Research paper

Thresholds in a low-threshold setting: An empirical study of barriers in a centre for people with drug problems and mental health disorders

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ABSTRACT

Background: Some services for drug users with mental health disorders can be characterised as low-threshold services. These aim at making help easily accessible for people who are not able to request help from services at higher levels. In this study we examine what kind of thresholds are experienced by clients at a low-threshold centre.

Methods: Ethnographic field work, including participant observation, individual interviews and focus group interviews with clients and staff in a low-threshold centre for the most vulnerable drug users in Oslo were employed.

Results: Our analyses agree with other studies in showing that the following three thresholds are significant, also in services for drug users with mental health disorders: the registration threshold, the competence threshold and the threshold of effectiveness. In addition to these, we suggest that a fourth threshold is of importance for this group: the threshold of trust. In the low-threshold centre we studied, we observed that for the clients, crossing the threshold of trust seemed to be an essential precondition for subsequently being able to cross the other thresholds in order to receive the help they need. We suggest that focus on the four thresholds can improve our understanding of clients' access to services. We also suggest that processes of recovery may be improved if increased attention is given to the barriers that clients experience.

Conclusion: The threshold of trust seems to be particularly important for people suffering from drug problems and mental health disorders. The results have implications both for practice and policy because if taken seriously into consideration, more clients could access the services they need. Services for this group may be improved by focusing on the fourth threshold: trust.

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Background

a growing number of low-threshold services for people with drug problems and mental health disorders. The term "low threshold" has become a well-used expression, especially in the drug field. The meaning of the term is nevertheless not clear-cut. In spite of the profusion of low-threshold services and the attention to these, there is little theory development in this field. In our view, the notion lacks a clear definition and our understanding of the term is incomplete. One may get the impression that low-threshold services provide help with few and almost no obstacles. Is that the case? If not, what kind of hindrances do users experience?

The idea of low-threshold services is associated with harm reduction. Harm reduction is a wider concept than low threshold, and can be defined as "interventions, programmes and policies

that seek to reduce the health, social and economic harm of drug

as an alternative public health approach to drug use, with the focus on reduction of harm as the main goal rather than the reduction of use per se (Eversman, 2010; Lenton & Single, 1998; Ritter et al., 2005; Tammi, 2004; Wodak, 1999). Harm reduction is characterised by easy access to help and care, help on the users' terms with few conditions, a focus on how to reduce injury related to health, hygiene, sexual conduct, family and economy, and a focus on an anti-stigmatising attitude (Ådnanes, Kaspersen, Hjort, & Ose, 2008). It is seen as a matter relating to both philosophy and practical measures, which makes the notion ambiguous, and the term difficult to define (Ball, 2007; Ritter et al., 2005). Low-threshold services may be seen as a tool for making measures for harm reduction more easily available.

The study presented here is part of an evaluation of a low-threshold centre in Oslo, Norway. The centre was established in August 2009 and the target group is people who suffer from poor physical and mental health and who have an extensive use of illicit

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drugs. This group is often defined as people who are hard to reach and hard to help. They may be seen as the core population in low-threshold services in Norway. Low threshold services or facilities vary from country to country. In Norway, the notion is used as an umbrella term for different services such as needle exchange programmes, shelters and health services. In Switzerland, "low-threshold facilities" refers rather to one type of service that exists all over the country (Gervasoni, Balthasar, Huissoud, Jeannin, & Dubois-Arber, 2012). Since low-threshold services are defined in different ways, it is therefore important to describe what kind of services are under study.

Aims

People often face hindrances when they seek help for different problems. These barriers, or thresholds, may be of different quality and size, some more difficult to cross over than others. In this study we examine and explain different thresholds and how they affect the availability and process of help in a low-threshold setting. By presenting empirical data, we show how the obstacles shown in threshold theory (Jacobsen, Jensen, & Aarseth, 1982) affect people who visit the premises we studied. Is it possible that the road to help in low-threshold facilities is paved with hindrances that we do not recognise? What characterises barriers in low-threshold services which are designed to meet the needs of those who are hard to reach and hard to help? If there are any barriers, how many exist, and what kind of obstacles do they present for the users of the centre? Our aim is to discuss the characteristics of different thresholds that users of low-threshold services need to cross in order to start or maintain a process of recovery. Our ambition is to stimulate reflection on barriers in a low-threshold setting and to contribute to the development of policy concerning recovery for clients in this field.

Before we present the study and our methods, we will introduce the main principles in threshold theory as outlined in Jacobsen et al. (1982). This theory has been used to show that access to health care and social services and the possibilities and skills needed in order to cross thresholds in social services are unequally distributed.

Threshold theory

Jacobsen et al. (1982) outline a theory of thresholds that throws light on important aspects of low-threshold services for drug users who also suffer from mental illness. The main point is that services have different thresholds that people must cross in order to gain access to them and make use of the help offered.

The authors present three thresholds: the *registration threshold*, the *competence threshold* and the *threshold of effectiveness*. Referring to the registration threshold, they argue:

> "In addition to barriers related to knowledge and emotions, there are a number of more prosaic conditions that may prevent needs being registered as demand. It may be that one lacks resources in the form of time or access to a telephone, or that one does not have the surplus energy needed to carry out other things in addition to the daily struggle to survive." (1982: p.39, authors' translation)

The registration threshold is central, because almost all offers of help and assistance in society at large are based on the clients' initiative and their willingness to register themselves as a person in need of help. The welfare state does not respond to needs, but to demands, and needs are not necessarily registered as demand: those who do not ask, do not receive help (Jacobsen et al., 1982).

The competence threshold concerns clients' capabilities to put forward their needs or requests in a way that the staff can understand and act upon. The system rewards people who have realistic expectations about what they can expect to achieve, and people who ask for the kind of help that is offered by professionals, even if it is not what they actually want. It is also an advantage to possess physical skills such as being able to see, speak, hear and move, and other skills such as being able to read and write (Jacobsen et al., 1982):

> "Registration will not necessarily lead to needs being met. The way in which the system functions, demands are made of potential clients in addition to them having to take initiative. There is a threshold of competence, and some clients cross this more easily than others." (Jacobsen et al., 1982: p. 39, authors' translation)

The efficiency threshold concerns clients who are rejected or receive less help than they need because satisfying their needs is in conflict with the employees' norms of efficiency, or their perceptions of (or emotions related to) how available resources can be managed most effectively (Jacobsen et al., 1982: p. 40):

> "It may be that meeting the needs of one client corresponds to meeting the needs of a dozen ordinary clients, and there must be very good additional reasons for giving priority to one client rather than to many." (Jacobsen et al., 1982: p. 40, authors' translation)

Threshold theory was developed for administration systems in general (Jacobsen et al., 1982), but it is also used in connection with other fields, such as low threshold health care services (Baklien, 1993). Threshold theory illustrates why some groups slide through the system as though they are "helped by an invisible hand", while others experience a slap in the face (Jacobsen et al., 1982; Lindblom, 1982). The thresholds described in the theory affect the weak groups in society and the authors claim that people are kept in inferior positions. In this respect, the threshold theory is related to power. However, power is not the main focus in our article. Rather, this article is a contribution to a further development of the threshold theory.

The study and methods

A centre close to the street

In this study, we evaluated a low-threshold centre open 24 h/7 days a week for individuals who suffer from severe mental disorders and drug problems. The users of the centre are persons who are not reached to a sufficient degree by the existing offers of help. The problem is not that they do not get offers of help and treatment, but that the help given is either not received or of a kind that does not promote change. Many people in this group lack hope of recovery and often resist offers of help from the municipal health care system. The average age of the clients at the end of the data collection was 36 years. The proportion of men was 69%. The centre is provided by the Church's City Mission, a non-governmental organization, and their philosophy is that everybody can be helped to recover. The staff are professionals such as psychiatrist, doctors, psychiatric nurses, nurses and social workers. In other words, the centre offers high intensity treatment in combination with care. One might say that the medical hierarchy is turned up side down by offering specialist health care in a low-threshold setting, where no referral is needed. Both the opening hours and the access and number of highly qualified staff make this service different from other services for this group in Norway.

The aim of the centre is to motivate clients to receive help and to recover by helping them to change their lifestyle, even if only on a very small scale. "Recovery" in this context does not refer to abstinence from drug use or no symptoms of mental illness, but to a process of multiple recovery that involves many levels of reparations (Lee Garth Vigilant, 2008) that hopefully will lead to a better quality of life, with less social exclusion and a more stable and safe everyday life. The aim is also to help clients to seek further help in the established health care services, e.g. in the municipal system. Clients are offered food, drinks, a free phone and internet access, a shower, clothes and the opportunity to rest and sleep. Nevertheless, it is not a place which meet clients' daily needs for social contact, food or care as such, as is the case in low-threshold services in general (Eversman, 2010; Ådnanes et al., 2008). Food and care are seen as tools to create therapeutic alliances. Clients are expected to present some kind of request and are encouraged to make use of the medical, psychiatric and psychological care offered at the centre. Clients do not have to cease drug use to use the centre.

Data collection

The first author carried out participant observation over a period of nine months at the centre. Data from a total of 45 field visits by the first author were analysed. She conducted 55 semi-structured individual interviews and two focus group interviews with clients (one group of men and one group of women, totalling 11 persons). Altogether 66 clients were included in the user survey. The focus group interviews and one of the individual interviews were audio recorded.

The second author collected data during two years of participant observation in combination with interviews and field talks with both staff and clients. She made 170 field visits at the centre, each lasting from 2 to 15 h. The most typical field visits lasted for about 3 h and consisted of a lot of talks, mainly informal, without the use of an interview guide. These talks were not audiotaped.

A topic guide was used in the semi-structured interviews to ensure that all relevant areas were discussed. The clients were encouraged to respond in a subjective and reflective way. The topic guide was modified as the process of interviewing generated ideas for new subjects (Bloor, 2001; Bloor, 1994; Bogdan & Taylor, 1975; Gubrium & Holstein, 2001; Morgan, 1997). In the individual interviews, efforts were made to ensure that the sample was fairly representative of the clients at the centre with respect to age, gender and ethnicity. Ethnicity here means that we spoke to clients of different nationalities, although the majority of the clients at the centre were Norwegian. Care was taken to make "thick descriptions" (Geertz, 1973). The data consist of interview notes and transcriptions of interviews, descriptive field notes and reflective notes about observations that were made (Gubrium & Holstein, 2001; Hammersley, 1996).

Carrying out fieldwork and participant observation provides access to information that clients and staff may not have given in a more formal setting, such as an interview (Hammersley, 1996). Informal talks served as a way of "intensive interviewing", i.e. guided conversations in order to provide rich and detailed material (Lofland & Lofland, 1984). Participant observation was done at different times during the day and by only one researcher at a time.

Analysis of data

The analysis process was dynamic and began at the start of the fieldwork. Field notes and interview notes were read repeatedly and the analysis was deepened and developed further with each reading. The data were broken down into units at a fine detail level (open coding) and compared to identify differences and similarities, following the constant comparative method of analysis (Strauss & Corbin, 1998). Situations and phenomena that appeared to be meaningful to the emerging research focus were continuously coded and categorised. Care was taken to use codes that reflected participants' language or "in vivo" codes. The aim was to present descriptions that were as close as possible to users' own constructions (Schatzman & Strauss, 1973; Strauss & Corbin, 1998). Examination of multiple data sources including interviews with clients and staff, focus group interviews with clients, field notes and documents from the centre, helped to ensure the accuracy and validity of the findings.

Ethics

Many of the clients were heavily intoxicated or in a poor state of mental health during their stay at the centre. Some interviews were cut off in the middle, as the client fell asleep, for instance due to heavy drug use. It is important to reflect on the ethical dilemmas related to interviews and the use of information from such situations.

All of the 66 people who participated in the user survey signed an informed consent. The other talks and interviews during field visits were carried out on the basis of oral consent to talk after ensuring that the client had understood that the communication was a research situation. Voluntary, informed consent is a relational process that has to be taken care of continuously throughout fieldwork (Fangen, 2010; Miller & Bell, 2002; Skatvedt, 2009; Smythe & Murray, 2000). It is important that a strict interpretation of ethical rules does not constrain important projects – this would lead to a risk that people we wish to protect become so protected that their stories remain untold. Our experience is that ethical guidelines often do not suit this kind of research with vulnerable people. As researchers, we made sensibility a priority and took special care when collecting data in interaction with our informants, e.g. by continuously evaluating the situation and the informant's state. We met the informants several times, which made it possible to talk in moments when they were in a talkative state and leave them be when we felt they were not. We have reason to believe that some of the stories that would otherwise not have been told were told during the interviews without transgressing ethical borders due to our exercising appropriate judgement of relevant ethical aspects at the time we met the clients.

The study was conducted in accordance with ethical guidelines for research (National Committees for Research Ethics in Norway, 2010) and approved by the Norwegian Social Science Data Services. All names and other identifying material have been altered to protect the anonymity of the clients.

Findings

The challenges outlined in threshold theory seem to be highly relevant for problem drug users, who are hard to reach and hard to help. Jacobsen et al. (1982) highlight the social imbalance of the ability to exceed barriers as a part of the theory. The registration and competence thresholds are especially suitable for revealing aspects of the low-threshold service we studied. In addition to drug use, many clients also suffer from mental illness, poverty and social exclusion. The result may be that clients do not have the surplus energy they need to seek help.

During the study, it became apparent that there was another important threshold in addition to the three outlined by Jacobsen et al. (1982). What we identified as a *threshold of trust* emerged from our empirical material and makes the theory of thresholds in this field broader. As we will show below, the clients spoke about this barrier in the interviews.

The threshold of trust

It seems essential to cross the threshold of trust in order to cross the other thresholds. One client said:

"If you do not trust the people working at the centre, you do not dare to ask for help. Especially if you have been a drug addict for some time, this is even more important because you are tired of losing face." (31 year old woman)

The trust threshold may be explained as follows: most clients express that they do not trust "the system" or the staff who can help them due to experiences of neglect from the same system in the past, for many of them from early childhood. For many clients in our study, this seems to be a significant experience. One of the staff we interviewed felt that the level of distrust of general services was especially high for people in this group:

"What strikes me is that many of the clients curse all the organised health and social services. They feel excluded, misunderstood and rejected. That is their perception of reality. They do not have any trust in the system. And in a way they are right."

This interviewee, a general practitioner, used an example from substitution treatment to underline the statement. The threshold of trust can be said to represent a missing link and come before the three threshold described by Jacobsen et al. (1982). Before a person even considers seeking help from a service, some level of trust must be reached. Then another and higher level of trust is necessary in order to build an alliance and relationship with the professionals. Trust needs to be negotiated continuously. If this threshold is not crossed, we find that it is less likely that the other thresholds will be crossed. For instance, clients told us that it was difficult to use their competence in seeking help if they did not trust the staff.

Some clients said that they had acquired competence by being part of "the system" for a long time. But this competence can turn against them. A form of learned helplessness that relates to mistrust may function as a barrier for making use of social skills. One example is clients who have lost faith in the welfare system and who withhold information from the staff so that it becomes difficult to give relevant help. When a client feels that he or she is neglected by the staff, the threshold for reporting what they need seems to grow higher. For many clients, it is difficult to "force" the helper to give them attention, especially if they do not trust the helper. Many clients said that they had a low level of trust for many public services, and that they have a poor opinion of the social services and the substitution treatment system. A lack of respect for the services is the greatest barrier to trust.

Respect for the clients also has a bearing on trust. Many clients said that they were met with respect by the staff, and that this differed from some of the other services they had experienced. According to clients, respect is not what they usually encounter in treatment services and in society at large. When they feel respect, they also trust the service. A female client said:

"We are used to being hustled around, and that is why we automatically show respect when we are treated well for once." (21 year old woman)

To be met in a respectful manner seems to trigger mutual respect. This woman said that she was touched by the way the staff showed the clients respect in a fundamental way. The fact that she kept on returning may be interpreted as a sign of faith in the

centre. Another client described how he had contacted the centre by telephone one day after he had been there several times. Due to anxiety, he did not want to visit the centre for his appointment with staff. He did not dare to go into the city centre where the centre is located. Instead a psychiatric nurse had offered to come to his place:

"(. . .) so he came home to me – in a cab!! And we just sat there, talking for more than two hours! They are flexible, and that really helps me. (Smiling)" (21 year old man)

The client expressed gratitude for the nurse's response. This way of working with clients may build trust, because it shows that by doing a "little extra", the staff care. It also alters the situational social hierarchy and power to a certain extent when the professionals move out of their offices and into the clients' home ground. We found that many clients spoke of mistrust in the official services for drug users and stated that the centre in this study is special with regard to trust. Some clients claimed that they trust services provided by non-governmental organizations more than public services.

The registration threshold

The clients spoke of how they got in contact with this centre and how visiting the centre may be difficult for them. Some had sought the facilities on their own initiative or had been accompanied by other people, such as social workers, police or friends. Strangers also escorted clients to the centre. Many of the clients discovered the centre by chance. This may be a sign of a low registration threshold. But to register is not necessarily just to step inside the door. Several levels of registration exist: knowing about the service, finding the centre, stepping inside the door (and often going up the stairs), being registered by the staff, and making a request can all be seen as aspects of the registration threshold. Clients with poor mental health sometimes refused to give their name or sign a consent that made it possible for staff to contact social services, doctors, etc. Others spoke about an ambivalence to register and come forward with their request because they feared what it may lead to. For instance, some expressed the fear that information about them was delivered to evil forces. Others said that they were not ready to stop taking drugs: they just wished for a home and more stability. This illustrates the inherent ambivalence of their situation: even though clients do not have to cease drug use in order to use the service, they face the difficult choice of sobering up and living in according to the behavioural codes of "ordinary life", or staying in harsh, but still familiar surroundings (Skog, 2006).

Drug problems and mental disorders may make it difficult to come to the centre and turn up for appointments, even in a low-threshold service like the one in this study. The centre has a large room which clients enter directly from the street. Some of the clients told us that the size of the room sometimes made them feel uncomfortable. The way the staff are positioned in the room can affect how available the staff seem to be to the users and how easy it is to register a request. Clients noticed differences between the various members of staff in relation to how available they seemed:

"Some of the staff are just here for the money. They do not really care about us, and are more interested in talking to each other." (54 year old woman)

According to the clients, it is easier to register if the staff are interested and available. It appears that the threshold for asking for help grows if the staff stand together and talk and laugh about

what happened last weekend. They are available physically, but not mentally. In other words, the staff's behaviour contributes to the construction and size of thresholds.

One day at the centre, a member of staff sat on the floor with a client who was heavily drugged. They were busy filling in some application forms. This may have lowered the threshold for registration for this particular client and for other clients who observed the interaction. Obviously, clients do not need to sit in front of a desk in order to explain their needs and they do not need to be sober to work on their application for help. The staff provided an outreach service to some extent and went out of the office to meet people in shelters, detoxification centres and clients' homes. In these situations, the clients did not have to climb the stairs and cross the threshold alone, as in the case of the client who did not dare to leave his house for an appointment at the centre.

The competence threshold

Many of the clients in our study were so heavily drugged that it was difficult to understand what they were saying. Others were suffering from mental illness that made it hard for them to express themselves in a way that others could understand. This makes it difficult for clients to use their competence. Most of the people in our study have some characteristics in common that make them vulnerable when it comes to the competence they need to have in order to seek and receive help. A low level of education is one factor that we can relate to the competence threshold (Jacobsen et al., 1982: p. 37). Many clients had little or no education, though there were exceptions.

Different types of competence seem to be important when people seek help from services for drug problems or mental disorders. It pays to have knowledge of the systems in general, which many of them have. It is also an advantage to know how to proceed when talking to the staff. One client experienced that the staff had greeted him, but not given him any further attention:

"There are many professional people working here, so there has to be something that they do. None of them have approached me and asked what I need. I need help for a number of things. I hope they will ask me soon." (42 year old man)

He wondered why he did not receive the staff's attention, despite frequent visits at the centre. In other words: it is not enough to have knowledge about one's needs for help and the ability to present them in an understandable manner. Clients also need competence and courage to express their needs in a way that the staff understands. Not only to be noticed, but also to be "seen", seems to be of great importance. It is difficult to have confidence in professionals who are supposed to help you but who does not see you, even though they are in the same room as you on several occasions. One of the staff told us about clients they had not spoken to:

"No . . . he has been here for a long time. We have to get hold of him and speak to him . . . I don't know much about him."

The staff made a list of clients they would focus on. The aim was to approach those who did not come forward by themselves. These are clients who often became "invisible" and stood at the back of the queue, behind those who were agitated and attracted a lot of attention. Our data show that clients have to catch the staff's attention in a manner that makes it possible for them to be taken care of, instead of walking around as invisible shadows.

For clients, information about the help offered at the centre may be difficult to understand. The room they enter from the street did not have any posters displaying information. Some clients did not know what kind of help they could get, other than the visible kind, like food and coffee. Many did not know that psychiatric and medical expertise was available. To make use of their competence, newcomers especially are dependent on getting information from the staff. One client said:

"In the beginning, they [the staff] walked around and informed us. But they do not do this so much now." (41 year old man)

When asked about this, the staff told us that since the centre had been established for some time now, it was not as natural as before to give the same information all the time. Some of the staff disliked the feeling of appearing importunate and bragging when they displayed their competence.

The efficiency threshold

The centre provides a service where clients are supposed to visit for a period and experience change, even though on a very small scale. With the help of the centre, they are supposed to establish or re-establish contact and relationships with the general health and social services as soon as possible. In other words, in order to be efficient, the staff's responsibility is to refer, lead and follow clients to other welfare services they are in need of, such as social services, detoxification centres, general practitioner services, psychiatric services and housing assistance. Some clients resist being referred to other places and may return again and again from the services which the centre helped them to establish contact with. Referrals to other health and welfare centres may in other words create a threshold that affects the level of efficiency and success. Other clients need a lot of time and reassurance before they ask for help, which also result in a low efficiency rate. As one member of staff put it:

"What about those who need 1000 cups of coffee before they start to speak about their needs?"

Some clients felt that many professionals had too high expectations of them: to be sober and to cope with social life in a better way than they do. One client who came to the centre because she wished to talk to a psychologist said:

"Actually, I've just finished treatment (in a psychiatric ward), but the anxiety is devastating in spite of that". (41 year old woman)

She lived in an apartment with some assistance, but according to her, she experienced her anxiety as too big to deal with by herself in her daily life. The aim is to achieve a continuum of small steps of change. It can be very difficult to measure the efficiency of a low-threshold service like this, where changes can be very small, but still significant for the people who have managed to master something new.

As we have shown, we identified all three thresholds in Jacobsen et al. (1982) in our study and in addition a trust threshold. In the following sections, we will discuss our findings.

Discussion

Our findings show several thresholds in a low-threshold service that need to be addressed. In addition to the registration, competence and efficiency thresholds, we argue that it is important to include the trust threshold as a barrier to recovery for this group. Trust is a comprehensive term and in this article we do not relate to all aspects of the term, or include all relevant authors in this field

(for further reading: Fukuyama, 1995; Gambetta, 1988; Luhmann, Backelin, & Grimen, 2005; Misztal, 1996; Putnam, 2000).

It is possible to rank Jacobsen's three thresholds (Jacobsen et al., 1982): our data indicate that the registration threshold is the lowest, then comes the threshold of competence and then the efficiency threshold as the third step of the stairway to receiving help. The threshold of trust seems to be the hardest one to cross. It is also related to the other three thresholds. To register with the centre, our data show that the person must feel some level of confidence, even though sometimes only a low level is required. Trust stands in direct relation to competence: when the users experience a certain level of trust, it seems easier for them to use the competence they have and to articulate their own theories of change and recovery. We found that in order to utilize the service effectively, the clients need to trust the service.

The trust threshold is meant to be easier to cross in low-threshold services than in other services, e.g. places the client needs to be referred to. Trust within the drug milieu is often weak, but significant because of a culture of sharing and rip-offs (Bourgois & Schonberg, 2012). This may influence the trust between helpers and clients by transferring the suspiciousness to the relation to the staff. If we did not trust anybody, all of us would be anxious and our social life would be difficult (Gambetta, 1988). Trust is closely related to ontological security, because absence of trust increases ontological insecurity (Giddens, 1984).

Reflexivity in modern society may result in fundamental insecurity, because "the truth" may change without notice due to the increased speed of modern society (Giddens, 1984). This creates radical doubt, which is a basic trait of the modern human being. Radical doubt exists on an institutional and an individual, existential level. To trust the system is essential to our feeling of ontological security and well-being. In addition to being a basis for our identity, ontological security gives us confidence in the social and material world. In other words: the concepts ontological security and insecurity provide a basis for understanding why people with drug problems and mental illness have problems with trusting individual relationships and the welfare system (Giddens, 1984; Gryt, 2005; Vigilant, 2001). The fact that most of our daily practice is routinised, contributes to our feeling of ontological security. Routinised practices reflect the basis on which we make our social world and personality fit together (Giddens, 1984). Substance misuse and mental illness may interrupt routines and create a critical situation in which ontological security fades and is replaced by insecurity and subsequent distrust. Many broken relationships, both personal ones and relationships with professional helpers, may also contribute to ontological insecurity, as is the case for the clients in this study.

People may be helped over the threshold of trust and gain confidence by establishing trust through building or repairing relationships. The service's reputation may help to develop the trust that is needed. Our findings indicate that the threshold of trust constitutes a substantial barrier to receiving help in order to recover. Lack of trust is one of many reasons why the clients can be seen to be trapped in a loop around the registration threshold. The clients may have enough trust to visit the centre again, but not enough to express their needs. In other words, they have to register again and again because they do not reach the next and higher threshold – the competence threshold. They do not get far enough to come in contact with the staff, or to use their competence. Another scenario is that clients return repeatedly because they mistrust other services they are referred to, or have been expelled from due to aggressive or otherwise unacceptable behaviour.

The registration threshold is related to access to the centre in general and to the staff in particular. As indicated by our findings, outreach work can help clients over the registration threshold. Outreach work is a matter of economic prioritisation

because it necessarily reduces the amount of resources available for other parts of the service. A lack of outreach work may lead to an exclusion of the weakest clients – those who are incapable of surmounting both the physical and the psychological barriers to the service.

We can argue that outreach work is one of the most effective measures to lower the registration threshold in a low-threshold service. Wherever there is a door to open or close, there is a threshold. There were some steps up to the entrance of the centre. But the registration threshold can be minimised if the staff go out into the street. Outreach work may also improve clients' confidence in the service because the staff come out of their offices. In this way, social hierarchical distances may be lowered during the interaction situations, which in turn open the door to talks that contribute to building trustful relationships (Skatvedt & Schou, 2010).

Competence, and in particular social competence, can be useful for people who contact welfare services and in particular the centre in our study. It is important to speak clearly enough to be understood and to have the motivation, competence and the courage to be able to talk to staff. If many clients ask for help at the same time, how a particular client acts in the room may have an impact on whether he or she receives help or not. The modest clients tend to put themselves in the background, while the noisy clients get attention more easily.

A general insight into how the systems of social services function is also useful when clients seek help – if they are able to use this insight constructively. There are numerous welfare services and it can be difficult to get an overview, especially after many social services in Norway have been reorganised. Nevertheless, it is clear that street education has given many clients knowledge about where they can turn in order to get different kinds of help. Knowledge and competence is often transferred from one client to another. The services that offer help also provide information. Street competence, "street capital", is defined as "knowledge, skills and objects that are given value in a street culture" (Sandberg & Pedersen, 2009: p. 33). This form of capital is inspired by Pierre Bourdieu (1984) in his work on different forms of capital. Street capital is a way of transferring Bourdieu's concept of cultural capital into a street context (Sandberg & Pedersen, 2009). Street capital may help the persons seeking help to cross thresholds. But it may also act as a barrier to using the services, because this kind of capital is not easily transformed into other forms of capital that are relevant in the treatment system and other areas of society. Street capital does not have the same value outside the street milieu, and people who contact low-threshold services sometimes lack other types of capital due to a life spent apart from "normal" society.

Clients' lack of competence can be compensated for by staff taking the role of supervisor. Staff can explain repeatedly, especially to new clients, what kind of help the centre provides. Staff can also try to get close enough to clients to understand their needs. Some of the most vulnerable clients have problems relating to other people in a manner that is acceptable. Their demeanour does not help them to make contact and build relationships. If the staff are patient and manage to cope with demanding conduct, paranoia and suspicion, the client may be helped to cross the competence threshold. When clients receive confirmation in spite of their lack of competence, they seem to get a step further along the road to help and recovery. They can gain confidence, which can enable them to use the competence they have. In other words, patience and confirmation may increase their level of trust.

We may argue that the efficiency threshold is not as important in this context as that of registration and competence and therefore a lesser obstacle for clients of low-threshold services. The efficiency threshold will be more significant for clients who receive help from professionals who prefer to work with clients or patients who have the ability to make use of professional techniques and the

treatment offered, and who recover faster (Album & Westin, 2008). The aim of the centre is to achieve change for clients who are especially vulnerable and out of reach for, or resist help from, the regular municipal health and social services. This is a group of clients who demand a lot of time and patience, often because they need help for many problems at the same time (Vigilant, 2001, 2008). Vigilant shows how methadone maintenance treatment patients deal with multiple recoveries (Vigilant, 2001, 2008). This seems relevant to the clients in our study, although not all of them receive substitution treatment. One challenge is to recognise the clients' different achievements. Slow recovery makes success difficult to spot. In a low-threshold service like this one, it is difficult for staff to measure the effectiveness of their work. It is not enough to count the number of clients. They have to count the number of clients who show a minimum of change. What is "change" in this perspective? Another challenge is that the same clients come back again and again because they drop out of other services they are referred to (e.g. municipal housing, detoxification centres or treatment institutions). "Swing-door-clients" may reduce measures of efficiency. Recovery for clients in this group is a complicated process which often involves simultaneous reparations due to high levels of morbidity, trauma and emotional stress (Vigilant, 2008). In this process, relapses may be regarded as failures or as a natural part of the process of recovery (Borg, 2007).

In "The Small Steps Method" (Kaltoft, 2009), the authors highlight the importance of recognising small changes and claim that "small steps lead further". The idea is that the offer of care and understanding in a safe and warm environment starts a process of recovery in itself. In terms of efficiency, however, the question is how long the staff can stimulate change before it is in conflict with the norm of efficiency. At the centre, the clients are asked which changes they wish for and what help they need. At the join-in centre described in "The Small Steps Method" (Kaltoft, 2009), there are no demands for change. Yet, because of just that, they claim that the clients recover. They state that the clients have poor experiences with staff who have high ambitions for rapid and big changes on behalf of them. Many clients have experienced being "a case" in the public welfare system for a long time. Demands for efficiency can also be an obstacle to help and recovery. On the one hand, our data show that it is difficult for the staff to help people in this group over the efficiency threshold due to the complexity of their problems and illnesses. On the other hand, the staff can contribute by actively focusing on how this threshold is related to this service and by continuously reflecting on meaningful definitions of efficiency standards regarding recovery for these clients. It seems important to recognise small steps of change and so-called "relapses" as a natural part of the process in order to support clients in their recovery (Borg, 2007; Kaltoft, 2009).

There are some limitations to the current study that should be recognised. First, because of the influence of drugs, interviewing some of the clients in this study was a challenge, as mentioned in the section on ethics. This influences the quality of parts of the material. Another limitation of the study is that we have only spoken to clients present at the centre and not out in the open drug scene in Oslo or in other low-threshold services. The reason for this choice is that the study is part of an evaluation of the centre itself. We would nevertheless argue that our findings are relevant also to other services for this group.

Concluding remarks

What we call the threshold of trust seems to be particularly important for people suffering from drug problems and mental health disorders, and trust seems to be intertwined in Jacobsen's three thresholds of registration, competence and efficiency

(Jacobsen et al., 1982). We suggest more research on related topics. For instance it is of interest to look into the relationships between the demands of efficiency, time, trust and power. It would also be interesting to search for other thresholds than those identified in this study. It is important to throw more light on unspoken assumptions about services to vulnerable groups in society in order to identify barriers which may obstruct the development of relevant services and policy. The more thresholds that have to be crossed to obtain a good, the more unjust access to that good becomes (Jacobsen et al., 1982).

The trust threshold seems to be of great importance when people who suffer from drug problems and mental health disorders seek help. This threshold strikes us as a serious barrier to recovery for these clients and needs to be continuously addressed by professionals working at all levels. Building relationships is a risky business for many of us and especially for vulnerable people with many experiences of broken relationships.

This study has some policy and practice implications. We have shown how thresholds can affect to what degree clients get the services they need. These findings have implications for both practice and policy because if taken seriously into consideration, more clients could get the services they need.

This study confirms that the concept "low threshold" is not a clear-cut or simple term. We have observed that the thresholds that clients need to cross when they contact a low-threshold service are not as low as they may seem to others. It is not possible to establish services without thresholds. There is almost always a door and a doorstep and it is not instantly recognisable how thresholds create barriers for different people. They operate differently for different clients, depending on the individual client's level of confidence and competence. Nevertheless, by highlighting thresholds in this study, and in particular the trust threshold, we have identified some reasons why there are people out in the streets despite the existence of many low-threshold services. Trust seems to have been taken for granted. If trust is taken more into account in policy development and when developing services for people with drug problems and mental illness, more people can be reached and helped.

Acknowledgements

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