Summary Literature Review: Drop-in Centers and Clubhouses

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Definition: According to the literature, Mowbray and colleagues (2009), defines a Clubhouse as "an intentional community composed of non-clinical, generalist staff who work there and the consumers who are its members." Membership is voluntary and on an as needed basis. The requirement is to have been diagnosed with a serious or persistent mental illness, which may include, but is not limited to, Major Depressive Disorder or Schizophrenia. To present a clear definition of a drop in-center, a clear definition of consumer operated services is also needed. Consumer-run drop-in centers (CRDIs) or simply drop-in centers are community "safe havens" for adults, who have been socially and economically disadvantaged by serious, and/or persistent mental illnesses, but are also providing and utilizing services (Iverson, 2016). CRDIs deviate from traditional mental health treatment facilities, because of their focus on psychosocial rehabilitation in a community setting.

Target Population: Clubhouse programs are appropriate for adults with serious mental illness who wish to participate in a structured program with staff and peers and have identified psychosocial rehabilitative goals that can be achieved in a supportive and structured environment. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members, and must not have behavioral/safety or health issues that cannot adequately be addressed in a program with a low staff-to-member ratio (Iverson, 2016).

Description: The following literature review summary will summarize what current literature states regarding consumer-run drop-in centers, and the implementation and effectiveness of the Clubhouse model. In addition, the summary will address different methods of measuring outcomes such as employment.

Research Summary: To reiterate, CDRIs are intended to play a critical social support function, especially for consumers with a history of an/or at high risk for psychiatric hospitalizations, providing organized and informal recreational and social activities in which consumers and the drop-in center's program staff can assist each other in solving their daily living problems (Mowbray et al., 2005). The goal of CDRIs are to provide a safe, supportive, and normalizing environment in the community for individuals labeled mentally ill, especially for those who are isolated in society; to provide an atmosphere of acceptance in which individuals feel needed and can grow in self-worth, dignity, and self-respect; to increase knowledge about the community by learning from one another; to provide a place where social and recreational activities can occur, enabling individuals with severe emotional difficulties to conquer social and communication problems and assume productive lifestyles in community settings (Mowbray et al., 2005). In CDRIs, people who use the services run the program; all the decision makers, providers, and recipients are on and the same (Zinman, 1986).

The Clubhouse model was a direct precursor to CDRIs and has provided a strong impetus for the consumer movement as it exists today. The Clubhouse is an intentional community composed of non-clinical, generalist staff who work there and consumers who are its members (Mobray et al., 2009). Staff and members work side by side to perform jobs essential to the operation of the Clubhouse, such as food preparation, maintenance, member orientation, reception services, clerical work, and record-keeping. The Clubhouse achieves rehabilitation goals by providing a protective community, the security of lifelong membership and continuous availability of Clubhouse support services, prevocational but meaningful work running the club, opportunities to develop and practice vocational skills, and the availability of paid work outside the Clubhouse (Mowbray et al., 2005). Both models address psychiatric disabilities and are voluntary, group-based, and open daily; both have a rehabilitation focus and emphasize client engagement in operations and client involvement in decision making across all aspects of the program. Both programs are located within the community and share a commitment to community integration for members. However, within Clubhouse programs, the authority to make decisions ultimately rests with the executive director (who is rarely a consumer) (Mowbray et al., 2009). Also, member responsibilities are more structured and routinized, based on the "work-ordered day." The work-ordered day is an eight-hour period, typically Monday through Friday, which parallels the typical business hours of the working community where the Clubhouse is located. All of the work in the

Clubhouse is for the Clubhouse and not for any outside entities. There are also no clinical therapies or treatment-oriented programs in the Clubhouse. Thus, although the two models are similar in certain respects, there are distinguishable structural and programmatic features.

Clubhouses and CRDIs are two of the most commonly used models of consumer-centered services for persons with serious mental illness (SMI)(Mowbray et al., 2009). Information on what types of users would benefit from which programs would prove useful in service planning. A study by Mowbray et al., (2009) on 31 geographically matched pairs of Clubhouses and CRDIs involving more than 1,800 consumers was conducted in order to answer the following question: are there significant differences in the characteristics and outcomes of members of Clubhouses versus CRDIs? Results from the analyses indicated that Clubhouse members were more likely to be female, to receive Social Security Insurance and Social Security Disability Insurance (SSI/SSDI), to report having a diagnosis of schizophrenia, and to live in dependent care; and both clubhouse users and CRDI users reported both a greater number of lifetime hospitalizations and current receipt of higher intensity traditional mental health services (Mowbray et al., 2009). When the researchers controlled for differences in demographic characteristics, psychiatric history, and mental health service receipt, Clubhouse members also reported higher quality of life and were more likely to report being in recovery (Mowbray et al., 2009). The results of the study suggest that CRDIs are a reasonable alternative to more traditional mental health services for individuals who might not otherwise receive mental health care.

Mowbray and colleagues (2005) conducted a statewide study of a matched sample of 29 Clubhouses and 29 CRDIs, with data gathered by obtaining documents from and conducting on-site interviews with agency directors. As, expected, the authors found greater member control and involvement at CRDIs and more instrumental services and activities at Clubhouses. Mowbray et al., (2005) also found that Clubhouses had substantially more resources than CRDIs and that CRDIs showed significantly greater variance across programs on most measures.

Table 1: Criteria for Consumer-Run Drop-in Centers (Mowbray, 2009)

- Consumer-operated
- Voluntary
- Consumer Determination of Policy, Operations, and Planning
- Availability
- Accessibility
- Exterior Physical Environment
- Interior Physical Environment
- Social Environment
- No Threat of Commitment
- Facilitating Referrals
- Member Retention
- Outreach to Recruit New Members
- Activities and Services Available
- Housing, Transportation, Education, and Job Assistance
- Social Recreational Activities
- Housing, Transportation, Education, and Job Assistance
- Social Recreational Activities
- Group Empowerment
- Recovery Orientation, Personal Growth and Development
- Consumer Involvement
- Membership Participation
- Consumer Choice/Decision Making
- Practice/Improve Social and Work-related Skills
- Nonhierarchical Structure
- Social Network Benefits and Social Support
- Sense of Community: Self Help and Reciprocity

Table 2: Values and Principles (Mowbray, 2009)

- Consumers are in control of the drop-in
- Everyone is equal at the drop-in
- Consumers are free to make their own choices and decisions
- CDRIs are democratic—everyone's output is valued

Table 1 depicts a list of fidelity criteria that came from consumer experts and the research Mowbray et al., (2009) conducted on the 31 CDRIs that these criteria are the most important things a CDRI should be and do. Table 2 lists the values and principles that represent the core of an effective CDRI.

In analyzing the effect of Clubhouses on reduced hospital stays, Plotnick and Salzer (2008) examined Clubhouse costs in the context of system transformation initiatives. They analyzed three years of data (2003-2006) for 29 Clubhouses that are part of the Pennsylvania Clubhouse Coalition in order to obtain program costs, annual costs per member, and costs per day. Their results indicate that Clubhouses play a substantial role in the Pennsylvania mental health system, providing almost 180,000 units of contact to more than 2,400 people. They found that Clubhouse costs are substantially lower than the costs of partial hospital services. Plotnick and Salzer (2008) report that Clubhouses serve an important role in lowering costs associated with supporting those who would otherwise utilize partial hospital programs.

In assessing whether or not Clubhouses help individuals obtain community based employment, Schonebaum & Boyd (2012) followed a group of individuals with SMI who were randomly assigned to a Clubhouse or a Program of Assertive Community Treatment (ACT). The researchers examined whether participation in the Clubhouse Work-Ordered Day had a positive effect on vocational outcomes. The relationship between Work-Ordered Day participation and employment duration for participants (N=43) was evaluated. What Schonebaum and Boyd (2012) found was that participation in the Clubhouse Work-Ordered Day had a significant positive impact on average duration of employment. On average, a 1-hr increase in participation in the Work-Ordered Day prior to employment led to an increase of 2.3 weeks in competitive employment. Improving quality of life is an important outcome associated with the involvement of members in Clubhouses. Gold and colleagues (2014) examined whether participation in competitive employment improves quality of life using data from a two-year, randomized trial (N=83) comparing a Clubhouse to a mobile Program of Assertive Community Treatment (PACT) program. Their regression analyses showed that, over 24 months of study participation, competitively employed Clubhouse participants reported greater global quality of life improvement, particularly with the social and financial aspects of their lives, as well as greater self-esteem, and service satisfaction compared to competitively employed PACT participants (Gold et al., 2014).

The aforementioned information provides service providers with important details about the characteristics of consumers who use CDRIs and Clubhouses. The results suggest that users of CDRIs are less willing or unable to use more structured mental health services (Mowbray et al., 2009). The critical ingredients endorsed by respondents as most important were the structural and process components emphasizing the value of consumerism: consumer control, consumer choices and opportunities for decision making, the voluntary nature of participation (and the absence of coercion), and respect for members by staff (Holter et al., 2004). Peer driven, recovery-oriented models of psychiatric rehabilitation, such as the Clubhouse Model are needed and expected in today's array of supports for individuals living with mental illness. The Clubhouse Model is consistent with recovery practices with its emphasis on member choice, self-determination, community integration, equal partnerships with members and staff working side-by-side, offering hope, and helping individuals live a meaningful life (McKay et al., 2016).

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