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ORIGINAL PAPER

Promoting Personal and Social Recovery in Older Persons with Schizophrenia: The Case of The New Club, a Novel Dutch Facility Offering Social Contact and Activities

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Abstract
Many older community-living persons with schizophrenia report unmet psychological and social needs. The Amsterdam-based New Club is a novel facility that intends to foster self-reliance and social participation in this group. To explore participants' and staff perceptions, a naturalistic qualitative study combined participant observation with interviews. The results illustrate how the New Club contributes to the personal and social recovery of its participants. At the personal level, attending the facility, activation and feeling accepted were valued positively. At the social level, engaging with others, experiencing a sense of community, and learning from one another's social skills were positive contributors. Next, various environmental factors proved important. The New Club demonstrates the feasibility of creating a facility that offers an accepting and non-demanding social environment to older community-living individuals with severe mental illnesses. It may offer a suitable alternative for the more demanding psychotherapeutic interventions offered to younger populations.

Keywords Schizophrenia · Older · Recovery · Personal · Social · Qualitative

Introduction

People aged 55 years and older will soon represent a fourth or more of individuals with schizophrenia, with the large majority residing in the community (Cohen et al. 2015a). Most older persons with schizophrenia developed the disorder at a relatively young age (Meesters et al. 2012). Although the intensity of psychotic symptoms tends to subside with ageing, only a minority attains permanent symptomatic remission (Meesters et al. 2011; Cohen and Iqbal 2014). Likewise, not more than 30% acquire a persisting non-depressed state (Cohen and Ryu 2015b; Meesters et al. 2014). Most older persons with schizophrenia have longstanding and substantial cognitive deficits, although in the large majority cognition does not decline more rapidly than in their age peers (Thompson et al. 2013). Interacting with the accelerated aging in schizophrenia (Jeste et al. 2011), many older persons suffer from physical comorbidity. The excess mortality reported for younger individuals with schizophrenia continues into older age, although at a somewhat lower level (Meesters et al. 2016). Accordingly, older persons can be viewed as a selective subset having survived into old age with an illness as severe and disruptive as schizophrenia.

In contrast with these sobering clinical facts, the social picture of older persons with schizophrenia is a more mixed one (Cohen et al. 2009). While many have to cope with the social scars and losses dating back to earlier stages of their disorder (e.g., small social networks, less education, lower income; Meesters et al. 2010), a substantial number may profit more from social opportunities than at earlier stages of

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their disease. Improvement in coping skills probably is one of the contributors to this shift in social perspective (Cohen et al. 2011). This concurs with general findings of the positive contribution of adaptive coping styles to resilience over the life span (Lerner et al. 2012). Resilience relates to the ability to overcome or bounce back from adversity. In advanced age, resilience is characterized by the balance between losses, restrictions and vulnerability on one side, and potential gains based upon wisdom, experience and social support on the other (Hayman et al. 2017). It has been suggested that in a substantial minority of older individuals with schizophrenia resilience levels may be comparable to healthy age peers (Edmonds et al. 2018). Resilience is among the predictors of quality of life in severe mental illnesses (Hofer et al. 2017). Remarkably, subjective quality of life may improve in later life schizophrenia (Cohen et al. 2017; Folsom et al. 2009). Still, there is a strong heterogeneity in how individuals perceive their actual functioning and what they expect of their future, ranging from despair through resignation to optimism (Shepherd et al. 2012).

In recent years, the concept of recovery in severe mental illnesses has generated growing interest (Wood and Alsawy 2018). Originating in the self-help and mutual support consumer movement, recovery nowadays is coming forward as a guiding vision also among formal health systems (Davidson 2016). Recovery refers primarily to the processes by which people living with mental illnesses find their own ways to minimize the disabilities associated with these conditions, striving for a life with meaning and purpose. While personal recovery focuses on the intra-individual process, social recovery relates primarily to the restoration of one's social functioning. In recovery based practices, emphasis is not put on disabilities or restrictions, but on strengths and self-determination. As yet, little attention is given to older individuals living with these disorders. Often they are seen as 'lost cases', a view dictated by stereotypes about both mental illness and age (Graham et al. 2003). Nonetheless, a number of North American publications reported promising effects of recovery promoting interventions in later life (Pratt et al. 2008). Regrettably, there still is a wide science-to-service gap (Drake and Essock 2009), with few older persons having access to these innovative approaches.

In a study into the care needs of older individuals with schizophrenia living in the southern district of Amsterdam, The Netherlands (Meesters et al. 2013), psychological and social needs were met significantly less often than environmental and physical needs, according to both the participants and their treating staff. Studies in the USA (Auslander and Jeste 2002), Great Britain (McNulty et al. 2003) and Australia (Futeran and Draper 2012) reported similar findings. In addition, the Amsterdam based study found a strong correlation between the total amount of unmet needs (as reported by the participants) and their subjective quality of life, explaining 36% of the variance in unmet needs (Meesters et al. 2013).

In response to these findings The New Club was founded in 2011, as a novel facility offering a welcome and non-demanding social environment to older (age 60 and over) individuals with severe mental illnesses (mostly schizophrenia). The New Club offers activities with the aim to promote self-reliance and social participation, and to contribute to the resilience of its participants. The New Club is situated in a community center in an old and lively neighborhood, aiming to avoid the connection to a mental health service and to facilitate the exchange with other age groups that take part in activities of the center. The New Club is a collaboration of the local mental health organization (GGZ inGeest) and a welfare service (Combiwel), while the local council supplies funding. To attend The New Club individuals living in the southern district of Amsterdam and aged 55 years or over have to be diagnosed with a severe mental illness. Exclusion criteria are physical disabilities that require intense staff supervision, and behavorial disturbances that are estimated as being too disruptive for other group members. However, when the staff has doubts whether a new applicant will be able to participate in a constructive manner, he or she is invited on a provisional basis to give it a chance. A relatively stable pool of around 20 participants attend The New Club, most of which live independently while some reside in a sheltered home. When necessary, participants are offered subsidized collective taxi transport to attend meetings. The age of participants varies between 60 and 80 years, with a mean around 70 years. Men are slightly overrepresented in comparison to women. The three main components of The New Club are: (1) weekly daytime activities (e.g. fitness, painting, games) combined with lunch, (2) weekly dinner, including cooking, (3) weekly outings (e.g. cinema, hikes, museum visits). Whenever possible, participants are given the lead in the choice and design of the employed activities. While some participants engage in all three components, most take part in either one or two activities. Compliance with attendance is relatively high, with most participants only refraining from visiting because of physical illnesses or other appointments. The New Club has a total capacity to attend to around 20 participants. Drop-out from The New Club is relatively low and mostly concerns either individuals who after one or two visits refrain from attending (often because they judge the other attendees as being too "mental"), or persons who after having visited The New Club for an extended period find it no longer has added value for them, often because they have joined other social activities. The activities are coordinated and supervised by experienced and well-trained activity coordinators (mostly social welfare workers) who are joined by a number of volunteers that are selected on the basis of their motivation and availability for a longer period of time. The mental health

organization provides an experienced psychiatric nurse who on a bimonthly basis coaches the staff of the facility.

Here we report the results of a qualitative study that aimed to clarify the specific aspects of The New Club that may promote personal and social recovery in its participants. The study used a qualitative design, intending to gain varying perspectives on the issues under investigation.

Methods

The study took place at The New Club from October 2014 to July 2015. It employed a naturalistic qualitative approach (Lincoln and Guba 1985), which implies that subjects are studied in their natural habitat while avoiding manipulation by researchers (Abma and Stake 2014; Green and Thorogood 2004). The design was not preset, but relevant 'issues' emerged in conversation with participants. This approach was chosen in order to gain insight into the lived experiences of participants in the context of the daily, natural flow of activities and events at The New Club, while keeping disruptions of daily activities and the burden for the participants to a minimum. A naturalistic, qualitative approach is preferred over more traditional methods of investigation (e.g. questionnaires) as these can pose barriers for people with severe mental illnesses to express themselves (Abma 1998).

Data Collection

The methods of data collection that were applied in this study included participant observation and interviews. Participant observation was applied as a method to gain insight into behavior and communication of participants as well as social interactions between them. In the context of this study two researchers acted as participants observers and were present at The New Club for 7 months as volunteers and assisted on a weekly basis in different activities. As The New Club has been working with volunteers from the start, the presence of the researchers did not bring about fundamental changes to its set-up. Observations were registered in the form of observation notes and structured with the help of an observation topic guide.

Interviews were held in order to gain insight into the lived experiences with and meaning of The New Club for individual members and for the activity coordinators. The interview phase started approximately 1 month after the start of the participant observation, in order to first invest time in establishing rapport between the researchers and people with a psychiatric vulnerability (as recommended by Abma 1998). Two types of interviews took place: open, conversational interviews (Kvale 1996) and semi-structured interviews. The open interviews were informal conversations within the setting of The New Club with 10 participants (Table 1).

Table 1 Characteristics of study participants

	Age	Diagnosis	Residency
Mrs. A	59	Schizophrenia	Independent
Mr. B	62	Schizophrenia	Sheltered
Mrs. C	63	Schizoaffective disorder	Independent
Mr. D	68	Schizophrenia	Independent
Mrs. E	69	Not available	Independent
Mr. F	69	Schizophrenia	Independent
Mr. G	70	Schizoid personality disorder	Independent
Mrs. H	71	Schizoaffective disorder	Independent
Mr. I	81	Schizoaffective disorder	Independent
Mrs. J	82	Schizoaffective disorder	Sheltered

During these interviews, experiences and opinions were broadly explored. Participants were selected based on diversity with respect to their role and involvement in the activities according to the observations made. This translated to the inclusion of participants who had a more active role as well as those who were more passively involved. Also, some interviewees attended one of the activities (daytime activities, dinner or outings), while others attended two or three of the activities. The open interviews had a duration of approximately 30 min. If the participant had attention problems, two shorter interviews took place instead of one. After the open interviews, eight semi-structured interviews took place: four with participants (who all had previously participated in the open interviews) and four with activity coordinators. The four participants were selected based on the information provided by them in the open interview, aiming to include participants with a variety of experiences and perspectives. The activity coordinators who participated were the social workers who were primarily responsible for organizing and guiding the activities. The interviews provided the opportunity to explore in depth prominent themes that had emerged from the open interviews. The semi-structured interviews followed a similar structure for participants and activity coordinators with 'personal recovery', 'social recovery' and 'organizational aspects' as the main interview themes. Participants were asked to speak from their own experience, while activity coordinators reflected on their experiences with the participants and the role of the facility. The interviews with participants took place in their homes, while interviews with coordinators were held in their work setting. All semi-structured interviews were tape-recorded and transcribed.

Analysis

Analysis of the observation and interview data took place in two phases following an iterative process of data collection and analysis (Green and Thorogood 2004). First data

from observations from the first months and from the open interviews were analyzed. This was done by carefully reading all observation and interview notes (Pope et al. 2000). Three main themes were established and several preliminary sub-themes. The main themes were: 'personal resources of recovery', 'social resources of recovery' and 'organizational factors'. These three themes and preliminary subthemes informed the set-up of the semi-structured interviews and the analysis thereof. The analysis showed that the data from the semi-structured interviews fitted the pre-established main themes and helped to finalize preliminary subthemes as well as identifying several additional subthemes.

Quality Procedures

With data collection, the principle of 'saturation' was used (Meadows and Morse 2001). This is the point at which no new notions, aspects or understandings are yielded, after which no new participants are recruited. A 'member check' was used to guarantee the internal validity (Barbour 2001). During one of the gatherings of The New Club a summary of the themes and interpretations from the interviews was presented to participants who were invited to provide feedback. As they had no crucial comments this did not lead to any changes or additions in the concept themes and descriptions. Furthermore, data triangulation was used for internal validity (Meadows and Morse 2001), with data obtained both from participants and activity coordinators. Also, several ways of data collection were used; both participant observation, open and semi-structured interviews. The researchers (LvdH and MD) kept a logbook of their experiences during the study to remain aware of their own 'frames' and their potential influence on the study. The coding of the material was conducted by at least two people and discussed to guarantee interrater reliability. For the purpose of guaranteeing external validity, the researchers tried to give a 'thick description' of the specific context of the study. This way readers themselves can assess to what extent the results can be generalized to other settings (Abma and Stake 2014).

Ethics

Before data were collected, the participants of The New Club were informed of the study's objective and procedures. Understanding of the information was verified by asking the participants to repeat this in their own words. Next they were requested to provide informed consent either verbally or in writing, depending on their preference. In addition, two experiential experts were consulted during three meetings about the research set-up, data collection and interpretation of preliminary findings. The experiential experts were older people who had personal experience with a severe mental illness. They were specifically consulted about the suitability and feasibility of the research design and methods for the target group. The research proposal was approved by the Medical Ethical Committee of the VU Medical Center.

Results

Personal Resources of Recovery

The facility appeared to tap into personal resources of recovery in three different ways. First of all, it contributes to activation of its participants by offering them something meaningful to do and somewhere to go. For several managing to attend the activities already feels like a substantial accomplishment. One participant said:

> .. it is a good moment when you enter, it's like 'I actually managed to come', that's my feeling, that you finally got somewhere, because I always think 'where should I go to?'. (Mrs. C, 63 years)

Activation also takes place through the activities themselves. Participants are invited to participate in relatively easy daily activities, such as grocery shopping or cooking. By doing such things, people may engage in activities that are new for them or practice skills that they neglected for many years. However, activation is not always easy to achieve. One activity coordinator explained: "I think people need to be pushed a little. They can be quite passive". After attending the activities for a while, participants often start to take more initiative, for example by bringing recipes or materials from home, proposing specific activities or spontaneously and independently undertaking tasks. An activity coordinator:

> Now she (participant) gets here by herself with the taxi and she takes much more initiative. I told her psychiatric nurse about all the things she does here and the nurse was flabbergasted, because she considers her to be a passive person.

Participants showed to gain self-confidence and trust by participating in the facility. They all have their own peculiarities, routines and preferences. One might always want to sit in the same chair, while the other has a permanent grumpy disposition and another has an endless repertoire of jokes. Still, there is a general acceptance of all kinds of—sometimes odd—behaviors. A participant:

> You feel like you are supported, a trusted shoulder. I think you don't have to be afraid that they would do something to you on purpose or laugh at you… a safe place, where you don't stand out if you behave a little strange… (Mrs. C, 63 years)

Some participants mentioned feeling somewhat uncomfortable at the facility, which also limits their participation. A participant:

> I do have a little bit of confidence, but not really at the facility. I do not feel completely at ease and I should engage more with other people. If I was at ease I would be more fun and chat, talk and laugh with everybody. (Mrs. A, 59 years)

By attending the activities of the facility, participants are regularly confronted with unexpected situations and changes in the program. Examples are a sudden ringing of the fire alarm or changes in coordinators, volunteers and participants. Such factors elicit various reactions from the participants: they may become nervous, others withdraw and others may stick to the activity coordinator. Participants always seem to find their balance again, although this takes longer for some than for others. Often their reactions are milder than expected by activity coordinators and care professionals, who generally expect older persons with severe mental illnesses to have great difficulty in dealing with change. The activity coordinators suggest that the safe environment of the facility helps its participants in adapting to change. A participant:

> A friend of mine recently passed away. They really paid attention to this on Monday and I appreciated this very much. (Mrs. E, 69 years)

Social Resources of Recovery

The facility fulfills a social purpose of recovery in various ways. For some participants it is a first and big step to be among other people and to feel comfortable in such a social situation. For a majority of the participants social contacts go further than just being among people. For them conversations and connecting to others are among the main benefits of participating. A participant:

> I really feel like I know the people, while I've just met them there [The New Club]. I just have a strong connection with them and that's great. (Mrs. E, 69 years)

The participants appear to care for each other and to be concerned with each other's wellbeing. They often ask about each other when someone is absent or ill. An activity coordinator:

> There was someone who broke her leg. Even though this is not the most talkative person of the group, the other participants missed her a lot. She did not come for three months and they often asked about her.

However, some participants felt that conversations during the activities still remained quite superficial and they would like to have more intimate conversations with others:

> Sometimes I would like to know something more personal about someone than just their body and face. (Mrs. C, 63 years)

Social contacts that developed during the activities, sometimes lead to contacts outside of the facility. Some participants engage in activities together and eventually become friends. An activity coordinator:

> The fact that someone is doing much better, has more social contacts and goes on a holiday, that is wonderful. It is great to see that this is possible. They meet up with each other to go swimming. I think this is the best result you can get.

Interacting with others requires a certain social flexibility from the participants, as they are confronted with each other's peculiarities, differences of opinions and critical comments. Sometimes this creates tensions between participants. However, this seldom escalates, either because of interference of the activity coordinator, or because of the flexibility of the participants themselves. By feeling that they are a member of the same group, it seems that they develop a shared responsibility to make sure that everything goes well. A participant:

> What I think is quite special, is the sense of community. That everybody is able to relate to each other, to solve things and to have dinner together, and divide tasks, such as doing the dishes, evenly. (Mr. B, 62 years)

Another participant however felt that tasks were not always equally divided and expressed some agitation about this:

> Actually we should do this all together, but the men don't do anything. I think this is strange. For example [male participant] may say: 'quick, quick, is dinner ready yet? Don't use so much salt!' But he doesn't do anything. (Mrs. A, 59 years)

In addition, participants learn from each other by observing each other's behavior. This helps some of them to reflect on their own behavior and adapt it accordingly, or they may learn new skills by copying others.

The facility not only contributes in connecting participants with each other, it also supports them in engaging with other aspects of society. The location, which is shared with other groups (other older people, children and youth) plays a role in this. The weekly outings appear to have an additional social function. Participants expand their social activities and visit places that they had not been to in a long time. The

activity coordinators play a key role in this, by suggesting options for activities—after which participants decide what to do—and taking care of practical matters such as transportation, fees and planning. However, it should be noted that not all participants are in the position to join these activities as this can physically or mentally be too strenuous for them.

Care and Environmental Factors Related to Recovery

Several organizational aspects appear to play a role in the mobilization of resources of recovery. The activity coordinators intend to focus on the abilities of participants, and not on their disabilities. This requires them to tailor their approach to the individual characteristics of participants. An activity coordinator:

> Certain people I can ask to go grocery shopping, and for others I am already happy if they peel the potatoes. The fact that one person can do something, does not mean that another person has to do the same thing. And that is what I always try to emphasize.

The facility tries to create a stimulating and flexible environment, while valuing group processes. Participants are facilitated to make their own plans and choices, for example with respect to smoking or leaving early. However, they also recognize that they are part of a group and may have to adapt to this. A participant:

> I feel like I can do things in my own way. But it depends, because it is also important to do the same thing as the group. You have to make sure that you cut [vegetables] as fast as the others. You have to adjust to the others. (Mrs. A, 59 years)

According to the activity coordinators, providing a safe environment is of major importance for the participants. If they feel secure it is easier to do something that they find scary or difficult. However, some participants express different needs than others with respect to security and protection. While some seek much confirmation from activity coordinators, others emphasize their autonomy. Several participants explained that they do not appreciate it when decisions are being taken for them or when they are not taken seriously. A participant:

> They hold back the bread, cheese and spread in case you might already start eating. It makes me think: 'how typical, we are no longer children.' (Mrs. C, 63 years)

For some participants their connection with the activity coordinators and how they are approached by them appear to play a key role on their motivation to keep coming to the facility or to stay away. This is illustrated by a participant who mentioned about a coordinator with whom she had a negative experiences: "If she stays, I will stop, then I will leave", and about another one who she highly appreciated: "If she would leave, I am not sure I would continue to come" (Mrs. E, 69 years).

During the interviews a number of environmental aspects where mentioned that were considered as important preconditions for the success of the facility. First of all, the accessibility was very relevant for participants, especially for those with impaired mobility. Spatial aspects of the facility were also considered important. Participants want to feel comfortable, they dislike cramped spaces and some wanted to have the possibility to go smoking. Some participants stated that the room which is used for the activities is too crowded for them. A participant:

> That room is so small, you sit very close together… a small space with too many people. (Mrs. C, 63 years)

Another crucial aspect was the financial accessibility. While the facility is mainly run on funding supplied by the local council, participants contribute with a small fee which they all find reasonable. Some mentioned the fact that getting a good meal for a small amount of money was also an important reason to come.

Discussion

This study illustrates how The New Club contributes at various levels to the personal and social recovery of its participants. It also demonstrates the feasibility of such a facility to offer an accepting and non-demanding social environment to older individuals with severe mental illnesses.

At the personal level, it is noteworthy that participants may profit from very basic achievements. This is well illustrated by the observation that for some attending the facility is a positive accomplishment of its own. Many older persons with schizophrenia are confined to their homes, due to psychological restraints (like paranoia or anxiety) or physical limitations. Overcoming this barrier by visiting the facility may generalize to other outdoor activities. The weekly outings offered by the facility can further stimulate this process. Next, the feeling expressed by participants that at the facility they can be who they are comes into view as a crucial aspect. Related to the exceptional nature of their experiences, many older persons with schizophrenia share the experience of being looked at as odd, laughable or even threatening. They often have internalized this stigmatization in the form of negative self-beliefs, shame and low self-esteem (Graham et al. 2003; Świtaj et al. 2016). The accepting and reaffirming social climate that participants experience at the facility challenges this self-stigmatization and may contribute to the restoration of self-esteem and of salient identities other than that of a psychiatric patient (Wong et al. 2010). Of note, many participants adjust to change with relative ease, often

to the surprise of the staff. This observation testifies to the capacity for adaptation that participants may hold, but more importantly reveals that others tend to underestimate this capacity at the risk of fostering overprotective attitudes.

At the social level, the opportunity to engage with others in a welcoming environment emerges as a major value created by the facility. While for some participants just being among people suffices, others develop reciprocal friendships and eventually meet up outside of the facility. Participants may learn from social skills demonstrated by one another, acknowledging that some peers are more skilled or experienced than others. The facility provides a safe environment to develop and practice skills that may be employed at a later stage in the community. This process testifies to the importance of social relations for psychological empowerment (Christens 2012). The social interconnectedness of participants is reflected in the sense of community and the self-correcting mechanisms that are visible within the group. Sense of community was coined as a concept crucial to well-being and quality of life by Sarason (1974) who denounced the segregation of the mentally ill, aged, and others in residential institutions. Psychological sense of community has been defined as 'a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together' (McMillan and Chavis 1986). Thus, sense of community is a multifaceted concept that over and above social support includes feelings of belonging to and identification with a larger social collective. Our findings repudiate ancient convictions that a disorder such as schizophrenia by its very nature impedes adequate social interaction, with afflicted individuals actively pursuing social isolation as a protective mechanism. Nowadays, social engagement is considered as one of the key positive psychosocial factors in recovery orientated practices (Jeste et al. 2017).

When considering care and environmental factors, the attitude of the activity coordinators is vital for the recovery orientated character of the facility. This attitude is characterized by a combination of facilitating the autonomy and initiatives of participants with providing structuring or limit setting interventions when required. Next, the creation of a safe environment within facilities such as The New Club essentially is a result of the beneficial interplay between a facilitating and permissive attitude among staff and the 'normal' social interactions—such as taking interest in and caring for one another, or sometimes friendly correcting one another—that take place among participants. As such, the safe environment that the facility offers is a creation and responsibility of both staff and participants.

Being attentive to physical impairments is an important age-specific aspect of the facility. Physical frailty, in combination with psychiatric restrictions due to for instance negative symptoms or cognitive disabilities make the ambition that an ideal recovery facility should be run by its participants not a realistic one. Moreover, research into peer support groups in younger persons with severe mental illnesses also indicated that minimal professional guidance is required to facilitate structure, provide security and secure continuity (Castelein et al. 2015). The community based location of the facility, avoiding the connection to a mental health institution, may strengthen the non-stigmatizing character of the facility and lower the threshold to participate. The accessibility of the facility, both physically and financially, is of basic importance. The impact of financial thresholds should not be underestimated in this economically often deprived target population. For funding agencies it is important to realize that, in addition to improvement of well-being in participants, recovery orientated interventions may also serve an economic goal by preventing or postponing institutional placement (Andrews et al. 2009).

The relevance of environmental factors for recovery is well in line with the ecological systems theory that stresses the person–context interrelatedness (Bronfenbrenner 1976). This theory states that there are various interacting levels of environmental influences that impact on an individual's personal and social functioning, from people and institutions immediately surrounding the person to societal forces. In this view, disabilities and social malfunctioning are not primarily understood as a consequence of illness but as determined by the environment which by a welcoming and accepting attitude may stimulate personal development and promote social inclusion.

A range of North American studies have reported on psychotherapeutic group interventions that may contribute to recovery in severe mental illnesses in later life. For instance, randomized controlled trials demonstrated positive effects on functioning and well-being of cognitive behavioral social skills training (Granholm et al. 2013) and functional adaptation skills training (Patterson et al. 2006). Broader intervention programs coupling skills training with health care management activities (Bartels et al. 2004) have also proved successful. It is well conceivable that in addition to the more specific therapeutic effects of these relatively high-structured interventions, the implicit opportunities for social contact among participants add positive value. Of note, the mean age of participants in these studies (55 to 60 years) was lower than that of the population of The New Club. Inspired by the same objectives as these more specialized interventions, facilities such as The New Club may offer a feasible alternative for individuals who lack the mental or physical capacity or the motivation to engage in more demanding psychotherapeutic interventions. At the same time, the explicit aims of these interventions to foster cognition, improve physical health and self-care, or train social competence may implicitly being attended to, to a certain

extent, in what The New Club has to offer to its participants. Examples of these are group games that appeal to cognitive abilities or social skills, discussions about healthy food while preparing meals or friendly phrased suggestions by staff that a smelly participant should shower before attending. As our study method does not allow for quantification of these contributions, we are aware that our considerations are of a speculative nature.

Another age-specific characteristic of facilities like The New Club is that for many participants the club is an endpoint instead of a stepping stone to wider societal opportunities. Recovery orientated facilities for younger adults (e.g., the clubhouse model; Tanaka and Davidson 2015) are primarily directed toward reintegration in the community, offering educational and work-placement programs. As such, they often have a temporary function for their users. Recovery in older age is more focused on the here and now, and on reflection upon past experiences. For many participants meeting others at The New Club constitutes their main source of social contact. At the same time, the example of The New Club demonstrates that participants may enlarge their social scope and engage in more societal activities than they did before joining The New Club.

The New Club is facilitated by specific characteristics of the mental health and social welfare systems in the Netherlands. Dutch mental health services are generally well equipped and psychiatric nurses are in the position to pay relatively frequent home visits to patients who are difficult to engage because of denial of illness or physical frailty. For several participants their psychiatric nurse helped to pave the way to join The New Club. Next, various social welfare services run community centers with a homely character for socially deprived people in general. These locations combine a non-stigmatizing environment with the possibility to encounter other individuals from various age groups. Finally, funding by the local council based on the Dutch social support law covers the main part of the costs to run the facility. With the salary of the activity coordinators representing the largest expenses, the cost of the facility is relatively modest. Of note, both mental health and social services have come under greater pressure in recent years due to cuts on funding.

In spite of the relatively low threshold for participation, it is important to realize that a substantial group of older persons with severe mental illnesses stays out of reach of The New Club. A range of reasons are responsible for this. For instance, severe chronic psychosis (either due to positive or negative psychotic symptoms) may induce behavior that would counteract the social climate of the facility. Physical afflictions that require intensive attention are not compatible with the number of staff of the facility. Care avoiding attitudes may withhold individuals from joining the facility, although a patient but persisting attitude in their health care workers may pave the way for a successful referral to The New Club in the long run. Denial of illness not necessarily stands in the way of participation in the facility, due to its non-demanding atmosphere and not disorder-oriented character.

A limitation of the present study is that we did not include former participants who had quit The New Club. Sometimes, newly introduced individuals refrained from participation after one or two meetings, often because they felt that they were not a good fit with other group members who they viewed as being service-users. In a few singular cases, participants decided in the long run that the facility no longer matched their aspirations. When these participants joined new social activities, this could be interpreted as matching a process of social recovery.

Facilities such as The New Club can be implemented successfully if a number of organizational requirements are fulfilled. Adequate funding is a sine qua non. Funding agencies tend to underestimate the number and quality of staff necessary to ensure a minimum quality of the facility. Appropriate selection and training of staff that familiarizes them with the values and the basic recovery components of the facility are key elements to its success. Next, ongoing consultation by a skilled psychiatric health worker needs to be ensured, as this provides tools for the staff of the facility to handle more complex situations. Provided these minimum requirements are fulfilled, facilities such as The New Club with relative limited means are able to make a difference for this fragile and underserved group. Eventually, recovery as a final goal will remain elusive for the large majority. However, when recovery is understood as a process, even little achievements may be appreciated as meaningful differences to participants. Future research should focus on how to modify and diversify the current model to include broader groups of older persons with severe mental illnesses, including individuals residing in institutions. Given the rapid growth of the target population and the current dearth of appropriate facilities, this field should be given priority.

Compliance with Ethical Standards

Conflict of interest The authors report no conflict of interest.

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