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Choices for Recovery

Community-Based Rehabilitation and the Clubhouse Model as Means to Mental Health Reforms

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An Overview of the Common Denominators and Key Concepts of the International Mental Health Policy Recommendations and their Practical Applications for Promoting Recovery and Social Inclusion of People with Mental Health Problems.

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Foreword

The main idea of this overview, like the whole project Empowering Adults with Mental Illness for Learning and Social Inclusion (EMPAD), is to develop, promote and disseminate good practice Community-Based Rehabilitation (CBR) aimed at helping people living with mental disorders. Different forms of psychosocial rehabilitation, like recovery approaches and the Clubhouse model, support them towards empowerment and a life where human rights and positive mental health prevail. The key theme which binds the different sections of this overview together is the ongoing process of mental health reform by diversifying the community-based service delivery.

During the past two decades intergovernmental organizations such as the United Nations, Council of Europe and the European Union have produced a set of about 30 different declarations, recommendations and other documents in the field of mental health policy due to be implemented in their member countries. Together these form a comprehensive international framework for the development of mental health policy and psychosocial rehabilitation services.

The purpose of this overview is to study interrelationships between the conceptual elements of the values, principles and goals of the different mental health policy frameworks and the key concepts of psychosocial rehabilitation. Common denominators between different policy recommendations are identified and they are compared with the International Standards for the Clubhouse programmes. In addition, the overview offers basic information about community-based rehabilitation and its components, as well as a summary of scientific research on its impact on the recovery and empowerment of people living with mental disorders. Also other outcomes and results are described, such as the cost-effectiveness of Clubhouses as a part of the general mental health services.

The subsection 4.5 is based mainly on writings of the experts of the International Center for Clubhouse Development – ICCD, which is a third country participant in the EMPAD project. Since 1994 the ICCD has been a global resource for Clubhouses which create opportunities for the recovery and social inclusion of people with mental health problems. At the same it is a community of the ICCD Clubhouses where recovery involves the whole person. The content of the subsection covers a major part of the written materials due to be produced by the ICCD as the EMPAD project deliverables.

This overview can be used as a sourcebook and training and learning material about the process of mental health reform and the recovery-orientated community-based rehabilitation of people with different mental health conditions.

This overview is a product of the EMPAD workpackage number 2.

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Ville Grönberg
Development Manager, Coordinator of the EMPAD project
National Institute for Health and Welfare, Helsinki, Finland

Abstract

This overview concentrates on the Mental Health Reform and on Community-Based Rehabilitation (CBR) and the Clubhouse model as one of its applications. It is a deliverable of the transnational project Empowering Adults with Mental Illness for Learning and Social Inclusion (EMPAD) consisting of partners from Finland Germany, the Netherlands, Romania, Slovenia, Spain, Sweden and the USA.

The main idea of this overview is to promote and disseminate good practices of the psychosocial CBR guidelines aimed at support people living with mental disorders. The overview is prepared in the context of international mental health policy recommendations.

During the last two decades intergovernmental organizations the United Nations and its specialist organizations WHO, ILO and UNESCO, and the Council of Europe and the European Union have strongly supported the Mental Health Reform. In all, these organizations have launched about 30 declarations, recommendations, agreements and expert groups' documents on how to develop nationally the mental health policy and services delivery. These documents are analyzed and applied in this overview.

The first aim is to build up an international policy context for the community-based mental health policy and services by identifying the common denominators of the different international recommendations and policy decisions. As a part of the EMPAD project an international needs analysis web-survey was carried out and targeted at mental health professionals, service-users and decision-makers of the EMPAD partner countries. The results indicate that the national Ministries of Health should more effectively disseminate information about the mentioned international policy frameworks which they have approved and signed.

Human rights, equal opportunities, gender equality, involvement and choices of users, community-based approach, health promotion, empowerment and social inclusion are common values and principles in several international mental health policy frameworks and recommendations. All of these have a high level of significance in the Clubhouses, provided that their activities are based on the International Standards for Clubhouse programmes.

A special strength of the Clubhouse model is the 25 years of experience in developing and to applying the quality management and assurance system for the Clubhouses. The regularly repeated quality accreditations keep the funding agencies aware of the "good societal, human and economic return on their investments" and overall cost-effectiveness of the Clubhouses. The positive impacts include the Clubhouse members' recovery and empowerment towards self-determination and participation in the everyday activities. However, all users are not motivated to continue in the Clubhouse programmes and need other choices.

According to the conclusions of this overview, the most applicable mental health policy is a combination of the World Health Organization's Pyramid Framework and the cross-sectorial CBR guidelines. The main messages of the WHO Pyramid Framework as combined with the multi-agency collaboration for organizing the optimal mix of mental health services are: (1) Promote self-care, coping skills and self-care management; (2) Build on other informal community level support; (3) Integrate formal mental health services into primary healthcare; (4) Build and diversify community based mental health services (e.g. community mental health centres, home service teams, residential units, CBR-services and Clubhouses); (5) Develop mental health services in general hospitals; (6) Reduce the use of psychiatric hospitals and long-term inpatient care, and invest savings to community-based services; and (7) Complement all above measures by coordination and collaboration with other sectorial community level agencies and relevant voluntary associations.

Key words: Mental health policy, community-based rehabilitation, Clubhouse model, psychosocial rehabilitation, recovery.

Main mental health concepts used in the overview

Concept of mental health (Lehtinen 2008: 25-27): Mental health as an indivisible component of general health reflects the equilibrium between individual and the environment and is influenced by individual biological and psychological factors, social interactions, societal structures, available resources and cultural values. Mental health has two dimensions:

- *Positive mental health* is a value in itself, people feeling well, or as a capacity to perceive, comprehend and adapt surroundings, to change them if necessary, to pursue self-esteem, optimism, and a sense of mastery and coherence, the ability to initiate and sustain mutual personal relationships, and the ability to cope with adversities in life. These are increasing person's capacity to contribute to family, motivation for learning and working, to other social networks and living in local community.
- *Negative mental health or mental ill-health* encompasses the concerned persons with mental health conditions, disorders, symptoms and problems. This group of people is the main concern in this overview, because the empowerment, community-based rehabilitation and Clubhouse approaches are targeted at supporting these people for recovery and social inclusion in local communities and mainstream activities in society.

Mental health conditions (WHO 2010d: 3; WHO 2010e: xxiv)

In this article the people whom the empowering community-based rehabilitation, recovery approaches and Clubhouse model are targeted are referred to as *people with mental health conditions.* Parallel concepts used are people *with mental health problems* and *people with mental disorders.* All three concepts include conditions such as schizophrenia and other psychoses, bipolar disorder, depression, substance abuse disorders, adolescent mental health problems, intellectual impairments and people with learning difficulties in general.

Definitions of service units (WHO 2011: 36, 48)

In its 2011 Mental Health Atlas the World Health Organization (WHO) gives the following definitions to different types of services and facilities in the mental health field:

Mental health outpatient facility: A facility that specifically focuses on the management of mental disorders and related clinical problems on an outpatient basis. These facilities are staffed with health care providers specifically trained in mental health.

Mental health day treatment facility: A facility that provides care for users during the day. The facilities are generally available to groups of users at the same time and expect

users to stay at the facilities beyond the periods during which they have face-to-face contact with staff and/or participate in therapy activities. Attendance typically ranges from a half to one full day (4 – 8 hours), for one or more days of the week. May also be called community mental health centres (CMHC).

Psychiatric ward in a general hospital: A ward within a general hospital that is reserved for the care of persons with mental disorders.

Community residential facility: A non-hospital, community based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions.

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with severe mental disorders. Usually these facilities are independent and stand alone, although they may have some links with the rest of the health care system. The level of specialization varies considerably.

Psychosocial intervention: An intervention using psychological and/or community-based rehabilitation methods to support the reduction of psychosocial distress and personal recovery and social inclusion of people with mental health problems.

Content

1   Introduction

The background and rationale of this overview is based on the EMPAD project plan, accepted for funding as a part of the European Union's Lifelong Learning programme in 2010. The two-year project commenced in November 2010 and ended in October 2012 (http://www.empad-project.eu). The EMPAD project promoted the quality of the Community-Based Rehabilitation (CBR) services - defined by the World Health Organization (WHO 2010b) - by offering new types of training opportunities to professionals, service-users, family members, decision-makers and other stakeholders in the field of mental health policy and services.

The project facilitated new CBR programmes and training possibilities in the field of psychosocial rehabilitation by promoting the use of the Clubhouse model in Europe, as defined in the International Standards for Clubhouse Programmes (http://www.iccd. org/quality.html). The main beneficiaries of the EMPAD project are adults with mental health problems in the project partner countries of Finland, Germany, The Netherlands, Romania, Slovenia, Spain/Basque Country and Sweden. As an expert organization the International Centre for Clubhouse Development (ICCD, USA) took part in the project, too. The utilization of project results and outcomes aims at the dissemination of the CBR based Clubhouse model into European countries and regions where Clubhouse services are not yet available.

The EMPAD project created a new training programme for adult education staff, mental health professionals, users' and carers' organizations and other stakeholders working for the recovery of people with mental health conditions. The EMPAD training gives an orientation to the CBR guidelines and services, and especially to the Clubhouse method which emphasizes the recovery orientation, learning opportunities, social inclusion and labour market integration of people with different mental health problems. An increased number of mental health Clubhouses - which realize the CBR principles and guidelines in practice - will open more opportunities for disadvantaged people to take part in lifelong learning and to be included in society. The EMPAD project implemented the European level policies which promote active inclusion and full participation of the disadvantaged people in society, and it is in line with the United Nations', Council of Europe's and European Union's human rights approaches to disability policy issues.

This overview looks for answers and evidence for successful promotion of the Community-Based Rehabilitation and the Clubhouse model as one of its applications in the EMPAD partner countries and elsewhere in Europe. The Clubhouse model is used as an example of a coherent, strengths-based and well-structured method to support people with different mental health conditions in their choices for personal recovery towards social inclusion, self-determination and participation in their living communities and society in general.

After the introduction, the text is divided into five chapters as follows:

- *Chapter 2* presents the process of mental health reform with a short historical background to motivate the need for community-based rehabilitation approaches. Subsections 2.2 and 2.3 focus on international mental health policy guidelines and recommendations adopted during the 1990s and the 2000s. Especially resolutions and recommendations by the United Nations, World Health Organization and European Union are described. Subsection 2.4 looks for the optimal mix of mental health policy and services, which helps to build up and sustain strategies for mental health reform and the community-based services delivery.
- *Chapter 3* concludes the previous parts by identifying common denominators of international recommendations and examines how they were realized in the EMPAD partner countries and more widely in Europe at the end of last decade. Also the main results of the EMPAD partners' needs analysis survey are described.
- *Chapter 4* focuses on the theoretical and conceptual analysis of the key concepts of empowerment, CBR, recovery approaches, social capital, social inclusion and the Clubhouse model. Also the distribution of existing Clubhouses worldwide and in Europe is described. In addition, this section summarizes research findings about the Clubhouse model.
- *Chapter 5* examines the interrelationships, shared values and principles of the abovementioned key concepts. The identified common components of the concepts are compared with the International Standards for Clubhouse programs and, finally, the concluding remarks are made.
- *Chapter 6* concludes the overview by summarizing the whole content of the writing.

The principal object of this overview, like the whole EMPAD project, is to develop, promote and disseminate good practice psychosocial community-based rehabilitation aimed at people living with mental disorders. The mental health care and psychosocial rehabilitation measures are aimed *to support their aspirations and choices towards recovery* and a life situation where positive mental health components and social inclusion prevail.

2 The mental health reforms and community-based policy

2.1 Historical background

During the 19th century and the first half of the 20th century mental hospitals and other isolated asylums were the mainstream structure for the care and treatment of people with mental health problems both in Europe and elsewhere. The years after World War II were the start-up for a long-lasting process of change. Since the 1940s the human rights movement expanded and gained more international influence. The Universal Declaration of Human Rights was approved in 1948 by the United Nations' General Assembly which focused attention also on violations of basic human rights of people with psychiatric disorders in mental hospitals. Research findings produced a growing body of evidence that psychiatric hospitals had little therapeutic impact and that they upheld patients' disorders or even made them worse. In the Eastern and Central European countries, which were earlier under the communist regime, this situation continued until the end of the 20th century. The process of change of policies and practices has varied also between different Western European countries (Shorter 2007, 15-29; Knapp et al. 2007; Rosenthal et al. 2004; WHO 2003a).

Particularly from the 1960s onwards the mentioned changes led to *a reformed mental health policy with the process of dehospitalization* also in many European countries. The number of patients in mental hospitals was reduced, downsizing and closing of hospitals begun, as well as the development of community mental health services as an alternative to inpatient care. In several countries a remarkable shift has taken place from hospital-based to community-based systems. The 1978 Mental Health Reform in Italy provides an illustration of this trend. In Trieste psychiatric hospitals were closed down and replaced by a wealth of community-based services providing medical care, psychosocial rehabilitation and treatment for acute episodes (WHO 2003a).

Parallel with the mental health reform the Clubhouse psychosocial rehabilitation model has been developed since 1948 in the Fountain House in New York, USA. In the 1970s Fountain House started its dissemination in the USA and in Canada, and a couple of years later in Europe, too (Propst 2003: 29-32).

The first community-based service innovations were invented and tested already before World War II, but more actively these were developed from the 1950s onwards. One of the contributors for the change was Erving Goffman (1961) with his book *Asylums.* Simultaneously, the ideas about therapeutic communities prompted to open neighborhood centres and Clubhouses and many other units as a result of the decreasing inpatient capacity in psychiatric hospitals. The first therapeutic communities for

people with mental health problems were created during the 1950s and 1960s. This was a source of inspiration for leaders in many countries globally.

According to Jenkins (2011), it was during those decades when the first day hospitals, home treatment teams and outpatient nurses started their activities. Starting from 1963 the first community mental health centres (CMHC) and acute psychiatric units in general hospitals were opened in the USA and some other countries. In addition, NGOs of and for people with mental disorders and their carers have been founded in many countries since the 1950s. The first European NGOs for mental health issues were founded during the 19th century.

In Italy and many other countries new schemes like protected housing – earlier halfway houses – and different kinds of support services were introduced in order to offer people with mental disorders better opportunities to become socially integrated in their communities. Several countries followed the Italian way in decreasing the use of mental hospitals and increasing the mix of different kinds of community-based services. Clubhouses were part of this development especially in Scandinavia and other Western European countries. By the end of the 1980s the Clubhouse model was disseminated into Australia, South-Korea, Japan, Hong Kong and in Europe (Propst 2003: 31). However, in a majority of the Eastern and Central European countries, e.g. the Baltic countries, Bulgaria, Hungary, Poland, Romania and Russia, the change of psychiatric services from hospital-based to community-based structures started in the late 1990s or during the first decade of the new millennium (WHO-Europe 2008b; Lavikainen et al. 2010).

WHO (2003a, 4) experts believe that the 21st century will see a significant improvement in the care of persons with mental health conditions. Advances in the social, behavioral and cognitive sciences have given new knowledge and insight into the social origins of mental disorders such as depression and anxiety. More effective psychotropic medications are today in use for a range of mental disorders. Research has demonstrated the effectiveness of community-based psychological interventions and psychosocial rehabilitation in speeding up and sustaining recovery from depression and anxiety, as well as from chronic conditions such as schizophrenia.

Significant disparities still prevail between different countries, regions and service districts. As a whole, Europe is still today the leading continent in terms of hospitalization of people with mental health problems. In most of the Eastern, South-Eastern and Central European transition countries psychiatric hospitals continued to be the prevailing mental health policy until the end of 20th century. (WHO 2009).

The implementation of deinstitutionalization process is a challenge in all countries. According to Jan Pfeiffer (2011) it includes at least four risk scenarios: over-investment in current institutions, maintaining parallel overlapping services, investing in alternatives with old institutional culture, and closing the institutions without community alternatives. In addition to the United Nations and its specialised organizations, the Council of Europe and the European Union have declared their support to the community-based structures instead of institutionalization and mental hospitals.

2.2   International mental health policy guidelines and recommendations during 1990s

At international level, the United Nations (UN) focused its member states' attention in the early 1990s to the inhumane and then still prevailing bad practices in the mental health care. In 1991 the UN General Assembly approved a resolution called The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. It contains 25 guiding principles starting from fundamental freedoms and basic rights, prioritizing life in the community, regulating medical examinations and medication, defining standards of care and treatment, requiring informed consent to treatment and notice to users on their rights, conditions in mental health facilities, and regulations on involuntary admissions, etc. (UN 1991). These so-called MI-Principles, which are non-binding, can be used as a guide to the interpretation of related provisions of international human rights conventions (Rosenthal et al. 2004: 6).

Based on these principles the *World Health Organization* published in 1996 its global recommendation of ten basic principles for mental health care law (WHO 1996). Later *the Council of Europe* (CoE 2004) published recommendations of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder. The resolution contains a major part of the UN resolution's principles from 1991 but is adapted to the European situation about ten years later.

In 1993 the United Nations' General Assembly adopted the resolution (48/96) The Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UN resolution 1993). The concept of disabilities covers both visible and invisible disabilities, mental and behavioural disorders. Although not a legally binding instrument, the Standard Rules represent a strong moral and political commitment of governments, and they serve as an instrument for policy-making and as a basis for technical and economic cooperation, as well as for capacity-building of national and international organizations.

The Standard Rules were a result from the international discussions in the 1980s which was also declared the United Nations Decade of Disabled Persons. These two actions increased the understanding that disabilities are societal constructions and are based on interactions between a person's abilities and functioning potentials and functioning opportunities made possible or impossible by the different environments and communities to him or her.

The new awareness on disabilities opened new routes to social participation and integration into society for people with any kinds of disabilities, people with mental health conditions included. *The social model* of disability policy emerged to complement the dominating medical model. The Standard Rules included also the human rights perspective which has since been developed into *a human rights disability model* (WHO 2010b).

The Standard Rules are divided into four main chapters under which each rule is explained. The first chapter discusses preconditions for equal participation and four rules for it (awareness-raising, medical care, rehabilitation and support services). *The*

second chapter includes target areas for equal participation and eight rules for it (accessibility, education, employment, income maintenance and social security, family life and personal integrity, culture, recreation and sports, and religion). *The third chapter* concentrates on implementation measures and contains ten rules (information and research, policy-making and planning, legislation, economic policies, coordination of work, NGOs of persons with disabilities, personal training, national monitoring and evaluation, technical and economic cooperation, and international cooperation). *The fourth chapter* covers the monitoring mechanism for how to follow-up on the implementation of the Standard Rules in UN member states.

In the mid-1990s also *the European Union* (EU), based on its new competences, created two new policy planning forums in the field of mental health (the European Network on Mental Health Policy and the European Network on Mental Health Promotion) and approved the initiative Promoting Mental Health on the European Agenda (Lehtinen et al. 1997: 45). In addition, the European Commission decided to fund a new Key Concepts project for evaluating and identifying the best options for the development of mental health promotion in Europe (Lahtinen et al. 1999: 5). In both project reports mental health is seen as an essential component of general health: There is no health without mental health.

According to the Key Concepts project, mental health is a result of various *predisposing factors* (e.g. early childhood experiences), unexpected *critical factors* (e.g. stressful life events), social context, *individual resources* (e.g. self-esteem) and experiences. *Positive mental health* refers to mental health as a capacity to perceive, comprehend and interpret our surroundings, to adapt to them and to change them if necessary, to think and speak and to communicate with each other. Positive mental health is determined by four main influences: individual factors and experiences, social interaction, societal structures and resources, and cultural values. *Mental ill-health (negative mental health)* forms a continuum which extends from the most severe mental disorders to a variety of symptoms of different intensity and duration, resulting in a variety of consequences. Much mental ill-health is experienced as a part of normal life and is not – usually – presented for care or recorded in epidemiological studies. Such everyday mental problems are correlates of personal distress and can take the form of e.g. lack of motivation, poor concentration etc. Mental health is created and jeopardized in families and schools, on streets and in workplaces. It is a result of the way we are treated by others, and the way we treat other people and ourselves. (Lahtinen et al. 1999: 9-10).

At the end of the 1990s the European Commission decided to fund some other projects in the field of mental health policy, e.g. Unemployment and Mental Health (Ozamiz et al. 2000), and Public Health Approach on Mental Health in Europe (Lavikainen et al. 2000), as well as the European Conference on Promotion of Mental Health and Social Inclusion organised in Tampere, Finland, in October 1999, and its pre-conference in Helsinki in January 1999. These all were parts of the Mental Health on the European Agenda process. As a result of the activities in the field during the 1990s the visibility

and awareness-raising of needs to develop further mental health promotion and mental health policy increased essentially at least in the EU member states.

Mental health is an indivisible part of general health. It is therefore of the utmost importance that mental health and its promotion should be integrated closely with all public health policies and strategies. The value of mental health needs to be recognised throughout the European Union, and across all levels and all sectors of society (Lavikainen et al. 2000: 14).

2.3 Mental health policy guidelines and recommendations in period 2001 – 2011

During the 2000s the UN and its specialised organizations (mainly WHO and its Regional Office for Europe), the Council of Europe and the European Union declared their support to community-based structures instead of institutionalisation in about 30 recommendations, guidelines and other documents, most of which are listed in Table 1. Together they form a comprehensive framework and an international context for mental health policy development at national, regional and local levels in all countries. ANNEX 1 contains a more detailed description of the key documents and guidelines.

Table 1: International documents forming the context of mental health policy 2001 - 2011

- 2001 WHO report: The world health report 2001. Mental health – new understanding, new hope. It was the basement for the later policy and practice recommendations.
- 2003 WHO series of guidebooks: Organization of services for mental health. Mental health policy and service guidance package. Launched the optimal mix of mental health services.
- 2004 WHO strategy: CBR – Community based rehabilitation, a strategy for rehabilitation, equalisation of opportunities, poverty reduction and social inclusion of people with disabilities. Joint position paper of WHO, ILO and UNESCO.
- 2004 Council of Europe: Recommendation of the committee of ministers to member states on the protection of human rights and dignity of persons with mental disorder.
- 2005 WHO European ministerial conference: Mental health declaration for Europe: Facing the challenges, building solutions. Helsinki declaration.
- 2005 WHO European ministerial conference: Mental health action plan for Europe: Facing the challenges, building solutions.
- 2005 European commission: Green paper for mental health policy in the EU.
- 2006 UN general assembly: Convention on the rights of persons with disabilities and its optional protocol (legally binding for the member states).
- 2007 WHO MIND project: The optimal mix of services → WHO pyramid framework. Mental health policy, planning and service development information sheet no 2.

- 2008 Monitoring Mental Health Environments –project's guide book: Building up good mental health, guidelines based on existing knowledge.
- 2008 EU and member states: European pact for mental health and well-being.
- 2008 WHO & European commission: Policies and practices for mental health in Europe – meeting the challenges. Baseline report on the 2005 Helsinki declaration assessment.
- 2009 WHO publication: Improving health systems and services for mental health. Publication of mental health policy and service guidance package.
- 2009 European commission: Report of the ad hoc expert group on the transition from institutional to community-based care (with recommendations).
- 2010 WHO et al: Community-based rehabilitation (CBR) guidelines. Introductory booklet for a series of sectorial and crosscutting booklets.
- 2010 WHO et al: Community-based rehabilitation (CBR) guidelines. Crosscutting empowerment booklet.
- 2010 WHO et al: Community-based rehabilitation (CBR) guidelines. Supplementary booklet including the guidelines for mental health field.
- 2010 EU Disability policy documents for 2010 – 2020. Strong commitment to support the deinstitutionalisation process in Europe, and initial plan of intended actions for 2011 – 2015 prioritized by the European Commission.
- 2011 European Commission's decision 1st December on the adoption of the 2012 work plan of second Health Programme enabling "joint action" on mental health involving member states, other stakeholders and international organizations, due to be implemented in years 2012 - 2015. One priority is managing transition from institutional care to community-based services and promoting social inclusion of people with mental health problems.

In 2006 the United Nations' General Assembly approved the UN Convention on the Rights of Persons with Disabilities and its Optional Protocol (UNCRPD) which covers people with different mental health conditions also. The convention came into force on May 3, 2008, and *it is legally binding* to the member states of the UN. The convention is both a development and human rights instrument and it covers cross-disability and cross-sectorial policy approaches (UN 2006: 4). Based on this new Convention the process of deinstitutionalization has recently been reactivated in many European countries which have ratified the UNCRPD, along with the European Union in March 2007. The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. The key principles of the Convention are (UN 2006: 5):

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion in society;
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- Equality of opportunity;
- Accessibility;
- Equality between men and women;
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

In addition, the UNCRPD has obliged UN member states to guarantee the rights of people with disabilities for education and learning, quality health care with health-related rehabilitation, work and employment possibilities on equal basis with others in open, inclusive and accessible workplaces and to promote vocational and professional rehabilitation and return-to-work programmes, adequate standard of living and social protection, participation in political and public life, as well as participation in cultural activities, recreation, leisure and sport. All mentioned obligations cover also people with mental health conditions (UN 2006).

The ratification of UNCRPD largely by UN member states has created *a window of opportunity* to re-encourage the mental health reforms and community-based services in Europe. Recent examples also show how financing provided by the European Union can support this process (Pfeiffer 2011). The main challenge lies in minimizing hospitalization practices and maximizing the development and delivery of community-based services. The EU's Structural Funds, second Health Programme and other funding possibilities can further support the mental health reforms and deinstitutionalization.

The way in which mental health services are organised has an important influence on their effectiveness and outcomes for users' recovery and social inclusion, as well as on the realisation of human rights. The proper implementation of the above UNCRPD convention principles and sectorial objectives can help European countries to build up sustainable human rights based mental health policy and service systems, where Clubhouses and other recovery models can demonstrate their positive performance. The exact form of service organization and delivery depends at the end on a country's social traditions and economic prospects for the future. Each country has to create its own mental health policy priorities and timetables to implement step-by-step the international policy recommendations for service development (WHO 2003b; WHO 2007).

Council of Europe's policy recommendations

The Committee of Ministers of the Council of Europe (CoE) approved in 2004 a set of guidelines as a recommendation for its member states on the Protection of Human Rights and

Dignity of Persons with Mental Disorder. Based on this decision the CoE approved in 2009 another recommendation on monitoring the implementation of the mentioned guidelines.

Together these two CoE decisions form a comprehensive toolkit for the development of an optimal organization for human rights based and integrated community-level mental health service system. Both CoE decisions are based on the Convention for the Protection of Human Rights and Fundamental Freedoms of November 4, 1950, and some other related conventions of the CoE and the United Nations.

Mental health policy and service guidance package

Parallel with the community-based rehabilitation development work, WHO was active also in other fields of the mental health policy. In the beginning of the 2000s it began producing a series of publications for the Mental Health Policy and Service Guidance Package, and organized the Mental Improvement of Nations' Development (MIND) project. The series includes about 15 guide books which provide a substantial analysis and evidence about the mental health policy development needs and recommendations on how to meet these needs.

Europe was in both 2000 and 2010 the leading continent in the world in terms of number of beds in mental hospitals and psychiatric wards in general hospitals per 100,000 population. But Europe is also the leader in providing day treatment facilities and community residential units. In fact, there are big disparities between different European countries in terms of availability of and access to different mental health services. (WHO 2001: 86; WHO 2011: 44).

2.4   Search for the optimal mix of mental health policy and services

In its publication *Organization of Services for Mental Health,* WHO launched its recommendation on the optimal mix of services for mental health (WHO 2003b). The whole book is based on this integrated and comprehensive optimal mix approach. In 2007 the model was revised slightly and renamed the WHO Pyramid Framework (WHO 2007). It was republished a couple of years later, again with minor changes (WHO 2009).

According to the World Health Organization (WHO 2003b; WHO 2009), very few countries have in place an optimal mix of mental health services. Some developing countries have made mental health services more widely available by integrating them into primary care services. Many other countries have also mental health services available in general hospitals and private settings.

The WHO Pyramid Framework consists of informal and formal community-based multisectoral services like community mental health centres (CMHC), and other related services such as day activity centres, Clubhouses and work units. These should make up the main part of the pyramid and be allocated a corresponding share of the available resources.

Certain countries and regions at *the leading edge* of the mental health reform can demonstrate good examples of diversification and integration of the community-based mental health services by intersectoral collaboration with different stakeholders, e.g. NGOs, user-organizations, researchers and other agencies (WHO 2010b; Jenkins 2011). The schematic structure and content of the Pyramid Framework are described below. Figure 1 presents the recommended policy approach:

Lowest need

Highest costs

Psychiatric specialist care, long-term facilities

Mental health services in general hospitals

Highest need

Community Mental Health Centers Cooperation with other sectors, CBR & Clubhouses, Day Centers, NGOs, Work units, Advocacy groups etc.

Lowest costs per person

Involving users and carers in all development of services and local activities Informal support & Self – care management

Source: WHO 2003 (Revised 2007), applied by E. Hänninen and E. Mielonen 2012

http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf
Accessed 2012-06-30

Figure 1: Pyramid framework for optimal mix of mental health services

The key message of the WHO *Pyramid framework* is that mental hospitals and specialist services present the highest cost, and yet they are the least frequently needed services of the mental health pyramid. Informal community services, advocacy and self-care, on the contrary, have a high frequency of need and can be provided at a relatively low cost (WHO 2007).

The pyramid illustrates that the mental health policy and services can be divided into *informal* and *formal parts.* The informal parts contain (1) support to strengthen self-care management and coping skills, friends, self-help teams and peer support, and (2) other informal community-level services and activities, such as participation in

voluntary associations, and support provided by family members, social networks and community advocacy groups.

People working in other local service sectors can help to organise informal activities which support individual recovery processes. The informal parts lie at the base of the pyramid. Informal services and support activities are a useful complement to formal mental health services and they can be important in improving recovery outcomes for persons with mental health condition. Informal community-level services usually have high acceptance and there are few access barriers as people, groups and organizations who provide the services are in most cases already present in the community they serve (WHO 2003b: 3-4).

According to the Council of Europe guidelines for integrated services (Munday 2007) the term "integration" is understood as a range of approaches or methods for greater coordination and effectiveness between different services to achieve improved outcomes for service users. Informal care and support activities should have ties and co-operative relationships both horizontally across the different sectors within a community and vertically between local, sub-regional and regional actors and agencies. The quality and quantity of these ties and relationships determine the level of integration and social cohesion in the community, which – at its best – may contribute remarkably to the empowerment of people with mental and psychosocial problems, and thus to more inclusive community development (Sadan 2004).

Formal parts of the optimal mix framework are located on the second, third and upper "floors" of the pyramid. The components of these middle "floors" are community-based mental health services directed and coordinated by specialists, mental health services in primary health care and general hospitals. The top floor consists of psychiatric specialised hospitals and long-term care. (WHO 2003b: 10; WHO 2009: 21-23). According to the revised pyramid framework when informal services are not enough, additional expertise and support is needed by more formal network of community-based services. In ascending order these include primary services like family doctors and school nurses and psychologists, followed by specialist community mental health centres (CMHCs) and psychiatric services in general health care, and lastly the specialist and long-stay mental hospital services.

Formal community mental health services include for example community-based rehabilitation, hospital diversion programmes like day hospitals, psychotherapies, mobile crisis teams, Clubhouses and day centres, therapeutic and residential supervised services, home help and support services, work in sheltered workshops or supported and transitional employment in normal workplaces, as well as community-based services for special groups such as children, youth and the elderly. Community mental health services need close links and cooperation with informal care and support providers, primary health care services and with general hospitals. One of the main recommendations is to integrate mental health services at all levels with general health care facilities and functions.

Well-organised community-based mental health services provide an opportunity for many people with severe mental and psychosocial problems to continue living in

the community and they thus promote social inclusion and integration in mainstream ways of living.

The pyramid framework is built on needs-led, participatory policy-making, and planning, organising and the continuous development of mental health services. Service-users and their carers should have a voice and the right to be heard at all stages of service processes, in advocacy work and in developing the mental health service system.

An essential part of the formal community mental health services are different forms of *community-based rehabilitation* (CBR). CBR has a strong emphasis on *empowerment* as the crosscutting approach (WHO 2010a). In addition to the CMHCs the WHO guidebook lists under psychosocial rehabilitation such services as day care centres, Clubhouses, drop-in centres, support groups, employment and rehabilitation workshops, sheltered workshops, supervised work placements, cooperative work schemes and supported employment programmes. Clubhouses are mentioned as a part of formal community mental health services also in two other sections: in the executive summary and in the chapter on how to create formal and informal community services (WHO 2003b: 3, 15 and 39).

As a result of the development in Europe since the 1980s the Clubhouse as a cost-effective form of psychosocial rehabilitation and a good practice has spread across Europe and expanded into a network of about 80 Clubhouses, which are members of the International Center for Clubhouse Development (Propst 2003; ICCD 2012). Some European Clubhouses are not members of the ICCD.

Coordination and collaboration of mental health services with other health and societal service providers and professionals are necessary in order to achieve positive results for the individual recovery processes. Coordination and collaboration must also take place across administrative boundaries with the organizations responsible for education, housing, employment, social welfare services and benefits, public transport, police and courts of justice, and so on. (UN 1993; CoE 2004; UN 2006; WHO 2010d).

Collaboration should be organised at all levels: local, regional and national levels, both vertically and horizontally. Cooperation strategies may include for example inviting other sectors' representatives, service-user organizations and other NGOs to participate in joint policy and development programme planning meetings, dividing responsibilities between different organizations, setting up information and communication networks, and establishing local, regional and national level advisory councils and coordinating task forces. (WHO 2003b: 51-53; WHO 2010d).

2.5   Summarizing remarks

In this chapter the key themes are the mental health reform which started after World War II with a special focus on the new types of community-based treatment, rehabilitation, residential and support services. At the same began the downsizing and decreasing the use of mental hospitals first in the USA, Canada and later in Western and Northern Europe as well. Changes took place slowly and at different speeds in different countries. The medical approach dominated the process until the 1980s and 1990s when the wider social paradigm emerged together with the strengthening human rights based approach.

During the period 1990 -2011 the international and intergovernmental organizations such as the United Nations with its specialist organizations WHO, ILO and UNESCO, and the Council of Europe and the European Union launched at least 30 different policy guidelines, recommendations or expert reports to coordinate and activate the mental health policy reforms. However, what essentially comes to question is how effectively National Governments are able to realize these policy recommendations at national, regional and local levels.

Many of the international policy frameworks and recommendations are quite comprehensive and some of them are complex. The most applicable of these and the one with the clearest message seems to be the *WHO Pyramid Framework for Optimal Mix of Mental Health Services, complemented with the collaboration across the different sectors and professions* as recommended in the UNCRPD-convention (UN 2006) and later in the CBR guidelines jointly by ILO, WHO and UNESCO. (WHO 2010b). The main messages from this combined policy framework to provide the optimal mix for the local and regional mental health services are:

- Promote and organise self-care, peer support and coping skills of the persons in need;
- Mobilise local resources to involve service users in the activities offered by the community;
- Integrate mental health services into primary healthcare;
- Build and diversify community based mental health services (e.g. open new community mental health centres, home service teams, residential units, CBR-services and Clubhouses, build up advisory councils where users and carers have a say and are listened to);
- Develop mental health services in general hospitals;
- Reduce the use of psychiatric hospitals and invest savings to community-based services; and
- Complement all above measures by coordination and collaboration e.g. with providers of education, housing, employment, social services and benefits agencies, police and courts of justice, service users and carers voluntary organizations and with other relevant voluntary associations.

3 Policy recommendations and situation in the EMPAD partner countries and in Europe

3.1 Common denominators of the international mental health policy frameworks

The different international frameworks and recommendations mentioned in Table 1 consist, amongst other things, of several shared values and principles. These major "common denominators" of the future services for people with different mental health conditions can be summarized as follows:

- Equal opportunities to exercise human rights and freedoms in all settings;
- Involving people with mental health problems in all decision-making and service development;
- Elimination of all kinds of discrimination and stigmatization;
- Full participation, reintegration and social inclusion in community on equal basis with others;
- Right to receive needs-based public services, like social protection, housing, healthcare, professional training, and employment services;
- Mental health policy built on community based optimal service mix, Clubhouses and other recovery support methods included, and where the use of mental hospitals is minimized;
- Coordinating community based services with primary healthcare and general health services;
- Self-determination and independent living which is assisted, if needed, by local support resources (e.g. families, friends, voluntary groups, NGOs and local authorities);
- Acceptance, dignity and respect in living environment;
- Awareness-raising and advocacy activities as a part of mental health policy to enhance cooperation and coordination with other administrative agencies; and
- Code of conduct or standards of ethics for steering the development of mental health policy and services.

In addition, one common feature of the mental health policy recommendations of the different intergovernmental organizations is the expectation that the governments of all member states should actively and by appropriate means promote the implementation and proper realisation of these policy recommendations according to each country's internal division of responsibilities.

According to Jose M. Caldas de Almeida and Helen Killaspy (2011, 16), from a scientific point of view what is at stake is the replacement of the strict biomedical model by a more holistic approach which understands mental disorders as a result of the complex interactions of biological, psychological and social factors. It combines the perspectives of users' treatment and rehabilitation with prevention and promotion leading towards recovery and social inclusion in different fields of everyday life.

3.2 The reality of mental health policy in the EMPAD partner countries and in Europe

The partner countries of the EMPAD project are Germany, the Netherlands, Romania, Slovenia, Basque country in Spain, and Sweden. Finland is the coordinating partner represented by the National Institute for Health and Welfare (THL), and the Clubhouses of Helsinki represented by the NGO Helsingin Klubitalot ry.

Two European policy documents were approved in 2005 by the ministerial conference of WHO Regional Office for Europe, held in Helsinki. The participants accepted and signed, firstly, the Declaration on Mental Health for Europe, and secondly, Mental Health Action Plan for Europe – facing the challenges, building solutions (WHO 2005a & b). The main priorities and areas for needed action of both of these policy framework documents are summarized briefly in Annex 1.

After the Helsinki conference the European Commission and WHO Regional Office for Europe signed a partnership agreement for sharing research information and comparative data on the development of mental health and mental health services in member states of the WHO European Region. The partnership started the Baseline Declaration Assessment project. The assessment report Policies and practices for mental health in Europe was published at the end of year 2008 (WHO – Europe 2008a).

In this section a comparative analysis of mental health policy realities in the EMPAD partner countries and more widely in Europe is prepared by using the data and conclusions provided by the joint baseline assessment report mentioned above. The comparisons cover only some key areas of mental health policy and services.

Latest update of mental health policy: A majority of the EMPAD countries have updated their mental health (MH) policy in 2005 or later (Finland, Germany, the Netherlands, Romania and Sweden). In Slovenia the latest MH policy update took place before 2005.

Latest update of mental health legislation: Two of the seven EMPAD countries have reviewed and changed their MH legislation in 2005 or later (Finland and Germany). The Netherlands, Romania, Slovenia and Sweden have last updated their legislation before 2005.

In the wider WHO – Europe: 84 % of countries have revised their MH policy in 2005 or later, 11 % in years 2000- 2004, and 5 % prior to year 2000.

Access to home treatment: In Finland, Germany, Netherlands and Sweden this service is available, but not in Romania and Slovenia. The situation concerning the Access to assertive outreach activity is similar: available in Finland, Germany, Netherlands and Sweden, but not in Romania and Slovenia.

Availability of community-based interventions: Best organised in Germany, where almost all in need have access to community-based interventions, in the Netherlands less than 50 % of those in need have access to these services, also in Romania and Finland services are available but for less than 20 % of those in need. In Sweden, services are available, but data on intensity is missing. In WHO – Europe community-based interventions were available in 25 % of countries, but the intensity as percentage of those in need is varying significantly.

Beds in community residential facilities (under both health and social sectors): In 2008 in Slovenia the number of beds in residential units was 122 per 100,000 population – the highest rate amongst the EMPAD countries – while in Finland the number was 106 beds per 100,000, and in Sweden about 80 per 100,000 population. In the Netherlands the number was 54 beds per 100,000 population, and in Romania only few beds were available. The baseline assessment report gives for Germany a low figure of 7 beds per 100,000 population (NGOs provide large amounts of all kinds of services in Germany). In WHO – Europe the average amount of community residential beds is about 55 per 100,000 population.

Integration of psychiatric wards in general hospitals: This is reality in all EMPAD countries, psychiatric wards are available in all countries as part of general hospitals, but the numbers vary significantly between countries. The integration process is on-going and after next five-year period the situation will be better.

Institutional care, total amount of all inpatient beds in mental hospitals and in general hospitals: In 2008, the lowest total numbers of inpatient beds between the EMPAD countries were in Spain, 53 per 100,000 population on average, and in Sweden, 55 beds per 100,000 population. In Finland the number was 70, in Romania 75, in Germany 78, in Slovenia 82, and in the Netherlands 115 beds per 100,000 population. The median figure for the WHO European region was 49.9 beds per 100,000 population, which varies significantly between member states and between regions in all countries.

Admissions to inpatient units, both to psychiatric wards in general hospitals and mental hospitals: the highest levels of admissions mentioned in the 2008 report were in Romania (1301/100,000), in Germany (1240/100,000), and in Sweden (1200/100,000). In Finland the figure was 900/100,000, in Slovenia 541/100,000, in the Netherlands 523/100,000. The median figure for the region of WHO - Europe was 568 admissions per 100,000 population, which includes significant variance between member states, as well as between national regions and service districts.

Programmes to improve social inclusion of people with mental health conditions were being carried out in all the EMPAD countries, mostly based on the funding opportunities from the EU structural funds, Spain included. The priorities of the regulations concerning the European Social Fund and European Regional Development Fund

require that part of the money allocated to EU member states must be used for the promotion of social inclusion, fight against social exclusion and anti-discrimination activities of the vulnerable groups, people with mental health problems included.

Collaboration with other sectors, especially with education, employment, housing, welfare and criminal justice is reality in most of the EMPAD countries. In Romania collaboration is not realised with employment and housing agencies although cooperation is organised with other sectors. Slovenia has reported that collaboration is not organised.

In more than a half of the WHO – Europe countries mental health units cooperate with the education, welfare, child protection and criminal justice sectors. Cooperation with the housing sector is reality in one third of the WHO – Europe countries. In the old EU countries (those who were members before 2004), collaboration with other agencies was organised in up to three quarters of the countries, but amongst the EU countries that joined the Union in 2004 or later the collaboration takes place only in about one third of the countries. In Eastern Europe outside the EU inter-agency cooperation is reality in fewer than one fifth of the countries.

Users' involvement in development committees and groups of mental health services is an essential part of the empowerment process, as well as users' and carers' personal participation in the planning of care, treatment and rehabilitation programmes. These both are important elements of the WHO pyramid framework recommendations. According to the baseline assessment results, users' and their family members' representation in committees and groups responsible for planning, implementing and reviewing mental health policy and services is reality in the EMPAD countries of Sweden, Finland, Germany, Slovenia and in some regions in Spain, Basque country included. The Netherlands and Romania have reported that the involvement of users, carers and family members in the mentioned committees and groups is not a real practice in their countries. Less than a half of countries in the WHO Region for Europe have involved users' and carers' representatives in the mentioned committees or working groups.

Human resources

The numbers of psychiatrists per 100,000 population are highest in Finland (26) and Sweden (24), which are five times the figures in Romania (4.7) and Slovenia (5.4). In Germany the figure is 8.7 and in the Netherlands 14.5.

The number of trained nurses in the mental health sector per 100,000 population is highest amongst the EMPAD countries in Finland (163), which is also the highest rate in the whole Europe. In the Netherlands the number is 120, in Sweden 73, in Germany 58, in Romania 22.5, and in Slovenia 5.8.

The number of psychologists per 100,000 population in mental health services: The number is again highest in Finland (47) and in the Netherlands (30). In all the other EMPAD countries the availability of psychologist's services is much more limited, for instance in Slovenia the number of psychologists is only 2 per 100,000 population.

The above comparison reveals that the variance of available specialised human resources for the mental health field between different countries is huge and unacceptable. In countries with the lowest levels of human resources the realization of the WHO pyramid framework, for example, is a big challenge and needs special measures.

3.3 Main results of the needs analysis questionnaire for key stakeholders

A needs analysis was carried out based on survey data from web-based questionnaires. To ensure the greatest possible transparency, as well as the involvement of main key stakeholders, the questionnaire was directed at the following groups of individuals: (a) mental health service users, (b) professionals in mental health organizations, and (c) policy makers or people who influence on mental health policy and/or legislation. By September 30, 2011, responses had been recorded as follows:

	Professionals	Users	Policy makers	Total
Slovenia	26	12	0	38
Germany	15	19	3	37
Finland	6	15	3	24
Netherlands	13	13	4	30
Romania	13	23	10	46
Spain	15	2	0	17
Total	88	84	20	192

Awareness on international mental health policy recommendations

In all countries (Slovenia, Spain, Romania, Germany, Netherlands, Finland) professionals were familiar with mental health service system and legislation in their respective country or region. However, professionals were less familiar or unfamiliar with:

- WHO's "Declaration on Mental Health and Action Plan for Europe" approved by European Ministerial Conference in Helsinki 2005;
- WHO's recommendation on the optimal mix of services for mental health: The WHO Pyramid Framework, published in 2003 and revised 2007;
- Council of Europe's recommendations on the protection of the human rights and dignity of persons with mental disorder, approved by Ministers of member states in 2004;
- The joint WHO, ILO and UNESCO guidelines for Community-Based Rehabilitation, draft published in 2004 and final guidelines in 2010.

These results imply that the national Ministries of Health have not disseminated effectively enough information about the international policy frameworks listed above which they have approved and signed.

Satisfaction of professionals with mental health services

In all countries (Slovenia, Spain, Romania, Germany, Netherlands, Finland), professionals expressed having medium or little influence on policy making in the mental health sector in their country or region. In Slovenia and Romania, professionals were unsatisfied with mental hospital services and psychiatric units in general hospitals; they were satisfied with vocational rehabilitation programmes and job opportunities in adapted work places.

In Spain, professionals were medium satisfied with mental hospital services and psychiatric units in general hospitals, but unsatisfied with the involvement of NGOs for people with mental health problems, and satisfied with vocational rehabilitation programmes and job opportunities in adapted work places. In Germany, professionals were satisfied with mental hospital services and psychiatric units in general hospital and medium unsatisfied with the vocational rehabilitation programmes and job opportunities in adapted work places.

In Slovenia, Germany and Romania professionals were medium satisfied with involvement of NGOs for people with mental health problems. In Slovenia and Spain they were unsatisfied or unfamiliar with the job club method. In Germany and Romania they were satisfied with Clubhouse programmes. In Finland professionals were most unsatisfied with community-based services in their locality and region in general, and with the share of primary health care in the MH system. They were the most satisfied with mental hospital services and the availability of additional training programmes for professionals.

In the Netherlands professionals were medium satisfied with all services for people with mental health problems. In Slovenia, Germany and Romania they said that users are only partly involved in development and changing the mental health services they use. In Spain professionals said that the users are not involved in development of and changing the mental health services they use. In Finland most of the professionals said that users are not involved in development and changing the mental health services they use. In the Netherlands a majority of the professionals said that users are only partly involved in developing and changing the mental health services they use.

In all of the countries mental health professionals thought that users are medium motivated or motivated for training, education and work inclusion.

In Slovenia, Romania, Netherlands and Spain professionals were partly familiar with community-based care and services for people with mental health problems. In Germany they were familiar with community based services. In Finland most professionals were unfamiliar with community-based services.

Service users' point of view

Service users who responded to the questionnaire were in Slovenia mostly visitors of day centres and individual therapies; in Spain most respondents were in psychiatric hospitals; in Romania the respondents were mostly users of community-based services and day centres; in Germany they were members of Clubhouses and users of primary health services; and in Finland they were members of Clubhouses. In the Netherlands, most respondents were Clubhouse members or users of individual therapy or mental health professionals' home visits.

In Slovenia, Spain, Romania, Germany the users were the most unsatisfied with job opportunities and the most satisfied with mental health services in general and the services they were using in particular. In Finland most users were satisfied with majority of services for people with mental health problems. In the Netherlands most users were unsatisfied with health services in general (other than mental health) and with adult education possibilities.

Service users in Slovenia were the least informed about where to turn to in case of complaint; the second least informed users were in Romania and Germany. The most informed users were in Spain, Finland and in the Netherlands.

Policy makers' opinions

In Romania, policy makers were the least satisfied with the legal basis for treatment of people with mental health problems, work opportunities for people with mental health problems and with community-based care; and satisfied with the possibilities of additional training programmes for professionals in mental health service.

In Germany some policy makers were satisfied with the legal basis for treatment of people with mental health problems, mental health services, and work opportunities for people with mental health problems, and the possibilities of additional training programmes for professionals in mental health service.

In Finland, policy makers were the least satisfied with work opportunities for people with mental health problems, and community based care; and satisfied with possibilities of additional training programmes for professionals, and practical implementation of legislation in mental health sector.

In the Netherlands, policy makers were unsatisfied with work opportunities for people with mental health problems, and satisfied with mental health services, programmes for developing quality of life for people with mental health problems, and practical implementation of legislation in mental health sector.

In Romania and Germany, policy makers were partly familiar or familiar with mental health services in the country, with legislation and WHO recommendations. In Finland the policy makers who responded to the questionnaire were partly familiar or familiar with mental health services in the country, with legislation and WHO recommendations. In the Netherlands the policy makers were partly familiar with mental

health services in the country and with relevant legislation, but unfamiliar with WHO recommendations.

3.4 Summarizing remarks

The challenge in all countries and service districts is how to organise mental health policy implementation and delivery of services by the most cost-effective and recovery-oriented way based on users' needs following the WHO pyramid framework described in Chapter 2. In all but one of the EMPAD countries multi-agency collaboration is reality today. The WHO – EC baseline assessment report (WHO–Europe 2008a) provides evidence that the structures and varieties of mental health policy and services are so far not following the optimal mix of services in any of the EMPAD countries. The same is true also more widely in Europe.

Inpatient care prevails in many European countries, binding a major part of all available resources for mental health. This bottleneck is hindering the local, regional and national authorities from developing community-based and human rights-oriented mental health services.

Based on the needs analysis questionnaire the users' point of view revealed that the main causes of dissatisfaction were in nearly all of the EMPAD countries their exclusion from the open labour market and the lack of job opportunities. In one country the lack of adult education possibilities caused dissatisfaction. Users were mostly satisfied with the mental health services they were using. The clear message is that the need for jobs and vocational training should be taken into account when the optimal mix of mental health services is being constructed. Users' low or partial involvement in service development is a cause of dissatisfaction.

The mental health professionals' views are divided concerning the dissatisfaction or satisfaction with services of mental hospitals and psychiatric units in general hospitals. In countries where the use of inpatient care is still the prevailing practice the professionals were unsatisfied with hospital services, while in countries where the community-level services and outpatient practices are more developed the professionals were quite satisfied also with the existing hospital services. An interesting finding was the rather low awareness of professionals on the international mental health policy frameworks. In countries where Clubhouses are available professionals were quite satisfied with the Clubhouse programmes.

The policy makers in most of the countries expressed dissatisfaction with the lacking employment possibilities for people with mental health problems. They were satisfied with the development of community-based services and with additional training programmes for professionals. Part of them expressed a need for more information about the international policy recommendations.

4 Empowerment, community-based rehabilitation, recovery approaches and the Clubhouse model

4.1 Introduction

Empowerment, community-based rehabilitation (CBR) and the ideas of many community-based services like comprehensive recovery approaches and the Clubhouse model are intertwined and are the main topics of this section. Empowerment is both the transversal and overall objective of all the mentioned interventions in the field of mental health. The development of the concept of empowerment and of the empowering community-based rehabilitation models have taken place in parallel since the 1970s with the development of the disciplines of community psychology and community psychiatry.

Empowerment-orientation is essential in healthcare and social services for promoting social inclusion and participation and for equalising opportunities of all people in disadvantaged positions, including people with mental health problems. Empowerment is an important cross-cutting component of community-based rehabilitation and the education system, in Clubhouses, and even in the fields of organizational and community development and business management. In addition, it has been evolved to a discipline of "empowerment evaluation" (Fetterman et al 1996). However, Perkins and Zimmerman (1995: 571) focus attention on the empowerment–disempowerment –continuum. In an oppressive society or organization or in less-equal and less-democratic environments the activities of groups and communities may lead to greater authoritarian control and disempowerment both at individual, organizational and community levels.

Historically, people with mental health problems have lacked a voice. Neither they nor their families have been involved in decision-making on mental health services, and they continue to be at risk of social exclusion and discrimination in all facets of life (e.g. Chamberlin 1997; Fawcett et al. 1996; WHO 2010d).

4.2 Definitions of empowerment

Perkins and Zimmerman (1995: 569) cite Rappaport's definition from the 1980s: "empowerment is a construct that links individual strengths and competences, natural

helping systems, and proactive behaviours to social policy and social change". Empowerment theory, research, and interventions link individual well-being with the larger social and political context, not only in the medical world. In the area of mental well-being the empowerment connects mental health to mutual help, trust, self-confidence, social relationships, and participation, and to the aspirations to create responsive communities. It engages us to think in terms of wellness vs. illness, competence vs. deficits, and strengths vs. weaknesses. Instead of blaming the victims or listing risk factors, empowerment research focuses on identifying capabilities. Empowerment-oriented interventions enhance wellness while they also aim to solve problems, provide opportunities for participants to develop knowledge and skills, and engage professionals as collaborators instead of authoritative experts.

These ideas put the Clubhouse model and recovery approaches in the focus of empowerment values, processes and outcomes, as will be described at the end of this section. Empowerment has different meanings in different contexts (WHO 2010c). Empowerment refers to the level of choice, influence and control on people's everyday living, i.e. self-determination and autonomy. At the same it is attentive to both empowering processes and outcomes or goals. Empowerment refers to the process of gaining influence over events and outcomes of importance to an individual, group or community (Fawcett et al. 1996: 162). Like many other authors, Perkins and Zimmerman (1995: 570) pay attention to the distinction between empowerment processes and outcomes because their definitions are critical to the empowerment theory. The process is empowering if it helps people develop skills so they can become independent problem solvers and decision makers in their life. Empowering processes at the individual level include participation in community organizations, processes at the organizational level include shared leadership and decision making, and at the community level they include collective action to access or influence on the government and administrative agencies, media, and other community resources. The empowered outcomes refer to realization of empowerment that allows studying the consequences and impacts of empowering processes. At the individual level outcomes might include situation-specific perceived control, skills, and proactive behaviors. Organizational outcomes include development of organizational networks, organization's growth, and influence on political decisions. Community level empowerment outcomes include evidence of pluralism and diversity, the existence of organizational coalitions, and the accessibility of community resources to all.

The core message of many researchers on empowerment (e.g. Fetterman 1996; Siitonen 1999; Nelson & Prilleltensky 2004) is that people empower themselves, often with assistance and coaching. This process is fundamentally democratic. It invites - if not demands - participation, examining issues of concern to the entire community.

A similar conclusion was reached in a grounded theory study conducted in Finland (Siitonen 1999) where the key feature internal feeling of power turned out to be synonymous with the concept of empowerment. The empirical results showed the following categories to be significant for the process of empowerment: freedom, responsibility,

appreciation, confidence, context, climate and positive regard. The basic assumption of the theory of empowerment in this Finnish study was that empowerment is an inherently human and individual process. It is a personal and social process in which the internal feeling of power is nontransferable to another. Comparable lists of dimensions of empowerment can be found also in many other authors' work.

According to Fetterman (1996: 8-9), self-determination which is the objective of empowerment consists of numerous interconnected capabilities, such as the ability to identify and express needs, establish goals or expectations and a plan of action to achieve them, identify resources, and make a rational plan of action to achieve them.

Based on the World Health Organization's view empowerment is "not a destination, but a journey" (WHO 2010a), a continued strengthening of individual, organizational or community level resources. Yin et al. (1996: 190-191) involve all stakeholders and describe the empowerment process as a group-oriented multidimensional activity. In this configuration empowerment means empowering all parties – not the implicit "technology transfer" whereby one external organization wants to transfer its ideas or models for use in other environments. Their recommendations for fostering empowerment at different levels are based on collaboration, partnerships and coalitions. A similar philosophy is the basis of the WHO's community-based rehabilitation guidelines (WHO 2010b).

Elisheva Sadan's (2004: 13-14) process of empowerment means a transition from a state of dependency or powerlessness to a state of more control over one's life, fate and environment. It changes three dimensions of social reality: (1) people's feelings and capacities, (2) life of the communities they belong to, and (3) the professional practices. From these three intertwined processes, which have systemic relations with each other, are identified the individual change process towards personal empowerment, community empowerment which is the social change, and empowering professional practices, i.e. organizational and cultural changes in service system.

Also many other authors see empowerment as connected with power relations or the internal feeling of power at individual, community and service practices' levels, as well as societal and/or cultural levels (e.g. Siitonen 1999; Page & Czuba 1999). Neal & Neal (2011) have summarized earlier findings on power in three structural overlapping categories: social power, psychopolitical power and relational power. All forms and subcategories of these powers are linked with the empowering or disempowering values, processes and outcomes at individual, organizational and communities' levels. Different forms of power are embedded in structural and social relationships, which have been and will be used as a means in political processes at all levels of society.

According to WHO recommendations (WHO 2004; WHO 2010c) empowered people with mental health problems or other disabilities make their own decisions and take responsibility for changing their lives and improving communities where they live. Empowered people have a say and are listened to, have choices and own decision-making opportunities, control over their lives, are free and independent and capable

of fighting for one's rights, are recognized and respected as equal citizens in the local community. The role of community-based interventions and support structures is to contribute to the empowerment process by promoting, supporting and facilitating the active involvement of people and their families in issues that affect their lives. People can be empowered on many ways: on psychological, physical, mental, social, political or economical capabilities and potentials.

Conclusions

The dimensions of empowerment discussed above entail that all individuals and groups in societies have their own unique empowerment profiles depending on their phases in physical, mental, cognitive, educational, employment, economic and other social development processes, as well as on their individual life experiences, their living conditions and socio-economic status in their communities. The empowerment profiles change according to the times of people's lifespan; the empowerment process concerns all people from the inception of life until death.

For the most part of our lifespan the human development process is continuous empowerment by lifelong learning and experiences, but it includes disempowering periods as well, e.g. during sickness periods and traumatic long-term conditions, accidents, and in old age. At societal and local community levels it is possible to identify legal, administrative, physical, cultural or other social structures and practices which are disempowering people, groups, organizations and communities. The challenge is how to change the disempowering factors and processes into empowering and inclusive social processes.

4.3 Community-based rehabilitation and CBR guidelines

4.3.1 Development process and structure of CBR guidelines

This part summarizes the WHO CBR guidelines (WHO 2010b, c, d). Over the past 30 years through collaboration with other UN organizations, nongovernmental organizations and disabled people's organizations, CBR has evolved into a multisectorial strategy to address the broader needs of people with disabilities, ensuring their participation and inclusion in society and enhancing their quality of life. With reference to CBR, empowerment has a dual role: it is both a component of CBR and its end objective or goal. CBR guidelines are global and they are applicable in all countries in the world, although practical solutions need to be differentiated according to the available resources in different settings.

CBR is a common-sense strategy for enhancing the quality of life for people with disabilities. This is achieved by improving service delivery in order to reach all those in

need by providing more equitable opportunities and by protecting their rights. CBR builds on the coordinated involvement of people with disabilities and their families (Helander 1993: 8). The collaborating international organizations ILO, WHO and UNESCO published first CBR documents during the1980s, joint draft papers in the 1990s, in 2003 and 2004. The decision to start creating international guidelines for CBR was made in an expert meeting in Helsinki in 2003.

The final version of the CBR guidelines was formulated after the UN General Assembly accepted the new legally binding Convention of Human Rights of Persons with Disabilities (UN 2006). After the ratification process it came into force in 2008. The CBR guidelines were published in October 2010. The guidelines are applicable and adaptive for all involved groups of people in all environments. This includes the application of CBR also in the mental health field. Special guidelines for mental health recovery were included in the supplementary booklet of guidelines (WHO 2010d: 3-20).

The guidelines are not intended to be prescriptive – they are not designed to answer specific questions related to any particular impairment, provide recommendations for interventions, or provide a step-by-step guide to programme development and implementation. The main focus of the guidelines is to provide a basic overview of key concepts, identify goals and outcomes that CBR programmes should be working towards, and provide suggested activities to achieve these goals.

The CBR guidelines consist of and are presented in seven separate booklets:

- **Booklet 1** – the introduction provides an overview of disability, the Convention on the Rights of Persons with Disabilities (UN 2006), the development of CBR, and the CBR matrix. The Management chapter provides an overview of the management cycle as it relates to the development and strengthening of CBR programmes;
- **Booklet 2** – describes the role of health policy and services in CBR from promotion and prevention to medical care, functional rehabilitation and assistive devices;
- **Booklet 3** – examines the role of education and learning in the empowerment processes from early childhood through primary, secondary, vocational and higher education to the lifelong learning;
- **Booklet 4** – examines the role of livelihood means from skills development, self-employment, wage employment, financial services and the social protection in general;
- **Booklet 5** – describes the role of social field in the empowerment covering personal assistance, personal relationships, culture and arts, recreational leisure and sports, and justice issues;
- **Booklet 6** – describes the dual roles of empowerment both as an end objective and cross-cutting means of CBR covering e.g. advocacy and communication, community mobilization, political participation, self-help groups and disabled people's organizations;

- **Booklet 7** – the Supplementary booklet: covers four specific issues, i.e. mental health, HIV/AIDS, leprosy and humanitarian crises, which have historically been overlooked by CBR programmes.

According to the Introductory booklet of CBR guidelines (WHO 2010b), the CBR guidelines:

- Provide guidance on how to develop and strengthen CBR programmes locally, regionally and nationally;
- Promote CBR as a strategy for community-based inclusive development involving people with disabilities, and promoting the coordination and integration of rehabilitation services across different sectors also for people with mental health problems;
- Support all stakeholders to meet the basic needs and enhance the quality of life of people with disabilities and their families;
- Encourage the empowerment of people with disabilities and their families by promoting their inclusion and participation in capacity-building and decision-making processes.

The CBR guidelines consist of five key components each divided into five key elements. A separate chapter is dedicated to each of these elements in the guidelines. The elements are further sub-divided into content headings. Each element has between four to nine content headings.

The CBR matrix provides an overall visual presentation of the guidelines. It illustrates the different sectors which can make up a CBR strategy together, either horizontally at a certain level, or vertically between different levels of society. The third option is to create a CBR strategy partly in vertical and partly horizontal collaboration at regional, subregional and local levels. The CBR approach is built on multiscience, multistakeholders' and multisectoral participatory collaboration and jointly coordinated work across different public and private agencies.

The components and elements are underpinned by a number of principles which inform the work. These principles are intended to be translated into tangible ways of working and should be observable in programme activities. It is a 'pick and mix' series of options, a set of components and elements from which the CBR practitioners can select. Any one programme may choose to address only some of the components and elements. At the same time, the implementers need to be in touch with other key organizations that usually take care of other components and elements.

MATRIX OF THE COMMUNITY-BASED REHABILITATION
Published by WHO, ILO and UNESCO for CBR - Guidelines, October 2010
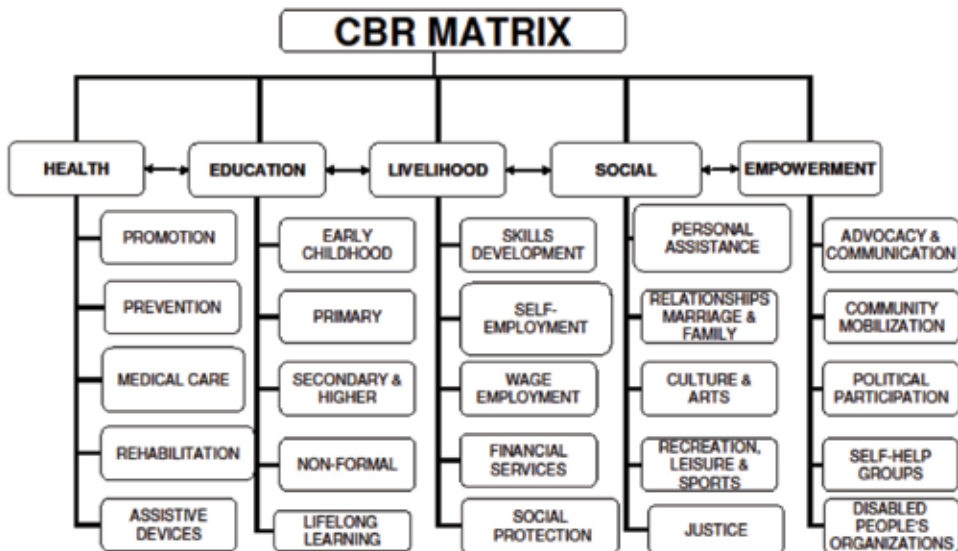
Main messages are involvement of users in all rehabilitation activities, and coordination and collaboration across different sectors and professions.

Source WHO website: http://www.who.int/disabilities/cbr/matrix/en/index.html (Accessed 2011-12-15)

Applied by E. Hänninen 2012

Figure 2: CBR Matrix covers different sectors, components and elements of the rehabilitation

4.3.2 CBR and mental health

The CBR guidelines are relevant to all people with disabilities, including people with mental health problems. The issues affecting people with mental health problems are largely similar to those affecting many other groups of people with disabilities (WHO 2010d: 3).

The goal of CBR implicates that people with mental health problems receive support to enable their inclusion and participation in all aspects of life and activities in the community to which they belong. The role of CBR programme is to promote and protect their rights, support their recovery and facilitate their participation and inclusion in their families and communities. CBR also contributes to the prevention of mental health problems and promotes mental health for all citizens.

Desirable outcomes for the people with mental health problems and for the whole community are:

- Mental health is valued by all community members and understood as a resource for community development;
- They and their family members are included in the planning and implementing of CBR programmes;
- Communities have increased awareness about mental health with a reduction of stigma and discrimination towards people with mental health problems;
- All CBR components, elements and support activities are needed in the individual recovery and empowerment processes. Also crosscutting support has to be available and accessible to people with mental health problems;
- They become empowered to make own decisions and choices with increased inclusion and participation in the decision-making in the community they are living.

More details and practical recommendations for different settings can be found in the Supplementary booklet of CBR Guidelines (WHO 2010d: 6-20). The CBR Guidelines for mental health are closely connected to another WHO document called User empowerment in mental health – a statement of the WHO Regional Office for Europe (2010a), which is summarised at the end of the section Crosscutting empowerment component.

4.3.3   Crosscutting Empowerment component

In this section we follow CBR guidelines booklet on the Empowerment component (WHO 2010c). Empowerment begins to come about when individuals or groups of people recognize that they can change their situation and begin to do so. Empowerment guidelines encourage and promote a move away from the traditional rehabilitation approaches (i.e. medical and dependency models) to a community-based inclusive CBR development model. The starting point of any CBR programme should be to facilitate the empowerment of people with all kinds of disabilities, their families and communities because this will lead to achievement of goals, outcomes and sustainability. Empowerment is a process that involves things like increasing awareness, learning and capacity-building leading to greater participation to greater decision-making power and control and to positive action for change.

People with any kind of disabilities, their family members and communities are in focus of the CBR Guidelines. The goal of empowerment means that people start to make their own decisions and take responsibility for changing their lives and improving their communities. The role of CBR is to contribute to the empowerment process by promoting, supporting and facilitating the active involvement of people with disabilities and their families in issues that affect their lives.

Desirable outcomes based on activities of the empowerment component and its elements, namely advocacy and communication, community mobilization, political participation, self-help groups and disabled peoples organizations, are as follows:

- People with disabilities are able to make informed choices and decisions, i.e. they are empowered for taking part in decision-making.
- People with disabilities are active participants and contributors in their self-help groups and living communities.
- Barriers in their environment are removed by advocacy and communication activities and people with disabilities are accepted as people with potential and resources in their community.
- People are heard and they are able to take part in the development processes and have access to all services in their communities by mobilizing and engaging the available resources.
- People with disabilities and their family members come together, form their own groups and organizations, and work towards addressing their common problems.

The key concepts which lead to empowering activities, or disempowerment, are defined as follows:

- **Disempowerment:** Many people with mental health condition or other disabilities experience disempowerment both in their family and in community, e.g. over-protected or forgotten by family members or excluded from community life because of stigma and discrimination; they become victims and objects of pity leading to powerlessness, low self-image and low self-esteem. This experience starts the search for empowerment on the disempowerment – empowerment continuum.
- **Empowerment and motivation:** Empowerment is a complex process. It is not something that happens immediately, or that can be given to someone. Change must start with people shifting their mindset from being passive receivers to active contributors. This shift in thinking is important for overcoming the attitudinal, administrative, physical and other barriers that may be present in the community. CBR programmes can facilitate this process.
- **Awareness raising** is assisting people, groups and organizations to understand that there are positive opportunities for change in the community. Successful awareness raising about mental health and/or disability issues and human rights helps to remove barriers of social inclusion and participation in decision-making.
- **Information** brings power, and one of key activities of CBR is to disseminate information. Providing information to people with disabilities ensures that they are better equipped to use their rights, social security benefits, public services and to grip on different opportunities.

- **Capacity-building:** People with disabilities need a range of skills and knowledge to enable them to participate and contribute meaningfully to their living conditions and communities. Strengthening existing skills and knowledge, and learning new skills may lead to increased self-esteem and motivation, which are important parts of the empowerment process.
- **Peer support:** When people meet other people with similar problems they may find that their problems are shared and that there are common solutions. Being together helps to minimize isolation and to increase mutual support.
- **Participation:** While participating in daily activities in some service centres or peer support groups or leisure and cultural centres people with disabilities can be motivated to contribute in many kinds of shared tasks and pieces of work. This brings social recognition which is promoting the empowerment process and outcomes.
- **Alliances and partnerships:** Groups of people with disabilities form alliances and partnerships with others who are working towards the same goals of inclusion and development. Inclusion works well when other groups are involved too. Collective action builds basis for influential power in the communities and supports empowerment.

A more detailed analysis on the content of the five elements of the CBR component can be found in the CBR booklet on Empowerment (WHO 2010c). The WHO Regional Office for Europe published also in 2010 a document "User empowerment in mental health – a statement by the WHO Regional Office for Europe" (2010a). The motto of this statement is "Empowerment is not a destination, but a journey". The document is one of the deliverables of the partnership project on user empowerment in mental health between WHO Regional Office for Europe and European Commission. In addition, A.E.Baumann, an expert of the WHO Regional Office for Europe, has produced a Fact sheet on empowerment in mental health (Baumann 2010). Both documents are compounded from recent scientific findings.

In the mental health context, empowerment refers to the level of choice, influence and control that users of mental health services can exercise over events in their lives. The key to empowerment is the removal of formal and informal barriers and the transformation of power relations between individuals, professionals, communities, services and governments. There is still a strong need for empowerment of people with mental health problems and carers. Empowerment is a multidimensional social process through which individuals and groups achieve better understanding and control over their lives. As a result they are enabled to change their social and political environment to improve their life circumstances. The multi-dimensionality covers the interests of users, carers, human rights experts, researchers, service providers and experts from other relevant areas.

At the individual level, empowerment is an important element of human development. It is the process of taking control and responsibility for actions that have the intent

to lead to fulfillment of potentials. This combines four dimensions: (1) self-reliance, (2) participation in decisions, (3) dignity and respect, (4) belonging and contributing to a wider community.

The empowerment of individuals is intended to help them adopt self-determination and autonomy, exert more influence on social and political decision-making processes and gain increased self-esteem. Communities can support individuals in this process by establishing social networks and mobilizing social support; these promote social cohesion between citizens and can support people through difficult transitions and periods of vulnerability in life. The empowerment of communities is composed of a stronger sense of belonging to the community, development of and participation in political activities, leadership of decision-making process and access to resources for the benefit of the community.

A process of empowerment requires measures at the societal and structural levels (e.g. new legislation), at level of service provisions and professional practices, community and the individual levels. Action for users' and carers' empowerment should cover the five key issues:

1. Protection of human rights of service users and fighting stigma and discrimination;
2. Inclusion in decision-making;
3. Ensuring high-quality care and resources;
4. Having access to information and resources;
5. Having local organizational capacity to make demands on institutions and governing bodies.

For the monitoring purposes a list of 19 indicators for user and carer empowerment are identified in the four areas: (1) protection of human rights - four indicators, (2) inclusion in decision-making – two indicators, (3) high-quality and accountability of services – six indicators, (4) access to information and resources – seven indicators. More information about these indicators is available in the aforementioned documents.

Many lists of the components of empowerment are available in literature, but the following list by Judi Chamberlin (1997) is perhaps the most comprehensive. It includes qualities that a person should have as the outcome of the empowerment process:

1. Having decision-making power;
2. Having access to information and resources;
3. Having arrange of options from which to make choices;
4. Assertiveness;
5. A feeling that the individual can make a difference, being hopeful;
6. Learning to think critically; learning the conditioning , seeing things differently; e.g.
   a. Learning to redefine who we are (speaking in our own voice),
   b. Learning to redefine what we can do;
   c. Learning to redefine our relationships to institutionalised power;

7. Learning about and expressing anger;
8. Not feeling alone, feeling part of a group;
9. Understanding that people have rights;
10. Effecting change in one's life and one's community;
11. Learning skills (e.g. communication) that the individual defines are important;
12. Changing others' perceptions of one's competency and capacity to act;
13. Coming out of the closet;
14. Growth and change that is never ending and self-initiated;
15. Increasing one's positive self-image and overcoming stigma.

The key characteristics of users' and carers' empowerment are: hope and respect, reclaiming one's life, feeling connected, understanding that people have rights, learning skills that individual defines as important, moving from secrecy to transparency, and growth and change that are self-initiated and never ending.

4.4   Recovery approaches

The Scottish Recovery Network's discussion paper series in 2004 – 2007 is the basis for descriptions of different recovery processes and pathways (Bradstreet 2004; Connor 2004; Dorrer 2006; Coutts 2007; McCormack 2007). Recovery theories are based on the recognition that people with mental illness have the same wants and needs as everyone else (e.g. employment, education, housing, relationships, and recreation needs). Users' choices and recovery are today at the forefront of mental health policy development.

More recently in the UK the Whole Person Recovery report (Daddow & Broome 2010) was published. It includes also the concept of recovery capital. Despite focusing mostly on alcohol and drug problems, the whole person recovery approach and recovery capital are applicable to recovery support also for other groups of people with mental health problems as has been demonstrated in the USA and Canada.

In a recovery-orientated service system the service users are included as full partners in every aspect of the service provision, including the setting of service priorities, sharing decision-making authority, and most importantly, having the option to agree or disagree with the treatment plan (i.e. full partnership).

4.4.1   Recovery and mental health in Scotland

The Scottish Recovery Network (SRN) believes that people can and do recover from even the most serious and long-term mental health problems. According to Bradstreet (2004: 3), the SRN exists to generate debate around recovery and to share the lessons learnt. International learning indicates that a number of key elements help to promote

and support recovery from long-term mental health problems. These include creating the conditions which foster hope and belief that change is possible and which give purpose and meaning to people's lives. Also important are the opportunities available for someone with long-term mental health problems to participate actively in choices and decisions about their life. Experience in many countries indicates that recovery is influenced by many different factors:

- The attitudes and expectations people hold about mental health and mental health problems;
- The support provided by helping services;
- The opportunities and obstacles people with long-term mental health problems meet in seeking to enjoy satisfying lives.

Several studies in many countries have concluded that people who experience long-term mental health problems are amongst the most socially excluded in society experiencing, for example, high levels of unemployment and social isolation. This is the starting point for development of the recovery and how to best promote and support recovery processes.

Bradstreet cites many definitions by different authors on the concept of recovery, and is summarizing that "recovery ... provides an empowering message of hope, which says that regardless of symptoms people with mental health problems should be given every opportunity to lead a fulfilling and satisfying life. It looks at life first and symptoms second, and propose that the opportunities available to members of a community should not be determined by their mental health. It is about much more than the absence of symptoms."

Recovery is a unique and individual experience and while there may be common themes and experiences, no two people's recovery journeys will be identical. SRN describe recovery as follows:

Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process. While recovery is a unique and individual experience it is possible to identify key themes and ideas in relation to the experience. The following list, while not exhaustive, highlights some of the most commonly identified elements.
- Recovery as a journey can have ups and downs and some people describe being in recovery rather than recovered to reflect this.
- Hope, optimism and strengths are widely acknowledged as key to recovery. There can be no change without the belief that a better life is both possible

and attainable. One way to realize a more hopeful approach is to find ways to focus on strengths.

- More than recovery from illness, some people describe being in recovery while still experiencing symptoms. For some it is about recovering a life and identity beyond the experience of mental ill health.
- Control, choice and inclusion: taking control can be hard but many people describe how important it is to find a way to take an active and responsible role in their own recovery. Control is supported by the inclusion of people with experience of mental health issues in their communities.
- Self management, one way to gain more control over recovery is to develop and use self management techniques. One self management tool which SRN promotes is the wellness action plan.
- Finding meaning and purpose, all find meaning in very different ways; many people describe the importance of feeling valued and of contributing as active members of a community.
- Supportive relationships based on belief, trust and shared humanity help promote recovery.

Source: http://www.scottishrecovery.net/ Accessed: 2012-06-30

One part of the Scottish Recovery Network's recovery-oriented methods is the Strengths based approach. According to McCormack (2007: 7) the assumption is that people have strengths, skills, and abilities. The traditional psychological short therapy methods are based on this, and see the service users as collaborators and equal partners, like many other human rights based approaches today.

With reference to Nika Dorrer (2006: 4) who has summarized several studies in the mental health field, recovery outcomes can be divided into two levels: *complete recovery* and *social recovery.* Complete recovery is understood to mean a return to pre-illness functioning including a loss of psychotic symptoms. Social recovery refers to levels of economic and residential independence as well as interpersonal adjustment. In addition, she refers to R.O. Ralph's findings that recovery can be divided in four dimensions: (1) internal factors, (2) self-management, (3) external factors, and (4) empowerment.

The indicators of different dimensions are described as follows (Table 2):

Table 2: Dimensions of Recovery

Dimensions of Recovery	Indicators
Internal Factors	The ability to have hope, trusting own thoughts, enjoying the environment, feeling alert and alive, increased self-esteem, knowing I have a tomorrow, increased spirituality...
Self-Managed Care	Consumer directed care, independence, self-advocacy, having choices, setting reasonable goals, idiosyncratic coping methods...
External Factors	Interconnectedness with others, professional support, love and care from friends and family, meaningful work, own space...
Empowerment	Self-determination and control, making a difference, a sense of self-worth, the authority to act as a free and useful person, self-actualisation, activism and social justice...

Source: Dorrer, N. (2006) Evidence of Recovery: The 'Ups' and 'Downs' of longitudinal outcomes studies. SRN Discussion Paper Series. Report #4. Glasgow. Scottish Recovery Network.

4.4.2   Consensus statement in the USA

In the USA the Substance Abuse and Mental Health Services Administration (SAMHSA, 2005) recently issued a consensus statement on recovery. Recovery orientation requires training, policies, procedures, and interventions that support the fundamental components of recovery. The consensus statement identified 10 fundamental components of recovery process:

- Self-direction, recovery must be self-directed by the individual who defines his/her life goals and paths towards them;
- Individualized and person-centered approaches, recovery is based on a person's unique strengths and needs, experiences and cultural background and is an ongoing journey;
- Empowerment, persons have to make choices from a range of options and to participate in all decisions that will affect their lives and are educated and supported in so doing, as well as learning to control his/her own destiny in life;
- Holistic views, recovery has to cover a person's whole life, including mind, body, spirit and community, as well as all aspects of life, e.g. housing, employment, education, mental health and social and healthcare services, community participation and family & peer support, access to meaningful activities;
- Nonlinearity, recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience and believing that positive changes are possible;

- Strengths-based recovery focuses on person's capabilities, talents, coping skills, new life roles through interaction with others in supportive, trust-based relationships;
- Peer support plays invaluable role in recovery, persons encourage and engage other peers in recovery with a sense of belonging, supportive relations, valued roles and community;
- Respecting person's human rights and dignity, and eliminating discrimination and stigma are crucial in achieving recovery, self-acceptance and regaining belief in one's self;
- Responsibility, people have personal responsibility for their self-care and journeys to recovery; and
- Hope provides the essential and motivating message of the better future, hope is the catalyst of the recovery process.

Source: http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf
Accessed 2012-01-30.

4.4.3 The whole person recovery and recovery capital

The whole person recovery is based on a systemic approach and includes the experiences of service users who participate in the designing of services needed for them. Training service users as peer researchers and involving them at each step with other stakeholders has been an important contributor to the creation of *recovery capital*. The theory of recovery capital is getting growing attention in the UK. It is defined as the sum total of personal, social and community resources that someone can call on to aid their recovery. Recovery capital provides an emerging more holistic model with which it is possible to enhance and sustain recovery outcomes (Daddow & Broome 2010: IV-VIII). The following summary on different dimensions of recovery capital is based on Daddow and Broome's work (ibid: 62-70).

Personal recovery capital formation is based on users' safe and secure housing conditions, good or improving physical and mental health, and purposeful activity like education, training and employment, which are sources of personal relationships. If some or all of the three sources of recovery capital provides negative outcomes, the situation does not support reintegration and contribution to different relationships, and thus, leads to personal recovery capital deficit.

Social recovery capital consists of peer support in its many different forms, and friends and family. Relationships with friends and family can have both negative and positive influences on an individual's recovery and on the formation of social recovery capital. Support through social networks, mutual trust and social capital both helps facilitate particular ends e.g. finding job, and promote recovery and to sustain social recovery capital.

Community recovery capital formation depends on (1) the extent and quality of stigmatisation and negative labelling, (2) available and accessible community resources,

and (3) possibilities to develop local recovery communities. Stigmatisation and labelling are complex processes in neighbourhoods, because e.g. drug use and alcohol-related harms are associated with crimes which are drivers of stigma. Community resources vary from one area to another, and ideally they cover all activities open to all citizens and activities for users of special needs or interests. Political resources are built on open access to community development and decision-making. Community recovery capital includes also multiagency collaboration and coordination across administrative boundaries. Local recovery communities have existed in USA and Canada more than a decade but in UK and Europe they are less well developed. Recovery communities put a face on recovery, share stories of hope and success, and are providing role models and promoting recovery. They organise access to informal and formal peer support, organise anti-stigma campaigns etc.

The emerging whole person recovery system model is a complex theoretical structure, but it has many common features with the empowering CBR guidelines and the concept of empowerment. Also many of its elements are the same as in the Clubhouse model: for example the definition of recovery capital could be applied directly to the Clubhouse model. In addition, the model is connected with other forms of capital formation, e.g. human capital, social capital, intellectual capital and experience capital, and so on.

4.4.4 Social capital, social cohesion, social inclusion and social integration

M. Sharon Jeannotte (2008: 1-6) has examined the definitions of and relationships between the concepts social capital, social cohesion, social inclusion and social integration. The purpose of this section is to find a comprehensive understanding how the above concepts are intertwined and what common elements they include. The key question is: Do they support the recovery of people with mental health problems who in many cases live in circumstances where disintegration, social exclusion, discrimination, distrust and isolation are the prevailing reality?

Social capital

Social capital formation contributes to social inclusion, social cohesion and social integration. Social capital refers to the networks of social relations that may provide individuals and groups with access to resources and supports (Jeannotte, ibid: 5). Three types of social capital have been identified, two of them by Robert Putnam (2000: 19) bonding and bridging. Bonding refers to social networks that reinforce exclusive identities and homogenous groups, while bridging refers to networks that are outward looking and encompass people across diverse social gaps and divides. The third type of social capital is linking which was identified in the World Bank's studies during the 1990s. Linking social capital means for instance civic leaders' capacity to leverage resources, ideas and information from formal local, regional or national institutions

beyond their own community; it is the vertical dimension of social capital while the bonding and bridging social capitals are horizontal by nature. Various types of social capital and their combinations are used for different purposes depending on the situations and goals of an activity. (Woolcock 1998).

According to Putnam (1995) and Lehtinen (2008), studies have identified a positive relationship between social capital and mental health as well as other related outcomes such as less social isolation, better social safety, lower crime levels, improved schooling and education, and improved work outcomes. The principal characteristics of social capital are: Community networks, voluntary action, personal networks, civic engagement, participation and use of networks, local civic identity, sense of belonging, solidarity and equality with community members, as well as reciprocity of cooperation, a sense of obligation to help others and confidence in return of assistance, and trust in the community.

Referring to the results of the project Monitoring Mental Health Environments and its publication Building Up Good Mental Health – guidelines based on existing knowledge (Lehtinen, ibid: 42-45), the relationship between the structure of the society and the psychological well-being of the population has been described by researchers for some time. In Canada a study demonstrated already in the 1960s that community-based work to improve integration within the community had a positive impact on people's mental health. Mental health of a population is strongly related to the characteristics of the community in which people live. Social, environmental and economic factors are all important determinants of mental health. People cannot achieve their full potential unless they are able to take control and self-determination of those things which determine their well-being. A healthy community is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing their skills and capabilities.

Social cohesion

Following Jeannotte's analysis (2008: 4), social cohesion is based on the willingness of individuals to cooperate and work together at all levels of society or community to achieve common goals. There are multiple inputs to social cohesion, or to a society with a given level of cooperation, and that government policies are only one set of these inputs. Civil society and the social and cultural capital that underpins it are also important components of the system, as are the institutions and values upon which the society or community is founded. There are three main causal mechanisms within this approach:

- First, the higher the degree of social cohesion in a society, the more political support there will be for public policy in such areas as education, health policy and income distribution programmes. These policies have demonstrable positive effects, particularly if they are provided on a universal basis.

- Second, the higher the degree of social cohesion, the greater adherence to social norms of behavior and the greater support for social institutions and values, such as trust, respect for the law and fair play. Institutions and communities based on these values tend to make cooperation easier and more riskfree, thereby increasing the efficiency of economic, social and cultural outcomes. However, it is important to note that not all norms promote social cohesion. Those that do not promote widespread inclusion and trust within a society may actually erode social cohesion.
- Third, higher levels of social cohesion increase participation in civil society, which not only contribute to good social outcomes but also enriches social capital – an indirect contributor to social cohesion.

Social inclusion

According to Jeannotte (ibid: 2-3), social inclusion like its counterpart social exclusion has many dimensions. One of the Canadian approaches has identified four dimensions: spatial, relational, functional and empowerment dimensions. Each dimension consists of more concrete elements, e.g. spatial dimension includes access to public and private spaces, physical location, proximity and distances; relational dimension has elements of emotional connectedness, recognition and solidarity. Social inclusion is one of the components of social cohesion and it is an outcome or result of policies and programmes that promote equality. For example, a state may have a variety of policies and programmes in place to promote social, cultural and economic equality. If these policies are effective, the substantive outcome will be citizens who feel included in the life of their communities.

According to Malcolm Shookner's (2002) concept of Inclusion Lens people feel included or excluded e.g. in family, neighbourhood, education, labour market or other community activities. Social and economic exclusion and inclusion have recently become the focus of attention among those who are concerned about poverty and its many negative effects on people: Those who are excluded, whether because of poverty, ill health, gender, race or lack of education, do not have the opportunity for full participation in the economic and social benefits of society. Social and economic exclusion and inclusion can be seen along several dimensions – cultural, economic, functional, participatory, physical, political, structural, and relational. These are illustrated in Figure 3. There are many elements to exclusion and inclusion that should be considered in analyzing a policy, programme, or practice.

Table 3 illustrates the different elements in relation to the eight dimensions of the Inclusion Lens. It is not intended to be a complete list, but to stimulate readers to think about which of these may apply to their particular situations. Some of the elements may relate to more than one dimension. Additional elements may also be identified (ibid.).

A lens is an aid to improve vision. It can also provide a new way to look at the root causes of old problems, like poverty, discrimination, disadvantage, and disability, people with mental health problems included. The term Inclusion Lens used here is a way of look-

ing at social and economic exclusion and inclusion. The Inclusion Lens is a tool for analyzing legislation, policies, programmes, and practices to determine whether they promote or not the social and economic inclusion of individuals, families, and communities. It will open up minds to new ways of thinking and open doors to new solutions for old problems. Ultimately, it provides a new way to encourage change that will transform society.

With help of the Lens it is possible to build up a self-assessment instrument in mental health service communities like in Clubhouses for members' exclusion – inclusion profiles, which could help members' awareness on their position on different dimensions and elements of social exclusion and inclusion.
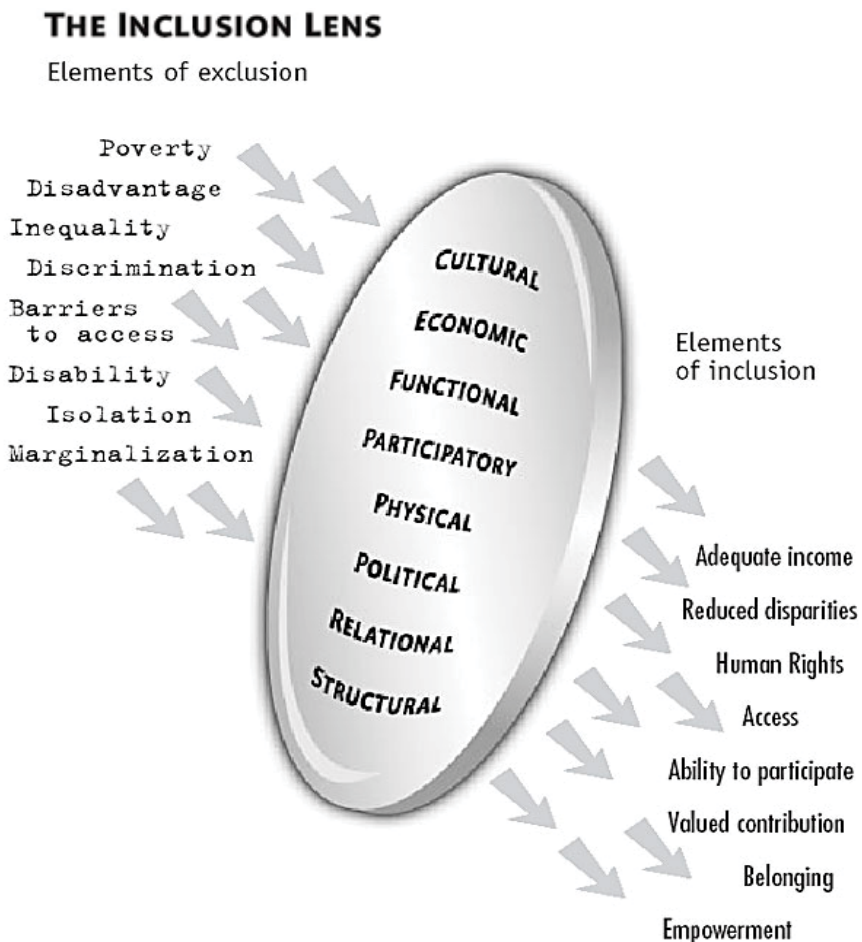
THE INCLUSION LENS

Elements of exclusion

Source: http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Inclusion_lens/
Accessed: 2012-01-25

Figure 3: Social exclusion and inclusion dimensions and elements by M. Shookner (2002)

Table 3: Dimensions and indicators of social exclusion and inclusion (Shookner, M. 2002)

Elements of Exclusion	Dimensions	Elements of Inclusion
Disadvantage, fear of differences, intolerance, gender stereotyping, historic oppression, cultural deprivation.	Cultural	**Valuing contributions** of women and men to society, recognition of differences, valuing diversity, positive identity, anti-racist education.
Poverty, unemployment, non-standard employment, inadequate income for basic needs, participation in society, stigma, embarrassment, inequality, income disparities, deprivation, insecurity, devaluation of caregiving, illiteracy, lack of educational access.	Economic	**Adequate income** for basic needs and participation in society, poverty eradication, employment, capability for personal development, personal security, sustainable development, reducing disparities, value and support caregiving.
Disability, restrictions based on limitations, overwork, time stress, undervaluing of assets available.	Functional	**Ability to participate,** opportunities for personal development, valued social roles, recognizing competence.
Marginalization, silencing, barriers to participation, institutional dependency, no room for choice, not involved in decision making.	Participatory	**Empowerment,** freedom to choose, contribution to community, access to programs, resources and capacity to support participation, involved in decision making, social action.
Barriers to movement, restricted access to public spaces, social distancing, unfriendly/unhealthy environments, lack of transportation, unsustainable environments.	Physical	**Access** to public places and community resources, physical proximity and opportunities for interaction, healthy/supportive environments, access to transportation, sustainability.
Denial of human rights, restrictive policies and legislation, blaming the victims, short-term view, one dimensional, restricting eligibility for programs, lack of transparency in decision making.	Political	**Affirmation of human rights,** enabling policies and legislation, social protection for vulnerable groups, removing systemic barriers, will to take action, long-term view, multi-dimensional, citizen participation, transparent decision making.
Isolation, segregation, distancing, competitiveness, violence and abuse, fear, shame.	Relational	**Belonging,** social proximity, respect, recognition, cooperation, solidarity, family support, access to resources.
Discrimination, racism, sexism, homophobia, restrictions on eligibility, no access to programs, barriers to access, withholding information, departmental silos, government jurisdictions, secretive/restricted communications. rigid boundaries.	Structural	**Entitlements,** access to programs, transparent pathways to access, affirmative action, community capacity building, inter-departmental links, inter-governmental links, accountability, open channels of communication, options for change, flexibility.

Source: http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Inclusion_lens/
Accessed: 2012-01-25

Social integration

Social participation contributes to our mental health, but the reverse is also true. A certain level of mental health is needed for a person to be socially active and integrated in her/his community or organization. The consequences of good mental health may directly contribute to levels of social capital, social cohesion and social integration. On the other hand, people experiencing mental health problems are easily marginalized and socially excluded.

The definition on social integration utilized in the Copenhagen Declaration on Social Development (Jeannotte, ibid: 6-7):

* Social integration is the process of fostering societies that are stable, safe and just and that are based on the promotion and protection of all human rights, as well as on nondiscrimination, tolerance, respect for diversity, equality of opportunity, solidarity, security and participation of all people, including disadvantaged and vulnerable groups and persons.

It has been repeatedly shown that social disadvantage is associated with an increased rate of mental disorders in the community. Several community interventions exist in which the main goal is to provide opportunities for social support and mutual responsibility. One example is the "community diagnosis" approach to enhance social interaction especially in socially disintegrated urban environments, developed by O. Dalgard and his co-workers in Norway; and another amongst various approaches is the Clubhouse model (Lehtinen 2008: 69).

Community-level mental health promotion usually involves collaborative activities, based on the enhancement of community participation and empowerment. Availability of and easy access to self-help groups in encountering different kinds of life crises and transitions have proved to be effective measures in mental health promotion and prevention of mental health problems. All these together contribute to strengthening social cohesion and social integration, and have positive impacts on personal recovery processes.

The involvement of people is an essential prerequisite for community action to be successful. Local people have the best knowledge of problems. Their participation in the planning and delivery of services and other activities is important. This also ensures a sense of ownership, sense of belonging and engagement in the common efforts in communities and organizations.

4.5 The Clubhouse model as a means to empowerment and social inclusion

This subsection is written mainly by experts of the International Center for Clubhouse Development, ICCD established in 1994. The ICCD is global resource for commu-

nity centres creating solutions for people with mental illness, and a community of Clubhouses where recovery involves the whole person. The content of this subsection covers a large part of the written materials due to be produced by the ICCD, and the ICCD contributions can also be found at their website (http://www.iccd.org):

- Learning materials about the Clubhouse model;
- Best practices of the community-based Clubhouse rehabilitation;
- Quality management in the community-based rehabilitation, i.e. the ICCD accreditation process; and
- Evidence-base of the Clubhouse psychosocial rehabilitation.

This subsection describes the origins of the Clubhouse model, defines the basic components of a Clubhouse, and answers the question "What is a Clubhouse?". The International Standards and the quality management process of the ICCD Clubhouses are described next. The final part of this chapter describes the dissemination of the Clubhouses in different countries worldwide, and summarizes research findings on the outcomes and results for the different stakeholders of the Clubhouse concept.

4.5.1   Origin of Clubhouses – from Fountain House to a worldwide concept

The word "Clubhouse" derives from the work and vision of Fountain House, the very first Clubhouse founded in New York in 1948. Since its inception, Fountain House has served as the model for all subsequent ICCD Clubhouses that have been set up around the world. Fountain House was formed when former patients of a New York psychiatric hospital began to meet together informally, as a kind of "club." The clubhouse was organized as a support system for people living with mental illness, rather than as a service or a treatment program. Communities around the world that have modeled themselves after Fountain House have embraced the term "Clubhouse" because it clearly communicates the message of membership and belonging. This message of inclusion is at the very heart of the Clubhouse way of working for recovery.

ICCD Clubhouses demonstrate the fact that people with mental health problems can and do lead normal, productive lives. ICCD Clubhouses provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education and housing. Clubhouses offer people who have mental health problems hope and opportunities to achieve their full human potential. They offer (ICCD 2011):

- A work-ordered day in which the talents and abilities of members are recognized and utilized within the Clubhouse;
- Participation in consensus-based decision making regarding all important matters relating to the running of the Clubhouse;

- Opportunities to obtain paid employment in mainstream businesses and industries through a Clubhouse-created Transitional Employment Program. In addition, members participate in Clubhouse-supported and independent programs;
- Assistance in accessing community-based educational resources;
- Access to crisis intervention services when needed;
- Evening/weekend social and recreational events; and
- Assistance in securing and sustaining safe, decent and affordable housing.

The personal stories of members and their families and an increasing body of research provide evidence that Clubhouses provide a holistic, inspiring and cost-effective solution for people living with a mental health condition.

4.5.2 What is a Clubhouse?

A Clubhouse is first and foremost a local community centre that offers people who have mental illness hope and opportunities to achieve their full potential. Much more than simply a program or a social service, a Clubhouse is most importantly a community of people who are working together to achieve a common goal.

A Clubhouse is organized to support people living with mental illness. During the course of their participation in a Clubhouse, members gain access to opportunities to rejoin the worlds of friendships, family, employment and education, and to the services and support they may individually need to continue their recovery. A Clubhouse provides a restorative environment for people whose lives have been severely disrupted because of their mental illness, and who need the support of others who are in recovery and who believe that mental illness is treatable.

Membership

A Clubhouse is a membership organization, and the people who come and participate in a Clubhouse are its members. Membership in a Clubhouse is open to anyone who has a history of a mental disorder. This idea of membership is fundamental to the Clubhouse concept: being a member of an organization means that an individual has both shared ownership and shared responsibility for the success of that organization.

To be a member of an organization means to belong, to fit in somewhere, and to have a place where one is always welcome. For a person living with mental illness, these simple things cannot be taken for granted. In fact, the reality for most people who live with mental health condition is that they have a constant sense of not fitting in, of isolation and rejection.

Mental illness often has the devastating effect of separating people from others in society. "Mental patient," "client," "disabled," "consumer" and "user" are all terms used by society as a reference to people living with a mental disorder. They are often segre-

gated according to these labels and defined by them as people who need something, or as people who are societal burdens that need to be managed.

The Clubhouse offers a complete change in this perspective. It is designed to be a place where a person living with a mental health condition is not treated as a patient and is not defined by a disability label. In a Clubhouse a person with mental disorder is seen as a valued participant, a colleague and as someone who has something to contribute to the rest of the group. Each person is a critical part of a community engaged in important work.

Membership in a Clubhouse gives a person living with a mental disorder an opportunity to share in creating successes for the community. At the same time, he or she is getting the necessary help and support to achieve individual success and satisfaction.

Values and principles of the Clubhouses

ICCD Clubhouses are built upon the belief that every member has the potential to sufficiently recover from the effects of mental illness to lead a personally satisfying life as an integrated member of society. Clubhouses are communities of people who are dedicated to one another's success, no matter how long it takes or how difficult it is. Clubhouses are organized around the belief that work, and work-mediated relationships, are restorative and provide a firm foundation for growth and important individual achievement (Beard, Propst, Malamud, 1982), and the belief that normalized social and recreational opportunities are an important part of a person's path to recovery.

Values and operational principles of any ICCD Clubhouse are based on the International Standards for Clubhouse Programmes. They are consensually agreed upon by the worldwide Clubhouse community and they define the Clubhouse model of rehabilitation. The principles expressed in Standards are at the heart of the Clubhouse community's success. The main values and principles are (ICCD 2011: 70-75):

- Recovery is possible, also from severe mental illness;
- Clubhouse community and peer support offer respect, hope, mutuality and promotes recovery;
- Clubhouse is consisting of members, not patients;
- Clubhouse builds on the strengths and abilities of members, not on illness;
- Clubhouse activities are based on side-by-side working and learning of members and staff, which means involvement and equal participation in all functions of the house;
- Clubhouse offers access to friendship, advocacy, housing, education and employment, i.e. social inclusion and empowerment for people with mental health conditions.

Human relationships: the core ingredient

The ICCD Clubhouse environment and structures are developed in a way to ensure that there is an opportunity for human interaction and that there is more than enough

work to do. Clubhouse staffing levels are purposefully kept low to create a perpetual need for the involvement of the members in order to accomplish their jobs.

Members also need the staff and other members in order to complete the work, but even more importantly, the relationships that evolve through this work together are the key ingredient in Clubhouse rehabilitation. (Vorspan 1986). The Clubhouse members and staff as a community are charged with prioritizing, organizing and accomplishing the tasks that are important to make the Clubhouse a successful.

The role of the staff in a Clubhouse is not to educate or treat the members. The staff is there to engage with members as colleagues in important work and to be encouraging and engaging with people who might not yet believe in themselves. Clubhouse staff is charged with being colleagues, workers, talent scouts and cheerleaders.

Components of a Clubhouse

Clubhouse is a "multi-idea" model. Clubhouses consist of several components which together bring in the positive evidence-based recovery outcomes for people with mental health conditions. For example, support for education and employment programmes are essential parts of the Clubhouse model.

Membership is voluntary - no time limits

In a Clubhouse, each member is given the message that he or she is welcome, wanted, needed and expected each day. The message that each member's involvement is an important contribution to the community is a message that is communicated throughout the Clubhouse day. Staff and other members greet each person at the door of the Clubhouse each morning with a smile and words of welcome.

The daily work of the Clubhouse community is organized and carried out in a way that continually reinforces this message of belonging. This is not difficult, because in fact the work of the Clubhouse does require the participation of the members. The design of a Clubhouse engages members in every aspect of its operation, and there is always much more work to be done than can be accomplished by the few employed staff.

The skills, talents, and creative ideas and efforts of each member are needed and encouraged each day. Participation is voluntary, but each member is always invited to participate in work which includes clerical duties, reception, food service, transportation management, outreach, maintenance, research, managing the employment and education programs, financial services and much more.

Meaningful relationships

Relationships between members and staff develop naturally as they work together side by side carrying out the daily duties of the Clubhouse. All of the staff has generalist

roles in the Clubhouse; they are involved in all of the Clubhouse activities including the daily work duties, the evening social and recreational programs, the employment programs, reach out, supported education and community support responsibilities. Members and staff share the responsibility for the successful operation of the Clubhouse. Working closely together each day, members and staff learn of each others' strengths, talents and abilities. They also develop real and lasting friendships. Because the design of a Clubhouse is much like a typical work or business environment, relationships develop in much the same way.

A work-ordered day

The daily activity of a Clubhouse is organized around a structured system known as the work-ordered day. The work-ordered day is an eight-hour period, typically Monday through Friday, which parallels the typical business hours of the working community where the Clubhouse is located. Members and staff work side by side, as colleagues to perform the work that is important to their community. All of the work in the Clubhouse is for the Clubhouse and not for any outside agency or business. There are no clinical therapies or treatment-oriented programs in the Clubhouse. Members volunteer to participate as they feel ready and according to their individual interests.

Employment programmes

As a right of membership, Clubhouses provide members with opportunities to return to paid employment in integrated work settings through Transitional Employment, Supported Employment and Independent Employment programmes.

Transitional Employment is a highly structured programme for members returning to work in local business and industry. Transitional Employment placements are at the employer's place of business, are part-time (15-20 hours per week), and include a lot of on-the-job and off-site support from Clubhouse staff and other members. These placements generally last from six to nine months. Members can then try another placement or move on to independent employment. Transitional Employment is specifically designed as a vocational rehabilitation programme where a member can gain or re-gain the skills and confidence necessary to have a job while he or she is employed in a "real world" position. The only requirement for the member to participate in Transitional Employment is the expressed desire to work.

As a defining characteristic of Clubhouse Supported Employment, the Clubhouse maintains a relationship with the working member and the employer. Members and staff in partnership determine the type, frequency and location of desired supports.

Independent Employment is a program of the Clubhouse through which members, when ready, are broadly helped by the Clubhouse to seek and obtain a job of their own. The Clubhouse then provides ongoing support and encouragement for the members as

long as they remain employed and want assistance. There is no on-site support at the place of business for members in Independent Employment; all support takes place at the Clubhouse, or in the community.

Evening, weekend and holiday activities

In addition to work opportunities, Clubhouses provide evening, weekend, and holiday social and recreational programming. Members and staff together organize structured and non-structured social activities. These activities are scheduled outside of the work-ordered day. Holidays are celebrated on the day on which they fall. Activities are scheduled both at the Clubhouse and in the community.

Community support

People living with mental illness often require a variety of social and medical services. Through the work-ordered day at the Clubhouse, members are given help in accessing the best quality services in their community. Help is given to members in acquiring and keeping affordable and dignified housing, psychiatric and general medical services, government disability benefits and any other needed services. Members and staff from the Clubhouse ensure all such support and assistance.

Reach-out

Part of the daily work of the Clubhouse involves keeping in contact with all active members. When a member does not attend the Clubhouse or is in the hospital a "reach-out" telephone call or visit is made. Each member is reminded that he or she is missed, and welcome and needed at the Clubhouse. This process not only encourages members to participate, but it is also an early warning system for members who are experiencing difficulties and may need extra help.

Education

Many Clubhouse members have had to interrupt their educational plans because of their mental illness. Some have not finished secondary school, while others had to curtail their university studies. The Clubhouse offers educational opportunities for members to complete or start certificate and degree programs at academic institutions and adult education providers. The Clubhouse also utilizes the talents and skills of members and staff to provide educational opportunities in the Clubhouse, particularly in areas related to literacy.

Housing

Safe, decent, dignified housing is a right of all members. The Clubhouse helps members to access quality housing. If there is none available for members the Clubhouse seeks funding and creates its own housing program.

Decision-making and governance

Decision-making and governance are an important part of the Clubhouse work. Members and staff meet in open forums to discuss policy issues and future planning for the Clubhouse. Clubhouses also have an independent board of directors or advisory board that is charged with oversight management, fundraising, public relations and helping to develop employment opportunities for members.

Summarizing remarks of the Clubhouse components

Although Fountain House started more than sixty years ago and has been replicated more than four hundred times around the world, the Clubhouse concept is still a radically different way of working in the field of community mental health. Most other programmes still focus on assessing a person's level of disability and limiting the expectations based on that assessment. Most use teaching or treatment as the vehicle for providing rehabilitation.

In a Clubhouse the expectations are high and mutual work, mutual relationships, and meaningful opportunities in the community are the vehicles of choice and personal recovery. The components of the Clubhouse model described above are presented more detailed in the International Standards for Clubhouse Programmes attached to this overview.

Clubhouse as a recovery pathway from dependency to empowerment and inclusion

Clubhouses integrate the pathway from dependency on mental health services towards independent living, professional training, labour market and social inclusion. Figure 4 on gives an idea on how Clubhouses can act, at their best, as linking bridges between medical world and mainstream everyday life.

Integrated Pathway from Dependency to Independent Living

Clubhouse as Learning Community
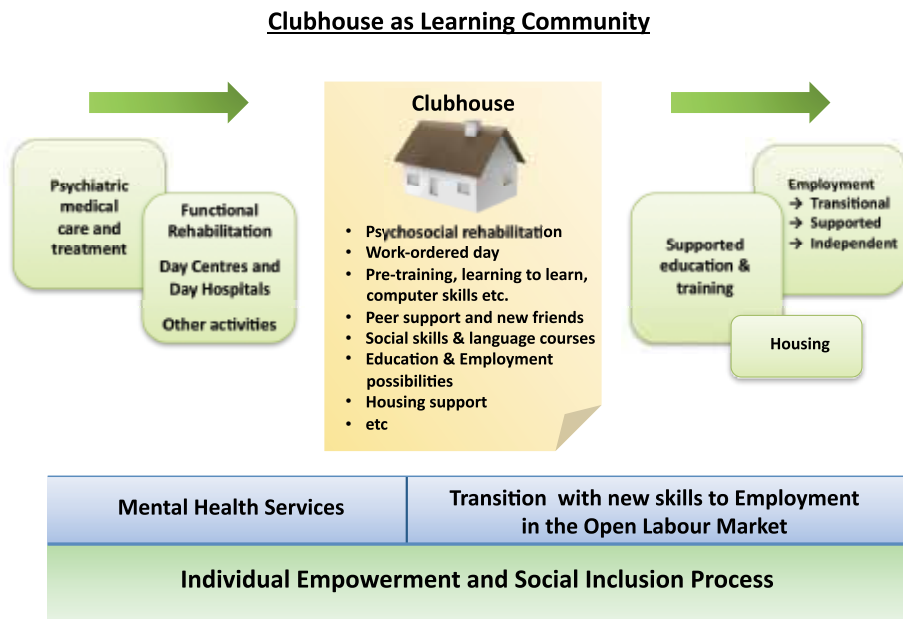
Source: Grönberg, V. & Hänninen, E. (2007): ELECT project plan and funding application to the European Commission.
Applied by E. Mielonen 2012-07-02.

Figure 4: Recovery pathway from dependency towards independent living

4.5.3 The international standards and quality management of Clubhouses

The Clubhouse model as a psychosocial rehabilitation innovation is based on the International Standards for Clubhouse Programmes, which have been developed over the past 25 years as an open innovation, i.e. members, staff, and other stakeholders have had and continue to have a voice in the process. They are reviewed by the Standards Review Committee of the ICCD, made up of members and staff of the certified Clubhouses from around the world, and discussed every two years in the International Clubhouse Seminars.

The Standards consist of eight chapters and 36 single standards steering the values and principles on which the practical arrangements of a Clubhouse are based. These chapters regulate the membership of a Clubhouse, relationships between members and staff, Clubhouse premises and facilities, the work-ordered day programme, employment

support programmes, education and training, and different functions of the Clubhouse. The revised 2012 International Standards are attached to this overview (ANNEX 2).

The Standards form the basis for the Clubhouse quality management and quality assurance processes in the form of the accreditation procedure (earlier certification process) to ensure the high level of fidelity of all Clubhouses to the International Standards for the continuous improvement of their functions. The standards define the Clubhouse model of rehabilitation (ICCD 2011: 70).

The principles expressed in the Standards are the heart of the Clubhouse community's success in helping people with mental health conditions to stay out of hospitals while achieving social, financial, educational and vocational goals. The Standards serve as a "bill of rights" for members and a "code of ethics" for staff, board and administrators (ibid: 70-75). As one of its main services to the Clubhouses, the ICCD coordinates and operates the accreditation process with help of the ICCD Faculty for Clubhouse Development. The process consists of a Clubhouse's Self-Study, peer reviewers' Site Visit, the Findings Report of the team, the definition of the Accreditation Status, and of the Ongoing Technical Support to Clubhouses. (http://www.iccd.org/accreditation).

Clubhouse accreditation is the ICCD's quality assurance programme, designed to determine whether an organization is providing a full range of Clubhouse opportunities to its members. The Clubhouse accreditation involves the entire Clubhouse community in an interactive process of self-evaluation and strategic planning. In the Self Study process, the Clubhouse begins to identify aspects of the program which they would like to improve. The self study facilitates a sense of ownership and teamwork amongst the members and staff at the Clubhouse, is a vehicle for increasing understanding about the Clubhouse model, assists each individual to better understand his/her specific role in the success of the Clubhouse, promotes consensus-building about improving the Clubhouse in relation to the Standards, generates a sense of empowerment for both members and staff at the Clubhouse, becomes the foundation for strategic improvement in the operation of the Clubhouse, and provides the ICCD faculty team with a groundwork to begin the consultation.

After developing its own in-depth Self Study, the Clubhouse is visited for 3-4 days by an ICCD Faculty team that reviews the Clubhouse's Self Study and its fidelity to the consensually established International Standards for Clubhouse Programmes. The two-person Faculty teams are trained members and staff from strong ICCD Certified Clubhouses around the world. Each team consists of one Clubhouse staff and one Clubhouse member. While on site, the faculty members confirm the information presented in the self-study, meet with members, staff, board members and other stakeholders of the Clubhouse. They participate in Clubhouse meetings, the work day and other Clubhouse activities. The team visits residential, employment and education sites where the Clubhouse is working with members.

The ICCD faculty evaluates how well the Clubhouse has implemented the International Standards for Clubhouse Programmes and provides ongoing consultation to the Clubhouse while on site. During the last day of the visit the faculty team makes a verbal presentation

to the entire Clubhouse community on their findings. They will highlight both areas of strength for the Clubhouse and make recommendations for improvement. This verbal report becomes the foundation for the written findings report submitted to the ICCD.

The Findings Report includes a detailed description of the Clubhouse, a review of the areas in which the Clubhouse is strong, and a set of specific recommendations about how the Clubhouse can improve and come more fully into compliance with the Standards. Along with the report, the faculty team submits a recommendation to the ICCD regarding accreditation status for the Clubhouse. The report is then read by at least two experienced staff and/or members at the ICCD, and is critically reviewed for clarity, accuracy, helpfulness, and congruence with the recommended certification outcome.

After reviewing the report and reaching agreement, the faculty team awards one- or three-year certification, or defers accreditation, and forwards a letter indicating this accreditation outcome, along with the written report, to the Clubhouse. Accreditation by the ICCD is a credential which affirms that a program is in fact operating as a Clubhouse, and is in substantial compliance with the International Standards for Clubhouse Programmes. Accreditation by the ICCD is awarded for either one or three years. This determination is made based on the extent to which the Clubhouse is complying with the Standards. Accreditation is deferred for those programmes that are significantly out of compliance with the Standards.

The accreditation process is repeated on regular basis and it serves as a guarantee to the funding organizations, Clubhouse members and staff, and other stakeholders that the Clubhouse is able to fulfil the expectations of members' recovery and empowerment outcomes, can operate cost-effectively, and has created a stakeholders' network to support the activities of the house.

Accreditation statistics

At the end of 2011 worldwide nearly half (45%) of ICCD Clubhouses were accredited. Out of the 80 European ICCD Clubhouses 27 were certified by the ICCD peer evaluation accreditation. The total number of certified Clubhouses in Europe is higher because the quality certificate is valid only for a maximum of three years. Some of the Clubhouses that have been previously certified have not yet renewed their quality accreditation process, and some of the new Clubhouses have not yet been able to begin their quality accreditation. Six out of the 24 Clubhouses in Finland belong to this category. In the beginning of 2012 out of all European Clubhouses whose quality certificate was still valid 22.5 per cent was in Finland (ICCD 2002 & 2012).

4.5.4   Dissemination of the Clubhouse model

After 25 years of development in the original Fountain House in New York the concept was defined and specified. The structured Clubhouse model was ready to be transferred
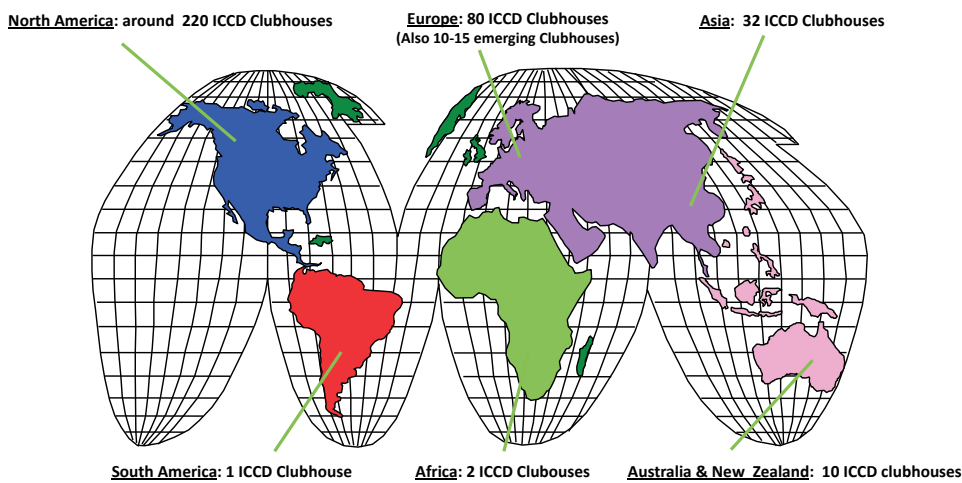
and disseminated into other parts of the USA and to other countries. Some of the success factors for dissemination were study visits, organized training, national and international seminars and consultations offered by the original Fountain House to interested groups, decision-makers and mental health professionals. Dissemination of the empowering Clubhouse model started in the USA and Canada during the 1970s and in Europe in the beginning of the 1980s. Several countries followed the USA and the Italian way in decreasing the use of mental hospitals and increasing the mix of different kinds of community-based services. Clubhouses were part of this development especially in North America, Scandinavia and in some other Western European countries. By the end of the 1980s the Clubhouse model was disseminated into Australia, South-Korea, Japan, Hong Kong and into many new countries in Europe (Propst 2003: 29-32).

The first European Clubhouses were opened in Sweden (Stockholm, 1980), Germany (Munich, 1984), and a couple of years later in Denmark, the UK and in the Netherlands. In the Baltic countries, Bulgaria, Hungary, the former Yugoslavian States, Romania and Russian Federation the change of psychiatric services from hospital-based to community-based structures started in the 1990s or during the first decade of the new millennium (WHO-Europe 2008b; Lavikainen et al. 2010).

At the end of the 1990s in average 240 ICCD member Clubhouses were included in the annual International Clubhouse Directories (later on directories). Between 2001 and 2005 the average number of ICCD member Clubhouses was 290 in directories. In 2006 – 2010 the average annual number increased closer to 330 ICCD Clubhouses. In 2011 totally 337 ICCD member Clubhouses were functioning, of which about 220 in North-America, 80 in Europe, 32 in Asia, 10 in Australia and New Zealand, two in Africa and one in South-America. (ICCD's strategic plan 2011-2016: 48; ICCD 2012).

Worldwide Clubhouse Community
Global Distribution

North America: around 220 ICCD Clubhouses

Europe: 80 ICCD Clubhouses
(Also 10-15 emerging Clubhouses)

Asia: 32 ICCD Clubhouses

South America: 1 ICCD Clubhouse

Africa: 2 ICCD Clubouses

Australia & New Zealand: 10 ICCD clubhouses

Worldwide about 350 ICCD Clubhouses are serving annually around 60 000 members. In addition part of existing Clubhouses are not members of the International Centre for Clubhouse Development (ICCD)

(Sources: ICCD Clubhouse Directory 2012, and data from Finland, Germany, Italy and Poland in May 2012)

Applied by E.Hänninen on part of data in Europe, May 2012

Figure 5: Dissemination of ICCD Clubhouse model in May 2012

Development in Europe

The first European Clubhouses were opened during the 1980s. By 1998 there were a total of 46 Clubhouses in 11 European countries (ICCD 1998). During the next four-year period up until 2002 six new countries and 23 new Clubhouses joined the ICCD Clubhouse community, which at that time consisted of 69 Clubhouses in 17 European countries (ICCD 2002). From 2002 until the end of 2011 many contradictory changes have taken place. The ICCD criteria have been tightened meaning that some of the formerly accepted Clubhouses are no longer included in the annual directory of the ICCD Clubhouses.

During the period (2003 – 2010) three countries (Albania, Macedonia and Romania where Clubhouse type of activities still continue) and a total of 22 European Clubhouses were left out of the ICCD directory. For instance, in England the number of ICCD Clubhouses decreased from 18 in 2002 to three in 2012. At the same time Austria and Italy were included in the directory with their five new Clubhouses. The number of Clubhouses increased during the period 2002 - 2012 in many other countries, like in

Finland from 11 to 20 ICCD Clubhouses (plus four other not-yet-ICCD Clubhouses). In Norway the increase was from two in 2002 to six in 2011, and also Ireland has doubled its number of ICCD Clubhouses to four. In 2012 a total of 80 ICCD Clubhouses were in operation in 19 different European countries. (ICCD 2011 & 2012). Based on the above figures, at least 15 emerging Clubhouse type centres are currently in operation in Europe in addition to the 80 ICCD Clubhouses. Part of these has earlier been included in the ICCD directories. Some Clubhouses have opted not to become members of the ICCD.

Overall, Finland is the leading European Clubhouse country with its 20 ICCD Club-houses making up 25 % of all European ICCD Clubhouses. In autumn 2011 one new Club-house started in Finland which joined to the ICCD in spring 2012. If we take into account the four "not-yet-ICCD Clubhouses" Finland's share will increase up to 30 % of all European Clubhouses. In addition, in year 2012 three new Clubhouses started operating in Finland – all in Northern Finland. By the end of 2012 Finland had a network of 26 Clubhouses.

Three Clubhouse realities in Europe

Three realities are prevailing in Europe. In the first group of countries belong "the leading edge countries", in the second group belong countries with a few mental health Clubhouses, third group is for rest of Europe and countries where no Clubhouses for people with mental health problems are available in 2011. In the following these three groups of countries are listed:

- In the six best Clubhouse countries Clubhouses are included in the national mental health policy, e.g. in Finland, Sweden, Denmark, Iceland, Norway and Scotland/UK;
- In 13 other European countries with one or few ICCD Clubhouses the model is approved but not actively promoted or disseminated so far;
- In about 30 other WHO – European Region's countries the Clubhouse model is not used and decision-makers are not aware about its positive integration and social inclusion potentialities for people with mental health problems.

The strategic task is that the more experienced Clubhouse countries start to transfer their positive outcomes for use in countries where Clubhouses are not available. To support this development the informal European Partnership for Clubhouse Development (EPCD) was created in the spring of 2007 by the European Clubhouses and the ICCD in Stockholm. This informal partnership later opted to be formalised and registered in the European Clubhouse Conference 2010 in Linz/Wesenufer (Austria).

Officially the new formal EPCD was accepted and signed by the founding members in July 2011 during the 16th International Seminar of the Clubhouse Community. The new EPCD was registered under the Danish law, and its secretariat locates in the city of Taastrup near Copenhagen. The first annual general assembly of EPCD convened in Reykjavik at the end of April 2012. (http://www.epcd.info).

4.5.5 Research evidence for recovery of members, cost-effectiveness and other outcomes

The first part of this subsection is written by Colleen McKay, manager of the ICCD Clubhouse Research Program. She concentrated on the recent scientific findings of international research, which was on task of the ICCD in the EMPAD project in 2010-2012. The rest of this subsection is written by the author of this overview and consists of the main results of the research in Denmark and Finland.

There are around 350 Clubhouses located in 32 countries and 36 US states that network through the International Center for Clubhouse Development (ICCD). The ICCD supports the development of new and existing Clubhouses; maintains a set of International Clubhouse Standards; coordinates Clubhouse training and technical assistance; and manages the accreditation/certification process. In the following section some of the recent published research outcomes about Clubhouses are described.

Recent research outcomes

The ICCD Clubhouses promote recovery: A recent study found that Clubhouse members were more likely to report being in recovery and having a higher quality of life compared with a group of participants from consumer run drop in centers (Mowbray, Woodward, Holter, et al, 2009). Clubhouse members indicate the Clubhouse provides valuable opportunities to pursue meaningful activities that help them address their mental health recovery at their own pace (Stoffel, 2008).

Clubhouses reduce hospital stays: Membership in a Clubhouse program resulted in a significant decrease in the number of hospitalizations (Di Masso, Avi-Itzhak, & Obler, 2001).

Clubhouses help members obtain community based employment: Researchers conducted a randomized controlled trial comparing an assertive community treatment (ACT) program with an ICCD certified Clubhouse in the delivery of supported employment services. Outcomes for participants in both programs met or exceeded most published outcomes for specialized supported employment teams. Compared with ACT participants, Clubhouse participants worked significantly longer (median of 199 days vs. 98 days) for more total hours (median of 494 hours vs. 234 hours) and earned more (median of $3,456 vs. $1,252 total earnings) (Macias, Rodican, Hargreaves, et al, 2006).

Using a longitudinal dataset which followed 2,195 individuals employed in 3,379 separate job placements over a four-year period, researchers explored movement between Transitional, Supported, and Independent Employment (TE, SE, and IE) offered by Clubhouses. 64 percent of employed members held only one job while and 36% held multiple jobs during the study. 46 percent of individuals holding multiple jobs moved between the employment types (TE, SE, and IE). When movement

occurred, Clubhouse members were significantly more likely to move from employment types offering more supports to those that offer less supports (McKay, Johnsen, Banks, et al, 2006).

ICCD Clubhouses are cost-effective: The cost of Clubhouses is estimated to be one-third of the cost of the IPS model; about half the annual costs of Community Mental Health Centers; and substantially less than the ACT model (McKay, Yates & Johnsen, 2007).

Clubhouses improve well-being and physical and mental health: One study suggests that service systems should prioritize services that offer ongoing social supports like Clubhouses, as they enhance mental and physical health by reducing disconnectedness (Leff, McPartland, Banks, et al, 2004). Researchers examining the increased morbidity and mortality from physical health conditions of people diagnosed with a mental illness conducted a survey of members of a rural Clubhouse in Virginia and found that involvement with a Clubhouse program or other supportive psychosocial program may promote regular physical health screenings (Tratnack & Kane, 2010).

Clubhouses improve quality of life: Researchers in China examined the effects of the Clubhouse model on various psychosocial issues for people diagnosed with schizophrenia living in the community. Clubhouse participants showed significant improvements in their symptoms, self-esteem, and quality of life after attending the Clubhouse for six months. The Clubhouse participants also had improved employment rates (Tsang, Ng, & Yip, 2010).

Pernice-Duca and colleagues examined factors that influence staff perceptions of a Clubhouse's organizational environment and found that staff in high fidelity Clubhouses endorsed the presence of more empowering elements of the Clubhouse as compared to low fidelity Clubhouses. These empowering elements included more positive recovery attitudes to recovery and the importance of finding paid work for members (Pernice-Duca, Saxe, & Johnson, 2009).

In a USA National Institute for Mental Health (NIMH) funded study examining over 1,800 participants in 31 geographically matched pairs of Clubhouses and consumer run drop-in centers researchers controlled for differences in demographics, psychiatric history, and receipt of mental health services and found that Clubhouse members reported having a higher quality of life and were more likely to be in recovery (Mowbray, Woodward, Holter, et al, 2009).

Research findings in Denmark

In 2011 three studies on Clubhouses were published in Denmark. At its start in 2010, the most extensive study covered seven Danish Clubhouses, and three additional Clubhouses were opened during its course (Hoejmark, Rosendal Jensen & Langager, 2011). The second study covered three Clubhouse settings in Denmark (Hoejmark, 2011), and the third one evaluated the Clubhouse in Vejle municipality

(Konsulentfirmaet KX, 2011). The findings of the second study are integrated in the report of the first one.

Natural expectations – Fountain Houses as a psychosocial model of rehabilitation (Hoejmark at al, 2011: 153-158), the largest of the three studies mentioned above, aimed to investigate "the outcome": Is it possible to identify whether participation in a Clubhouse has a positive impact on mentally ill people and other people characterized by serious psychosocial difficulties? Research methods were based on anthropological studies of the practices of everyday life and searching for the meanings of expressions collected by qualitative interviews from members of Clubhouses and leaders and members of staff. The main conclusion of the results regarding the psychosocial model of rehabilitation of the Clubhouse is that it is remarkable and significant for the majority of the members as a "good practice" by virtue of its approach to the socio-psychiatric paradigm. The Clubhouse model implicitly draws on well-known assumptions of good practice from education: The most effective way of contributing to other peoples' personal development and learning is not situated in direct relational meetings; it is in the preparing and organizing the conditions (support structures and frameworks) within which long-term processes of personal change, learning and development become possible.

In addition, the report on Natural expectations concludes that in the working organization of a Clubhouse the focus is on the strengths, resources and skills of the members to take part in and contribute to the functions of the house. In the practice of Clubhouses stability provides continuity, and continuity means a possibility of change for members in their personal recovery by creating a structured daily activity, learning new working and communication skills, and building social relationships. In Clubhouse activities members can use their working capacity and learn new capabilities as well as experience being expected, wanted and necessary. Individual rehabilitation seems to take place while the members are busy managing the Clubhouse in cooperation with their colleagues and staff of the house. Given the increasing need for psychiatric treatment, the Clubhouse model is recommended for wider use in Denmark.

The study report on the Fontaenehuset Vejle (Konsulentfirmaet KX, 2011) consists of an evaluation during period 2007 – 2010 and future perspectives for years 2011 – 2013. The report confirms that also in Vejle the members' participation in the Clubhouse activities decreases the use of psychiatric inpatient care services and other social and health services. The study found that Clubhouse participation had positive impacts both on members' individual recovery and on the development of their working skills and social competence. Based on these findings, the future perspectives were defined and "the growth plan" for years 2011 – 2013 prepared, according to which the Clubhouse Vejle plans to boost its capacity from 60 places to 100 places, and its budget will grow respectively by about 50 per cent. Taking into account the evidence on cost-effectiveness, it has been proposed that the funding of "the growth plan" should come from the savings made in the costs of other services. This means that the realization of "the growth plan" is for the Vejle municipality a profitable investment with positive societal, human and economic returns.

Additional results from Finland

In Finland the amount of Clubhouses has grown fastest in Europe since 1995. At the end of 2012 Finland had a network of 26 Clubhouses giving support for recovery and social inclusion to nearly 4,000 Clubhouse members. The total population in Finland is 5.4 million. The funding authorities have commissioned in Finland already four evaluation studies concerning the Clubhouse model, published in years 2000, 2004, 2006 and 2009. In addition, about 10 other studies on Clubhouses have been carried out and published as graduate-level theses in Finnish universities after 1998. The latest multimethod Finnish study (Hietala-Paalasmaa et al. 2009) was based on data collected during years 2004 – 2006 from 18 Clubhouses and about 190 newly-joined members, from long-term members and from the funding municipalities. According to the researchers the latest data shows quite consistently – irrespective of the source – that:

- Clubhouses for mental health rehabilitees play a crucial, cost-effective and complementary role in the mental health service system in Finland. The results on cost-effectiveness of the Finnish Clubhouses are similar with the US studies.
- The results demonstrate the evidence that regular participation of the newly joined members in the Clubhouse activities decreased their use of psychiatric inpatient services (both the number of inpatient days and the costs of hospitalization decreased about 75 % as compared to the period before Clubhouse membership), and also that Clubhouse participation improves the general well-being of Clubhouse members in Finland (evidence is similar with previous studies).
- The Finnish findings (Hietala-Paalasmaa et al. 2009) indicate that the key strengths of the Clubhouse activities are the sense of belonging and sense of community they provide. At its best, the Clubhouse enables members to share their experiences of living with a mental disorder and break out of the circle of helplessness and victimisation. Despite the fact that the illness may become chronic, the Clubhouse community provides a place where members can feel valued and productive, a place where they can be themselves. Members also have access to help and support for the daily life whenever they need it. Especially for those members with long-term illness, the combination of improved self-esteem and social support was found to be the most important benefit of the Clubhouse.
- According to the mentioned Finnish study, in terms of the established norms and framework, what separates the Clubhouse model from other rehabilitation services and community-based rehabilitation models is the distinctiveness of the sense of community.

Three other Finnish Clubhouse-related studies and evaluations are summarized below:

- Here you work for yourself – Clubhouses and member houses as new alternatives in rehabilitation and employment (Hietala, Valjakka & Martikka, 2000). Then the first six Clubhouses and 14 so-called "member houses" of people with mental health

problems were included in this study. A total of 2,200-2,400 persons per year participated in the activities of the member houses; the six Clubhouses had about 600 participants per year in total. The average number of daily participants in both types of houses was 20 persons (the data was collected in 1998-2000). The study was conducted during the inception phase of Clubhouses in Finland, which means that not all aspects of the International Clubhouse Standards were yet in the focus of the activities of the Finnish Clubhouses. According to the study report experiences from transitional employment program were positive. However, some problems (e.g. benefit trap) have occurred in the implementation due to national legislation and the social security system. The most important immediate impact of transitional employment was an improvement of the members' quality of life. The first Finnish Clubhouses were also successful in creating pathways towards work and education. In addition, many Clubhouse ideals such as equality, empowerment and meaningful activity were realized in the first Finnish Clubhouses.

- The second evaluation report Transitional Employment (TE) of the Finnish Clubhouses (Saloviita & Pirttimaa, 2004) was published four years later. In autumn 2003 when the study commenced there was a network of 17 Clubhouses in Finland, out of which five were certified by the ICCD international quality assurance procedure. The researchers identified that Transitional Employment is closely related to the Supported Employment methodology. The study included 150 persons who had taken part in a Transitional Employment period outside the Clubhouse community, i.e. in open labour market. The participants' main expectations from the TE period were the opportunity to test one's own working ability (39 %), earning additional money (37 %), return to working life (21 %), and the experience of rehabilitation (18 %). In some cases the Transitional Employment experiences were frustrating. As conclusions, the researchers noted that Transitional Employment seems to promote a person's rehabilitation and recovery well. Members' answers reflected better physical and mental well-being as well as an increased motivation to return to the labour market or to continue their interrupted studies in an educational institute. Based on a quite short experience in organizing Clubhouse operational services in Finland, the Finnish scale of Transitional Employment was still quite modest during the study period which indicated a need for further studies in the future.

- The third Finnish evaluation study produced the report Work, support and mental health - Employment models for persons with mental health problems (Valkonen, Peltola & Härkäpää, 2006). The study compared three employment models for people with mental health problems – Transitional Employment (Clubhouses), Job Coach Services (Supported Employment), and Sheltered Employment. The results indicated that the support of the three approaches differed from each other based on their historical roots and the mode and magnitude of support provided, as well as in regard to their practical implementation and target groups. For persons with mental health problems, work means an opportunity for a meaningful life and social interaction, improvement

in one's financial situation, and strengthening of self-esteem. In the three employment models job satisfaction and coping with work were connected to individual and social factors as well as relevant accommodations at the working place. Participants´personal motivation was one of the key contributors to success. Work plays an important role in advancing and improving one's mental health and well-being, i.e. the recovery process. However, statistically significant differences between the three approaches were not found, but Clubhouse Transitional Employment was not less significant either.

A summary of two graduate-level study reports is presented below (in addition, several similar Master's theses have been produced with the same types of findings):

- The Fountain House and Its Support to Members to the Next Level (Säkkinen, 2005): The research task was to study how the Kuopio Clubhouse supports its members in their transition to the "next level" in life, for example, to school, work, or in some cases home. The material was collected by interviews and the data were analysed by qualitative content analysis. The results confirmed that the Kuopio Clubhouse supports its members by giving them social support, helping them to learn new skills, and encouraging them to look ahead to the future. The results showed that the Kuopio Clubhouse is necessary for the rehabilitation of its members and it improves their functional ability. It also helped the members get their voices heard.
- Participation in Clubhouse Activities at Keski-Uudenmaan Klubitalo and its Influence on the Individuals's Psychosocial Functioning Ability (Vuorinen, 2008). The results indicate that the rehabilitants' self-image had improved when they had started taking part in the Clubhouse programs. Furthermore, the members felt that it was easier for them to cope with their everyday life now than before. Their experienced social skills had improved and they had a much more positive outlook for the future than before the Clubhouse experience. Participating in different activities at the Clubhouse had improved their quality of life. The results showed that those recovering from mental health problems were less depressed and more stress-tolerant than before. Furthermore, there was less need for hospitalisations. Taking part in the Clubhouse activities had made it easier for the rehabilitants to return to their studies and working life.

Some critical points of view

Clubhouses are not "a patent solution" to all difficulties people with mental health problems encounter during their lifetime. A well-known fact is that not all members of any Clubhouse are active members. This is connected to the general consensus that there are no "one size fits all" solutions (Munday, 2007). Clubhouses for mental health rehabilitees play a crucial, cost-effective and complementary role in the mental health service system in Finland, but Clubhouse support is not satisfying the needs of all members (Hietala-Paalasmaa et al. 2009: 141-143).

A recent study on the non-active members of a Clubhouse in Finland (Nääppä & Rantanen, 2009) found that most of them had started other important activities and other ways to increase the content of their lives outside the Clubhouse. A lowered ability to function and insufficient resources to participate had certain effect on some members to become non-active. Some members were not satisfied with the amount and quality of the work tasks in the Clubhouse. Some members thought that the work tasks in the Clubhouse were not useful outside the Clubhouse community; some felt that their area of expertise, resources and overall ability to function were not taken into consideration enough. The numbers of new friends and relationships as well as the amount of peer support were seen as quite limited. Also the available support, help and guidance were found to be inadequate in some parts of the Clubhouse.

In one study three different groups of members of the Clubhouses were identified: first, members like "boats without steering" who need more motivation and attention in the Clubhouse; second, members who are active inside the Clubhouse; and third, those who experience Clubhouse as "a trampoline" towards social inclusion and labour market integration (Salenius, 2009).

The recent multi-method study in Finland (Hietala-Paalasmaa et al, 2009: 97-121) used three types of orientations to examine new members' experiences of Clubhouse activities and the meanings they assigned to the activities. This was put in relation to the members' life situations, expectations and conceptions of the effect of their mental illness on their prospects.

According to the study (ibid, 2009: 97-98), an even orientation was defined by a need to compensate for disabling and stigmatising effects of mental illnesses. The life situations of members who used an *even orientation* to interpret the Clubhouse activities were influenced by factors such as long-term illnesses, social exclusion, weak employment situations and social welfare-based livelihood. Some members had longer work experience and were also relatively well educated, but they still felt that problems related to paid work had had a detrimental impact on their mental health. The key elements of Clubhouse activities included: a community that is understanding and tolerant about symptoms and other hardships; a respectful and encouraging staff; and support for self-care and participation based on individual interests and capacities. These elements were considered as important in terms of maintaining mental health and stability and improving self-esteem.

In an *enhancing orientation* the emphasis was on the significance of the Clubhouse community as an enhancer of self-esteem and facilitator of social learning. At the same time, however, interviewees also reported that the Clubhouse encouraged and supported their individual talents and interests. The interviewed members appreciated the freedom of choice in terms of Clubhouse tasks, as well as the possibility to take responsibility for themselves and the whole community. In relative terms, younger members were more likely to view the Clubhouse activities based on the enhancing orientation as their lives, relationships and livelihood had not yet taken their final form. In this case, the perceived advantage of the Clubhouse activities was that they include an approv-

ing, stigma-reducing, peer-based approach combined with a democratic community that respects, encourages and emphasises individual autonomy. The Clubhouse with its members and staff were thus perceived, in terms of their value base, as alternative sources of normalcy and self-esteem, as opposed to the outside community with its dominant accents of normalcy and productivity, which was seen as very challenging and even daunting. The key in terms of social learning and rehabilitation was the possibility to engage in very varied tasks in the Clubhouse and participate in planning and decision-making. This gradually aroused discussion and hopes of finding employment or education outside the Clubhouse community.

A weakening orientation entailed a slightly different approach to describing members' experiences of Clubhouse activities and the challenges concerning Clubhouse development. Those who had a weakening orientation were older members, most of them with fairly unbroken educational and work histories. Their sources of income ranged from sickness allowance and rehabilitation benefits to pensions. By the time of the follow-up interviews, most of the interviewees with a weakening orientation had considered dropping out of the Clubhouse programme, but had not yet made any concrete decisions. At the time of the initial interview, however, expectations reflected the basic elements of an even and enhancing orientation: a regular day rhythm, meaningful tasks and social contacts. The follow-up interviews highlighted individual-level interests related to work, education and outside social contacts as well as changes that had already taken place in these areas. Some members also reported being confused and disorientated because they felt estranged from the Clubhouse community, believing they had a higher social status and a more severe illness than other members.

In terms of Clubhouse development, perhaps the most challenging orientation was that dimension of weakening orientation which emphasised, on one hand, the burden brought on by mental illness and, on the other hand, self-dissatisfaction and the resulting exasperation. For interviewees with this orientation, the effect of the Clubhouse on improving social functioning remained insignificant after the initial stage. They did not feel a satisfactory connection with other Clubhouse members, nor with people outside the Clubhouse. They also felt that Clubhouse tasks were either too challenging or too demanding, or simply uninspiring. However, they had realised that, ultimately, finding employment and a positive change in life depended on their own actions, abilities and motivation. They felt that dropping out of the Clubhouse programme was the only way to achieve this. It was not always seen as a positive alternative, since the future looked unclear for many of the members (ibid, 108-122).

Positive outcomes exceed the criticism

Based on the growing body of evidence on the positive outcomes and impacts, the Clubhouse model was approved in Finland in 2009 as a part of National Mental Health Services Development. First time the Finnish Ministry included in 2001 the Clubhouse

model in the national quality development programme for local mental health services. According to the latest programme, the Clubhouse model should be taken into use in all Finnish mental health service regions and service districts (Ministry of Social Affairs and Health, Finland 2001 & 2009). This means that the Clubhouses may double in amount by the year 2020, as compared to situation in 2011.

De facto the Clubhouse model is part of mental health development programmes in major part of States of the USA, in the Canadian territories, in some regions of Australia and Japan, and most recently in South-Korea and in People's Republic of China. Also in Sweden, Denmark, Norway, Iceland and Scotland, as well as in Bavaria Germany, the Clubhouse model has been accepted as a part of the national mental health policies.

4.6   Summarizing remarks

Community-based rehabilitation (CBR) binds together all the subsections of this chapter which is also the principal chapter of this overview. The goal of CBR implicates that people with mental health problems receive support to enable their inclusion and participation in all aspects of life and activities in the community they are living. The role of a CBR programme is to promote and protect their rights, support their recovery and facilitate their participation and inclusion in their families and communities.

The concept of empowerment means that people start to make their own decisions and choices and take the responsibility for changing their lives and improving their living communities. The Clubhouse model offers a suitable framework for these empowering activities. Clubhouses are evidence-based good psychosocial rehabilitation practices committed in the recovery-orientation.

SAMSHA (USA Substance Abuse and Mental Health Services Administration) has approved the Clubhouse model as evidence based good practice (http://www.nrepp. samhsa.gov/).

In Finland the Clubhouse model has been approved by STAKES and THL (National Institute for Health and Welfare) as a good practice based on several evaluation studies (in Finnish language only): (http://www.sosiaaliportti.fi/fi-FI/hyvakaytanto/ kuvaus/?PracticeId=7b66e441-fd65-4c39-8be4-cd7f15c28908).

Since the 1980s the scientific community has produced growing evidence on the positive impacts of the Clubhouse model to the empowerment of the Clubhouse members, and to the economic benefit of the funding agencies.

Available evidence substantiates the fact that ICCD Clubhouses provide communities around the world with a cost-effective solution for dealing with the devastating impact which mental health problems has on society, and for helping people who live with a mental disorder achieve their full potential in their communities. According to available research evidence, ICCD Clubhouses achieve the following

tangible results for members and their communities (McKay 2011; ICCD 2011; Hietala-Paalasmaa et al, 2009; Nääppä & Rantanen 2009):

- Clubhouses promote members' recovery;
- Participation in Clubhouse activities reduces hospital stays and costs;
- Regular participation helps members obtain community-based employment and motivates them to education and training;
- Clubhouses are cost-effective;
- Taking part in Clubhouse activities improves well-being and physical and mental health of members;
- Participation in Clubhouse activities improves members´quality of life;
- However, Clubhouse activities are not satisfying the needs of all members.

5   Interrelationships of mental health policy frameworks and empowering rehabilitation

The aim of this section is to study interrelationships between the conceptual elements of different international mental health policy frameworks and key concepts of rehabilitation. The conceptual elements or content of different approaches and models are described in the earlier sections of this overview. In addition to the common denominators of the different international mental health policy frameworks, the elements of key concepts (a) community-based rehabilitation, (b) empowerment, (c) recovery approaches, (d) social capital, and (e) social inclusion and social cohesion, are selected for this comparison. After that the common elements of different frameworks and rehabilitation concepts are compared with International Standards for Clubhouse programmes.

International mental health policy frameworks consist of conventions, resolutions, recommendations or guidelines approved by the inter-governmental organizations. Some of them, like the UN Convention on the Rights of Persons with Disabilities and its Optional Protocol (UNCRPD), are legally binding and require national legislation for appropriate implementation process which includes also a system for monitoring the realization of the UN Convention in each country. Other types of policy recommendations, resolutions or guidelines by the inter-governmental organizations are at least morally binding, because they are approved and signed by a Ministry level representative from respective member states. In both cases the international mental health framework decisions are expected to lead to changes or new contents of the national mental health policies.

5.1   Key values, principles and goals of the policy frameworks and rehabilitation concepts

The key values, principles and goals expressed in the international policy framework decisions should be realized in each country at the levels of service users, professional practices and the content of mental health services. Referring to the needs analysis survey described earlier in the sub-section 3.3 the results imply that the national Ministries of Health and/or Social Affairs should draw more attention to the dissemination of information about the mentioned international mental health policy frameworks, because not all mental health professionals and decision-makers are familiar with these recommendations and guidelines.

Values, principles and goals of the different mental health policy frameworks are described in Table 4. The first column of the table summarizes the general common denominators of the different decisions and recommendations approved by the intergovernmental worldwide organizations during the 2000s.

The second column consists of components and elements of the Community-Based Rehabilitation (CBR) Guidelines, planned and accepted jointly by the International Labour Organization (ILO), United Nations' Education, Science and Culture Organization (UNESCO) and World Health Organization (WHO) in collaboration with international NGOs and other stakeholders.

The third column brings the key values, principles and goals to the individual's level by describing the main elements of the personal empowerment process. The concept of empowerment has different meanings depending on the context where it is used. In the CBR context empowerment has dual roles both as an end objective and as a crosscutting means of the whole CBR process as explained earlier in the sub-section 4.3.1. Based on its end objective role the content of empowerment is compared with the values, principles and goals listed in the first and second columns.

Table 4: Key values, principles and goals of the different mental health policy frameworks

International mental health policy frameworks	Community-based rehabilitation guidelines	Empowerment of persons with mental disorders
Policy priorities based on: Human rights; Equal opportunities; Gender equality; Involving users in development; Anti-discrimination; Right to mainstream services; Health promotion and prevention; Optimal mix of mental health services; Community-based instead of hospitals; Living in community like all others; Acceptance, dignity and respect; Awareness-raising by using media; Participation and service coordination; Health and mental health in all policies; Standards of ethics; Empowerment and social inclusion;	**CBR activities and services built on:** Human rights; Equal opportunities; Gender equality; Involving users in all decisions; Living in local community using informal and formal resources; Contributing to activities in the local community; Cooperation across sectors: - health and mental health services, - lifelong learning and education, - livelihood, wage and social benefits and social protection, - social services, relationships, culture, arts and leisure time, - justice system and legal support, - advocacy, self-help groups, - awareness-raising on needs, - participation in local activities, - mobilizing community resources;	**Empowering actions aimed at:** Realization of a person's human rights, equal opportunities and gender equality; Involving users in all decisions; Hope & recovery motivation; Own decisions, own choices; Skills for self-determination; Strengths and abilities; Learning new competences; Self-management & coping; Peer support groups and networks; Sense of belonging; Self-esteem & self-reliance; Trust on personal relationships and organizations; Self-confidence and assertiveness; Internal feeling of power;
Expected to lead to: Revised National Mental Health Policy and Service Development Programmes; Coordinated implementation of the revised policy at operational levels.	**Lead to:** Empowerment, accessibility, participation and social inclusion.	**Lead to:** Growth of social, human & mental capital, social inclusion and self-determination.

   Table 4 implies that the key values, principles and goals defined in the international policy frameworks are transformed to more operational strategies, for example, in the CBR Guidelines, European Union's Disability Policy 2010 – 2020 and WHO Pyramid Framework for optimal mix of mental health services. These are, in turn, frames of the individually tailored planning and selection of methodology for personal empowerment processes. During personal empowerment the "higher level" principles and goals are

translated into empowering activities as a response to a person's needs for strengthening her/his potentials in relevant fields of everyday life.

Table 5 includes an additional set of rehabilitation concepts: recovery approaches, social capital, social inclusion and social cohesion. The first column is a summary of the Scottish Recovery Network's research findings, the consensus statement on recovery of the USA Substance Abuse and Mental Health Services Administration, and the UK Whole Person Recovery approach with the concept of recovery capital. The second column summarizes social capital and related concepts of human and mental capitals. The third column concentrates in multidimensionality and elements of social inclusion – exclusion continuum. The last column describes some main aspects of the concept of social cohesion linked with the other concepts in the whole table.

Table 5: Comparison of recovery approaches, social capital, social inclusion and social cohesion

Recovery approaches	Social capital	Social inclusion	Social cohesion
Focus on strengths, skills and abilities: Persons with a mental disorder have same wants & needs as anyone of us; Respect of users' voices and choices; Respecting human rights and dignity; Users as full partners in all aspects of recovery; Users' power to agree or disagree with care plans; People can & do recover even from severe illness; Users' hope, optimism and focus on strengths; Users as experience informants in mental health issues in their community; Self-care & self-management tools in use; Find meaning & purpose and contribution to local activities;	**Social relations open access to social capital:** Networks of social relations may provide individuals and groups with resources and support; Bonding social capital refers to homogenous groups with strong ties, e.g. close friends; Bridging social capital refers outward looking networks with weak ties, e.g. distant friends and colleagues; Linking social capital refers links to people or groups further up or lower down the social ladder, or links with formal agencies as source of resources;	**Multidimensionality is key to social inclusion:** Social exclusion and inclusion are ends of the same continuum and have eight dimensions; - cultural, - economic, - functional, - participatory, - physical, - political, - structural, and - relational; Exclusion part of the continuum consists of eight elements: - poverty, - disadvantage, - inequality, - discrimination, - barriers to access, - disability & ill-health, - isolation, and -marginalization.	**Social cohesion is based on people's will to work together in community:** Many societal factors may strengthen or weaken the social cohesion; Government agencies, other public organizations, private industries and civic society's actors all contribute to social cohesion by their mutual collaboration; Human, social and cultural capital are linked with community civic identity, solidarity and sense of community, trust, respect for the law and fair play; The same factors that contribute to social inclusion, support the social cohesion;

Supportive relationships based on belief, trust and shared humanity; Concept of personal, social & community recovery capital;	Positive relationship exists between social capital and mental health, e.g. less isolation, crime and social exclusion; Trust and confidence in the community, active participation and sense of belonging, networks, all strengthen social capital; Human capital, social capital & mental capital are intertwined reinforcing each other.	Inclusion part of the continuum covers also eight elements: - adequate income, - reduced disparities, - human rights, - accessibility, - ability to participate, - valued contribution, - sense of belonging, and - empowerment.	Institutions and communities based on above values tend to make cooperation easier and more riskfree; Groups & entities that do not promote widespread inclusion, trust or respect of laws in society or in community, erode or decrease social cohesion; Higher levels of social cohesion activate people to participate in civil society groups and organizations.
Lead to: Complete recovery or social recovery, and empowerment & social inclusion of people with mental health condition.	**Lead to:** Local community civic identity, solidarity and equality, sense of community etc.; At individual level empowerment and self-determination; Contributes to better social inclusion and positive social cohesion.	**Lead to:** Formation of unique exclusion – inclusion profiles both at individual, organizational and community levels; Emerging needs for local, sub-regional, regional and national inclusion policy and strategies.	**Lead to:** Increased efficiency of economic, social and cultural outcomes in the community; Optimism and positive prospects for the future.

In the recovery approaches five new concepts need to be explained, namely personal, social and community recovery capitals, and concepts of complete recovery and social recovery. Personal recovery capital formation is based on service-user's safe and secure housing conditions, good or improving physical and mental health, and purposeful activity like education, training and employment which are sources of personal relationships. Social recovery capital consists of peer support in its many different forms. Relationships with friends and family can have positive and/or negative influence. Social

networks help for example to find a job and to promote and sustain social recovery capital. Community recovery capital is depending on the extent of stigma and negative labeling, available community resources, and on possibilities to develop local recovery communities. (Daddow & Broome 2010: 62-70).

Complete recovery is understood to mean a return to pre-illness functioning including a loss of psychotic symptoms. Social recovery refers to levels of economic and residential independence as well as interpersonal adjustment and acceptable level of adaptation. (Dorrer 2006: 4).

As a part of the second column human, mental and social capitals are referred. Human capital means the knowledge, skills, competences and attributes that allow people to contribute to their personal and social well-being. Education and training is the key factor in forming human capital. People with better education tend to enjoy higher incomes – a benefit that is also reflected in improved economic growth. Raising human capital raises health levels, community involvement and employment prospects. The importance of human capital will only grow in the years to come. Sadly, too many people today are not being given the opportunity to fully develop their abilities. (Gurria 2007: 3).

Human and social capital do not exist in isolation from each other. The two are linked in complex ways and, to some extent, feed into each other. Social capital promotes the development of human capital and human capital promotes the development of social capital, although the process is complex and needs more attention from the research community. Illness can be socially isolating, but also the reverse is true. By damaging the mental well-being of people living at the margins of society, social isolation can in itself cause illness, both physical and mental, even to the extent the people with weaker social ties are more likely commit suicide. (Keeley 2007: 105-106).

Mental capital is a resource, formed by the mental health of individuals. It can be an attribute of an individual, a group, a community or even a country or a global region. Investing in mental health pays off in the form of increased mental capital. The benefits of mental health go well beyond the health sector. In order to achieve mental well-being of Europeans and to build a common mental capital we need to see all policies accepting mental well-being as their own interest and responsibility. (European Communities 2011: 21-22).

5.2 The Clubhouse model compared with mental health policy frameworks and guidelines

In this sub-section the values, principles and goals of the above mentioned mental health policy frameworks (Table 4), and the key concepts of empowering rehabilitation of people with mental health condition (Table 5) are compared with the Clubhouse model and with the International Standards for Clubhouse Programmes.

Table 6: Realization of the international mental health policy frameworks and empowerment in the Clubhouses committed in the international standards

Key principles of the policy frameworks and guidelines	Significance level of the guiding principles in the Clubhouses			Verification and remarks (CH = Clubhouse)
	Low	Medium	High	
1. Common in several guidelines				
- Human rights			X	All Clubhouse Standards[1]
- Equal opportunities			X	Standards # 4, 8, 15, 20
- Gender equality			X	Standards in general
- Involving users in decisions			X	Standards # 5, 8, 9, 11, 22i, 36
- Community-based activities			X	Standards # 13, 21, 23, 24, 27
- Health promotion & prevention			X	Standards # 27, 35
- Empowerment			X	Standards # 11, 15, 19, 21, 25
- Social inclusion			X	Standards # 20, 21-24, 25
2. MH policy frameworks				
- WHO Pyramid Frame & Optimal Mix of MH services	X			WHO pyramid framework is not yet generally known
- Deinstitutionalization process			X	CH is a dehospitalization tool
- UN Convention UNCRPD 2006		X		CH follow all human rights
- MH Action Plan for Europe 2005		X		CH model is part of the plan
- European Pact for MH etc 2008	X			CHs not yet part of the Pact
- Community-Based CBR Guides			X	Equivalences to CH Standards
- Cross-sectorial MH Cooperation		X		CHs work with many sectors
- EU/MH Joint Action Project	X			CHs contribute, not partners
- CHs Part of National MH Policy		X		Yes in Denmark, Finland, Iceland, Norway & Sweden
3. Recovery approaches				
- Focus on strengths & abilities			X	CHs share the same principle
- Users full partners in recovery			X	CHs share the same principle
- Respect users' voice & choices			X	CHs share the same principle
- Users have power to decide			X	CHs share the same principle
- Recovery from severe illness			X	CHs share the same principle
- Finding meaning & purpose			X	CHs share the same principle
- Contribution to community			X	CHs share the same principle
- Users as experience informants			X	CHs share the same principle
- Lead to complete or social recovery outcome[2]			X	CHs share the same principle

1) International Standards for Clubhouse Programmes, described in subsection 4.5.2 (ANNEX 2).
2) Concepts of complete recovery and social recovery are explained in the subsection 5.1.

4. Social inclusion - social capital				
- Hope, optimism & motivation			X	Also in CHs open ways ahead
- Self-esteem & self-confidence			X	Are basis in CHs for inclusion
- Trust & sense of belonging			X	Are basis in CHs for inclusion
- Assertiveness & coping skills			X	Important for social inclusion
- Networks of friends & relations			X	Key for peer support & help
- Leading to self-determination			X	End goal of empowerment

Human rights, equal opportunities, gender equality, involvement of users, the community-based approach, health promotion and prevention, empowerment and social inclusion are common values and principles in several international mental health policy frameworks and recommendations. All of these have a high level of significance in the Clubhouses, provided that their activities are based on the International Standards for Clubhouse Programmes.

The Clubhouse model is mentioned as a community-based formal mental health service, which in addition to the Community Mental Health Centres (CMHC) and other recovery and rehabilitation approaches is located in the basement of formal part of the WHO Pyramid Framework for optimal mix of mental health policy and services. The Clubhouse model is one tool for promoting the community-based services and dehospitalization process for people with mental disorders. Clubhouses promote human rights as described in the UN Convention of Rights of Persons with Disabilities. The Clubhouse model is one means to promote in practice the implementation of the Mental Health Action Plan for Europe, as well as the European Pact for Mental Health and Well-being. The Community-Based Rehabilitation CBR Guidelines and the International Standards for Clubhouse Programmes have several coinciding equivalences, which makes Clubhouses an important method in implementing the CBR Guidelines for people with mental health condition. One essential point of view is that Clubhouses work in collaboration with employment agencies, social security agencies, educational institutions, private and public sector employers, trade unions, local and regional authorities, general health services, and mental health professionals and decision-makers.

Based on its evidence-based positive influence on the recovery and empowerment of people with mental disorders, the Clubhouse model is approved in the national development programmes in the field of mental health policy in several European countries, e.g. in Austria, Denmark, Finland, Iceland, Norway, Scotland, Sweden and in Bayern Germany. In addition, the awareness about positive opportunities offered by the Clubhouse model is increasing for example in France, Italy, Poland, Romania, Slovenia and Spain. (http://www.empad-project.eu).

In addition, the Clubhouse model shares most of the values and principles steering the different recovery approaches used in Europe and in the USA. The same is true concerning the Standards of the ICCD Clubhouses with the ingredients of the social capital and social inclusion: hope and optimism, strengthening of self-esteem and self-confidence, trust and the sense of belonging and sense of community, assertiveness and coping skills, as well as networks of friends and human relationships are all important contributing factors for helping people with mental disorders towards self-determination – the end goal of empowerment process.

5.3   Summarizing remarks

As summarized by researchers of the latest multi-method Clubhouse study in Finland (Hietala-Paalasmaa et al. 2009) the Clubhouse membership does generate positive economic impacts that support the wider use of Clubhouse rehabilitation model. Alongside the economic efficiency the study indicated that the key strengths of Clubhouse activities are the feeling of belonging and a sense of community they provide. The Clubhouse community is a place where members can feel themselves valuable and productive. In addition, the factor that separates the Clubhouse model from other community-based rehabilitation models is the distinctiveness of the sense of community. Clubhouses play a crucial, cost-effective and complementary role in the mental health service system. A special strength of the Clubhouse model is the 25 years of experience in developing the quality management and quality assurance system for the Clubhouses, which was quite unique at the end of the 1980s and during the 1990s in the field of community-based mental health services. The creation and continuous development of the International Standards for Clubhouse Programmes and the accreditation process have secured a possibility for Clubhouses to keep their operational practices high on the fidelity scales in relation to the Standards.

The Standards and the accreditation process guarantee to the funding agencies and steering authorities the good quality of the content of Clubhouse services that they support. The regularly repeated accreditation processes serve to keep the funding agencies aware of the "good social and economic return on their investments", including positive impacts on the Clubhouse members' recovery and empowerment towards self-determination, more independent living and social inclusion in their community.

6 Summary of the overview

This overview demonstrates the common denominators between the practical applications of the concepts of empowerment, community-based rehabilitation (CBR), social capital, and the Clubhouse model in the promotion of recovery and social inclusion of people with a mental health condition.

The EMPAD project implements the European level policies which promote the active inclusion and full participation of the disadvantaged people in society, and are in line with the United Nations', Council of Europe's and European Union's human rights approaches to disability policies. This overview looks for evidence for successful promotion of the CBR principles and guidelines in the EMPAD partner countries and elsewhere in Europe. This paper is one of the deliverables of the EMPAD project.

From negative mental health conditions towards positive mental health and recovery

The principal idea of this overview is to develop, promote and disseminate good practice psychosocial rehabilitation models aimed at people living with a mental health condition. Mental health care, rehabilitation, recovery approaches and Clubhouses are aimed to support these people towards a life situation where the positive mental health components of empowerment, recovery and social inclusion prevail. The Clubhouse model is used as an example of a coherent, strengths-based and well-structured method to support people with different mental health conditions in their personal recovery towards social inclusion, self-determination and participation in their living communities.

Mental health reform created opportunity for the Clubhouse model

After World War II new inventions of psychiatric medication and political will started the process of downsizing of mental hospitals and decreasing levels of institutionalization especially in the US and later also in Europe. This created expectations to find new community-based rehabilitation approaches. The Clubhouse development started in the 1940s and the first "Fountain House" club was opened in New York in 1948. During its first two decades Fountain House focused on the creation of a rehabilitation model which could demonstrate better individual level recovery outcomes than other forms of community-based services. During the 1970s the Fountain House type of Clubhouses started to disseminate first in the US and in Canada, and since 1980 also in Europe and other continents.

International Standards and ICCD as the coordinator for global development

At the end of the 1980s the first version of International Standards for Clubhouse Programmes was published and since that they are developed by using "the open innovation" procedure. The international Clubhouse community in its biannual seminars decides on any changes in the Standards. Based on the growing global interest in Clubhouses, the International Center for Clubhouse Development (ICCD) was established 1994 in Fountain House New York. ICCD became legally independent not-for-profit corporation in 2012. As an affiliation of the ICCD, the European Partnership for Clubhouse Development (EPCD) was established in 2011.

International recommendations for community-based services

During the 1990s the United Nations published its recommendations on how to develop mental health care systems towards a more community-based direction (UN 1991), and the Standard Rules for Equalizing Opportunities for People with Disabilities, which also included people with mental disorders (UN 1993). The three UN expert organizations WHO, ILO and UNESCO published during the 1990s their first joint discussion paper on community-based rehabilitation, its revised version in 2004, and finally approved the CBR guidelines in 2010. In 2006 the UN General Assembly approved a new Convention on Human Rights of Persons with Disabilities and Optional Protocol, which is legally binding to all member states who ratify the Convention (UN 2006).

In addition, WHO published in 2003 – 2009 a series of guide books called Publications of mental health policy and service guidance package. The Clubhouse model was one example of community-based services as a part of the "optimal mix of mental health services" (WHO 2003b). Later the optimal mix was renamed the WHO Pyramid Framework (WHO 2007). Parallely the Council of Europe (CoE 2004), WHO Regional Office for Europe (WHO 2005b) and the European Union (EU 2008 & 2011) published their own political recommendations on how to strengthen community-based mental health policy and services.

Empowerment, community-based rehabilitation, social capital and the Clubhouse model

Empowerment research and interventions link individual well-being with the larger societal and political context and not solely in the medical world. In the area of mental well-being, empowerment connects mental health to mutual help, trust, self-confidence, social relationships, self-determination and participation. Empowering interventions such as Clubhouses enhance wellness while they also aim to solve problems, provide opportunities for participants to develop knowledge and skills, and engage professionals as collaborators instead of authoritative experts. Empowerment is an

important element of human development by taking control and responsibility for actions that have the intent to lead to fulfillment of personal potentials. This combines four dimensions: (1) self-reliance, (2) participation in decisions, (3) dignity and respect, (4) sense of belonging and contributing to a wider community.

Community-Based Rehabilitation (CBR) is a strategy for enhancing the quality of life of people with disabilities by improving services, providing more equitable opportunities and protecting their rights. CBR builds on the full involvement of people with disabilities and their families in all decisions. CBR guidelines are global and applicable in all countries in the world, although practical solutions need to be differentiated according to the available resources in different settings. Multiprofessional, multi-stakeholders' and multisectoral collaboration is important in all CBR activities. The International Standards for Clubhouse Programmes are based on similar principles. In order to realize the positive recovery support and empowerment outcomes for their members Clubhouses have to create a cooperation network which consists of funding agencies, educational institutions, public and private employers' representatives, other mental health and public health agencies, social services experts, relevant mental health NGOs, and so on.

Recovery approaches: A number of key elements promote and support recovery from long-term mental health problems. These include creating the conditions which foster hope and belief that change is possible and thus give purpose to people's lives. Recovery is a unique and individual experience and while there may be common themes and experiences, no two person's recovery journeys will be identical. Scottish elements for recovery, consensus statement on recovery in the USA, and whole person recovery approach include same coinciding factors. The whole person recovery includes the experiences of service users participating in the design of services they need. The recovery capital is defined as the total of personal, social and community resources that someone can call on to aid recovery. The Clubhouse activities are coincident with the mentioned elements. Clubhouses are also recovery communities.

The concept of social capital refers to features of social life such as positive networks, cooperation between different social actors, trust and confidence in institutions, sense of belonging, solidarity and reciprocity of interaction. Self-help and peer support groups, which can empower people with mental disorders to cope with different life crises and/ or symptoms, are important elements in this context. The Clubhouse model is based on evidence that people with mental health problems can successfully participate in society through learning opportunities, education, employment, friendships and other social activities.

Evidence on the positive outcomes of the Clubhouse model

Clubhouses offer people hope and opportunities to achieve their full human potential, and they support members in creating social capital, a sense of belonging and a sense of community. Personal stories of Clubhouse members and their families and the

increasing body of research from different continents and cultures provide evidence that Clubhouses are a holistic, inspiring, human rights based, empowering and cost-effective solution for people living with mental health conditions.

According to available research evidence, ICCD Clubhouses achieve the following tangible results for their members and communities: Clubhouses promote members' recovery, participation in Clubhouse activities reduces hospital stays and hospital costs, regular participation helps members obtain community-based employment, and Clubhouses are cost-effective. Participation in Clubhouse activities improves well-being and physical and mental health of members and participation improves the quality of life in general.

Based on evidence, SAMSHA (USA Substance Abuse and Mental Health Services Administration) has approved the Clubhouse model as an evidence-based practice (http://www.nrepp.samhsa.gov/). Also in Finland the Clubhouse model has been approved by the National Institute for Health and Welfare (THL) as a good and cost-effective practice based on evaluation research. (http://www.sosiaaliportti.fi/fi-FI/ hyva-kaytanto/kuvaus/?PracticeId=7b66e441-fd65-4c39-8be4-cd7f15c28908). Since the 1980s the scientific community has produced growing evidence on the positive impacts of the Clubhouse model for recovery (http://www.umassmed.edu/clubhouse_research.aspx).

The Clubhouse model was approved in Finland (2009) as a part of National Mental Health Services Development Programme. According to the programme, the Clubhouse model should be taken into use in all Finnish mental health service districts. This means that in Finland the number of Clubhouses as compared to the situation in 2010 may be doubled by the year 2020. Also in Sweden, Denmark, Norway, Iceland and Scotland the Clubhouse model has been accepted to be part of the official national mental health development policies. However, the Clubhouse model is not yet available in about 150 countries worldwide, including 30 European countries. Knowledge transfer and dissemination activities are needed for awareness-raising on the positive potentialities of the Clubhouse model as means to the mental health reforms.

The most applicable mental health policy recommendation

Many of the international policy frameworks and recommendations are quite comprehensive, and some of them are complex. The most applicable one with the clearest message is the WHO Pyramid Framework for optimal mix of mental health services, complemented with the collaboration across the different sectors as recommended in the CBR guidelines jointly by the ILO, WHO and UNESCO (WHO 2010b). The main messages from this combined policy framework to provide the optimal mix for the local and regional mental health services are:

- Promote and organise self-care, peer support and coping skills of the persons in need;

- Mobilise local resources to involve service users in the activities offered by the community;
- Integrate mental health services into primary healthcare;
- Build and diversify community based mental health services (e.g. open new community mental health centres, residential units, CBR-services and Clubhouses, build up advisory councils where users and carers have a say and are listened to);
- Develop mental health services in general hospitals;
- Reduce the use of psychiatric hospitals and invest savings to community-based services; and
- Complement all above measures by coordination and collaboration e.g. with providers of education, housing, employment, social services and benefits agencies, police and courts of justice, service users' and carers' voluntary organizations and with other relevant voluntary associations.

ANNEX 1: Main policy recommendations and guidelines in years 2000 - 2011

Year	Organization launched	Main content of the recommendations
2001	World Health Organization: The World health report 2001	The report gave the evidence that Europe was still in year 2000 the leading continent of hospitalization with 9,3 psychiatric beds per 100 000 population in the whole world. This position has continued until today. • Governments need to set policies that will protect and improve the mental health of the population. Policies should be drawn up with the involvement of all stakeholders and based on reliable information. Policies should ensure the respect of human rights and take account of the needs of vulnerable groups. • Care should be shifted to community based services that are integrated into general health services and collaborating with other relevant sectors in the communities. • Psychotropic drugs need to be available, and the required professionals need to be trained. • The mass media and public awareness campaigns can be effective in reducing stigma and discrimination. • NGOs and user groups should also be supported, as they can be instrumental in improving service quality and public atti-tudes. • Mental health is as important as physical health to the well-being of individuals, local communities and countries.
2005	Mental Health Declaration for Europe: Facing the challenges, Building Solutions (WHO European Ministerial Conference on Mental Health, Helsinki 12-16 January 2005)	The main priorities for the decade until 2015 are to: • Foster awareness of the importance of mental well-being; • Collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process; • Design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery; • Address the need for a competent workforce, effective in all these areas; • Recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.
2005	Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions (WHO European Ministerial Conference on Mental Health, Helsinki 12-16 January 2005). The action plan includes 108 recommendations and 12 milestones.	The commitments centre on twelve key areas of action: • Promoting mental well-being for all; • Demonstrating the centrality of mental health; • Tackling stigma and discrimination; • Promoting activities sensitive to vulnerable life stages; • Preventing mental health problems and suicide; • Ensuring access to good primary care for mental health problems; • Offering effective care in community-based services for people with severe mental health problems; • Establishing partnerships across sectors; • Creating a sufficient and competent workforce; • Establishing good mental health information; • Providing fair and adequate funding; • Evaluating effectiveness and generating new evidence.

Year	Organization launched	Main content of the recommendations
2003 / 2007	The WHO MIND Project: Mental Improvement of Nations Development The Optimal Mix of Services for Mental Health. WHO pyramid framework.	The optimal mix of services for mental health. First published in the WHO publication on the Organization of services for mental health. Publication of mental health policy and service guidance package (2003b: 34). Pyramid framework was revised in 2007. WHO key recommendations for mental health policy development are: • Promote and organise self care management; • Build informal community mental health services; • Integrate mental health services into primary health services; • Build community mental health centres and other community based services (e.g. day centres, clubhouse services, occupational activities, sheltered workcentres, supported employment and social enterprises); • Develop mental health services in general hospitals; and • Limit the use of traditional mental hospitals.
2006	UN Convention on the Rights of Persons with Disabilities and its Optional Protocol, approved 13 December 2006, and entry into force 3 May 2008	What is unique about the new Convention: • It is both a development and human rights instrument; • It is a policy instrument which is cross-disability and cross-sectorial; • It is legally binding of the member states; • Purpose of convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity; • Article 1 of the convention states that persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments and attitudinal and environmental barriers that hinders full or effective participation in society on an equal basis with others; • The convention confirms major part of the 1993 resolution about the Standard rules of equalizing the opportunities for people with disabilities; • Participation is important to correctly identify specific needs, and to empower the individuals; • Full and effective participation and inclusion in society is recognized in the Convention as (1) a general principle, (b) a general obligation, and (3) a right; • The convention includes 50 paragraphs and the optional protocol; • In the follow-up the National Human Rights Institutions play an important role; • So far, only in very few countries and/or regions the UN convention has been implemented;
2008	European Pact on Mental Health	European Council and European Commission decided after the launch of so-called Green Paper on Mental Health in May 2005 that the EU level mental health policy should be promoted by a joint operation between EU Commission and the member states. This consultation resulted a joint decision on the European Mental Health Pact, which was approved by EU institutions during the years 2007 and 2008. This new approach was launched in a high level of European mental health conference in June 2008 in Brussels. More information available: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

ANNEX 2: International Standards for Clubhouse Programmes, 2012 edition

The International Standards for Clubhouse Programs, consensually agreed upon by the worldwide Clubhouse community, define the Clubhouse Model of rehabilitation. The principles expressed in these Standards are at the heart of the Clubhouse community's success in helping people with mental illness to stay out of hospitals while achieving social, financial, educational and vocational goals. The Standards also serve as a "bill of rights" for members and a code of ethics for staff, board and administrators. The Standards insist that a Clubhouse is a place that offers respect and opportunity to its members.

The Standards provide the basis for assessing Clubhouse quality, through the International Center for Clubhouse Development (ICCD) accreditation process. Every two years the worldwide Clubhouse community reviews these Standards, and amends them as deemed necessary. The process is coordinated by the ICCD Standards Review Committee, made up of members and staff of ICCD-certified Clubhouses from around the world.

MEMBERSHIP

1. Membership is voluntary and without time limits.
2. The Clubhouse has control over its acceptance of new members. Membership is open to anyone with a history of mental illness, unless that person poses a significant and current threat to the general safety of the Clubhouse community.
3. Members choose the way they utilize the Clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.
4. All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.
5. Members at their choice are involved in the writing of all records reflecting their participation in the Clubhouse. All such records are to be signed by both member and staff.
6. Members have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a threat to the Clubhouse community.
7. The Clubhouse provides an effective reach out system to members who are not attending, becoming isolated in the community or hospitalized.

RELATIONSHIPS

8. All Clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed.

9. Clubhouse staff are sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement.

10. Clubhouse staff have generalist roles. All staff share employment, housing, evening and weekend, holiday and unit responsibilities. Clubhouse staff do not divide their time between Clubhouse and other major work responsibilities that conflict with the unique nature of member/staff relationships.

11. Responsibility for the operation of the Clubhouse lies with the members and staff and ultimately with the Clubhouse director. Central to this responsibility is the engagement of members and staff in all aspects of Clubhouse operation.

SPACE

12. The Clubhouse has its own identity, including its own name, mailing address and telephone number.

13. The Clubhouse is located in its own physical space. It is separate from any mental health center or institutional settings, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.

14. All Clubhouse space is member and staff accessible. There are no staff only or member only spaces.

WORK-ORDERED DAY

15. The work-ordered day engages members and staff together, side-by-side, in the running of the Clubhouse. The Clubhouse focuses on strengths, talents and abilities; therefore, the work-ordered day must not include medication clinics, day treatment or therapy programs within the Clubhouse.

16. The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems.

17. The Clubhouse is open at least five days a week. The work-ordered day parallels typical working hours.

18. The Clubhouse is organized into one or more work units, each of which has sufficient staff, members and meaningful work to sustain a full and engaging work-ordered day. Unit meetings are held to foster relationships as well as to organize and plan the work of the day.

19. All work in the Clubhouse is designed to help members regain self worth, purpose and confidence; it is not intended to be job specific training.

20. Members have the opportunity to participate in all the work of the Clubhouse, including administration, research, enrollment and orientation, reach out, hiring,

training and evaluation of staff, public relations, advocacy and evaluation of Clubhouse effectiveness.

EMPLOYMENT

21. The Clubhouse enables its members to return to paid work through Transitional Employment, Supported Employment and Independent Employment; therefore, the Clubhouse does not provide employment to members through in-house businesses, segregated Clubhouse enterprises or sheltered workshops.

TRANSITIONAL EMPLOYMENT

22. The Clubhouse offers its own Transitional Employment program, which provides as a right of membership opportunities for members to work on job placements in the labor market. As a defining characteristic of a Clubhouse Transitional Employment program, the Clubhouse guarantees coverage on all placements during member absences. In addition the Transitional Employment program meets the following basic criteria:
    a) The desire to work is the single most important factor determining placement opportunity.
    b) Placement opportunities will continue to be available regardless of the level of success in previous placements.
    c) Members work at the employer's place of business.
    d) Members are paid the prevailing wage rate, but at least minimum wage, directly by the employer.
    e) Transitional Employment placements are drawn from a wide variety of job opportunities.
    f) Transitional Employment placements are part-time and time-limited, generally 15 to 20 hours per week and from six to nine months in duration.
    g) Selection and training of members on Transitional Employment is the responsibility of the Clubhouse, not the employer.
    h) Clubhouse members and staff prepare reports on TE placements for all appropriate agencies dealing with members' benefits.
    i) Transitional Employment placements are managed by Clubhouse staff and members and not by TE specialists.
    j) There are no TE placements within the Clubhouse. Transitional Employment placements at an auspice agency must be off site from the Clubhouse and meet all of the above criteria.

SUPPORTED AND INDEPENDENT EMPLOYMENT

23. The Clubhouse offers its own Supported and Independent Employment programs to assist members to secure, sustain and subsequently, to better their employment. As a defining characteristic of Clubhouse Supported Employment, the Clubhouse maintains a relationship with the working member and the employer. Members and staff in partnership determine the type, frequency and location of desired supports.

24. Members who are working independently continue to have available all Clubhouse supports and opportunities including advocacy for entitlements, and assistance with housing, clinical, legal, financial and personal issues, as well as participation in evening and weekend programs.

EDUCATION

25. The Clubhouse assists members to reach their vocational and educational goals by helping them take advantage of adult education opportunities in the community. When the Clubhouse also provides an in-house educational program, it significantly utilizes the teaching and tutoring skills of members.

FUNCTIONS OF THE HOUSE

26. The Clubhouse is located in an area where access to local transportation can be assured, both in terms of getting to and from the program and accessing TE opportunities. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.

27. Community support services are provided by members and staff of the Clubhouse. Community support activities are centered in the work unit structure of the Clubhouse. They include helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in finding quality medical, psychological, pharmacological and substance abuse services in the community.

28. The Clubhouse is committed to securing a range of choices of safe, decent and affordable housing including independent living opportunities for all members. The Clubhouse has access to opportunities that meet these criteria, or if unavailable, the Clubhouse develops its own housing program. Clubhouse housing programs meet the following basic criteria:
    a) Members and staff manage the program together.
    b) Members who live there do so by choice.
    c) Members choose the location of their housing and their roommates.
    d) Policies and procedures are developed in a manner consistent with the rest of the Clubhouse culture.
    e) The level of support increases or decreases in response to the changing needs of the member.

f) Members and staff actively reach out to help members keep their housing, especially during periods of hospitalization.

29. The Clubhouse conducts an objective evaluation of its effectiveness on a regular basis.

30. The Clubhouse director, members, staff and other appropriate persons participate in a comprehensive two or three week training program in the Clubhouse Model at a certified training base.

31. The Clubhouse has recreational and social programs during evenings and on weekends. Holidays are celebrated on the actual day they are observed.

FUNDING, GOVERNANCE AND ADMINISTRATION

32. The Clubhouse has an independent board of directors, or if it is affiliated with a sponsoring agency, has a separate advisory board comprised of individuals uniquely positioned to provide financial, legal, legislative, employment development, consumer and community support and advocacy for the Clubhouse.

33. The Clubhouse develops and maintains its own budget, approved by the board or advisory board prior to the beginning of the fiscal year and monitored routinely during the fiscal year.

34. Staff salaries are competitive with comparable positions in the mental health field.

35. The Clubhouse has the support of appropriate mental health authorities and all necessary licenses and accreditations. The Clubhouse collaborates with people and organizations that can increase its effectiveness in the broader community.

36. The Clubhouse holds open forums and has procedures which enable members and staff to actively participate in decision making, generally by consensus, regarding governance, policy making, and the future direction and development of the Clubhouse.

International Center for Clubhouse Development (ICCD)
New York, New York 10036, USA Telephone: ++1 212 582 0343, Fax: ++1 212 397 1649
Web: www.iccd.org October, 1989 © Revised as of March, 2012.

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http://www.who.int/mental_health/resources/policy_services/en/
(directory of WHO documents)
http://www.who.int/mental_health/resources/en/context.PDF (2003a)
http://www.who.int/mental_health/resources/en/Legislation.pdf (2003b)
http://www.who.int/mental_health/resources/en/Advocacy.pdf (2003c)
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http://www.who.int/mental_health/resources/en/Quality.pdf (2003e)
http://www.who.int/mental_health/policy/mental_health_Policy_final_update.pdf (2004)

WHO resource book on mental health, human rights and legislation:
(http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf (2005)

WHO: The optimal mix of services for mental health (2007):
http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf

WHO guide Improving health systems and services for mental health: http://www.who.int/mental_health/policy/services/mhsystems/en/index.html (2009)

The role of international human rights in national mental health legislation (by Eric Rosenthal & Clarence J. Sundram):

http://www.who.int/mental_health/policy/international_hr_in_national_mhlegislation.pdf (2004)

United Nations 2006 Convention on the rights of people with disabilities:
http://www.who.int/disabilities/media/news/unconvention/en/index.html
http://www.un.org/disabilities/default.asp?id=259

United Nations' Standard rules on equalization of opportunities for people with disabilities:
http://www.un.org/esa/socdev/enable/dissre00.htm (1993)

Empowerment: What is it? (Article in Journal of Extension 1999, Vol. 37, number 5; by Page, N. and Czuba, C.E.): http://www.joe.org/joe/1999october/comm1.php

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http://www.euro.who.int/__data/assets/pdf_file/0009/128088/Factsheet_MNH_Empowerment.pdf (November 2010)

Community-based rehabilitation (CBR) guidelines, launched in October 2010 by WHO (a series of 7 booklets and CBR matrix):

http://www.who.int/disabilities/cbr/guidelines/en/ (2010)
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World Health Organization (2010): Community-based rehabilitation (CBR) guidelines. Crosscutting empowerment booklet. http://whqlibdoc.who.int/publications/2010/9789241548052_empower_eng.pdf

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WHO-Europe and European Commission. Baseline report on the 2005 Helsinki Declaration Assessment:
http://www.euro.who.int/__data/assets/pdf_file/0006/96450/E91732.pdf (2008)

Clubhouse model as means to individual empowerment and social inclusion:
ICCD – International Center for Clubhouse Development → http://www.iccd.org/
How ICCD clubhouses can help? → http://www.iccd.org/how.html
International directory of ICCD clubhouses → http://www.iccd.org/search_form.php
The program for clubhouse research
→ http://www.umassmed.edu/cmhsr/clubhouse_research.aspx
Cost-effectiveness of clubhouse model → http://www.iccd.org/effectiveness.html

Clubhouses in Europe:
European Partnership for Clubhouse Development (EPCD, registered in 2001)
→ http://www.epcd.info
Clubhouse development in Europe/EPCD (2007 – 2010)
→ http://www.elect-project.eu/epcd.html
Clubhouse development in Europe/ELECT-project (2007 – 2009)
→ http://www.elect-project.eu
Empowering Adults with Mental Illness for Learning and Social Inclusion
(EMPAD, 2011 - 2012)
→http://www.empad-project.eu

ICCD training bases in Europe:
1. Mosaic Clubhouse, London UK.
→ http://www.mosaic-clubhouse.org/about.asp?lAboutUsID=4
2. Helsinki Clubhouse (Helsingin klubitalo), Helsinki Finland
→ http://www.helsinginklubitalo.org/index.php?page=english