Recovery-promoting factors in day centres and Clubhouses for people with psychiatric disabilities. A comparative study.

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Recovery-promoting factors in day centres and Clubhouses for people with psychiatric disabilities

— A comparative study

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Abstract

The thesis aims to compare two approaches to psychosocial rehabilitation – day centres and clubhouses – and to explore if either appears better suited to support people in mental health recovery. The recovery focus is on opportunities for engaging in meaningful daily occupations, accessibility to social interaction and factors pertaining to perceived health and well-being. The thesis consists of four quantitative studies based on self-report questionnaires administered to users of day centres (DC) and clubhouses. Study I showed that there was an association between occupational engagement and motivation to attend the DC/clubhouse in the study group as a whole. Albeit that there were few differences between DC and clubhouses regarding the studied factors, the clubhouses appeared to be somewhat more beneficial in terms of users' opportunities for choice and decision-making in the programme. Furthermore, the clubhouses also appeared somewhat more beneficial for stimulating socialization among the participants. The results from Study II showed that the clubhouse group had larger social networks and more often someone they would nominate as a close friend compared to the DC group. Moreover, the results of Study II showed that a high level of self-esteem and having seen a friend recently were strong predictors of belonging to the group with a larger network in a cross-sectional perspective (baseline). Strong indicators of belonging to the group with a larger social network at follow-up were being a woman and attending a clubhouse programme, and also having scored high on social network at baseline. The result from Study III showed that, in the total sample, subjective quality of life (SQOL) at follow-up was associated with baseline self-esteem, social network, satisfaction with daily occupations and the SQOL at baseline. The strongest indicator for belonging to the group with the highest scores on SQOL at follow-up was attending a clubhouse, indicating that attending clubhouse programmes is beneficial for SQOL in the long term. The relationships between various subjective perceptions of everyday occupations and recovery were explored in Study IV. Self-reward occupational value showed a bivariate relationship with recovery at both baseline and the follow-up. These results suggest that self-reward occupational value and recovery mutually influence each other. Although a number of bivariate associations were established between subjective perceptions of occupation and recovery, none of these became statistically significant in the regression analyses. The findings suggest the importance of providing valued and engaging occupations in clubhouses to maximize opportunities for recovery.

The results of this thesis add to previous knowledge of DC services and clubhouses and discern some strengths of the Clubhouse Model. The results may be used when developing community-based mental health services.

Key words: community mental health services, mental health recovery, occupational therapy, psychosocial rehabilitation, self-esteem.

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Till Alice, Johan och Oscar

Content

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Abbreviations and definitions of central concepts

DC	Day centre
GAF	Global Assessment of Functioning
ICF	The International Classification of Functioning, Disability and Health
MOHO	Model of Human Occupation
PEO	Person-Environment-Occupation
SMI	Severe mental illness
SQOL	Subjective quality of life
ValMO	The Value and Meaning in Occupations Model
WHO	World Health Organization
Occupation	*"Human occupation refers to the doing of work, play, or activities of daily living within a temporal, physical, sociocultural context that characterizes much of human life. Thus, daily occupations include all types of everyday occupations people perform, such as self-care, home chores, work, leisure activities, and socializing with others"* (1).
Occupational balance	*"A satisfying pattern of daily occupation that is healthful, meaningful, and sustainable to an individual within the context of his or her current life circumstances"* (2).
Occupational engagement	Concerns the extent to which a person experiences a sense of meaning in occupations and has a range and variety in their daily occupations that form a structure that organizes time (3).
Occupational value	The value people experience when performing their daily occupations According to the ValMO model, there are three dimensions of occupational value: concrete value, symbolic value and self-reward value (4)
Psychiatric disability	Long-term consequences of SMI significantly interfering with the individual's performance of major life activities and participation in everyday life and that these difficulties are sustained over time(5) .
Psychosocial functioning	Entails psychological, social, and occupational functioning (6).
Psychosocial rehabilitation	Refers to a range of educational, behavioral, cognitive, occupational and social interventions and services to support people with psychiatric disabilities and enhance their recovery (7). It can also include family education and support (8).
Recovery	The term is commonly defined according to two categories. Clinical recovery can be defined as an improvement in symptoms and dysfunction to a degree where they would be considered to be within a normal range. Personal recovery, however, may or may not include symptom remission

	or a return to normal functioning, but is seen as a process of personal growth and creating a meaningful life in spite of any illness (9).
Self-esteem	An overall affective evaluation that entails self-worth, self-regard, self-respect and self-acceptance (10).
Severe mental illness	Any mental disorder with a psychosocial functioning score (GAF) (21) ≤50 and a duration of service contact for 2≥ years. Mental disorders which are commonly associated with SMI are schizophrenia and other psychoses and affective disorders (11)
Social network	A set of individuals and the patterns of relationships between them (12).
Social interaction	A social exchange between two or more individuals (13).
Subjective quality of life	"An individual's perception of their position in life in the context of the culture and value systems in which they live in relation to their goals, expectations, standards and concerns" (14).

List of Publications

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Preface

I first came in contact with occupation-based rehabilitation during field work in the occupational therapy undergraduate programme. It was my first experience of meeting people with psychiatric disabilities and I learned a lot from them and from my colleagues. My interest for, and engagement in, mental health was awakened from this experience, and remains to this day. After graduation I worked in out-patient occupation-based rehabilitation and later in various in-patient and out-patient psychiatric settings. When working in child- and adolescent psychiatry at the Stone Institute of Psychiatry, Northwestern Memorial Hospital in Chicago, US, I first came in contact with children with learning disabilities and autism. Returning home, I had a new-found interest and since then I have mainly worked in different occupation-based day centres in the community for adults with learning disabilities, autism or acquired brain damage. Mental ill health is relatively common within this heterogeneous group, and this has been of special interest to me in my clinical work. When I got the opportunity to work in a project aiming to compare two occupation-based approaches to psychosocial rehabilitation – day centres and clubhouses – and to explore if either appears better fitted to support people in recovery I did not hesitate. In a sense I am coming full circle.

Introduction

Long-term mental ill health can lead to a psychiatric disability that often has a severe impact on the individual's life circumstances. A lack of meaningful daily occupations and few or no social contacts, which are of importance for health, well-being and mental health recovery (15-17) are common in the target group (18). The term recovery in mental health is often defined according to two categories that originate from different influences (9). Clinical recovery has a biostatistical approach (19) where recovery can be defined as an improvement in symptoms and dysfunction to a degree where they would be considered to be within a normal range. Personal recovery, however, originates from the user movement and has a holistic approach (19). In the personal approach, which has mainly been adopted in this thesis, recovery may or may not include symptom remission or a return to normal functioning. It is instead seen as a process of personal growth and the creation of a meaningful life in spite of any illness (9). Research has shown that people with psychiatric disabilities can experience a better recovery process and pursue better quality of life with appropriate support and services (20-22). This thesis explores recovery promoting factors and subjective quality of life, as well as other health and well-being related factors, among people with psychiatric disabilities using community-based day center services or clubhouses.

Setting the scene

There is, according to Thornicroft and Tansella (23), evidence supporting the concept that mental health services models should include both hospital and community services. In areas where the societal level of resources is medium to high, as in Sweden (24), the community-based services should include alternative rehabilitation (23). Regarding occupation-based rehabilitation there are mainly three community-based approaches in Sweden today that aim to support people with psychiatric disabilities and provide meaningful occupations and social interaction. Municipality-run day centres (DC) (25) form the most common rehabilitation alternative. There are also private for-profit providers and clubhouses. The latter are based on the Clubhouse Model that has been implemented in over 300 sites globally (26). The clubhouses in Sweden are organized as foundations, or non-profit organizations, and are partly funded by grants from the municipality and regional health authorities (27). Which type of support and intervention is the most helpful in the rehabilitation process for people with psychiatric disabilities, and if DC services or clubhouses are more relevant in this respect, has been scarcely researched.

In a Swedish report (28), focusing on a national action plan for 2012 - 2016, three overarching areas of interest for mental health interventions and services were prioritized. These were: 1) equal, knowledge-based, accessible and good quality care and services, 2) accessibility to work and meaningful daily occupations and 3) opportunities for participation and influence. The report concludes that the accessibility to work and meaningful daily occupations needs to be improved. Furthermore, the need to increase evidence-based methods in care and social services for people with psychiatric disabilities is emphasized in the report (28). The Substance Abuse and Mental Health Services Administration's (SAMSHA) national register (29) of evidence-based practice concerning employment, quality of life and recovery in the USA has included the Clubhouse Model since 2011, but the need for further research has also been highlighted. Research regarding clubhouses in Sweden is scarce in spite of these being described as an alternative or complement to existing services (30). Research into DC has failed to show evidence for their effectiveness, for example, in terms of improvement in quality of life and psychosocial functioning and the need for randomized studies has been maintained (31). Participation in DC and

clubhouses is based on individual choice, however, which thus makes naturalistic studies more feasible, particularly since participation in DC is a legal right for people with psychiatric disabilities (32).

This thesis aims to enrich the knowledge about DC and clubhouses by comparing them to each other, with a particular focus on recovery-oriented factors and recovery-promoting experiences among the users. The recovery-oriented factors addressed in this thesis are opportunities for engaging in meaningful daily activities and accessibility to social interaction, which are central tenets in DC and clubhouses. Factors pertaining to perceived health and well-being will also be addressed.

Background

Severe mental illness and psychiatric disability

The term ‘severe mental illness’ (SMI) is commonly used in the literature and Tansella and colleagues (33) proposed that severe mental illness can be defined as any mental disorder with a psychosocial functioning score (GAF) (6) ≤50 and a duration of service contact for 2≥ years. SMI is one of the leading causes of disability worldwide (34). Mental disorders which are commonly associated with SMI are schizophrenia and other psychoses and affective disorders (23). Another term is ‘psychiatric disability’ which can be seen as long-term consequences of SMI significantly interfering with the individual’s performance of major life activities and participation in everyday life and that these difficulties are sustained over time (5). This definition of psychiatric disabilities does not focus on diagnoses but on the everyday difficulties, the disability entails. The target group of this thesis is people who have a psychiatric disability and live with the long-term consequences of SMI. The people in the target group have various diagnoses such as schizophrenia and other psychoses, affective disorders, anxiety, personality disorders or neuropsychiatric disorders. Their common denominator includes limitations in both activity and participation, which can be targeted by recovery-promoting factors in mental health services such as DC and clubhouses.

Recovery

There are several studies reporting subjective experiences of individuals recovering from a psychiatric disability (17, 35, 36). Recovery can from a clinical approach be seen as an outcome (37). Recovery can, however, from a personal approach be seen as both a process and an outcome (35, 38). Deegan (35) proposed that personal recovery is the lived experience of rehabilitation, which is a process where people are not “rehabilitated” but active in the process of overcoming the limitations in activity and participation (35). There are some studies, however, proposing that a polarized view on recovery may be unfounded. The results of a study by Davis and colleagues (39) showed that nonclinical (i.e. social, functional, existential, physical) components of recovery could mediate the relationship between clinical recovery and more community participation. Furthermore, Resnick, Rosenheck and Lehman (40), when developing a model of factors associated with a recovery orientation, found that severity of psychiatric symptoms was negatively associated with a subjective perception of and a positive attitude towards recovery. The authors concluded that the biomedical and personal recovery models were not incompatible, and that the use of services appeared to increase knowledge and support a recovery orientation (40).

A number of frameworks or models for personal recovery, based primarily on qualitative research, focus on the individual and propose that the recovery process is non-linear and involves stages or phases (21, 38, 41). While the recovery process has been described as a deeply personal journey there are several common characteristics that may help or hinder recovery such as connectedness, hope, identity, choice, personal development, meaning in life and empowerment (38, 42, 43). There are also personal factors that may impede recovery, such as negative beliefs, self-stigma (44, 45), and physical health problems (43).

Furthermore, research has shown that a lack of material resources, such as poverty, inadequate accommodation or lack of transportation are additional barriers for recovery because of their impact on possibilities and choice (43). Moreover, social exclusion, prejudice, stigmatization and discrimination are both individual experiences and social and political factors (46, 47). Focusing on mental healthcare services, negative staff attitudes, poor service quality and limited choice regarding services have also been described as impeding recovery (43).

Another framework for personal recovery was proposed by Onken and colleagues (17) who applied an ecological perspective on recovery. The ecological perspective focuses on both the individual and the environment, and particularly on the intra-action within the individual or the environment, and the interaction between both. Reoccurring themes regarding personal factors promoting recovery according to this perspective are for example: self-determination, hope, a sense of agency and meaning and purpose (17). Factors in the environment supporting recovery are for example: opportunities for meaningful daily occupations, social support and inclusion (17). By applying an ecological perspective, recovery can be facilitated or hindered by the interplay of characteristics and factors within the person (such as self-determination and self-esteem) or the environment (such as opportunities for meaningful daily occupations and social support). Further, the dynamic interaction between the individual and the environment can promote or hinder recovery, in terms of for example choice and opportunities regarding occupations (17).

This thesis applies a predominately ecological perspective by investigating personal factors such as self-esteem, subjective quality of life (SQOL), and self-rated health and environmental factors such as characteristics of services and people's social network. Opportunities for meaningful daily occupations will also be addressed by exploring subjective perceptions of aspects of occupation and the targeted rehabilitation settings' provision of such support.

Psychosocial rehabilitation

Occupation is widely used as a tool within the field of psychosocial rehabilitation (48) and the two rehabilitation contexts addressed in the present thesis, DC and Clubhouses, both focus on occupation-based rehabilitation. The word "occupation" is commonly referred to as paid work, but in this thesis, the concept denotes all types of activities, as defined by Kielhofner (1):

> "Human occupation refers to the doing of work, play, or activities of daily living within a temporal, physical, sociocultural context that characterizes much of human life". Thus, daily occupations include all types of everyday occupations people perform, such as self-care, home chores, work, leisure activities, and socializing with others."

The term psychosocial rehabilitation broadly refers to a range of educational, behavioral, cognitive, occupational and social interventions and services to support people with psychiatric disabilities and enhance their recovery (7). It can also include family education and support (8). Services that provide psychosocial rehabilitation aim at long-term recovery through a process of supporting the restoration of well-being and skills pertaining to work, leisure, daily living and social interaction (7). Other examples of psychosocial rehabilitation, not addressed in this thesis, are case management (49) and Individual Placement and Support (IPS) (50). Thornicroft (51) defined case management as the "coordination, integration and allocation of individualized care within limited resources". IPS is a vocational rehabilitation intervention (50) that has been found to be on par with or superior to the Clubhouse Model with respect to supporting open-market employment (52). Open-market employment, however, is only one of the goals of the Clubhouse Model. Whereas the latter is commonly described in the literature as an approach to psychosocial rehabilitation (26) the clubhouses have described themselves as intentional communities (53) where the members' participation has rehabilitative effects. Nevertheless, the Swedish National Clubhouse Association (Sveriges Fontänhus) states that the clubhouses provide an inclusive

rehabilitation programme (54). On the other hand, the legislated role of the DC is to provide meaningful daily occupations for the target group (32), and they do not necessarily have a rehabilitative approach. Although DCs just as clubhouses strongly emphasize psychosocial aspects, they may have more of a care approach, considering the fact that the staff often include people with nursing qualifications. The DCs are linked to the psychiatric services run by the municipalities while the clubhouses originate from the civil society. However, since meaningful daily occupation is an important component of psychosocial rehabilitation, DCs are generally considered to be a part of the rehabilitation services (25). Moreover, some DCs have over time been inspired by recovery principles and IPS.

Another important feature of psychosocial rehabilitation, apart from occupation, is the social environment and the provision of opportunities for social networking and social interaction (48). Both DC and clubhouses have been found to facilitate social interaction (55, 56). Participation has been described by both groups of users as creating feelings of inclusion and belonging (56, 57). The term social network refers to a set of individuals and the patterns of relationships between them (12). Social interaction and social support are two of the processes that may take place within the social network (58). Townly et al. (59) found that casual social interaction with community members could predict recovery and community integration, however, the more traditional social network support (for example family, friends or staff) was even more influential in these respects. Cohen and Wills (60) proposed two separate models to explain the mechanisms by which social networks influence health outcomes. The main effects model suggests that high levels of social support promote mental health regardless of the level of stress, whereas the stress-buffering model proposes that social support only acts as a buffer during times of high stress, thereby influencing the individual's health outcomes (60). Thoits (61) proposed, however, in more contemporary research, that the two models may not be mutually exclusive. It is possible that some dimensions of social support may affect mental health via main effects or "everyday" social support and other dimensions via stress buffering, or "major stress-related" social support (53). Social relationships, as in the case of other environmental factors, for example attitudes, may support or impede recovery. Although it is generally acknowledged that social interaction and social support play an important role in the recovery from mental illness (17), the interaction and support may also entail psychological costs in the sense of indebtedness (62) and dependency that may lead to feelings of helplessness and thus be disabling (58). It should also be noted that smaller social networks, which are common in the target group (63), do not necessarily reflect a perceived need for more social interaction and greater support (64) or imply less satisfaction with the social network (65).

Tanaka and colleagues (66) proposed that social environments such as those available in psychosocial rehabilitation programmes like DC and clubhouses can provide a safety net which can be beneficial for the users' recovery process. Conversely, researchers have argued that relying on relationships tied to programmes pose a risk for the users, and therefore the programmes should facilitate finding support in the community (67). Other researchers have described the safe and inclusive social environment at both clubhouses and DC as paradoxical since the safe and inclusive environment may present a risk to the users in developing a dependency that in turn can be counterproductive to orientation towards open-market employment (68, 69). This paradox has been addressed in terms of DC by Bryant and colleagues (70), who stressed the value of a safe and inclusive environment, and Swan (71) who argued that DC should open up more to the surrounding community.

Two approaches to psychosocial rehabilitation: day centres and clubhouses

During the last 40 years, many European countries have devolved hospital-based psychiatric care and developed community mental health services. Several of these countries have developed occupation-based rehabilitation programmes like clubhouses and day centers, for example social cooperatives in Italy (72) and mental health centres in Norway (73). Bryant (74) has described the evolvement of mental health day services, including DC, in Britain from the 1940s through the mid-nineties. She proposed

that the evolvement came out of a belief in the importance of social inclusion and recovery (74). According to Bryant (74) the multifaceted nature of the day services and DC has made studies of their effectiveness difficult, which was also concluded in a review by Catty et al. (31). DC services in the UK have traditionally had a collective approach which has limited user decision-making and choice in service provision (74). Bryant (74) argued that this collective approach in DC services may not be in concordance with the increased emphasis on the more individualized care and support in modern mental health services. Indeed, social care policies in the UK have aimed at making public service provision more tailored to the individual service user during the last decade (75). Through the introduction of individual mental health budgets people with psychiatric disabilities have been given greater choice, flexibility and control over their use of services. This can pose a challenge for providers of traditional mental health services like DC where the collective approach may hamper the possibilities to develop a more individually tailored approach (76).

In Sweden, the DC services were developed in the 1990s as a consequence of a reform largely transferring the responsibility for psychosocial rehabilitation from the county council health authorities to the local municipalities (77). The DCs in Sweden are mainly organized in two types; meeting-place oriented or work-oriented (25). The meeting place-oriented DCs offer activities such as playing games and socializing, whereas work-oriented DCs offer mainly scheduled productive activities, for example, cleaning, providing catering services or manufacturing goods. There are also DCs that are a combination of both (25). The DC services were developed with a general commitment to improve the lives of people with psychiatric disabilities. No model or theory was proposed as a foundation for the development, however, which means that in the local development of DC services several different models or approaches may have been applied.

The first clubhouse, Fountain House in New York, was founded in 1948, and as for the DC services initially lacking a guiding model or theory as a foundation (78). Fountain House was founded as a self-help group by former patients and staff from a closed-down mental hospital. After hiring John Beard as an executive director, who had a rehabilitative approach, a collaborative and organic process started that has led to the established Clubhouse Model of psychosocial rehabilitation of today (78). Contemporary research from Australia and the US (69, 79) has found the Clubhouse Model to be in concordance with several different theoretical frameworks for example Bronfenbrenner's ecological theory of development (80). This ecological framework is also what Onken et. al (43) proposed to organize and interpret factors of importance for personal recovery as previously described under the heading "Recovery". The first Swedish clubhouse opened in Stockholm in 1980 and there are currently twelve clubhouses in Sweden (54). All are members of Clubhouse International, which monitors a set of quality standards (International Clubhouse Standards) that serve as basis for the daily operations of the clubhouse (26). Two cornerstones of the model are: 1) an egalitarian relationship between the users (referred to as members) and the staff and 2) the work-ordered day (WOD). The WOD refers to a regular 9 to 5 workday where members join work-crews and together with peers and staff organize and run the daily operations of the clubhouse (81). The clubhouses are not consumer-run but strongly consumer-centered (82). Unlike DC services, which are only open during regular working hours, clubhouses also provide evening, week-end and holiday activities (81).

Descriptive and comparative research

A few international studies have compared DCs with other forms of care and support. Iancu et al. (83) explored experiences of recovery in DC participants and participants in a care farm programme. Compared to DCs the care farms were experienced as more open, real-life work settings with a variation in activities and a closer connection to society (83). Further studies have mainly compared DCs to day hospitals focusing on differences in the programmes offered and characteristics and needs of users (31). The results of these studies were inconclusive with respect to the users' clinical, social and service needs.

Swedish research on DC has been both qualitative and quantitative. Tjörnstrand et al. explored the characteristics of the daily occupations at DC in Sweden (25) and further found that the attendees' participation in these occupations created a feeling of social inclusion (57). The results of a study by Eklund and Sandlund (84) showed that DC attendees had more profound needs pertaining to support in daily life and used psychiatric services less often when compared to patients in out-patient care. Argentzell and colleagues reported that the DC attendees were more often engaged in activities than the group in out-patient care, but were not more satisfied with their everyday activities in general (85). A further study by Argentzell et al. (65) showed that the DC attendees had larger social networks than the group in out-patient care but they were not more satisfied with their networks.

The previous research on Swedish clubhouses has been mainly qualitative. Meeuwisse (86)found that there was a strong ideology at the Malmö Clubhouse, which most of the members identified with. The occupations at the clubhouse were characterized as having a clearly productive approach and the atmosphere was described as friendly. Some members claimed, however, that there was a fear of conflict from staff resulting in issues not being addressed (86). Norman (81) found that the personal relationships and the supportive environment at the clubhouse were dependent on and supported by the WOD. Further, the results of a Fountain House study in Stockholm by Karlsson (30) showed that the Clubhouse Model and its ideology and the daily practice were in concordance. This afforded the members with meaningful productive occupations and enriched social opportunities. Boregren Matsui and Meeuwisse (87) compared how the implementation of peer support was carried out in the everyday life in a Swedish and a Japanese clubhouse and found the Japanese clubhouse members' involvement in making decisions was relatively limited compared to that of the Swedish clubhouse members.

Studies comparing clubhouses with other forms of psychosocial rehabilitation by means of quantitative methodology appears to be scarce. There are, however, a few international studies comparing the Clubhouse Model with other programmes of psychosocial rehabilitation. The results have demonstrated that clubhouses' members had a better quality of life (88, 89), significantly lower scores on perceived stigma (88), fewer hospitalizations and less treatment utilization (89, 90), and were more economically self-sufficient than people in other psychosocial rehabilitation programmes (52, 91). The research so far leaves many questions unanswered, however, and to the author's knowledge, no study appears to have compared Swedish clubhouses with another approach to psychosocial rehabilitation.

Subjective aspects of occupation in relation to health

A core belief in occupational therapy is that health can be influenced through engagement in meaningful activity, that is, by occupation. Several subjective aspects of everyday occupations have been found to be associated with perceived health and well-being in occupational therapy and occupational science research (92, 93). One is occupational balance, defined by Matuska and Christiansen as "a satisfying pattern of daily occupation that is healthful, meaningful, and sustainable to an individual within the context of his or her current life circumstances" (2). It can also be defined as the individual's perception of having the right amount of daily occupations with the right variation (94). People with psychiatric disabilities are at risk for being under-occupied due to fewer occupational opportunities and less social interaction (55). The opposite situation, being over-occupied, has been found to be less common in the target group (95-97). Furthermore, how satisfied a person is with his or her daily occupations is another aspect of importance for health and well-being (98).

A further aspect is occupational engagement, which concerns the extent to which a person experiences a sense of meaning in occupations and has a range and variety in their daily occupations that form a structure that organizes time (3). Qualitative research has identified a connection between occupational engagement and one's self-perception as a healthy and capable person (99, 100). Quantitative research has shown that higher levels of occupational engagement tend to be related to fewer psychiatric symptoms and better self-rated health and well-being (3), quality of life and satisfaction with life as a

whole (15, 93), and increased empowerment (101). The results of a study by Eklund and Leufstadius showed that people with psychiatric disabilities who spent more time working, and those who spent time engaged in occupations in general were better off in terms of factors pertaining to health and well-being such as self-rated health, perceived self-mastery and social interaction (98). Furthermore, the results of a qualitative study by Kelly and colleagues (102) found several benefits from occupational engagement including: "feelings of social cohesion, meaning, purpose, normalisation, routine, competence, productivity, skill acquisition, routine and pleasure". These findings corroborate findings from other narrative studies that have highlighted a link between occupation, mental health and recovery (41, 103)

Person, environment and occupation perspectives

There are several different occupational therapy models. In the theoretical basis of these models, the two-dimensional ecological framework as described by Onken et al. (17) is commonly extended by adding occupation as a third dimension. One of these models is the Person Environment Occupation (PEO) Model (104). The concepts of the PEO-model are the person, the environment, the occupation and, in the interaction of these, occupational performance (Figure I).

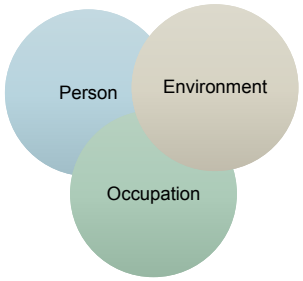

Figure I. The PEO-model adapted from Law et al (103).

The PEO-model emphasizes the interdependence between the person and the environment. It is assumed that the person is dynamic and interactive with the environment. This continues throughout the lifespan, and when the environment changes so do the person's occupational performance. The PEO-model also addresses the fit between the person, the occupation and the environment. Changes in occupational performance are regarded as a consequence of variations in person, environment and occupational fit and a maximized fit thus maximizes occupational performance (104).

The Model of Human Occupation, MOHO (1) is another conceptual practice model that guides practice and research in occupational therapy. MOHO explains how meaningful daily occupations are motivated, organized into everyday life patterns, and performed in the context of the environment. As in the case of the PEO-model it is maintained in the MOHO that the person and the environment (physical, social, cultural, economic and political) cannot be separated in occupational performance. All environments can thus potentially offer opportunities or constraints, resources or demands. Within the frameworks of the MOHO and the PEO-model disability can be understood as occupational performance problems that are sustained over time and that can occur when there is a mismatch between the person, the environment and the occupation (1, 104).

This definition of disability is congruent with the International Classification of Functioning, Disability and Health (ICF) (105). The ICF is a classification of health and health-related domains and it is the WHO framework for measuring health and disability at both individual and population levels. According

to the ICF, a disability is not simply the consequence of a diagnosis that a person has, but reflects an individual's abilities and limitations in relation to the supports and demands of the environment where the person engages in daily occupations and participates in society. The ICF is structured in two parts, each with two components: 1a) body functions and structure, and 1b) activities and participation factors and 2a) environmental factors and 2b) personal factors (105). Body functions and structure include global mental functions for example energy and drive, and specific mental functions, such as memory. The environmental factors focus both on the individual's environment such as the workplace and on societal factors such as services like DC and clubhouses. In ICF, the activity component comprises of nine different domains, of which one example is "community, social and civic life", and participation is defined as involvement in a life situation. Finally, the personal factors may include for example: gender, age, lifestyle, habits and individual psychological assets such as self-perceived health, self-esteem and subjective quality of life, all of which may play a role in psychiatric disability (105).

A third occupational therapy framework, congruent with the aforementioned ones, is the Value and Meaning in Occupations (ValMO) model (4). In the ValMO framework, the values of occupations are generated in the dynamic interplay between the person, the task performed, and the environment. The ValMO model especially emphasizes the value people experience when performing their daily occupations since this is related to how they perceive meaning in life, which in turn is important for health and well-being (106). This has also been confirmed in empirical studies (106). According to the ValMO model, there are three dimensions of occupational value. Concrete value is when an occupation leads to a concrete result, such as a product or learning something. Symbolic value concerns personal representations connected with an occupation. A person experiencing symbolic value in an occupation can feel strengthened in an important life role, such as being a parent. The third type of value, self-reward value, is when an occupation is performed solely for fun and pleasure (4).

A final model is the Canadian Model of Occupational Performance and Engagement (CMOP-E) which was founded by Polatajko, Townsend and Craik (107). The CMOP-E is a further expansion of the Canadian Model of Occupational Performance (CMOP) where E for engagement is added as a conceptual advancement of the original model. As in the models previously described in this section, occupational performance is the outcome of the dynamic interplay between the person, the environment and the occupation. The CMOP-E, however, proposes that as for performance, engagement is also an outcome of the dynamic interdependent relationship between the person, the environment and the occupation.(107).

The CMOP-E and ValMo perspectives as described above can be applied to illustrate personal factors in the target group and environmental factors in the setting of this thesis, which are of importance for recovery (Figure II).

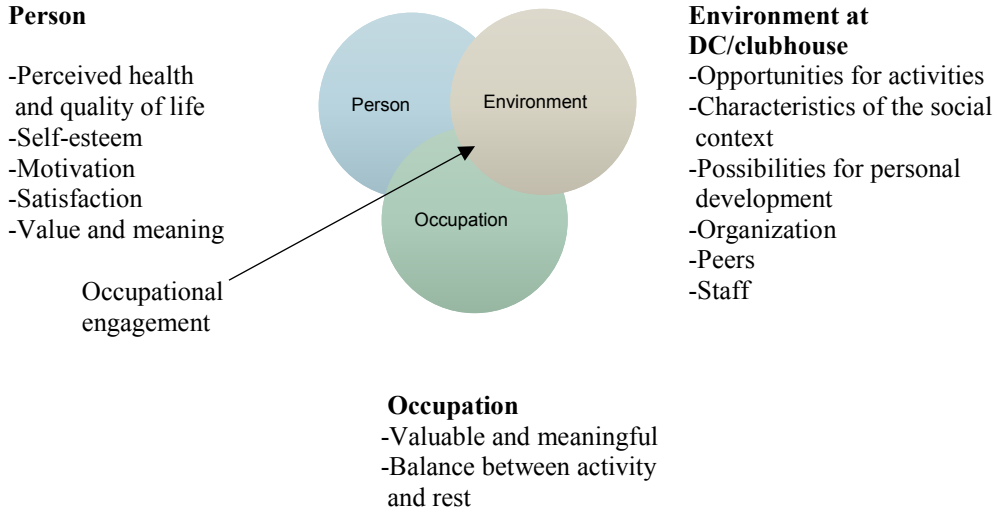

Figure II. Applying the CMOP-E and ValMO models on the thesis' target group and setting (adapted from Townsend et al [107] and Persson et al. [4]).

Rationale

Previous comparative research indicates that the Clubhouse Model has advantages, in terms of the factors focused on here, in comparison with some forms of psychosocial rehabilitation. In the US, the Clubhouse Model is included in the SAMSHA's national register (29) of evidence-based practices. The Swedish government has stressed the need to increase evidence-based methods in social services like DC (28), which makes comparisons with the Clubhouse Model interesting. Few studies have been found that compare either DCs or the Clubhouse Model to an equivalent approach to occupation-based psychosocial rehabilitation, however, and no study seems to have compared DCs with clubhouse programmes. When considering the importance of meaningful daily occupations, socialization and community participation for mental health recovery (108, 109) there is a knowledge gap that needs attention regarding how the attendees perceive the services provided by DC and clubhouses in these respects. Whether either of the two approaches has advantages over the other and is better fitted to support people in their participation in daily activities and society, and thereby in their recovery process, is unknown and research is warranted.

Previous research shows that factors of importance for recovery, for example the social network, often decrease over time in the target group. It is thus of importance for services that offer long-term support like DC and clubhouses to support the individuals in maintaining stability over time regarding factors that may promote their recovery. Furthermore, research is warranted regarding predictors of recovery-promoting factors in the target group of this thesis. As occupation constitutes the major tool for rehabilitation, exploring the relationship between aspects of occupation and recovery is also of importance. Increased knowledge in these respects can form an important basis for the planning of psychosocial rehabilitation and support within community mental health services.

Thesis aim and specific aims

The overarching aim of this thesis was to compare two approaches to psychosocial rehabilitation – day centres and clubhouses – and to explore if either appears better suited to support people in recovery. This was addressed by studying: i) differences between participants in the two rehabilitation approaches in a cross-sectional perspective, ii) maintenance of recovery-promoting factors over time, and iii) if participation in any of the settings would predict recovery-promoting factors. The recovery focus of this thesis is on opportunities for engaging in meaningful daily occupations, accessibility to social interaction and factors pertaining to perceived health and well-being.
More precisely the aims were to:

Study I

The main objective of this study was to compare DCs and clubhouses concerning recovery-generating factors in terms of the users' perspective on unit and programme characteristics, and different aspects of their everyday occupations in terms of engagement and satisfaction. Furthermore, this study aimed at exploring attendees' motivation for participation in DCs and clubhouses and the relationship with aspects of occupation.

Study II

The overarching aim was to compare users of DCs and clubhouses regarding perceptions of their social network and social interaction. The specific aims were a) to compare the groups on social network size and social interaction, and investigate change in each group separately from baseline to a nine-month follow-up; b) to compare the groups regarding the roles of persons identified as giving the users emotional support; and c) to explore which baseline factors could predict the social network size cross-sectionally and longitudinally.

Study III

The primary aim was to compare users of DCs and clubhouses regarding subjective quality of life (SQOL), and the maintenance of SQOL over time. A further aim was to investigate predictors of SQOL. Two hypotheses were tested:
1. Both clubhouse and DC participants would maintain their SQOL in a nine-month follow-up perspective.
2. Type of rehabilitation service (DC versus clubhouse) and baseline factors pertaining to self-esteem, psychosocial functioning, social network, satisfaction with daily occupations, choice and opportunity to influence decisions in the programme, and satisfaction with DC/clubhouse programme would influence SQOL at follow-up.

Study IV

The primary study aim was to explore which factors could predict personal recovery at baseline and follow-up among users of clubhouses when considering occupational value, occupational balance, satisfaction with daily occupations, occupational engagement and socio-demographic and clinical factors as predictors. A secondary aim was to investigate stability over time in personal recovery from baseline to a nine-month follow-up.

Material and methods

An overview of the study design, participants and settings and methods for the four studies of the present thesis are presented in Table I.

Table I. An overview of study design, participants and settings, data collection and data analysis.

Study	Study design	Participants and settings	Instruments	Method of data analysis
Study I Programme characteristics, motivation and relation to occupations	Comparative combined cross-sectional and longitudinal quantitative	Participants in day centres n=128 (116)* Participants in clubhouses n=57 (37)*	EPM-DC GAF Motivation among DC attendees and clubhouse members POES-P SDO-B Self-reported diagnosis Socio-demographic questionnaire	Statistical analyses with IBM SPSS version 21
Study II Social network	Comparative combined cross-sectional and longitudinal quantitative	Participants in day centres n=128 (116)* Participants in clubhouses n=57 (37)*	GAF ISSI/AVSI Rosenberg Self-esteem scale POES-P, two items Self-reported diagnosis Socio-demographic questionnaire	Statistical analyses with IBM SPSS version 21
Study III Subjective quality of life	Comparative combined cross-sectional and longitudinal quantitative	Participants in day centres n=128 (116)* Participants in clubhouses n=57 (37)*	GAF MANSA Rosenberg Self-esteem scale Self-rated health (SF-36) CSQ-8 SDO EPM-DC subscale IV Self-reported diagnosis Socio-demographic questionnaire	Statistical analyses with IBM SPSS version 21
Study IV Recovery and subjective perceptions of occupations	Combined cross-sectional and longitudinal quantitative	Participants in clubhouses n=57 (37)*	GAF IMR OVal-Pd POES-P SDO-B Self-reported diagnosis Socio-demographic questionnaire	Statistical analyses with IBM SPSS version 21

*=follow-up

Study design

The study employed an observational, naturalistic design. Studies I-III employed a combined cross-sectional and longitudinal comparative design. The samples compared were people with psychiatric disabilities attending DC services or clubhouses. The studies explored subjective perceptions of occupation and the relationship with motivation for participation in the programmes (Study I), social interaction (Study II), and factors related to health and well-being (Study III). Study IV explored the relationship between subjective perceptions of occupations and recovery among clubhouse members. Two measurement points were chosen to obtain more robust data for investigating the main aims, but also to address stability over time regarding the addressed factors.

Study context

A total of ten DCs were purposefully selected to represent rural and urban areas with different socio-economic circumstances and included in the project. Six of these were from one region in central Sweden and four from three regions in southern Sweden. An inclusion criterion for the DCs was that there should be no changes in organization of services or how services was provided during the time of the study. The DC units were of work-oriented as well as of meeting place-oriented character. The professional backgrounds of the staff at DCs were, for example, occupational therapists, social workers, recreational therapists and craftsmen.

There are currently a total of 12 clubhouses that are located in both cities and rural areas in central and southern Sweden. Five of these clubhouses were purposefully selected to represent rural and urban areas that were socio-economically equivalent to those where the DC sampling was made. The majority of the staff at the clubhouses were, for example, social workers, teachers, guidance counsellors or artists. There was also staff who had expertise in, for example, computers and crafts.

Participants and inclusion criteria

All eligible DC attendees and clubhouse members in the selected settings were invited to participate. A minimum attendance of four hours per week was an inclusion criterion. Exclusion criteria were: substance abuse as the main diagnosis and co-morbidity with dementia or learning disabilities. No interpreter was used, and since the interview and the self-report instruments were in Swedish, the participants had to be able to understand spoken and written Swedish. Characteristics of the participants are presented in Table II. Comparisons between the samples showed no significant differences regarding gender ($p=0.467$), age ($p=0.978$), civil status ($p=0.902$), education ($p=0.528$), having children ($p=0.148$), or self-reported diagnosis ($p=0.159$). There was a significant baseline difference regarding psychosocial function measured by the GAF score, DC attendees being rated lower ($p=0.010$), but no such difference could be established at the follow-up ($p=0.060$). At baseline the study included a total of 185 participants, of whom128 were DC attendees and 57 clubhouse members. At follow-up the DC group consisted of 116 participants and the clubhouse group of 37 participants. Reasons for attrition were open-market employment, a decline in mental health, inability to locate the person or not wanting to participate in the study.

Table II. Socio-demographic and clinical characteristics of the participants at baseline.

Characteristics	DC (*n*=128)	Clubhouses (*n*=57)
Gender: male: *n(%)*	60(47%)	23(41%)
Age: *mean (min.-max.)*	48.7(23-72)	48.7(28-69)
Civil status; married or cohabitant: *n(%)*	17(14%)	8(14%)
Educational level: *n*(%)		
not completed compulsory school	8(6%)	1(2%)
completed compulsory school	35(28%)	12(23%)
completed sixth-form college	61(48%)	28(54%)
completed undergraduate studies	22(18%)	11(21%)
Having children; yes: *n(%)*	59(46%)	19(35%)
Hours per week at DC or clubhouse: m*ean(min[1]-max)*		
Baseline	15(2-35)	21(5-40)
Follow-up	15(1.5-35)	21(4-40)
Self-reported diagnosis: *n(%)*		
Psychoses (F20)[1]	27(21%)	8(14%)
Mood and anxiety disorders (F30+F40)	47(37%)	29(51%)
Autism/neuropsychiatric disorders (F80+F90)	16(12%)	5(9%)
Other disorders (mostly F60 and unknown)	38(30%)	15(26%)
Global Assessment of Functioning (GAF): *med(min-max)*	47(20-85)	51(30-80)

Note: Internal attrition was between 0 and 8 on the above variables.[1)] One DC participant reported less than the stipulated minimum of four hours on both occasions due to an episodic decline.[1] F20, F30, F40, F60, F80 and F90 are codes in the clinical cataloguing system ICD-10 (International Statistical Classification of Diseases and Related Health Problems - Tenth Revision.

The accessibility of clubhouses is considerably lower than for DC, due to the fact that there are only a total of twelve clubhouses in Sweden today. Partly because of this, participation may be a result of choice, coincidence, or a mixture of both. Since DC is a legislated service, the vast majority of the 290 Swedish municipalities provide these services. Small municipalities with few potential users may reimburse a neighbouring municipality or private provider for these services. In some municipalities, participation in DC is based on a needs assessment performed by the local social services.

No previous study could provide information for an empirically based power analysis, which made the research team perform a calculation based on effect size. The analysis indicated that a sample size of n=60 in both groups would be sufficient for detecting a moderate effect size (0.70) with a power of 0.80 at $p<0.05$. This number was not reached for the clubhouse group, but the statistical power in the comparative analyses was increased by the fact that the DC group was larger than the clubhouse group. According to Altman (110), a larger sample size in one of the groups can compensate for a smaller number in the other, up to a proportion of 1 to 3, which was approximately the ratio between the groups at the follow-up (110).

Recruitment at setting level

Studies I-IV

The DC attendees came from two different projects. Firstly, the four DCs in the three regions in the south of Sweden had served as a control group in an intervention study. Representatives of DC services in the three regions were invited to an information meeting. Eight DCs agreed to participate in the study, and were subsequently randomized into two equivalent groups, the intervention or the control condition. The study aimed at investigating the effectiveness of an intervention to improve DC services (111). The intervention was tailor-made to bridge identified gaps in the services. It consisted of several steps and both DC attendees and staff took part. The control group could be included in the present study since they had not been part of the intervention. The data collection included a baseline measurement and a follow-up after seven to nine months, which were used for the present thesis.

Secondly, the six DCs in central Sweden came from a project investigating organizational change in DCs due to new Swedish legislation concerning freedom of choice in social services and health care (112). The change to be launched was an open-market system that included users' freedom to choose any DC in the city and possibilities for alternative providers of DC services to enter the market. Before the new providers entered the market, two measurements with a nine-month interval were made to establish a baseline before the change had been launched. These data were used for the present thesis.

The managers of the selected DCs in central Sweden were contacted. They were informed about the study and asked whether the researchers and project assistants could visit the unit to inform attendees and staff about the study. The procedure was the same for the five clubhouses, except that the managers first asked for the members' approval before agreeing to a visit. At the clubhouses the author of this thesis, and a research assistant on two occasions, were invited to meetings where all clubhouse members had the opportunity to attend. The follow-up in the clubhouse sample was conducted after nine months. After giving informed consent the study participants, in both contexts, were contacted by a project assistant to schedule a time for data collection.

Data collection

Several different instruments were used to collect the data in Studies I-IV (Table I). The data in the DC sample were collected between 2008 and 2011, and in the clubhouse sample between 2012 and 2014.

Instruments

Evaluation of Perceived Meaning in Day Centers (EPM-DC)

The Evaluation of Perceived Meaning in Day Centers (EPM-DC) was used to compare DCs and clubhouses concerning unit and programme characteristics (113). The instrument consists of 60 items in total which characterize the DC and its activities in terms of meaningfulness. These items comprise four aspects of perceived meaningfulness: A. Opportunities for activities (17 items), B. Characteristics of the social context (11 items), C. Possibilities for personal development (21 items), and D. The organization of the day centre (11 items). All items are rated on a four-point scale where a higher rating reflects more perceived meaningfulness. Psychometric testing of the EPM-DC has shown good scaling properties and satisfactory construct validity (113). Cronbach's alpha for the present sample was 0.83.

GAF

Global Assessment of Functioning, GAF (6) was used to measure psychosocial functioning. The GAF consists of two separate scales one for symptoms and another for functioning. The GAF score denotes psychological, social, and occupational functioning on a hypothetical continuum ranging from extremely good mental health (=100) to extremely bad mental ill-health (=0) (6). The scales have 100 scoring possibilities, from 1 to 100 where a higher value indicates fewer and/or less severe psychiatric symptoms and higher psychosocial functioning. The lower of the two scale ratings is the final score when using only one score, as in this thesis. The research assistants had received specific training including calibration for the GAF rating. Psychometric research has found the GAF to be reliable after a relatively short period of rater training (114).

Illness Management and Recovery (IMR) Scale

The consumer (client) version of the IMR scale (115, 116), which provides self-reports on clinical, functional, personal and social domains of recovery, was used in the present study. The IMR contains 15 items in the following areas: personal goals, knowledge of mental illness, involvement with significant others, impaired functioning, symptoms, stress, coping, relapse prevention, hospitalization, medication, and use of drugs and alcohol. Each item is rated on a 5-point Likert scale ranging from 1=very little recovery to 5=a great deal of recovery (115). Psychometric testing of the IMR has shown moderate to high estimates of internal consistency and strong test–retest reliability (115, 117). Cronbach's alpha for the present sample was 0.62.

The Manchester Short Assessment of Quality of Life (MANSA)

MANSA (118) was employed to assess SQOL. MANSA includes an individual's subjective rating of general life satisfaction and satisfaction with 11 different domains of QOL. The domains include work, financial situation, social relations, leisure, living situation, personal safety, family relations, sexual relations, and physical and mental health. Ratings are made on a scale ranging from one (could not be worse) to seven (could not be better) (118). The mean ratings from the different domains form a general SQOL score. In the present study both the specific SQOL domains and the general SQOL score were used to explore correlations. The Swedish version of MANSA has been found to be psychometrically sound in terms of internal consistency and construct reliability (119). Cronbach´s alpha for the current sample was 0.80.

Motivation among DC attendees and clubhouse members

The present study employed four items to assess motivation to attend the DC/clubhouse. These four items were developed in a previous study by Eklund and Tjörnstrand (120)to assess motivation in DC attendees. The items were: "How motivated are you to attend this DC/clubhouse?"; "To what extent do you agree with the statement 'I set up clear goals for what to do in this DC/clubhouse'?"; "How much would you prefer to spend your time on your own?"; and "How much would you prefer to have paid work to go to?". These items were rated on a visual analogue scale (VAS) ranging from 1 to 100. Two expert panels, one composed of researchers within the field of psychosocial rehabilitation and the other of representatives for people attending DC, were engaged to discuss the face validity of the items. The items were found to adequately reflect motivation for attending DC by both panels (120). Furthermore, the four items have shown test-retest stability (121).

Occupational engagement

Occupational engagement was measured by means of the Profiles of Occupational Engagement in people with Severe mental illness – Productive occupations (POES-P) (122). The POES-P consists of two parts, the first being a time-use diary covering the last day at the clubhouse, and the second an eight-item rating of occupational engagement based on the time-use diary. The eight items, which target aspects such as autonomy, perceived meaning and taking responsibility, are rated on a four-point scale where 1= not at all and 4= always. The total score indicates the level of engagement in daily productive occupations (123). A psychometric study found that the internal consistency of POES-P was good and that there was support for construct validity (123). The test-retest stability of POES-P is as yet unknown. The Cronbach's alpha based on the present sample was 0.78.

Occupational Value with predefined items (OVal-pd)

The revised 18-item version of the OVal-pd (124) was used to assess occupational value in the present study. It comprises six items reflecting concrete value, four reflecting symbolic value and eight reflecting self-rewarding value. The assessment has four response alternatives: 1=not at all, 2=rather

seldom, 3=rather often, and 4=very often. The respondents rate how frequently they experience the type of value exemplified in the statements. A mean rating for the overall occupational value rate, as well as a rating for each type of occupational value, is obtained. The 18-item version of OVal-pd has shown good internal consistency and construct validity (124, 125) although its test-retest stability is as yet unknown. The Cronbach's alpha for the present sample was 0.91.

The Interview Schedule for Social Interaction

The Swedish self-report version (ISSI-SR) (126), of The Interview Schedule for Social Interaction (ISSI) (127) was used in this thesis. Psychometric testing has indicated good reliability and validity of the ISSI-SR when used with people with different psychiatric conditions (126). The ISSI-SR comprises 30 items that form four sub-scales. Two of the sub-scales examine aspects of social interaction: Availability of Social Integration (AVSI), which addresses the amount of social contacts a person has, and Availability of Attachment (AVAT), which concerns access to close relationships. The other two address the quality of the same aspects. The present study used a brief scale to measure the social network; it combines five items from the AVSI sub-scale, which has shown the best psychometric properties of the ISSI-SR subscales (123) and two items from the AVAT sub-scale. This brief scale has been proposed as adequate when using several instruments with respondents that are easily exhausted, such as people with psychiatric disabilities (A. Bengtsson-Tops, personal communication, September 1, 2009). The maximum sum score of this brief scale is seven. A Cronbach alpha coefficient of 0.58 based on the current sample indicates somewhat low internal consistency but sufficient for group comparisons (128).

The Satisfaction with Daily Occupations and Occupational Balance (SDO-OB) scale

The SDO-OB scale (97) was used to assess satisfaction within four domains of daily occupations (work, leisure, domestic tasks, and self-care) and occupational balance. The scale is based on the original Satisfaction with Daily Occupations (SDO), which is an interview-based instrument. The SDO has shown good psychometric properties concerning factor structure, construct validity, internal consistency, test–retest validity and criterion validity among people with and without mental disorders (129, 130). The SDO consists of 14 items where each item consists of two parts. In the first part, the person is asked if he/she presently performs the occupation. In the second part, satisfaction with this is rated on a seven-point Likert scale where 1= worst possible and 7=best possible, regardless of whether or not the person presently performs the occupation. The SDO-OB also contains five questions addressing occupational balance from "a doing perspective"; one for each of the four domains (work, leisure, domestic tasks, and self-care) and one addressing general occupational balance. These questions focus on whether the respondent thinks he/she has been doing just enough, too much or too little of the targeted occupations. A five-point scale is used for the occupational balance rating, from -2 =way too little to 2 =way too much (97). The Cronbach's alpha for the present sample was 0.80.

Satisfaction with DC/clubhouse services

The participants' perceived global satisfaction with the DC/clubhouse was measured with the Swedish version of the CSQ-8, which is a short version of the Client Satisfaction Questionnaire, CSQ-18 (131). The eight items of the CSQ-8 are rated on a four-point scale ranging from 1 (very dissatisfied) to 4 (very satisfied). An overall score is produced by summing all item responses. The results of a study by Attkisson and Zwick (132) showed that the CSQ-8 had excellent internal consistency. In a previous Swedish study where the sample was DC attendees the alpha coefficient was 0.85, thus indicating good internal consistency (120). The Cronbach's alpha of the present project was 0.84.

Self-esteem

The Rosenberg Self –Esteem scale (RSES) which was used in the present thesis was designed to measure a global sense of self-worth (133). The scale consists of ten questions that in the present study were

answered with yes or no by the respondent. The RSES has two subscales, indicating positive and negative self-esteem, and the final score, which may vary from -1 (negative) to 1 (positive), is expressed as a balance between the two. The RSES has been found in psychometric testing to have satisfactory item convergent and discriminant validity, internal consistency and to be without floor and ceiling effects (134) and to have good test-retest reliability (135). Cronbach's alpha of the present sample was 0.80.

Socio-demographic and clinical factors

A questionnaire devised specifically for this thesis was used to collect socio-demographic factors such as gender, age, civil status, educational level and hours spent weekly at the day centre or clubhouse. The participants were also asked if they had a close friend and had seen this friend during the last week or not. Furthermore, the participants were asked for their self-reported diagnosis. A diagnosis made by a professional could not be obtained since no medical records were kept at the DCs or clubhouses. Based on these self-reports a specialist psychiatrist made ICD-10 diagnoses according to a previously validated procedure (84).

Data analysis

Studies I-IV

The data analyses were performed with the IBM-SPSS software, version 21 (Chicago, IL). The level of significance was set at <0.05.

The data were mainly ordinal and non-parametric statistics were thus used:

- The Mann–Whitney U test was applied to investigate differences between the two groups; DC attendees and clubhouse members at baseline and follow-up.
- The Kruskal-Wallis' H-test was used when comparing three or more groups on ordinal scales.
- The Wilcoxon signed-rank test was applied to investigate within-group differences over time.
- The Spearman rank correlation was employed to examine relationships between variables.
- Logistic regression analyses were performed to further analyze which of the investigated independent variables could best explain the level of social network (Study II), subjective quality of life (Study III) and recovery (Study IV). P<0.10 was set as the limit for including independent variables in the regression analyses.
- Categorical variables were investigated using the Chi-square test, and the Kruskal-Wallis' H-test when the categorical variable had more than two categories.

Missing data are common in self-report surveys, and they occurred in this study. Imputation with the individual's mean was applied to handle missing data in the measurements as recommended by Hawthorne and Elliott (136). The limit for imputation was 75%; when a smaller proportion of items was completed the individual measurement was treated as missing data.

Ethical considerations

According to the Act concerning the Ethical Review of Research Involving Humans (137) a fundamental principle is the respect for the individual and his or her right to self-determination and to make informed decisions. Furthermore, the subject's welfare must always take precedence over the interests of science and society, and the subject is allowed to withdraw his/her consent to participate in a research project at any time (137). As part of the ethical consideration the ethical principles of respect for autonomy, beneficence, non-maleficence and justice (138) have been taken into consideration. The thesis studies were approved by the Regional Ethical Review Board at Lund University. Regarding the DC sample, the participants consented to participate in the original studies (Reg. no. 2008/274; Reg. no. 2009/625). The Regional Ethical Review Board at Lund University later approved that the data could be used in the present thesis project, together with the approval for the Clubhouse study (Reg. no. 2012/70). The principle of respect for autonomy.

Research is allowed only if the subject has consented to the research that concerns him or her. In order for the consent to be valid the subject must receive information on the research beforehand. The consent is to be voluntary, explicit, and specific to a certain research project. Furthermore, the consent needs to be in writing. Consent may be withdrawn at any time, effective immediately (134). In the present study the participants received oral and written information about the study aims, research designs, and confidentiality before giving their written consent. All participants were also informed that their participation was voluntary and that they could withdraw their consent at any time without any consequences for their ongoing participation in the programmes.

The principles of beneficence and non-maleficence

With regards to the principles of beneficence and non-maleficence (138) there were no immediate risks of harm being done to the participants. Most participants expressed a willingness to share their experiences and wanted to contribute to the knowledge of psychiatric disability and rehabilitation. Discomfort may, however, have occurred during data collection, since it required both time and concentration. Breaks were thus taken when needed. Furthermore, the instruments used in the study included sensitive data on for example diagnosis and health, which may be considered private. The research assistants therefore emphasized the participants' own decision to answer the questions and strove to create a safe environment during the data collection. All data were anonymous and stored in a locked cabinet to ensure that no unauthorized person could access it. Moreover, all findings were presented on a group level, preventing the identification of individuals.

The principle of justice

According to the principle of justice (138) all participants should be treated equitably. The recruitment of the study participants was based on the aims of the thesis and did not discriminate because of gender, age or religion. All the participants received the same information about the project and had the opportunity to contact the author for additional information.

Summary of findings

Programme characteristics, motivation and everyday occupations

The two samples were compared concerning unit and programme characteristics. They did not differ in the total EPM-DC score at baseline. A difference was found, however, regarding the subscale 'the organization of the DC', where the DC attendees rated this at a lower level. Similarly, there was no difference between DCs and clubhouses in the analysis of the total EPM-DC score at follow-up. The DC attendees, however, again scored lower on the subscale 'the organization of the DC' and also on the subscale 'characteristics of the social context'.

Two aspects of everyday occupations were explored: occupational engagement and satisfaction with everyday occupations. When comparing the two settings in terms of occupational engagement, the analysis did not reveal any difference between the two groups either at baseline or at follow-up. Furthermore, the DC attendees scored higher at baseline than their counterparts in clubhouses on satisfaction with everyday occupations. At follow-up there was no such difference.

Regarding the users' motivation to attend the programmes and setting clear goals for the participation in DCs or clubhouses the analysis showed no significant baseline differences between the groups. Both groups were highly motivated to participate in the respective programmes. Both groups rated low levels for the item 'would rather spend my time alone', and the clubhouse members scored significantly lower in this respect. Furthermore, the clubhouse members scored significantly higher on 'would rather have open-market employment'.

In the DC group, a positive association between the 'motivation to attend DC' and both occupational engagement and satisfaction with everyday occupations was found. Furthermore, there was an association between motivation in terms of 'setting clear goals for what do at the DC' and occupational engagement as well as satisfaction with everyday occupations. The analyses showed negative associations between 'rather wanting to spend time alone' and occupational engagement as well as between 'rather be employed' and satisfaction with everyday occupations. Regarding the clubhouse group, 'motivation to attend the clubhouse' and 'to set clear goals for what to do at the clubhouse' were positively associated with occupational engagement. 'To set clear goals' for what to do at the clubhouse also showed a significant association with satisfaction with everyday occupations.

Finally, stability over time was examined. The result showed that satisfaction with everyday occupations increased more in the clubhouse group but the unit and programme characteristics variables (EPM-DC) and occupational engagement were shown to be stable in both groups. Hours of attendance remained stable between baseline and follow-up in the DCs as well as in the clubhouses.

There were few differences between DC and clubhouses regarding the studied factors. The clubhouses, however, appeared to be somewhat more beneficial in terms of users' opportunities for choice and decision-making in the programme, and for stimulating socialization among the participants.

Social interaction

Perceived social engagement and social functioning did not differ between the groups and remained stable over time. The DC group scored significantly lower on size of the social network compared to the clubhouse users at both baseline and follow-up.

Fewer participants in the DC reported having a close friend but there was no difference regarding having recently (the past week) seen a friend. The persons who were named by the DC attendees and clubhouse members as providing them with emotional support could be divided into the following five different categories: no one, family (for example partner, spouse, parent, sibling, or grandparent), friend, staff at DC/clubhouse, and professional (e.g. psychologist, mental health worker, social worker, clergy). The analysis showed no difference between the groups regarding the response to "Someone who would feel happy just because you are happy". When naming "someone with whom you can share your innermost thoughts and feelings", the DC group named more professional contacts, fewer friends and more often "nobody" compared to the clubhouse group. The naming of family members and DC/clubhouse staff were similar in the groups.

In the study of the predictors of social network at baseline, which was analyzed on the two samples together, the odds ratios indicated that a high level of self-esteem was associated with a close to threefold chance, and having seen a friend a fourfold chance, of belonging to the group with a larger network in a cross-sectional perspective (baseline). Strong indicators of belonging to the group with a larger social network at follow-up were being a woman and attending a clubhouse programme, both of which were associated with a close to a threefold chance of belonging to the group with a larger social network. Belonging to the group with a larger social network at baseline showed an odds ratio of 2.5 for belonging to the group with a larger social network at follow-up. Despite the slightly lower odds ratio, the social network at baseline was highly significant, more so than for gender and group. The findings indicate that all three factors, gender, type of service and baseline social network, played important roles for social network at follow-up.

To conclude, female gender showed to be beneficial for size of social network and visiting clubhouses appeared to be advantageous in a longer-term perspective.

Subjective quality of life

Both the clubhouse and the DC group showed low SQOL in various respects. Neither group reached satisfaction (a rating of 5 or more) at baseline for life as a whole or for the domains of economic situation, sex life, physical health and mental health. Furthermore, the clubhouse group was not satisfied with leisure activities and the DC group was not satisfied with the working situation. At follow up, the DC group still scored below 5 on life as a whole, work situation, economic situation, sex life and physical and mental health. The clubhouse group, however, only scored below 5 on economic situation, sex life and physical health.

The groups did not differ regarding the SQOL index at baseline. Analyses of differences between baseline and the follow-up showed that the SQOL index was maintained in both the clubhouse group and the DC group. However, at follow-up the clubhouse group scored significantly higher than the DC group.

In the total sample, SQOL at follow-up was associated with baseline self-esteem, social network, satisfaction with daily occupations and the SQOL at baseline. The dependent variable in the regression model was the dichotomized variable SQOL at follow-up. The fact that the samples differed

significantly regarding the SQOL index at follow-up supported that the variable group (DC/clubhouse) should be included as an independent variable in the regression model. Further independent variables included in the model were the baseline variables: self-esteem, social network, satisfaction with daily occupations and the SQOL index. The strongest indicator for belonging to the group with the highest scores on SQOL at follow-up was attending a clubhouse, showing an odds ratio of 2.9, followed by SQOL at baseline, showing an odds ratio of 1.1. Despite the lower odds ratio, the SQOL at baseline was highly significant. The findings indicate that both of these factors, type of service and baseline SQOL, played important roles for SQOL at follow-up.

The result indicates that attending clubhouse programmes is beneficial for SQOL in the long term. The results, together with the results from the two previous studies in the larger project, suggest that clubhouses appear to be advantageous in terms of factors of importance for mental health recovery.

Recovery and subjective perceptions of occupations in Clubhouses

The sample at baseline was n=57. Due to attrition the sample decreased, however, and was n=20 at follow-up. The attrition analysis showed that there were no differences between the drop-outs and those who completed the study regarding gender, age, hours attending the clubhouse at baseline, or diagnosis.

At baseline, there was an association between the domains of concrete value and self-reward value and personal recovery. The domain of symbolic value and the summed occupational value were not related with recovery. There were also no associations between any aspects of occupational balance or occupational engagement and recovery,

The analysis of associations between the baseline predictor variables and recovery at follow-up indicated no association between the summed occupational value score or the three domains concrete value, symbolic value or self-reward value and recovery. Experiencing a good balance in work activities, within or outside the clubhouse, was associated with a better recovery at follow-up. No other occupational balance aspect at baseline was associated with recovery at follow-up; nor was baseline occupational engagement.

Three logistic regression analyses were performed to investigate possible predictors of personal recovery. Two of these used cross-sectional data (one used baseline data and one follow-up data). Although a number of bivariate associations had been established, as described above, none of these became statistically significant in the regression analyses. The third regression model used baseline data, including baseline recovery, as predictors of recovery at follow-up. The only baseline predictor of recovery at follow-up was baseline recovery, showing an odds ratio of 1.26.

The findings suggest the importance of the clubhouses providing valued and engaging occupations to maximize opportunities for recovery.

Discussion

Results from an environment perspective

The results of Study I showed that clubhouses appeared to be somewhat more beneficial when compared to DC in terms of the users' opportunities for choice and decision-making. This provides some support to previous, mainly qualitative, research where clubhouses have been described as empowering settings where members can make choices and take part in all aspects of clubhouse governance (78). Another empowering feature is the egalitarian relationship with staff (78, 81). The differences between DC and clubhouses regarding recovery-promoting factors may to some extent be explained by service empowerment, which relates to the extent to which users of services participate in decisions (139). The concept also includes reciprocity and respect in the relationship with staff (139). The results of a study focusing on case management (140), an approach to psychosocial rehabilitation briefly mentioned in the background, showed that users' perceptions of service empowerment were a powerful predictor of recovery outcomes. The relationship between members and staff, however, was not explored specifically in the present thesis. Service empowerment may differ due to differences in terms of a care approach vs. a more rehabilitative approach by services and by staff (141). In general, services that have a care approach have less of a recovery orientation (141) and previous research has shown that mental health professionals' attitudes are a key factor in recovery-oriented services (142, 143). The quantitative study design of this thesis may have missed nuances that could have shed light on organizational and environmental factors, such as relationships with staff, which may have been beneficial for factors of importance for the users' recovery. Such information might be important for service development, and future research that includes a qualitative or mixed-methods design might be appropriate to achieve this aim.

Social networks and social support have shown to be of importance for recovery (16). The results from Study II showed that the clubhouse group had larger social networks and more often someone they would nominate as a close friend compared to the DC group. Both of these features of the social network have been found important for recovery (16). Previous research in the clubhouse setting (56) has highlighted how clubhouse participation and social interaction created a sense of inclusion and possibilities for forming new friendships. The participants in the present study were asked to nominate "Someone with whom you can share your innermost thoughts and feelings". The result showed a significant difference indicating that the DC attendees relied largely on professional contacts. This might be due to more frequent professional contacts, although this does not have any support in previous research in the DC context, indicating low-frequency use of psychiatric services (131). Furthermore, when compared to the clubhouse members, the DC attendees mentioned more seldom a friend as someone with whom they could share their innermost thoughts and feelings. This is in line with our finding that the DC group to a lesser extent had someone they saw as a close friend compared to the clubhouse group. No firm conclusion can be made regarding the difference between DC and clubhouses regarding size of social network, but it could be a result of the programmes' characteristics and organization. If this is the case, the DC services were less successful in supporting the establishment of informal social relationships, and thus less successful in applying an important principle of personal recovery.

On the other hand, the results from Study II showed that DC and clubhouses did not differ regarding perceptions of the social interaction in the programmes, and similarly there were no changes for any of the groups' ratings over time. This indicates that both approaches were equally suited for providing support in maintaining the accomplished level of social interaction. When compared to clubhouses, DC

services are generally more densely staffed. The balance between staff and peers may play a role in how the users perceive social interaction and relationships. Further studies could preferably explore this and also the reciprocity in users' relationships with peers, where for example, roles can switch from receiving help and information to giving help and sharing information, which has been found to be important in the recovery process (47).

Results from a person perspective

Socio-demographic factors were explored and gender, age, marital status, having children, educational level, and diagnosis did not differ between the groups. Together with the self-rated health scores supports the perception that the two groups mainly originate from the same target group. The only sociodemographic factor that showed to be significant was female gender, which in Study II showed to be associated with larger social network.

The results from Study I showed that the motivation to attend the services was high and that motivation did not differ between the groups. This is in line with previous research in the DC context (120). Which factors motivate the users to participate in the programmes was not explored in the present study, but previous research in the DC context has shown that the most important factor for participation was the provision of a structure for the day (120). Furthermore, opportunities for socialization and having something pleasurable to engage in was highly motivating (120). Where the clubhouses are concerned, previous research suggested that recovery-oriented values and the organizational climate were important motivators (144).

In terms of self-rated health, the analysis showed no difference between the groups. Psychosocial functioning differed between the groups at baseline, with the DC group being rated lower, but at follow-up, however, there was no such difference. The results from Study III indicated that attending a clubhouse programme was beneficial for SQOL in the long term, which has also been found in previous research (145). Another factor of importance for SQOL was self-esteem, which is similarly in line with previous research (146), however, no differences were found between the groups concerning self-esteem. No firm conclusion can thus be made as to causes for the identified differences in SQOL, but future research should explore this being as SQOL is an important service outcome (147).

Self-esteem showed to be an important predictor of both size of the social network and of SQOL. With this in mind it appears important for DCs and clubhouses to ensure that the activities in the programmes allow the users to utilize their competencies and abilities and that the activities are at an appropriate level of engagement. These have been shown to be key elements when striving to support people in developing their self-concept (100). Occupational therapy theory and the ecological framework for personal recovery as proposed by Onken et al (17), stress the dynamic interaction within a person and between the person and the environment. The results illuminate this regarding the personal factor self-esteem which was associated with SQOL, but also with size of the social network.

Recovery and SQOL have been described as overlapping concepts (148), which can be supported by an analysis presented here but not included in any of the papers in the appendix. The correlation between recovery and SQOL in the clubhouse group was moderate with an r-value of 0.282 ($p=0.043$), thus indicating that they are separate although associated phenomena.

Results from an occupation and occupational engagement perspective

Occupation constitutes the major tool for rehabilitation in DCs and clubhouses. The results from Study I showed that users of DCs were more satisfied with their everyday occupations at baseline, but the ratings for this factor increased more in the clubhouse group and there was thus no group difference at follow-up. To the authors' knowledge, no previous studies have compared users of DC and clubhouses regarding satisfaction with everyday occupation. Focusing on occupational engagement, the analysis did not show any difference between the two groups at baseline or at follow-up. Moreover, occupational engagement showed stability over time in both groups. The benefits of occupational engagement for recovery have been reported in qualitative research (41, 102). Since there was no difference between the groups in Study I in terms of occupational engagement, the results suggest that both approaches were equally fitted to support engagement in occupations, and thus in supporting recovery in this respect.

Occupational engagement showed to be related with motivation to attend the DC/Clubhouse in the study group as a whole. This suggests that flexibility in the services is important so they can be adapted to individual needs and preferences in order to sustain motivation and thereby the users' engagement. Furthermore, both occupational engagement and satisfaction with daily occupations showed a relationship with "setting clear goals for what to do at the DC/Clubhouse". Setting clears goals is an important component of psychosocial rehabilitation (149) and day-to day goals can provide a sense of agency and self-efficacy. Supporting the users to set individual goals for participation can maximize occupational engagement and satisfaction with daily occupations, thus promoting the recovery process.

The finding of a relationship between motivation for attendance and occupational engagement indicates that both of the studied rehabilitation approaches need to consider what motivates their users and which occupations these find meaningful to engage in, so that the programmes can be successful in meeting the needs of the users and assist recovery.

The relationship between aspects of occupation and recovery was explored in Study IV. Self-reward occupational value showed a bivariate relationship with recovery at both baseline and the follow-up. These results suggest that self-reward occupational value and recovery mutually influence each other. No occupational baseline variables or socio-demographic factors, however, could explain baseline recovery in a logistic regression model. At follow-up there was an association between occupational engagement and recovery, which corroborates results from qualitative research (102, 150), and Study IV appears to be the first quantitative study to have established an association between occupational engagement and recovery

In conclusion, the aggregated results from Studies I-III suggest that clubhouses appear to have some advantages when compared to DCs in relation to the factors of importance for recovery focused on in the present study. The results should be interpreted with caution, but it appears as if there is a potential for development in DC services. The results of the present study showed, however, that DC and clubhouse users were equally satisfied with their programmes. Furthermore, there were no real differences regarding perceptions of occupations. These results combined suggest that it may not be the actual doing in the programmes as much as how it is done that makes a difference. Assuming that the Clubhouse Model includes principles that are of importance for recovery and go beyond what is actually done, the question arises whether those principles can be transferred to the DC context. Bachrach (151) has proposed that principles of model programmes can be adapted in other programmes. Thus, the administrators of the DC services could consider whether principles such as opportunities for choice and peer support could be developed in those services. A further important principle is the egalitarian relationship between users and staff, which could entail a challenge if it included a change in ideology and attitudes. The egalitarian relationships in the clubhouses, which entail each member being an equally important person and one who is needed for the daily operations (78) may form a factor that is of importance for recovery-related outcomes.

The clubhouses in Sweden operate according to international guidelines (152), while for the DCs there are national guidelines (153) that include a mandate for all municipalities to provide such services. No

standardized agenda exists, however, for how the DC services should operate. The DCs are a legal right (32) for people with psychiatric disabilities, but every municipality makes their own decision about how to organize and operate the services (154). Differences regarding social, economic, and political factors and also limited knowledge about the needs of the target group can thus have an impact on the organization of services. It appears likely that the DCs as a group differ to a greater extent than the clubhouses. Being as each individual municipality makes decisions about and runs the DC services, the accessibility and choice regarding services can vary greatly between the municipalities. Accessibility to clubhouse programmes also differs since there are only twelve clubhouses in Sweden at present.

Finally, the fact that this thesis has identified possible room for improvement in the DC services does not entail that they are of poor quality. Previous research has shown that the DC users are highly motivated to participate and satisfied with the services (120), and that the DC, the peers and the staff are of great importance for them (155). Any attempt to develop the DC services locally would benefit from user involvement.

Methodological considerations

The thesis project employed a longitudinal, observational and naturalistic design.

The longitudinal design served to increase the internal validity by providing both cross-sectional and longitudinal findings, but also to study stability over time. The present project is, however, not without limitations, one of which concerns diagnoses. Clubhouses and DCs in Sweden do not keep medical records. Previous research has shown, however, that both DC attendees and clubhouse members represent a variety of mental disorders that cause psychiatric disability (84, 156). Previous research (84) gives some support to the validity of self-reported diagnoses as used in this thesis.

Furthermore, few naturalistic follow-up studies have investigated the variables targeted in this thesis project and the nine-month follow-up interval can thus be questioned. Previous studies have found stability in SQOL over 6 months (147) and over 18 months (157) and although there are no recommendations in this respect, our choice falls within the interval of what other researchers have found relevant. The nine-month span employed in the current study seems relevant for addressing stability in the targeted variables, particularly since attrition may increase with longer follow-up intervals and thus jeopardizing both internal validity and the generalizability of the study (158).

Moreover, no information was gathered regarding the participants' tenure in the DC or clubhouse. Thus, there is no information to confirm whether the groups differed regarding length of stay in the respective programmes and therefore assumptions about the impact of duration of stay on social network, SQOL or recovery cannot be made. The results of a previous study in a DC context render some evidence that longer duration of using the services is associated with a larger social network (159). The size of a social network, however, is not necessarily related to satisfaction with the social network (64, 65). Two studies in the clubhouse context found, however, that length of time in the programme was not associated with social network size (160) or with recovery (161). Further research is warranted, however, to investigate whether length and frequency of attendance play a role for the size of social networks, SQOL or recovery among user of DCs and clubhouses.

The generalizability of this study is an issue since the number of non-participants could not be exactly estimated. The external validity would be limited if the DC attendees and clubhouse members who were most affected by their psychiatric disability chose not to participate. Albeit both groups included persons with low ratings on psychosocial functioning the median rating was close to 50 in both groups. This indicates that people with greater psychiatric disability tended not to participate in the study, which implies that the investigated group may not fully represent the target group.

There is a lack of consensus regarding the definition and conceptualization of recovery. This has resulted in the development of a number of instruments designed to assess recovery-oriented outcomes, or progression towards recovery (162). A review of recovery measurements showed that only three out of thirteen recovery instruments had been psychometrically re-tested since the initial test, and used to assess recovery of service users over time (162). One of the three instruments was the Illness Management and Recovery (IMR) Scale (116) which was used to measure recovery in Study IV of the present thesis. The different ways of conceptualizing and measuring recovery complicate comparison both in research and practice. To also measure recovery-related factors by means of psychometrically well-tested instruments, such as the Manchester Short Assessment of Quality of Life (MANSA) (119) appears to be of importance. Moreover, measuring recovery-promoting factors such as subjective quality of life, self-esteem, social network and different aspects of occupation appear to be important, particularly when trying to improve occupation-based psychosocial rehabilitation for people with psychiatric disabilities.

Data collection and statistical procedures

All the instruments in the studies were psychometrically tested and should have produced reliable and valid data. The statistics used in all four studies were non-parametric since the data were primarily on ordinal scales. A power calculation was performed that indicated that a sample size of n=60 in both groups would be sufficient for detecting a moderate effect size (0.70) with a power of 0.80 at $p<0.05$. This number was not reached for the clubhouse group, but the statistical power in the comparative analyses was increased by the fact that the DC group was larger than the clubhouse group. According to Altman (110), a larger sample size in one of the groups can compensate for a smaller number in the other, up to a proportion of 1 to 3, which was approximately the ratio between the groups at the follow-up. When analysing the data in the logistic regression models applied in Studies II-IV, data were dichotomised. This meant that some variation in the data was lost. Since the data were of ordinal nature, however, this was the most appropriate statistical regression method (110). For the variables of social network size (Study II) and recovery (Study IV) the Cronbach's Alpha was at the lower end indicating that these results should be interpreted with caution.

Conclusions and clinical implications

The clinical implications generated by this thesis refer to factors that may be of importance for the operation and development of community-based settings for people with psychiatric disabilities.

- Motivation for participation was high in both contexts. The findings indicated, however, that further development was desired such as more work-like occupations or open-market employment in the DC group. If DCs or clubhouses cannot meet the needs of an individual, despite having made all possible attempts to do that, the staff can support a change of setting into one that better fits the user's needs.

- Autonomy and a feeling of social inclusion, which are concepts of importance for well-being and recovery, were perceived to exist to a greater extent in the clubhouse group. Thus, DC may consider how choice and ability to influence decisions about the programme and peer support can be incorporated in the services.

- In order to better target the users' needs and try to promote recovery, it is important for both approaches to evaluate the services, train staff so that they are cognisant of the importance of

meaningful everyday occupations, and support users in setting individual goals for participation in the programmes.

- Having friends may be an essential factor for the size of the social network in a short-term perspective. Thus, providing opportunities for people with psychiatric disabilities to add non-relatives to their social network is important for strengthening their chances for personal recovery. Such opportunities may be created by organizing psychosocial rehabilitation in such a way that it enhances access to community-based social arenas and contacts with the surrounding society. Visiting clubhouses appear to be advantageous for the social network in a longer-term perspective. The current findings in relation to previous research implicate that developing strategies to increase peer support as well as striving to improve an environment that further supports the establishment of informal social relationships appears warranted in the DC services

- DC and clubhouses were equally suited for supporting their users in maintaining SQOL. Visiting clubhouses, however, appeared to be more beneficial for greater SQOL in a longer-term perspective.

- Self-esteem showed to be an important predictor of size of the social network and of SQOL. It thus appears to be important for DCs and clubhouses to ensure that the activities in the programmes allow the users to utilize their competencies and abilities and that the activities are at an appropriate level of engagement when striving to support the participants' self-esteem.

- The results of Study IV indicated the importance of clubhouses maximizing occupational opportunities for the experience of occupational value and occupational engagement in an effort to support the members' recovery process.

Implications for further research

The results of this thesis add to previous knowledge of DC services and clubhouses and discern some strengths of the Clubhouse Model. The quantitative findings of this thesis can be further explored and highlighted in qualitative research.

Further studies could explore how the balance between staff and peers may play a role in how the users perceive social interaction and relationships. Furthermore, the reciprocity in users' relationships with staff and peers could be explored as this has been found to be important in the recovery process. Although this study contributed some new knowledge, further research should also address which circumstances are associated with maintaining stability in one's social network, and preferably increasing both its size and adequacy.

Moreover, further research should address which circumstances are associated with maintaining stability in SQOL. This information would contribute to service development.

Additional research is also needed to examine which aspects of the WOD and the after-hour occupations can generate experiences of occupational value and engagement. Further research should also address which circumstances in the clubhouse context are associated with maintaining stability in one's recovery.

Summary in Swedish/Svensk sammanfattning

Bakgrund

Långvarig psykisk ohälsa kan orsaka en psykisk funktionsnedsättning som ofta har en allvarlig inverkan på individens livssituation. Brist på meningsfulla dagliga aktiviteter och få eller inga sociala kontakter, vilka är av betydelse för hälsa, välbefinnande och återhämtning (15-17) är vanligt i målgruppen (18). Begreppet återhämtning definieras ofta enligt två kategorier. Klinisk återhämtning kan definieras som en förbättring av symtom och dysfunktion till en grad där de kan anses vara inom ett normalt intervall (20). Begreppet personlig återhämtning däremot innebär inte nödvändigtvis symptomlindring eller en återgång till normal funktion, utan ses som en process av personlig utveckling där individen skapar ett meningsfullt liv trots sjukdom eller symptom (5). Denna avhandling undersöker i huvudsak faktorer som främjar personlig återhämtning så som socialt nätverk, livskvalitet och andra faktorer som är relaterade till hälsa och välbefinnande hos personer med psykisk funktionsnedsättning som deltar i kommunbaserad daglig sysselsättning eller fontänhus.

Kommunbaserad daglig sysselsättning (DS) (25) utgör det vanligaste aktivitetsbaserade rehabiliteringsalternativet för personer med psykisk funktionsnedsättning i Sverige. Ett annat alternativ är fontänhus vilka bedrivs som stiftelser eller ideella föreningar i Sverige. Fontänhusen grundar sin verksamhet på fontänhusmodellen, och det finns fontänhus på över 300 platser globalt (26). Vilken typ av stöd eller vilka insatser som är de mest verksamma i rehabiliteringsprocessen för personer med psykisk funktionsnedsättning, och om DS eller fontänhus är mer relevanta i detta avseende, är relativt obeforskat.

En svensk regeringsrapport (28) påtalade att tillgängligheten till arbete och meningsfulla dagliga aktiviteter behöver förbättras för personer med psykisk funktionsnedsättning. Dessutom belyste rapporten behovet av att öka evidensbaserade metoder inom vård, stöd och omsorg för målgruppen (28). I USA anses fontänhusmodellen vara en evidensbaserad metod (29) när det gäller meningsfull sysselsättning, livskvalitet och återhämtning. När det gäller DS finns inga studier som påvisar deras effektivitet när det gäller exempelvis förbättrad livskvalitet (31).

Denna avhandling syftar till att öka kunskapen om DS och fontänhus i Sverige genom att jämföra dem med varandra, med särskilt fokus på återhämtningsinriktade faktorer och återhämtningsfrämjande upplevelser bland deltagarna. Faktorerna som belyses i denna avhandling är möjligheter till meningsfulla dagliga aktiviteter och tillgång till social interaktion, därutöver kommer faktorer som är kopplade till hälsa och välbefinnande att undersökas.

Återhämtning

Flera författare har presenterat modeller för personlig återhämtning som fokuserar på individen och menar att återhämtningsprocessen är icke-linjär och omfattar stadier eller faser (21, 38, 41). Forskning har visat på ett antal faktorer som kan stödja återhämtning exempelvis känsla av samhörighet, valmöjligheter, personlig utveckling, hopp, meningsfullhet och egenmakt (38, 42, 43). Omvänt finns det också personliga faktorer som kan hindra återhämtning såsom negativa föreställningar och självstigma (44, 45), samt hälsoproblem (43). Förutom personliga hindrande faktorer har forskning också visat att brist på materiella resurser såsom fattigdom, bristfälligt boende eller begränsade transportmöjligheter är ytterligare hinder för återhämtning på grund av deras inverkan på möjligheter och val (43). Dessutom kan social utslagning, fördomar, stigmatisering och diskriminering, vara hinder för återhämtning (46,

47). När det gäller den psykiatriska vården har negativa attityder hos personal, låg kvalitet på vård och stöd samt begränsade valmöjligheter när det gäller vård- och stödinsatser också beskrivits som hinder för återhämtning (43).

Onken och kollegor (17) har föreslagit en modell som tillämpar ett socio-ekologiskt perspektiv på återhämtning. Det socio-ekologiska perspektivet fokuserar både på individ och miljö, och i synnerhet på interaktionen inom individen eller miljön, samt samspelet mellan de båda. Återkommande teman gällande personliga faktorer som främjar återhämtning enligt detta perspektiv är till exempel självbestämmande, hopp, mål och mening (17). Faktorer i omgivningen som stödjer återhämtning är till exempel möjligheter till meningsfulla dagliga aktiviteter och socialt stöd (17). Genom att tillämpa ett socio-ekologiskt perspektiv, kan återhämtning underlättas eller hindras av samspelet mellan egenskaper och faktorer inom personen (såsom självbestämmande och självkänsla) eller miljön (såsom tillgång till meningsfulla dagliga aktiviteter och socialt stöd). Vidare kan det dynamiska samspelet mellan individ och miljö främja eller hindra återhämtning när det gäller till exempel att välja och ha tillgång till meningsfulla dagliga aktiviteter (17).

Denna avhandling tillämpar ett i huvudsak socio-ekologiskt perspektiv genom att undersöka personliga faktorer såsom självkänsla, subjektiv livskvalitet (SQOL), och självskattad hälsa samt miljöfaktorer såsom verksamheternas karaktär samt sociala nätverk. Möjligheter till meningsfulla dagliga aktiviteter kommer också att belysas genom att utforska subjektiva uppfattningar kring aspekter av aktivitet.

Psykosocial rehabilitering

Aktivitet är ett vanligt medel inom området psykosocial rehabilitering (48) och bägge kontexterna som behandlas i avhandlingen, DS och fontänhus, fokuserar på aktivitetsbaserad rehabilitering. Begreppet aktivitet i denna avhandling avser alla typer av aktiviteter, enligt Kielhofners (1) definition:

> *”Mänsklig aktivitet avser utförandet av arbete, lek, eller aktiviteter i det dagliga livet inom en tids, fysisk, sociokulturell kontext som kännetecknar en stor del av människors liv. Således inkluderar dagliga aktiviteter alla typer av aktiviteter i vardagen som människor utför, såsom personlig vård, hushållsarbete, förvärvsarbete, fritidsaktiviteter, och att umgås med andra "* (1).

Fontänhusmodellen beskrivs vanligen i forskning som en metod för psykosocial rehabilitering (26), medan fontänhusen själva har beskrivit sig som inkluderande miljöer (53) där deltagandet kan ha rehabiliterande effekter. När det gäller DS är deras uppdrag enligt Socialtjänstlagen (32) att erbjuda meningsfull daglig sysselsättning för målgruppen, men de behöver inte nödvändigtvis ha ett rehabiliterande förhållningssätt. Även om DS precis som fontänhus starkt betonar psykosociala aspekter, kan de ha ett mer omvårdande tillvägagångssätt med tanke på att personalen inte sällan är utbildad vårdpersonal. Men eftersom meningsfulla dagliga aktiviteter är en viktig del i psykosocial rehabilitering, inkluderas DS vanligtvis i begreppet psykosocial rehabilitering (25). Dessutom har vissa DS med tiden inspirerats av principer för återhämtning.

Daglig sysselsättning och fontänhus

I Sverige utvecklades DS under 1990-talet som en följd av en reform som i stort innebar att ansvaret för psykosocial rehabilitering överfördes från landstinget till kommunernas socialtjänst (77). DS är huvudsakligen uppdelat i två typer; mötesplats-orienterad eller arbetsinriktad (25). Mötesplats-orienterade DS erbjuder aktiviteter som att spela spel och umgås, medan arbetsinriktade DS i huvudsak erbjuder schemalagda produktiva aktiviteter, till exempel städning, tillhandahållande av catering eller tillverkning av produkter. Det finns också DS som är en kombination av båda typerna (25)

Det första fontänhuset, Fountain House, grundades 1948 i New York som en självhjälpsgrupp av tidigare patienter och personal från ett nedlagt mentalsjukhus (78). Över tid har verksamheten utvecklats till den i dag etablerade fontänhusmodellen (78). Det finns för närvarande tolv fontänhus i Sverige (54). Två

hörnstenar i modellen är 1) ett jämlikt förhållande mellan användarna (som benämns medlemmar) och personal samt 2) den arbetsinriktade dagen som avser en vanlig 8-5 arbetsdag. Medlemmar och personal arbetar sida vid sida i den dagliga driften av fontänhuset i aktiviteter som matlagning, städning och kontorsarbete (81).

Tidigare studier har jämfört DS med psykiatrisk dagsjukvård (31) och resultaten av dessa studier gav inga tydliga svar när det gällde användarnas kliniska-, sociala- eller vård- och stödbehov. När det gäller fontänhus finns ett fåtal internationella studier som jämför fontänhusmodellen med andra former av psykosocial rehabilitering. Resultaten har visat på fördelar för fontänhusmodellen såsom bättre livskvalitet (88, 89), mindre upplevd stigma (88), färre inläggningar på sjukhus och mindre utnyttjande av vård och stödinsatser (89, 90). Forskningen hittills lämnar många frågor obesvarade dock, och så vitt författarna känner till har ingen tidigare studie jämfört svenska fontänhus med ett annat alternativ till psykosocial rehabilitering.

Subjektiva aspekter gällande aktivitet i relation till hälsa

Ett grundantagande inom arbetsterapi är att hälsa kan påverkas genom för individen meningsfulla aktiviteter. Flera subjektiva aspekter av dagliga aktiviteter har visat sig vara relaterade till upplevd hälsa och välbefinnande (92, 93). En sådan aspekt är aktivitetsbalans, som kan definieras som individens uppfattning om att ha rätt mängd dagliga aktiviteter med rätt variation (2). Vidare har hur nöjd man är med sina dagliga aktiviteter visat sig vara av betydelse för hälsa och välbefinnande (98). En ytterligare aspekt är upplevelse av engagemang i aktivitet, som rör i vilken utsträckning en person upplever en känsla av mening i sina aktiviteter och där omfattningen och variationen i de dagliga aktiviteterna bildar en struktur som organiserar tid (3). Forskning har visat ett samband mellan upplevelse av engagemang i aktivitet och att känna sig frisk och kapabel (99, 100). Dessutom har forskning visat att högre nivåer av engagemang i aktivitet tenderar att vara relaterade till mindre psykiatriska symptom och bättre självskattad hälsa och välbefinnande (3), bättre livskvalitet och tillfredsställelse med livet som helhet (15, 93) samt ökad egenmakt (101).

Person-, miljö- och aktivitetsperspektiv

Det finns flera olika arbetsterapeutiska generella praxismodeller. I den teoretiska grunden för dessa modeller utökas vanligen den tvådimensionella socio-ekologiska perspektivet som beskrivs av Onken et al. (17) genom att lägga till aktivitet som en tredje dimension. En av dessa modeller är PEO-modellen (Person-Environment-Occupation) (104). PEO-modellen betonar det ömsesidiga beroendet mellan personen och miljön, där person ses som dynamisk och interaktiv med miljön. PEO-modellen betonar också matchningen mellan individ, aktivitet och miljö. Förändringar i aktivitetsutförande betraktas som en konsekvens av variationer i individ, miljö och/eller aktivitet och en maximal matchning maximerar således aktivitetsutförandet (104). Model of Human Occupation, MOHO (1) är en annan generell praxismodell. MOHO förklarar hur dagliga aktiviteter motiveras och organiseras i ett vardagligt livsmönster. Liksom PEO-modellen hävdar MOHO att personen och miljön (fysisk, social, kulturell, ekonomisk och politisk) inte kan separeras i aktivitetsutförande. Därmed kan alla miljöer potentiellt erbjuda möjligheter eller begränsningar, resurser eller krav. Inom ramarna för MOHO och PEO-modellen kan funktionsnedsättning definieras som problem med aktivitetsutförande som är ihållande över tid, och som kan uppstå när det finns en obalans mellan person, miljö och aktivitet (1, 104).

För att sammanfatta så tyder tidigare jämförande forskning på att fontänhusmodellen har fördelar i förhållande till de faktorer som studeras i denna avhandling, jämfört med vissa former av psykosocial rehabilitering. I USA ingår fontänhusmodellen i SAMSHAs nationella register (29) över evidensbaserade metoder. Den svenska regeringen har betonat behovet av att öka evidensbaserade metoder inom sociala tjänster så som DS, vilket gör jämförelser med fontänhusmodellen intressant. När

man överväger vikten av meningsfulla dagliga aktiviteter, social interaktion och delaktighet för psykisk hälsa och återhämtning (108, 109) finns det en kunskapslucka som fodrar uppmärksamhet när det gäller deltagarnas uppfattning om verksamheten som tillhandahålls av DS och fontänhus. Ökad kunskap om faktorer som kan stödja återhämtning kan utgöra en viktig grund för planeringen och utvecklingen av psykosocial rehabilitering inom kommunerna.

Syfte

Det övergripande syftet med denna avhandling var att jämföra två metoder för aktivitetsbaserad psykosocial rehabilitering-DS och fontänhus-och att undersöka om någon av dem verkar bättre rustade att stödja personer med psykisk funktionsnedsättning i deras återhämtning. Detta adresserades genom att studera i) skillnader mellan deltagarna i de två rehabiliteringskontexterna i ett tvärsnittsperspektiv ii) stabilitet gällande återhämtningsfrämjande faktorer över tid, samt iii) om deltagande i någon av de två kontexterna kunde förutsäga återhämtningsfrämjade faktorer.

Fokus när det gäller återhämtning i denna avhandling är på möjligheterna att delta i meningsfulla dagliga aktiviteter, tillgång till social interaktion samt faktorer som är relaterade till upplevd hälsa och välbefinnande.

Urval, metod och resultat i avhandlingens fyra delstudier

Studien hade en naturalistisk-, observationsdesign. Delstudierna I-III tillämpade en kombinerad tvärsnitts- och longitudinell, jämförande design. Grupperna som jämfördes var personer med psykisk funktionsnedsättning som deltog antingen DS eller fontänhus. Delstudierna undersökte subjektiva uppfattningar om aktivitet och relationen till motivation för deltagande i verksamheterna (Studie I), social interaktion (Studie II), och faktorer relaterade till hälsa och välbefinnande (Studie III). Studie IV undersökte sambandet mellan subjektiva uppfattningar om aktivitet och återhämtning hos fontänhusmedlemmar. Två mätpunkter valdes för att få mer robusta uppgifter för att undersöka delarbetenas olika syften, men också för att undersöka stabilitet över tid gällande de adresserade faktorerna.

I studien ingick tio DS enheter och fem fontänhus. De fem fontänhusen var belägna i södra Sverige och i Mellansverige. Deltagarna i DS-gruppen kom från två olika projekt. Det ena projektet var en interventionsstudie i södra Sverige. Studien syftade till att undersöka effekten av en intervention för att förbättra den lokala DS-verksamheten (111). Kontrollgruppen som bestod av deltagare från fyra olika DS enheter kunde inkluderas i föreliggande studie eftersom de inte hade varit en del av interventionen. Datainsamlingen inkluderade en baslinje mätning och uppföljning efter sju till nio månader, vilka användes för denna avhandling.

De resterande deltagarna kom från sex DS enheter i Mellansverige och ett projekt som undersökte organisatoriska förändringar med anledning av ny svensk lagstiftning gällande valfrihet i vård och sociala tjänster (112). Förändringen som skulle implementeras gällde användarnas möjligheter att fritt välja kommunala DS enheter eller alternativa leverantörer av DS verksamhet. Innan de alternativa leverantörerna av DS inkluderades som en valmöjlighet gjordes två mätningar med ett nio- månaders intervall för att etablera en baslinje innan ändringen hade inletts. Data från dessa två mätningar användes i denna avhandling. Studiens totala antal deltagare var 185 varav 128 personer från DS och 57 från fontänhus.

Flera olika självskattningsinstrument, samt även frågor om bakgrundsfaktorer (t.ex. kön, ålder, familjesituation) har använts för att samla in data i studie I-IV (Tabell I), Data i DS samlades in mellan 2008 och 2011, och i fontänhusen mellan 2012 och 2014. Insamlad data var i huvudsak på ordinalnivå, därmed analyserades den med icke-parametrisk statistik.

Studie I visade att det fanns ett samband mellan engagemang i aktivitet och motivation att delta i DS/fontänhus i studiegruppen som helhet. Även om resultatet visade på få skillnader mellan DS och fontänhushus gällande de studerade faktorerna tycktes fontänhusen vara något mer fördelaktiga när det gällde medlemmarnas möjligheter till val och beslutsfattande i verksamheten. Dessutom verkade fontänhusen något mer fördelaktiga när det gällde att stimulera till social interaktion bland deltagarna.

Resultaten från studie II visade att fontänhusgruppen hade större sociala nätverk och oftare någon som de ansåg vara en nära vän jämfört med DS-gruppen. Dessutom visade resultaten av studie II att en hög grad av självkänsla, och att ha träffat en vän nyligen, var betydelsefulla för att tillhöra gruppen med ett större socialt nätverk i ett tvärsnittsperspektiv (baslinje). Betydelsefulla faktorer för att tillhöra gruppen med ett större socialt nätverk vid uppföljningsmätningen var att vara kvinna och delta i fontänhusverksamhet, samt att även ha skattat högre på sociala nätverk vid baslinjemätningen. Storleken på det sociala nätverket minskade över tid i DS-gruppen, men i fontänhusgruppen visade det sig vara det stabilt.

Resultatet från studie III visade att det i den totala undersökningsgruppen fanns ett samband mellan subjektiv livskvalitet (SQOL) vid uppföljningsmätningen och självkänsla, storleken på socialt nätverk, tillfredsställelse med dagliga aktiviteter samt SQOL vid baslinjemätningen. Den mest betydelsefulla faktorn för att tillhöra gruppen med hög nivå av SQOL vid uppföljningsmätningen var att delta i fontänhusverksamhet vilket indikerar att delta fontänhusverksamhet är fördelaktigt för SQOL på längre sikt. Nivån av skattad SQOL visade sig vara stabil över tid i båda grupperna.

Förhållandet mellan aspekter av aktivitet och återhämtning undersöktes i studie IV. Att uppleva själv-belönande aktivitetsvärden visade ett bivariat samband med återhämtning vid både baslinje- och uppföljningsmätningen. Dessa resultat tyder på att själv-belönande aktivitetsvärde och återhämtning ömsesidigt påverkar varandra. Även om ett antal bivariata samband fastställdes mellan aspekter av aktivitet och återhämtning, blev ingen av dessa statistiskt signifikant i regressionsanalyserna. Resultaten visade också att graden av återhämtning var stabil över tid på gruppnivå.

Kliniska implikationer

- Resultaten från studierna I-IV i denna avhandling kompletterar tidigare kunskap om DS och fontänhus och visar på en del styrkor hos fontänhusmodellen. Den kliniska betydelsen som genereras av denna avhandling avser faktorer som kan ha betydelse för driften och utvecklingen av samhällsbaserade inställningar för personer med psykiska funktionshinder.

- Motivation för deltagande var hög i båda verksamheterna Resultaten visade dock att vissa deltagare i DS-gruppen önskade förvärvsarbete. Om DS eller fontänhus inte kan tillgodose behoven hos en individ, trots att alla möjliga försök att göra det har gjorts, kan personalen stödja ett byte till någon annan verksamhet/rehabiliteringsinsats som bättre matchar deltagarens behov.
- Autonomi och en känsla av social integration, som är begrepp som är viktiga för välbefinnande och återhämtning, upplevdes i högre utsträckning i fontänhusgruppen. Således kan DS överväga hur valmöjligheter när det gäller t.ex. aktiviteter och möjlighet att påverka beslut om verksamheten, samt kamratstöd, kan utvecklas i DS verksamheten.

- För att bättre möta deltagarnas behov och försöka främja återhämtning, är det viktigt för både DS och fontänhus att utvärdera verksamheterna, utbilda personal så att de är medvetna om vikten av meningsfulla dagliga aktiviteter, och stödja deltagarna att sätta individuella mål för deltagande i verksamheterna

- Vänner kan vara en viktig faktor för storleken på det sociala nätverket i ett kortare perspektiv. Således är det viktigt för verksamheterna att skapa möjligheter för personer med psykisk funktionsnedsättning att utöka sina sociala nätverk för att stärka deras chanser för återhämtning. Sådana möjligheter kan skapas genom att organisera psykosocial rehabilitering på ett sådant sätt att det förbättrar tillgång till samhällsbaserade sociala arenor och kontakter med det omgivande samhället. Att delta i fontänhus förefaller fördelaktigt för det sociala nätverket i ett längre perspektiv. De aktuella resultaten i förhållande till tidigare forskning indikerar att utveckling av strategier för att öka kamratstöd, samt att sträva efter att förbättra den sociala miljön så att den i ännu högre grad stöder utvecklingen av informella sociala relationer, förefaller motiverat i DS.

- Självkänsla visade sig vara en betydelsefull faktor för storleken på det sociala nätverket och subjektiv livskvalitet. Det förefaller således vara viktigt för DS och fontänhus att säkerställa att aktiviteterna som erbjuds i verksamheterna gör det möjligt för deltagarna att utnyttja sin kompetens och förmåga och att aktiviteterna är på en lämplig nivå av engagemang i strävan efter att stödja deltagarnas självkänsla.

- Resultaten från studie IV indikerade vikten av att fontänhusen maximerar möjligheter till aktiviteter där deltagarna kan uppleva engagemang och ett själv-belönande aktivitetsvärde i strävan efter att stödja medlemmarnas återhämtningsprocess.

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