different components; feeling relaxed, reduced anxiety with no fear, oasis, no pressure, hanging coats without a doubt of theft/that it may be stolen. 4. It is not the physical space of the café that provided therapeutic benefits, but the attendee's perception of access, support and autonomy that made it a space safe and impacted on recovery. 5. Some services closed due to funding, but participants were reluctant to attend other services due to anxiety of going into a new place.

						6. A place to be yourself and meet people who understand because they share similar experiences. Building social networks, which promote social inclusion such as meeting friends outside the day centre. 7. Social stigma persists in the outside world with limited choice due to self-stigma and perceived social stigma. 8. Higher potential for stigmatisation creating awareness of the prejudice and stigma from people outside of the day centre which makes participant value the informal spaces but might also lead to dependency on the space and reluctant to attend other spaces or engage in social and community integration.
30.	Argentzell, Håkansson and Eklund (2010)	To examine the different facets of meaning that unemployed people who are severely mentally ill who attend a day centre may find in their everyday occupation	Sweden	12	Qualitative Interview	1. Safe space with different components; feeling relaxed, reduced anxiety 2. Increase social contacts/friendship with people who understand because they share similar experiences which result in individual and

						collective shared experiences of health status or social care 3. High tolerance and acceptance through shared understanding and experiences with increased empathy. 4. Having somewhere to go is beneficial because nothing to do and nowhere to go increases symptoms of mental health challenges may take over because. 5. Routines provide structure when attendees are being creative and productive 6. There is always something new to do. 7. Attendees have valued activities than non-attendees.
31.	Nordström *et al.* (2009)	To describe and analyse how older adults with psychiatric disability experience places, social relations and activities in different areas of their everyday lives	Sweden	12	Qualitative Semi-structured in-depth interviews	1. A sense of belonging in a non-judgemental space which they call a community 2. Spending time with others who you are familiar with reduces mental health symptoms through their presence in the space.

		Day centre				3. Access to a place/ somewhere to go was a motivating factor to leave the house. Living alone is a reminder of loneliness and isolation and being alone at home made the loneliness more obvious. 4. Routines provide structure. 5. Access to a place where participants could meet and make friends with other people outside their family and health professional circle. Different types of friendships; deeper and shallow. 6. Perception of ordinary people. You can't talk to them because you have to be careful not to make mistakes or upset them. Sustained interactions and encounters lead to friendships, so people feel accepted 7. Friendships that extend outside the day centres, going out together and taking the path in other activities. 8. Participating together actively or passively (sit and watch or talk). Passive participation could also relate to those who

						are attending the space for the first time and are anxious. 9. The categorisation of people; normal or ordinary people and people with mental health challenges.
32.	Eklund and Sandlund (2016)	To describe day centre attendees' previous experiences of open-market employment	Sweden	77	Questionnaires.	1. Day centres are safe spaces but also spaces that do not encourage community integration. 2. A meeting place orientation where people can come and go as they wish with no expectations to fulfil any duties 3. The more attendees visit a centre, the larger their social networks 4. Day centres may create a dependency on the space and may reduce the participant's willingness to engage in other spaces and in the community, which might minimise community integrations.
33.	Eklund and Sandlund (2012)	To explore day centre attendee's life situation, including sociodemographic	Sweden	93 who visit day centre 82 who do not visit a day centre	Quantitative Cross-sectional study	1. Two types of day centres; meeting and work-oriented. 2. Day centres provide structure and routines for people with mental health challenges.

		and clinical characteristics, satisfaction with care, perceived health and well-being, and everyday activities				3. Day centres facilitate spaces that motivate people with mental challenges to leave their home. Otherwise, they will be socially isolated as they may not have other places to visit. 4. Those who attended day centres had limited education, but they had more friends. 5. Those who did not attend had increased use of psychiatric care.
34.	Phutane *et al*. (2012)	Evaluation of barriers to discharge from the day centre to actual workplace	India	76	Cross-sectional study Semi-structured interview Questionnaire	1. Reduced motivation to engage in other settings due to perceptions of safe space where they currently attend. 2. Fear of an increase in mental health symptoms discourages people from leaving or ending their attendance. 3. Recommendation: Behavioural modification to encourage integration into the community.
35.	Iancu *et al*. (2014)	To analyse and compare experiences of recovery on care farms and day centres	Netherlands	26	Qualitative Semi-structured interview	1. Compared to participants in the work projects, participants in the creative day centre group lacked clear goals with reduced interest in work or learning-related program/services and

						2. Reported recovery and reduced mental health symptoms. 3. Both groups had general goals of having somewhere to go and something to do during the day. 4. Participants had goals that they wanted to achieve at the centres, reduced symptoms, exercise, making friends reduce isolation, having something to do. 5. Isolation due to social anxiety, perceived lack of interpersonal and communication skills. 6. When there is nowhere to go and nothing to so, symptoms of mental health challenges increase 7. Social functioning by interacting with people outside the day centre and preventing the uni-directional relationships of being on receiving a social benefit to a bi-directional one of volunteering/social responsibility of giving back to the community. 8. Community integration is encouraged so that participants

						are now able to interact with people outside the day centres 9. Access and freedom to choose what to do were motivations for participants to leave their houses and attend the services.
36.	Peloso and Valentini (2016)	To describe the features of the Day Centres in the Italian Mental Health Departments	Italy			1. Three types of day centres; activity, model-oriented, which combines recovery-oriented interventions and staying oriented model. 2. Work-oriented day centres may exclude attendees who do not wish to partake in the work-oriented activities as noted in the interview data where most of the participants would not attend the recovery colleges 3. A sense of belonging in a non-judgemental space where attendees feel tolerated and accepted. 4. A goal is that participants attend without the need to take part in any interventions. 5. Dependency on the space due to participants hesitation to engage in community integration, and this reduces

						rehabilitation and makes it difficult for new members to attend because attendees are not moving on to other services. 6. Routines, being creative and productive and there is always something new.
37.	Eklund and Markström (2014)	To investigate the outcomes of the freedom of choice reform as perceived by the users of day centre services	Sweden	123	A naturalistic study Background questionnaires to gather socio-demographic data and self-reported diagnosis Open-ended questions	1. Users can choose which centre they wish to attend, or they can be referred to the day centres as long as their needs have been assessed and decisions are made by the local authority who funds the centres. 2. Attendees having the autonomy to decide where to attend results in greater user satisfaction 3. Increase social contacts/friendship. 4. Attendees have valued activities than non-attendees 5. Empowerment enables participants to take control of their life and recovery process which promote empowerment, activity and social interaction.
38.	Liou and Jarrott (2018)	To capture the perceptions of staff	Taiwan	23	Focused ethnography	1. The adult day service centre that provides respite for family

		and clients in a day Taiwan day service centre			Participant observation Interviews Grounded Theory	caregivers of people with a physical or psychiatric disability. 2. A safe space that creates a sense of belonging. 3. Participants were forced to participate in activities.
39.	Iecovich and Biderman (2012)	To examine adult day care centres (ADCC) and its relation to loneliness among frail older adults.	Israel	817	Case-control study Face-to-face interviews using a structured questionnaire	1. The provision of a day centre does not reduce the use of in-patient and out-patient services. 2. Off-set refers to when the provision of one type of service leads to a reduction in the use of other related services. 3. People who attend day centres will have reduced use of health services when compared to those who do not attend day centres or other informal community mental health services. 4. Interventions that aim to reduce social isolation and promote social interaction and recovery such as the café could impact on the health of the attendees and reduce hospital admission and the use of health care services

Appendix 8 Research information sheet, pages 1-4

Participant Information Sheet
Final Version 1.0: 28/07/17

FMHS REC Ethics Ref no: 113-1709

The title of Study: Place, people and processes: Ethnography of a community mental health café.

Name of Researcher(s): Josephine NwaAmaka Bardi (PhD Student), Professor Paul Crawford, Professor Stephen Timmons, Dr Nicola Wright

We would like to invite you to take part in our research study. Before you decide if you would like to participate in the research study, we would like you to understand why we want to carry out the research study and what it would involve for you. The PhD student will go through the information sheet with you and answer any questions that you may have. Please feel free to ask any question about anything that you do not understand about the research study, and feel free to discuss anything about the research study with other patrons, volunteers and trustees.

What is the purpose of the study?
This study wants to understand what happens at the Dragon Cafe and ask the patrons, trustees, and volunteers why they attend the Dragon Café.

Why have I been invited?
You are being invited to voluntarily participate in the research study because you have attended the Dragon Café for more than two months.

Do I have to take part?
You do not have to take part. However, if you do decide to take part, the PhD student will give you this information sheet to keep, and she will ask you to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. Therefore, it is not compulsory that you take part.

What will happen to me if I take part?
If you wish to take part, you will be asked to take part in a discussion with the PhD student. The discussion will be between one to two hours, and it will be audio recorded in a tape recorder so that the PhD student can listen to it after the discussion, type it and use it as part of the information for the research study. The discussion will take place in a quiet area within the Dragon Café, and you can ask a volunteer or trustee to sit with you during the discussion if you wish. The PhD student will ask you some questions about your experiences of attending the Dragon Café such as when you started attending and why you attend, who you attend with, what activities you participate in and why, and what the Dragon Café means to you.

Expenses and payments
You will not be paid to take part in the research study

What are the possible disadvantages and risks of taking part?

There are no expected risks in taking part in this study. However, sometimes, during the discussion people who participate in a research study sometimes speak about an experience that may upset them. Should this happen, the PhD student will stop the discussion, and you can decide if you would like to proceed with the discussion or not.

What are the possible benefits of taking part?
The information we get from you participating in this study will add to what we already know about informal community mental health services such as the Dragon Café. Therefore to gain an in-depth understanding of what the Dragon Café can offer society and people with mental health problems, it is necessary to ask you, other patrons, trustees and volunteers about their experiences of attending the Dragon Café. Importantly, such an investigation could provide valuable understanding into what the Dragon Café and similar informal community mental health services delivered to people with mental health problems contributes, and hopefully inform the development of these kinds of resources in future.

Will my taking part in the study be kept confidential?
Yes. The research team, authorised people from the University of Nottingham, the Economic and Social Research Council (ESRC) and the ethics committee members will follow the ethical and legal practice to ensure that all information about you will be handled with confidence in accordance with the Data Protection Act 1998. The PhD student will collect data as observations and discussions and interviews. Observations are when the PhD student observes what happens in the Dragon Café such as the space, the activities and how people interact and participate in the creative activities. The interviews will be a discussion between you and the PhD student about your experiences of attending the Dragon Café. All the information collected from the research study including the notes from observations and your discussion with the PhD student will be **strictly confidential.** Therefore, the PhD student will not disclose your name and the name of the Dragon Café, and nobody can identify you because the PhD student will allocate you an individual code which will be used to identify you or what you will say. The PhD student will ensure that all information that you provide for the research study is saved in a password protected computer with antivirus, backed-up on encrypted memory sticks and locked in a secure locker and locked office.

After the research study, we will also seek further consent from you to store the information that you will provide for at least seven years. This is optional, but it would be helpful if you can indicate that you agree to this on the consent form. All information collected for the research study will be secured for at least seven years at the University of Nottingham. Afterwards, if the information from the research study is needed for future research, they will be securely saved in a Central Repository for research data at the University of Nottingham and the ESRC, where only authorised persons can have access to them with strict confidence. If the information from the research study is no longer needed after seven years, the PhD student will dispose of them securely in accordance with the University of Nottingham and the ESRC Code of Conduct for research data.

Although what you say in the interview is confidential, should you disclose anything to the PhD student which might put you, the PhD student or others at risk, the PhD student will inform the gatekeepers at the Dragon Café and supervisors at the University of Nottingham. This action will be taken to protect you, the PhD student, and others.

What will happen if I don't want to carry on with the study?
Taking part in this study is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw, the information collected so far cannot be erased, and the PhD student may still use the information in the analysis of the research study.

What will happen to the results of the research study?

Results from this research study will be written up as an academic thesis for my PhD qualification. They will also be used in local and national publications including academic journals, and at social sciences events that are relevant for informing service development and improvements such as conferences, seminars, and workshops.

Who is organising and funding the research?
The Economic and Social Research Council (ESRC), is funding this research study as part of a PhD study at the University of Nottingham.

Who has reviewed the study?
An independent group called the Research Ethics Committee monitors all research conducted at the University of Nottingham, to protect your interests. This study has been reviewed and given a favourable opinion by the Faculty of Medicine & Health Sciences (FMHS) Research Ethics Committee.

What if there is a problem?
If you have a concern about any aspect of this study, you can ask to speak to the Chief Investigator nicola@wright.nottingham.ac.uk, and she will do her best to answer your questions. The full contact details of the research team have been provided at the end of this information sheet. If you still have concerns after contacting the Chief Investigator and the research team, and you wish to make a formal complaint, you can contact the:

FMHS Research Ethics Committee Administrator
c/o The University of Nottingham
School of Medicine Education Centre B Floor
Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH.

E-mail: louise.sabir@nottingham.ac.uk.

Contact details of the researcher and supervisors

Josephine NwaAmaka Bardi (PhD Student)
University of Nottingham
Room B22, Business School South
Jubilee Campus
NG8 1BB.
Email: josephine.bardi@nottingham.ac.uk

Supervisors

Chief Investigator
Professor Paul Crawford
Professor of Health Humanities, Faculty of Medicine & Health Sciences
Room 421 Derby Education Centre
Royal Derby Hospital
Uttoxeter Road
Derby
DE22 3DT
Email: paul.crawford@nottingham.ac.uk

Co-investigators

Professor Stephen Timmons
Nottingham University Business School
Jubilee Campus
Nottingham
NG8 1BB
Email: stephen.timmons@nottingham.ac.uk

Dr Nicola Wright
Assistant Professor in Mental Health
Faculty of Medicine
School of Health Sciences
University of Nottingham
Royal Derby Hospital, Uttoxeter Road
Derby
DE22 3NE
Email: nicola.wright@nottingham.ac.uk

Appendix 9 Participant consent form, pages 1-2

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

The University of Nottingham

Participant consent form
Version 1.0 28/07/17

Project title:	Place, people and processes: Ethnography of a community mental health café
REC ref:	113-1709
Researcher's name:	Josephine NwaAmaka Bardi
Supervisor's name:	Professor Paul Crawford, Professor Stephen Timmons, Dr Nicola Wright
Participant's name:	.....

Please write your initials in the boxes below

1. I confirm that I have read and understand the information sheet version number dated.....for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that the interview will be audio recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
4. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself ☐
5. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐
6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent (if different from Principal Investigator)	Date	Signature
Name of Principal Investigator	Date	Signature

3 copies: 1 for participant, 1 for the project notes, 1 for gatekeepers

Contact details of the researcher and supervisors

Josephine NwaAmaka Bardi (PhD Student)
University of Nottingham
Room B22, Business School South
Jubilee Campus
NG8 1BB.
Email: Josephine.bardi@nottingham.ac.uk

Professor Paul Crawford
Professor of Health Humanities, Faculty of Medicine & Health Sciences
Room 421 Derby Education Centre
Royal Derby Hospital
Uttoxeter Road
Derby
DE22 3DT
Email: paul.crawford@nottingham.ac.uk

Professor Stephen Timmons
Nottingham University Business School
Jubilee Campus
Nottingham
NG8 1BB
Email: Stephen.timmons@nottingham.ac.uk

Dr Nicola Wright
Assistant Professor in Mental Health
Faculty of Medicine
School of Health Sciences
University of Nottingham
Royal Derby Hospital
Uttoxeter Road
Derby DE22 3NE
Email: Nicola.wright@nottingham.ac.uk

Appendix 10 Ethical approval from the University of Nottingham

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

14 September 2017

Josephine NwaAmaka Bardi
PhD Student
c/o **Dr Nicola Wright**
Assistant Professor in Mental Health
School of Health Sciences/Institute of Mental Health
Room 414
Royal Derby Hospital
Uttoexter Road
Derby
DE22 3NE

Dear Josephine

Ethics Reference No: 113-1709 **– please always quote**	
Study Title: Place, people and processes: Ethnography of a community mental health café.	
Short Title: Ethnography of a community mental health café	
Chief Investigator/Supervisor: Dr Nicola Wright, Assistant Professor in Mental Health, School of Health Sciences/Institute of Mental Health, Derby Education Centre.	
Lead Investigators/student: Josephine NwaAmaka Bardi, Economic and Social Research Council (ESRC) PhD student, Mental Health and Wellbeing.	
Other Key Investigators: Professor Stephen Timmons, Professor of Healthcare Innovation, Business School, Faculty of Social Sciences, Professor Paul Crawford, Professor of Health Humanities, Director of the Centre for Social Futures at the Institute of Mental Health, Derby Education Centre.	
Type of Study: PhD Student project (Mental Health and Wellbeing), Qualitative/ethnography Overt observations/Interviews.	
Proposed Start Date: 1/10/2017	**Proposed End Date:** 31/07/2018 - 6-9 mths
No of Subjects: 20-30	**Age:** 18+years
School: Health Sciences	

Thank you for submitting the above application which has been considered by the Committee at its meeting on 11th September 2017 and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 28.07.2017

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion is given on the understanding that the conditions set out below are followed:

1. You should follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
2. You must notify the Chair of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 11 Administrative approval letter from the café gatekeepers, pages 1-3



Mental Fight Club

'Our Business is to Create'

11th March 2017

Dear Josephine,

Research at the Dragon Cafe

We are really pleased to hear about the progress of your PhD and we are very supportive of the research you wish to undertake.

Further to the meeting at the Dragon Café on the 7th March 2017 our consent as Mental Fight Club Trustees is provided currently: -

- to have access to the Dragon Café and attendees
- based on our understanding of your research aims and approach as described by you and stated below
- is subject to you continuing to collaborate with us on ensuring that the research aims, approaches and methodologies are appropriate to the needs of those within the space of the cafe and in line with the Dragon Cafe ethos.
- And much like that of our patrons, can be withdrawn at any time

The detail that you have provided to us is: -

1. The proposed research topic is:

Place, People and Processes: ethnography of a community mental health cafe

Mental Fight Club

PO Box 73587

LONDON

SE1P 5YJ

Registered Charity: 1158926

2. Supervisors are:

Dr Nicola Wright

Professor Stephen Timmons

Professor Paul Crawford

3. Methodology: Qualitative research

4. Data collection: Observations, field notes and interviews with participants and key informants (Trustees, boards of directors and volunteers).

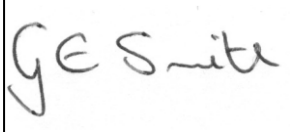
5. Duration of fieldwork: 6 months-1year

6. Number of participants: 20-30

7. Ethical considerations: Informed consent and confidentiality

We are delighted and pleased that you are undertaking this research at the Dragon Café and any findings (anonymous if required) should be shared with the Mental Fight Club Trustees as part of the research project.

Please contact me if you have any queries.



Grace Smith and Lamis Bayar

Trustees

Mental Fight Club

PO Box 73587

LONDON

SE1P 5YJ

Registered Charity: 1158926



Mental Fight Club

'Our Business is to Create'

6th November 2018

Dear Josephine,

Naming The Dragon Café in Your Research

We are very pleased with the work you have undertaken in The Dragon Café to date. In particular, we are very grateful for the dedication you have shown to the embeddedness process, for your sensitivity to context, and for your spirit of methodological collaboration in working with us to build on approaches developed under Mental Fight Club's Research, Learning and Evaluation project strand. The presentation you gave at The Dragon Café being so well received is a reflection of all the hard work you have put in.

As we covered in our Research Meetings, the following process applies to naming the Dragon Café and all other MFC Projects in research outputs, be they academic, clinical or artistic:

1. MFC Projects can be named in communications with your supervisors – be they private email communications, supervision meetings, or presentations.

2. MFC Projects can be named in drafts submitted to your supervisors;

3. MFC requires sight of a pre-final draft.

4. Upon consideration of the pre-final draft, MFC will map the gamut of possible impacts naming or anonymisation will be likely to have on its patrons both individually and collectively. Based upon which, MFC will take one of three possible courses of actions:

- Sign off the draft for final submission with MFC Projects named e.g. The Dragon Cafe

- Propose any such edits as necessary to mediate impact on its patrons; both individually and collectively without having to anonymise MFC Projects;

- Ask for MFC Projects to be anonymised.

5. MFC requires a copy of the final research document to be submitted to MFC.

Appendix 12 General data protection regulations, pages 1-3

General University of Nottingham privacy information for data subjects

How the University of Nottingham processes your personal data

The University of Nottingham, University Park, Nottingham, NG7 2RD (0115 951 5151), is committed to protecting your personal data and informing you of your rights in relation to that data.

The University of Nottingham is registered as a Data Controller under the Data Protection act 1998 (registration No. Z5654762).

One of our responsibilities as a data controller is to be transparent in our processing of your personal data and to tell you about the different ways in which we collect and use your personal data. The University will process your personal data in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 and this privacy notice is issued in accordance with the GDPR Articles 13 and 14.

We may update our Privacy Notices at any time. The current version of all of our Privacy Notices can be found below, and we encourage you to check back here regularly to review any changes.

The Data Protection Officer

The University has appointed a Data Protection Officer. Their postal address is:

Data Protection Officer,
Legal services
A5, Trent Building,
University of Nottingham,
University Park,
Nottingham
Ng7 2RD

They can be emailed at dpo@nottingham.ac.uk.

Your personal data and its processing

We define personal data as information relating to a live, identifiable individual. It can also include "special categories of data", which is information about your racial or ethic origin, religious or other beliefs, physical or mental health, the processing of which is subject to strict requirements. Similarly information about criminal convictions and offences is also subject to strict requirements. "Processing" means any operation which we carry out using your personal data, for example obtaining, storing, transferring or deleting.

We only process data for specified purposes and if it is justified in accordance with data protection law. Details of each processing purpose and its legal basis is given in each privacy notice listed below - please consult the one more relevant to your relationship to the University.

How long we keep your data for

Unless specific time periods are given in the relevant Privacy Notice, your data will be kept in line with the University's Records Retention Schedule.

To determine the appropriate retention period for personal data, we consider the amount, nature and sensitivity of the personal data, the potential risk of harm from unauthorised use or disclosure of your personal data, the purposes for which we process your personal data and whether we can achieve those purposes through other means, and the applicable legal requirements.

If you need more detailed advice on how long your data will be kept for, please contact the data protection team.

Your rights as a data subject

You have the following rights in relation to your personal data processed by us:

Right to be informed
The University will ensure you have sufficient information to ensure that you're happy about how and why we're handling your personal data, and that you know how to enforce your rights.

The University provides information in the form of privacy notices. Our Privacy Notices pages can be found at https://www.nottingham.ac.uk/utilities/privacy/privacy.aspx.

Right of access / right to data portability
You have a right to see all the information the University holds about you. Where data is held electronically in a structured form, such as in a database, you have a right to receive that data in a common electronic format that allows you to supply that data to a third party - this is called "data portability".

To make a request for your own information please see the link here: https://www.nottingham.ac.uk/governance/records-and-information-management/data-protection/data-protection.aspx

To receive your information in a portable form, send an email your request to data-protection@nottingham.ac.uk

Right of rectification
If we're holding data about you that is incorrect, you have the right to have it corrected.

Please email any related request to data-protection@nottingham.ac.uk.

Right to erasure
You can ask that we delete your data and where this is appropriate we will take reasonable steps to do so.

Please email any related request to data-protection@nottingham.ac.uk.

Right to restrict processing
If you think there's a problem with the accuracy of the data we hold about you, or we're using data about you unlawfully, you can request that any current processing is suspended until a resolution is agreed.

Please email any related request to data-protection@nottingham.ac.uk.

Right to object
You have a right to opt out of direct marketing.

You have a right to object to how we use your data if we do so on the basis of "legitimate interests" or "in the performance of a task in the public interest" or "exercise of official authority" (a privacy notice will clearly state to you if this is the case). Unless we can show a compelling case why our use of data is justified, we have to stop using your data in the way that you've objected to.

For direct marketing, there will be an opt-out provided at the point of receipt. To object to how we use your data, email your request to data-protection@nottingham.ac.uk.

Rights related to automated decision making including profiling
We may use a computer program, system or neural network to make decisions about you (for example, everyone that is on a particular course gets sent a particular letter) or to profile you. You have the right to ask for a human being to intervene on your behalf or to check a decision.

Please email any related request to data-protection@nottingham.ac.uk.

Withdrawing consent

If we are relying on your consent to process your data, you may withdraw your consent at any time.

Exercising your rights, queries and complaints

For more information on your rights, if you wish to exercise any right, for any queries you may have or if you wish to make a complaint, please contact our Data Protection Officer.

Complaint to the Information Commissioner

You have a right to complain to the Information Commissioner's Office (ICO) about the way in which we process your personal data. You can make a complaint on the ICO's website.

Privacy notices

Please consult the privacy notice that best fits your relationship with the University.

Appendix 13 Summarised general data protection regulation given to participants



E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

General Data Protection Regulation
Use of Personal data in Research Projects

University of Nottingham
UK | CHINA | MALAYSIA

Research participant privacy notice

Title of Research: Place, people and workshops at the Dragon Cafe

Name of Patron: Josephine NwaAmaka Bardi

Why Josephine asked for your details

Josephine asked for your details when you signed the consent form to take part in a discussion with her. This is because of the terms of the University's Royal Charter in the University of Nottingham's capacity as a teaching and research body to advance education and learning. The main reason Josephine asked for your details is because she wants to have a discussion with you about your experiences of attending the Dragon Café.

Legal basis for processing your personal data under GDPR

The legal basis for processing your personal data on this occasion is in Article 6(1a) consent of the data subject OR Article 6(1e) processing is necessary for the performance of a task carried out in the public interest OR Article 6 (1b) processing is necessary for the performance of a contract OR Article 6 (1f) processing is necessary for the purposes of the legitimate interests pursued by Josephine.

How long we keep your data

Josephine may store the information that she collects at the University of Nottingham for up to 25 years and for a period of no less than 7 years after the research project finishes. Josephine may also store the data indefinitely and reuse it in future research. To safeguard your stored data Josephine will back up all data files in encrypted memory sticks, lock audio recorded discussions and handwritten field notes securely in cabinets and save transcripts of discussions that you had with her in password protected computer with virus protection to avoid corruption of the data. Josephine will use numbers instead of your name in everything that she will write about your discussions with her so that nobody can identify you or what you said during the discussions.

For information about the University's obligations with respect to your data, who you can get in touch with and your rights as a data subject, please visit:
https://www.nottingham.ac.uk/utilities/privacy.aspx

FMHS REC Ethics Ref no: 113-1709

Appendix 14 Demographics of participants who signed the consent forms, pages 1-2

Singed consent forms	Gender	Date of signing the consent form	Duration of interview	Suedonyms First Names	Suedonyms Last Names	Years of attending the café	Age group	Post Code
1	M	05-Mar-18	IC - Retrospective	Salifu	Khalid	Not known	0	0
2	F	28-May-18	20.28	Tianna	Chafin	Not known	60-70	SE15
3	M	05-Mar-18	IC - Retrospective	Segun	Olori	Not known	0	0
4	M	21-May-18	12.42	Mitch	Kevin	3yrs	20-25	W4
5	M	03-May-18	43.16	Dewitt	Hellman	6yrs	60-70	E8
6	F	05-Mar-18	25.12	Anthony	Shemwell	3yrs	40-50	0
7	F	30-Apr-18	21.38	Victoria	Avitia	4mths	40-50	SE6
8	F	02-Jul-18	19.11	Hoyt	Cassese	6yrs	50-60	SM6
9	F	17-May-18	19.31	Shade	Ishaga	8yrs	60-70	SE1
10	F	12-Mar-18	IC - Retrospective	Kate	Snowman	Not known	0	SE1
11	M	12-Mar-18	IC - Retrospective	Alex	Elderson	Not known	0	0
12	M	30-Apr-18	25.23	Teri	Conte	4yrs	40-50	SE4
13	M	21-May-18	9.22	Arnold	Deford	3yrs	30-40	SE16
14	M	11-Jun-18	24.34	Gaye	Almond	6yrs	40-50	SE14
15	M	19-Mar-18	IC - Retrospective	Usman	Malik	Not known	20-30	0
16	F	26-Mar-18	IC - Retrospective	Simisola	Olusegun	Not known	20-30	0
17	M	28-Mar-18	Handwritten	Don	Sheild	Not known	0	E8
18	F	18-Jun-18	13.28	Jasmine	Dalisay	3yrs	60-70	SW1
19	F	02-Jul-18	28.05	Fredie	Mathias	1yr	0	0

45	M	18-Jun-18	IC - Retrospective	Lewis	Green	Not known	40-50	0
46	F	02-Jul-18	31.58	**Paulette**	**Genova**	2yrs	50-60	SW15
47	F	02-Jul-18	15.27	**Rosen**	**Huff**	3yrs	40-50	SE14
48	F	16-Jul-18	17.43	**Esther**	**Peewill**	Not known	30-40	0
49	F	09-Jul-18	18.19	**Catarina**	**Kenley**	1yr	60-70	SE5
50	F	09-Jul-18	22.24	**Sharonda**	**Johnson**	Not known	60-70	0
51	F	03-Sep-18	IC - Retrospective	Fiona	Harris	3yrs	50-60	SW9
52	F	03-Sep-18	IC - Retrospective	Fadiya	Begum	2yrs	70-80	E11
53	F	03-Sep-18	IC - Retrospective	Elizabeth	Clarke	18mths	60-70	BR5
54	F	03-Sep-18	IC - Retrospective	Camilla	Martins	Not known	0	0
55	M	06-Sep-18	Handwritten	**Mohammed**	**Amir**	Not known	40-50	0
56	F	26-Sep-18	IC - Retrospective	Sherry	Sinclair	Not known	20-30	0
57	F	01-Oct-18	Handwritten	**Mitchell**	**Francis**	Not known	60-70	0
58	F	09-Oct-18	IC - Retrospective	Barbara	Walker	Not known	30-40	0
59	F	01-Oct-18	IC - Retrospective	Abigail	Evans	Not known	50-60	SW4
60	F	01-Oct-18	Handwritten	**Celesta**	**Godfrey**	Not known	50-60	0
61	F	01-Oct-18	IC - Retrospective	Alison	Robinson	Not known	20-30	0
62	F	22-Nov-18	IC - Retrospective	Ashley	Thomas	Not known	30-40	0

Blue, participants who took part in the interviews, M = Male, F = Female, IC informal conversations with consent sought before data were used.

Appendix 15 License to Use' archived photographs approval letter, Pages 1-3

DEFINITIONS For the purpose of this agreement 'the Client' refers to the individial(s) or organisation wishing to purchase use of photographs taken at a Dragon Café or Mental Fight Club event. 'The Photographer' refers to Liz Gorman. "Photographs" means all photographic material furnished by the Photographer, whether transparencies, negatives, prints or any other type of physical or electronic material. "Mental Fight Club" refers to the charity Mental Fight club (Registered charity number: 1158926) for whom the Photographs are created. "The Dragon Café" refers to Mental Fight Club's project where the Photographs are created.

RIGHTS All Images and rights relating to them, including copyright and ownership rights in the media in which the Photographs are stored, remain the sole and exclusive property of the Photographer. This license provides the Client with the limited right to reproduce, publicly display, and distribute the Photographs only for the agreed upon terms as set forth in the Client Invoice and Licence To Use and signed by both parties. Photographs used for any purpose not directly related outside of those terms, must be with the express permission of the Photographer and may include the payment of additional fees, unless otherwise agreed to in writing.

USE The Licence to Use comes into effect from the date of payment of the relevant invoice(s). No use may be made of the Photographs before payment in full of the relevant invoice(s) without the Photographer's express permission. Any permission which may be given for prior use will automatically be revoked if full payment is not made by the due date. The Licence only applies to the Client and intended use as stated on the front of the form and its benefit shall not be assigned to any third party without the Photographer's permission. The Photographer's permission must be obtained before any use of the Photographs for other purposes e.g. use in relation to another project or sublicensing through a photolibrary. Permission to use the Photographs for purposes outside the terms of the Licence will normally be granted upon payment of a further fee, which must be mutually agreed (and paid in full) before such further use. Unless otherwise agreed in writing, all further Licences in respect of the Photographs will be subject to these terms and conditions.

EXCLUSIVITY ***The Photographer has created these images for Mental Fight Club and The Dragon Café to use as they wish; therefore the Client is not for any period of time entitled any exclusive use of the Photographs.*** The Photographer retains the right in all cases to use the Photographs in any manner at any time and in any part of the world for the purposes of advertising or otherwise promoting his/her work.

RELATIONSHIP OF THE PARTIES The parties agree that Photographer is an independent contractor, and that neither the Photographer, nor Photographer's employees or contract personnel are, or shall be deemed to be, employees of Client. No agency, partnership, joint venture, or employee-employer relationship is intended or created by this Agreement. Neither party is authorized to act as agent or bind the other party except as expressly stated in this Agreement. The Photographer and the Photographs or any other deliverables prepared by the Photographer shall not be deemed a work for hire as defined under Copyright Law. All rights granted to Client are contractual in nature and are expressly defined by this Agreement.

CREATION The manner and method of creating any Photograph is solely at the discretion of the Photographer and the Client has no right to control the Photographer's manner and method of

performance under this Agreement. The Photographer will use his/her best efforts to: (a) ensure that the Photographs conform to Client's specifications; and (b) submit all Photographs to Client in publishable quality, on or before the applicable deadlines.

DELIVERY Artist may select delivery of photographs in JPEG, TIFF, PNG, or other standard format, at a resolution that Artist determines will be suitable for the Photographs as licensed. It is the Client's responsibility to verify that the Photographs are suitable for reproduction and that if the Photographs are not deemed suitable, to notify the Photographer within fourteen (14) business days. Artist's sole obligation will be to replace the Photographs at a suitable resolution but in no event will the Photographer be liable for poor reproduction quality, delays, or consequential damages. Unless otherwise specifically provided, the Photographer is not responsible to provide images 1) Photographs larger than A3 or equivalent size or 2) in a format higher than 8-bit or in RAW format. The Photographer has no obligation to retain or archive any Photographs delivered to Client.

ALTERATION In the event that the Client wishes to make changes to the Photograph(s) provided by the Photographer, certain alterations are permitted. Cropping the Photograph(s) is permitted when the Photograph is used as part of a social media profile (e.g. Twitter or Facebook Banner) or printed pamphlet. Manipulation of the Photograph(s) using digital manipulation software such as Adobe Photoshop, GIMP or similar programmes is not permitted. Any alterations to the Photograph(s) require written permission from the Photographer.

FEES All fees and expenses payable under this agreement are required no later than fourteen (14) business days from the delivery of the Photographs and payable irrespective of whether Client makes actual use of the Photographs. If full payment has not been received within thirty (30) days all rights are revoked at Photographer's discretion. In the event rights are revoked, all images in the possession of the Client will be removed from all forms of media and permanently destroyed within ten (10) days. The Client shall provide the Photographer with written statement that all images have been removed and destroyed.

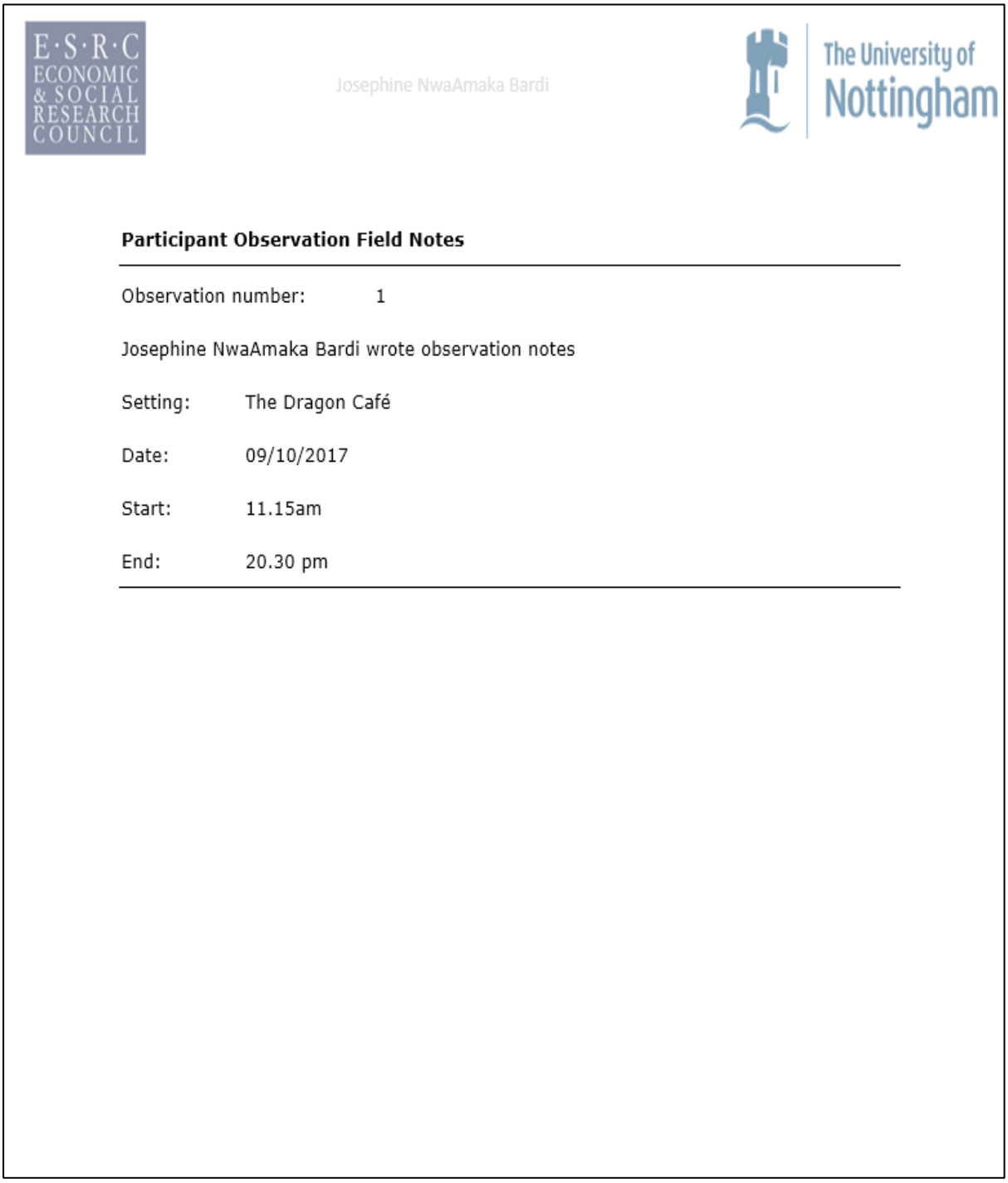
REJECTION Unless a rejection fee has been agreed in advance, there is no right to reject on the basis of style or composition.

CREDIT The Photographer's name will be printed on or in reasonable proximity to all published reproductions of the Photograph(s).

APPLICABLE LAW This agreement shall be governed by the laws of England & Wales

VARIATION These Terms and Conditions shall not be varied except by agreement in writing

Appendix 16 Observation data collection sheet



E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Josephine NwaAmaka Bardi

The University of Nottingham

Participant Observation Field Notes

Observation number: 1

Josephine NwaAmaka Bardi wrote observation notes

Setting: The Dragon Café

Date: 09/10/2017

Start: 11.15am

End: 20.30 pm

Appendix 17 List of questions gathered during the fieldwork, pages 1-4

1. What is a mental health café?
2. Who is a patron and what does patron mean?
3. What defines a gatekeeper?
4. How many levels of gatekeepers are there for gaining access to a research setting and participants in a mental health café?
5. How does a temporary space influence people's views a mental health café?
6. Why do people participate in the activities at a mental health café?
7. What is the significance of the temporary café space on people's views of their sustained access?
8. What makes people behave in such a polite manner in a mental health café?
9. Would people attend a mental health café if they had to pay to access the space and participate in the activities?
10. Are there any differences between the activities in a mental health café and the activities in other informal mental health services?
11. What motivates people to volunteer with a mental health café?
12. Why do people attend a mental health café?
13. What is the significance of a membership card to access a mental health café?
14. What are the barriers and facilitators to participating in the activities provided in a a mental health café?
15. How does a researcher's choice of language change the answers that participants give to questions?
16. How does the issue of space impact on the relationship between the volunteers and patrons?
17. Does space matter in a pop-up space?
18. What are people's views about the noise levels in Space Two?
19. Can anyone learn ability? If so, why do we assume that some people are not capable?
20. Disability or This, ability?
21. What does mixing to people mean to the people who attend a mental health café?
22. What do patrons think about the temporary pop-up massage space?
23. Why do people arrive and queue outside the Dragon Café entrance for half an hour before opening in this cold?
24. Is noise a significant influence on the timing of workshops? How does noise levels affect workshops?
25. *What workshop do patron view as linked with focus?*
26. What does being judged mean to patrons at the Dragon Café?
27. How do the Dragon Café trustees implement their long-term plans while supporting the short-term plans of the Dragon, Café manager?

28. What is the Dragon Café volunteer's views and opinions of the 'borrowed installation', 'staged' and the 'make-believe' idea of the Dragon Café space and workshops?
29. What is the significance of a word in promoting communication in a research setting?
30. How does the word 'problem' shift the focus of a research conversation when used in place of experience?
31. What meaning do patrons attach to the temporary nature of the Dragon Café events?
32. What does the idea of a pop-up, one day a week café mean to patrons?
33. How does patrons' participation in creative workshops shape the social space and workshop that take place in The Dragon Café?
34. What is the reason for counting the number of people who visit/attend The Dragon Café?
35. Can people socially interact in The Dragon Café if they cannot speak English?
36. Is language a barrier for to social interaction in a mental health café?
37. Why the last room is called a Quiet Zone?
38. How does forced participation influence people's decision to attend a mental health café?
39. How do you know when to end a conversation with a patron at the Dragon Café?
40. Why do people recommend a mental health café to their friends?
41. Why do university students volunteer at the Dragon Café?
42. What is the significance of space for coordinating workshops in a mental health café?
43. At what point does a researcher go native?
44. Why is it important to record the existing patron's attendance?
45. What does participating in activities outside the café mean to those who attend a mental health café?
46. Why are there more female volunteers on the reception duty?
47. What does it mean to 'chill out' in the Dragon Café?
48. What is the difference between individual and group workshops in a mental health café?
49. How does the idea of a temporary set up impact on a researcher view of the sustainability of their research setting?
50. What meaning do the volunteers with learning disabilities attach to the volunteering their role at the cafe café?
51. What meaning do university students attach to their experiences of the café?
52. Why do universities recommend the café to medical students?
53. What meaning do people attach to a café that is located in a church?
54. What does it mean to have a cafe membership card?
55. What meaning do volunteers attach to their experience of the cafe?
56. What are the views and opinions of patrons about the government opening more spaces like the café?

57. How might the government impact on a space like a mental health café for?
58. Why do people travel from outside the UK to visit a mental health café for?
59. What does recovery mean to the people who attend a mental health café for?
60. What are the similarities or differences in the definition of recovery between the gatekeepers and the people who attend the café?
61. What meaning do gatekeepers attach to their association with a mental health café?
62. Does social connection happen regardless of the weather?
63. What makes the people who wait outside a mental health café on rainy and cold days?
64. Why do people wait outside a mental health café for more than 30 minutes before opening time?
65. How did people hear about the mental health café?
66. What significance do participants attach to the word 'Dragon' in the name of a mental health café?
67. Why do people continue to attend a mental health café?
68. What does it mean to connect with other people in a mental health café?
69. What do participants think about the word 'diagnosis' in the context of a mental health café?
70. What do people mean why they say they come to a mental health café to be themselves?
71. Can a mental health café survive without volunteers?
72. How do structures outside a mental health café influence people's agency and choices?
73. What does belonging mean in a mental health café?
74. What do the people who attend a mental health café mean when they say, 'being a part of something'?
75. Why does mean to the people who attend a mental health café?
76. How far do people have to travel to attend a mental health café?
77. Would people wait outside in a cold, rainy and freezing weather if there was an alternative mental health café in the same area?
78. What meaning do people who attend a mental health café attach to their participation?
79. Do people have a choice whether to attend a mental health café or not?
80. How do family members and friends view the people who attend a mental health café?
81. What meaning do people who attend a mental health café attach to their relationships with each other outside the café?
82. In ethnography, is the intention to befriend participants for the sole purpose of recruiting them for informal conversations or interview, overt or covert? Or is the sole of purpose of immersion in the field overtly covert because of the intentions behind most actions towards building relationships with participants to recruit them?
83. Is it possible to be lonely in a mental health café with lots of people and activities?

84. Who do some people choose not to participate in any workshop provided by a mental health café?
85. Why do some patrons choose to sit alone without participating in the workshops at the Dragon Café? In other words, what does sitting alone in the mix of people mean?
86. Why do some patrons choose to sit on the same table and space?
87. What does space entitlement mean to the people who visit a mental health café?
88. What meaning do the people who take part in the Art workshop attach to their artworks?
89. What does commonality mean in a mental health café?
90. What workshops do people who visit a mental health café participate in, and why?
91. Would people attend a mental health café if it was open every day of the week?
92. What does participation mean to the people who attend a mental health café?
93. Activity coordinator or the workshop? Which influences people's attendance?
94. How do the people who attend a mental health café define 'barrier' to their attendance of other services?
95. Is observation possible when the researcher is too tired to write fieldnotes?
96. Can the trustee ever satisfy the needs of the people who visit a mental health café?
97. What role do people attach to my presence in a mental health café?

Appendix 18 Interview guide titled 'Discussion Information Sheet'

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

The University of Nottingham

Discussion Information Sheet

Title of Research: Place, people and processes at The Dragon Café

Name of Patron: Josephine NwaAmaka Bardi

Thank you for volunteering to take part in discussions with Josephine.

- ✓ You have been invited today because you signed a consent form to take part in discussions with Josephine about your experiences of attending the Dragon Café.
- ✓ Your participation is voluntary, and you are free to withdraw from the discussion at any time, without giving any reason.
- ✓ Josephine will audio record your answers, but all your answers will be anonymous in any reports written from the study.
- ✓ Everything that you tell Josephine will be anonymous and confidential except for information revealed during the interview which may be of potential risk to yourself or anyone else.

Interview questions

1. How did you hear about the Dragon Café?
2. How would you describe your experience of the Dragon Café?
3. What is it about the Dragon Cafe that makes you attend every week?
4. Tell me about your experiences of the activities.
5. What does that activity mean to you?
6. Is there anything you would like to say or add that we haven't discussed?

Josephine may invite you to take part in future discussions about your experiences of the Dragon Café. Please tick one of the boxes below to show your answer.

Yes ☐ **No** ☐

Appendix 19 Transcriber and proofreader non-disclosure agreements, pages 1-2

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

University of Nottingham
UK | CHINA | MALAYSIA

SCHOOL OF MEDICINE
UNIVERSITY OF NOTTINGHAM

CONFIDENTIALITY ACCEPTANCE FOR PROOFREADERS

- I understand that the material I am transcribing is confidential.
- I undertake to store the data securely on a password protected computer and to delete the file of each interview/focus group once I have received confirmation from a member of the research team that they have received and stored the transcript.
- I will store discs and other media containing interviews and other data in a locked cabinet pending return to the research team.
- I understand that I should remove all references to individual names and places from the research transcripts. These will generally be referred to by initials or more general descriptions only. Where possible I shall use the codes assigned by the researchers to designate respondents.
- I undertake to maintain the confidentiality of persons and information revealed in the interview recordings and transcripts and will not divulge any details of these to anyone other than members of the research team.

Signed: JBird Date: 10th August 2018.

Name: JANINE CEENEY-BIRD.

Address: LEARNING SUPPORT CENTRE,
PHOENIX YARD, JUBILEE BUILDING,
5, UPPER BROWN STREET,
LEICESTER LE1 5TE.

Confidentiality Acceptance for Transcribers Form version 1.0 2018

SCHOOL OF MEDICINE
UNIVERSITY OF NOTTINGHAM

CONFIDENTIALITY ACCEPTANCE
FOR PROOFREADERS

- I understand that the material I am proofreading is highly confidential due to the protected characteristics of the participants involved in the research activity.
- I undertake to store the data securely on a password protected computer and to delete the file of each data sent to me once I have received confirmation from a member of the research team that they have received and stored the proofread data.
- I undertake to maintain the confidentiality of persons and information contained in the thesis document and will not divulge any details of these to anyone other than members of the research team that shared the document with me.

Signed: D R Booker Date: 14-9-20

Name: DAVID RUSSELL BOOKER

Address: 67, MIDLAND ROAD
THRAPSTON, KETTERING,
NORTHANTS NN14 4JS

Appendix 20 Data management plan, p1-3

The type of data	Qualitative
Method of data collection	Observation and interviews
How to keep copies of data	Back up all data files in encrypted memory sticks for collecting data and make copies of fieldnotes and interview transcripts
How to back up and store data to ensure confidentiality	Lock audio recorded interviews and handwritten fieldnotes securely in cabinets. Save transcripts in password protected computer with virus protection to avoid corruption of the data.
Who can gain access to the data?	Researcher, supervisors, internal assessor and examiners
File type and format	Microsoft Word
Software programme used to process data	None. Data were analysed manually
How data are processed and documented	Microsoft Word
Who owns the rights and intellectual property of the data	• The University of Nottingham • Economic and Social Research Council • The Researcher
What will happen to the data after the research?	• Publications in research journals, presented at conferences and seminars, sharing information with participants and secure archive storage. • In compliance and accordance with the University of Nottingham Code of Research Conduct and Research Ethics, the ESRC or the Principal Investigator (PI) will maintain and retain all data from the PhD study for seven years or longer if necessary. In the absence of the PI, a named person within will be nominated to take responsibility. • All data will be anonymised, meta-encrypted with codes and archived securely at the University of Nottingham secure archives facilities.

1. What data will be produced?

What physical data will you study? (e.g. artefacts, samples, paper archives, etc.) And what digital data will be 'captioned'/derived from these? (field-notes, images, measurements, spreadsheets, survey data, etc.)

What data will be 'created' digitally? (images, some analytical and survey data, etc.) Describe the methods/standards for data creation

What file formats and software will you use?

Consider how many individual files you expect to make, anticipated file sizes, and total storage volume

2. How will the data be documented and described?

Think about what contextual information is required to make the data understandable to others: Will any standards be used to record the data?

What information on the data collection methods, standards, and context ('metadata') will be recorded for each data type/set?

Where will the metadata for each data type/set be located? (e.g. within the data file and/or as separate metadata text document, and/or in method chapter/appendices in the thesis)

Is it important for the research to be reproducible? If not, why? If so, what additional documentation or pointers will be required?

3. How will your data be structured and stored?

Has a file naming convention and directory structure been agreed? (e.g. date created/date amended/version no.)

If data is to be entered into a shared database, has a database submission protocol been agreed? Is the storage platform local or external?

4. What are the plans for data sharing and access after submission of the thesis?

Who, if any, are the anticipated future users of any digital data/resources from the research?

Will any of the digital data supporting the thesis be made available to others on request or open access (website or repository)?

5. Are there any 'special' requirements for your data?

Are there conditions on who may view your data (e.g. confidentiality)?

Are there funding body/institutional requirements for the re-use of, or open-access to, the data? What are your supervisor's thoughts on sharing 'their' research data, if on a project team?

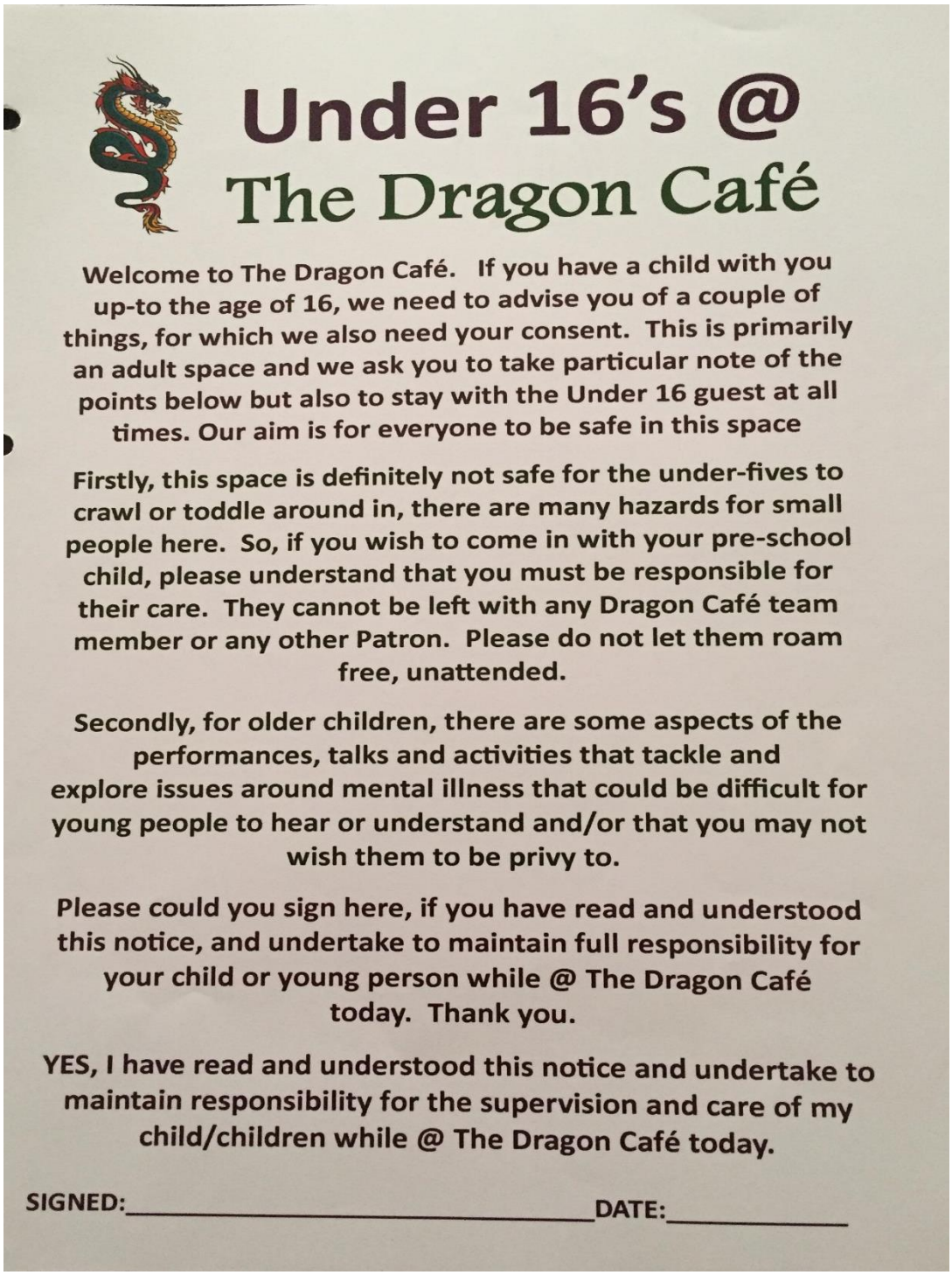
6. What are the plans for the long-term archiving of data supporting your research?

Will the digital data be archived? If you or your research group leave the University, will you still be able to access your work?

What options are there to archive the digital data? (e.g. institutional: Edinburgh DataShare (http://datashare.is.ed.ac.uk/); disciplinary repository or other repository.

Adapted from University of Cambridge (http://www.lib.cam.ac.uk/preservation/datatrain/documents.html)

Appendix 21 Under 16's agreement for adults with children



Under 16's @ The Dragon Café

Welcome to The Dragon Café. If you have a child with you up-to the age of 16, we need to advise you of a couple of things, for which we also need your consent. This is primarily an adult space and we ask you to take particular note of the points below but also to stay with the Under 16 guest at all times. Our aim is for everyone to be safe in this space

Firstly, this space is definitely not safe for the under-fives to crawl or toddle around in, there are many hazards for small people here. So, if you wish to come in with your pre-school child, please understand that you must be responsible for their care. They cannot be left with any Dragon Café team member or any other Patron. Please do not let them roam free, unattended.

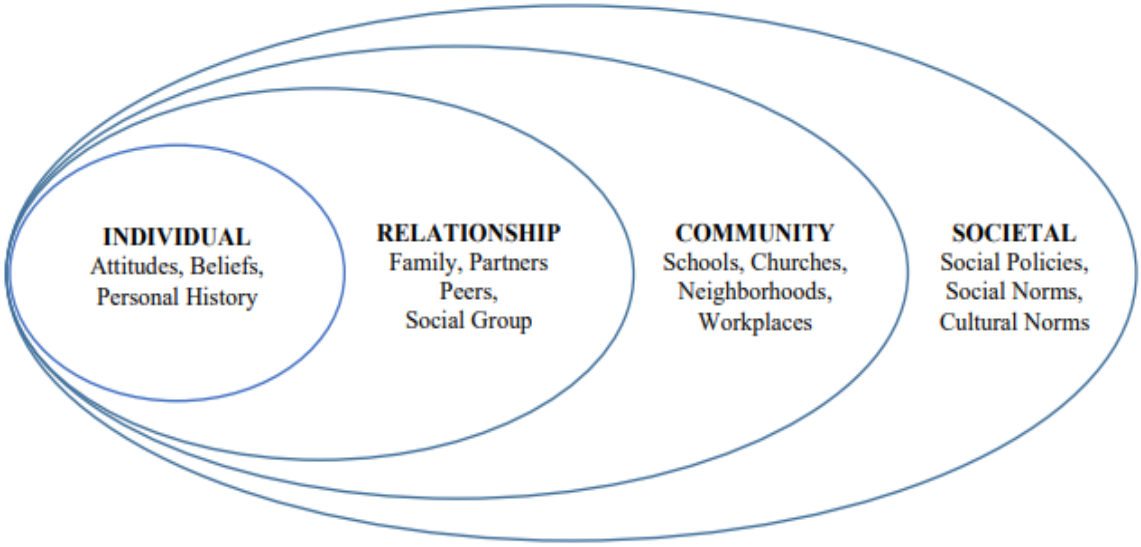
Secondly, for older children, there are some aspects of the performances, talks and activities that tackle and explore issues around mental illness that could be difficult for young people to hear or understand and/or that you may not wish them to be privy to.

Please could you sign here, if you have read and understood this notice, and undertake to maintain full responsibility for your child or young person while @ The Dragon Café today. Thank you.

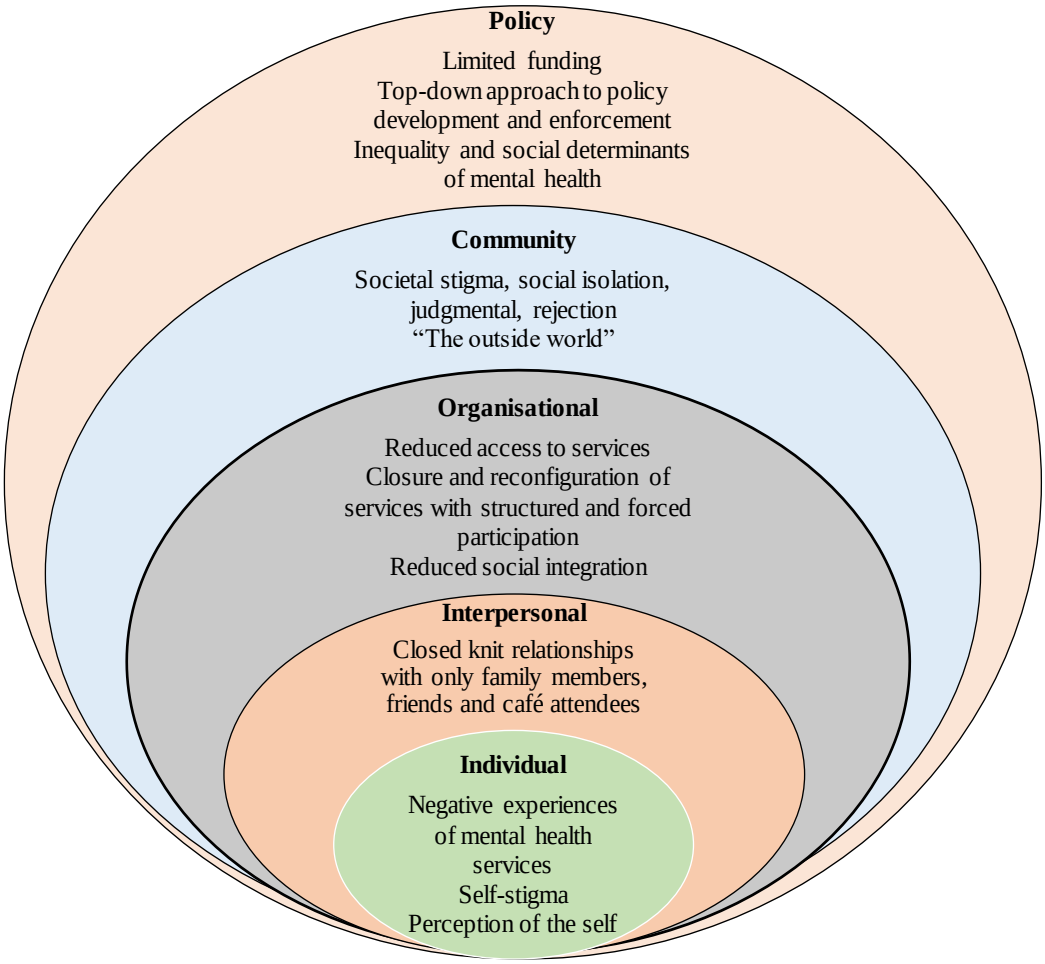
YES, I have read and understood this notice and undertake to maintain responsibility for the supervision and care of my child/children while @ The Dragon Café today.

SIGNED:_____DATE:_____

Appendix 22 The Socio-ecological model (Bronfenbrenner, 1977)



Socio-ecological model adapted from the findings of this study



Appendix 23 List of some existing mental health cafés not empirically researched

1.	The Dragon Café	2.	Memory Café
3.	Recovery Cafés	4.	Selby Community Cafés
5.	The Pod Café	6.	Active Mid Café
7.	Safe Haven Café	8.	Ed's Café
9.	Frazzled Café Wax	10.	Conversation Cafés
11.	Serenity Café	12.	The Bridge Café
13.	Safe Room Café	14.	Café Haven
15.	The Happy Cafés	16.	Alzheimer Cafés
17.	Crisis Cafés	18.	Good mental health café
19.	Frazzled Café	20.	Littlemore Restore Café and Shop
21.	Pop-up happy cafés	22.	Restore Garden Café
23.	Head Room Cafés	24.	Star Café
25.	Drop in Cafés	26.	Bridge Café
27.	The Solace Café	28.	Al's Café
29.	Social Café	30.	Cocktails/Cake before Therapy Café
31.	Sparky's Café	32.	The Worry Tree Café
33.	Manchester Mind Café	34.	Hammerton Community Café
35.	Well-bean Café	36.	Mood Café
37.	Rosie's Café	38.	Dementia Cafés
39.	Community Drop-in Cafés	40.	Mental Health Night Café
41.	Community Companion Café	42.	Sam's Café
43.	Wellbeing Café	44.	Calming Café
45.	Selby Community Cafés	46.	The Old School Café
47.	Tamar FOLK Community Café	48.	Create Café
49.	Rainbow Heron Late Night Art Café	50.	Chatty Café
51.	Hope café	52.	Tamar FOLK Community Café
53.	Springboard Café	54.	The Veterans Community Café
55.	Social Café	56.	The Liverpool Light Café
57.	The Oasis Café	58.	Stir Café
59.	Renew Wellbeing Cafés		

Appendix 24 List of conferences attended, p.1-2

Oral Presentations 2016-2019 SPACE: Ethnography of The Dragon Café.

- Allied Health Promotional Conference, University of Nottingham.
- The Dragon Café, London
- Ethnography Symposium, Copenhagen Business School, Denmark.
- European Commission Knowledge Exchange seminar. London School of Economics and Political Science (LSE), London.

Floorboards, Whitewalls and Butterflies: Autoethnography of The Dragon Café

- International Qualitative Research Methods Conference, Halifax, Canada.
- The Dragon Café. The Dragon Café, London, SE1 1JA.
- Ethnography Symposium, Copenhagen Business School, Denmark.
- 7th International Health Humanities Conference, University of Southampton.
- PhD and Early Career Academics Conference. Business School, University of Nottingham.
- Recovery Research Network, London. The St Georges University of London.
- Economic and Social Research Council (ESRC) Pecha Kucha

Habitus, Field and Social Capital: Visual Ethnography of The Dragon Café

- 7th International Health Humanities Conference, University of Southampton.
- Economic and Social Research Council (ESRC) presentation, University of Nottingham

Scoping review of coffee, coffeehouses, cafés and mental health cafés

- 7th International Health Humanities Conference, University of Southampton
- Institute of Mental Health, University of Nottingham
- Centre of Social Futures Seminar. Institute of Mental Health, Nottingham
- 5th International Health Humanities Conference, University of Seville

Raising Awareness of Mental Health in Higher Education

- World Health Promotion Conference: Rotorua, New Zealand
- University of Nottingham.
- Westminster Briefing, London
- University of Middlesex
- University of Bristol

Poster Presentations 2016 – 2019 SPACE: Ethnography of The Dragon Café

- Allied Health Professionals Conference, University of Nottingham

- The Dragon Café, London, SE1 1JA
- Ethnography Symposium, Copenhagen Business School, Denmark.
- Economic and Social Research Council (ESRC) University of Liverpool.
- 5th International Health Humanities Conference, University of Seville
- The Royal College of Psychiatrist, London.

Media Radio and TV 2016 – 2019

- Bristol Radio, Raising Awareness of Mental Health in Higher Education (RAMHHE).
- 2018, Kemet Radio, Every Mind Matters, first Mental Health Campaign by Public Health England in the East and West Midlands.
- Eave Radio, Every Mind Matters, first Mental Health Campaign by Public Health England in the East and West Midlands.
- TEDx Talk, University of Nottingham All the Silver Linings in my Dark Cloud
- BBC Radio, Raising Awareness of Mental Health in Higher Education
- Sky TV, Raising Awareness of Mental Health in Higher Education