FOUNTAIN HOUSE

The Community Effect

How Clubhouses for People with Serious Mental Illness Reduce Loneliness

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About Fountain House

For more than 75 years, Fountain House has been a beacon of hope and recovery for people living with serious mental illness. Our pioneering clubhouse model of psychosocial rehabilitation has transformed the lives of tens of thousands of New Yorkers and inspired 200 communities across the country to create clubhouses that today benefit more than 60,000 Americans annually.

In 2020, with generous support from the Dauten Family Foundation, Fountain House expanded its capacity to conduct ongoing data analysis and other research to further expand the base of evidence supporting the efficacy of clubhouses and influence public policy. This paper is a product of that effort.

The Research, Analytics, Knowledge, and Evaluation (RAKE) department at Fountain House is a living laboratory operated in partnership with people living with serious mental illness. Researchers work especially closely with Fountain House United — a network of clubhouses across seven states that have committed to collecting and sharing uniform data — to create a shared research agenda and advocate for policy change.

To learn more about Fountain House and our research, visit **fountainhouse.org**.

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Executive Summary

Humans are innately social. We evolved from surviving through safety in numbers to joining together in common purpose and valuing, supporting, and caring for one another to feel that we belong and are not alone. And yet, levels of loneliness for Americans have risen high enough that the Surgeon General has declared loneliness an epidemic. For people with a serious mental illness such as schizophrenia, bipolar disorder , and major depressive disorder, loneliness and accompanying isolation have even more severe ramifications.

Enforced social isolation during the COVID-19 pandemic elevated the already widespread problem of loneliness and its repercussions on mental health, highlighting loneliness as both a cause and a consequence of mental illness. Yet traditional interventions for people living with a serious mental illness and standard day programs rarely nurture the web of relationships that are fundamental to their recovery and overall well-being. Interventions that target the negative symptoms of serious mental illness — such as social withdrawal, lack of interest, enjoyment or pleasure from life's experiences, and the inability to initiate or engage in goal-directed behaviors — are also needed to support recovery and thriving over their lifetime.

As a complement to clinical treatment, the clubhouse model of social practice presents an antidote to loneliness. Clubhouses leverage the power of an intentionally designed community to promote recovery and personal growth. Created by and for people living with serious mental illness, clubhouse members meet each other where they are, without judgment, providing the affirmation, fellowship, and support people need to move forward in their lives. The members feel a sense of belonging through their work together to run the clubhouse and other joint projects.

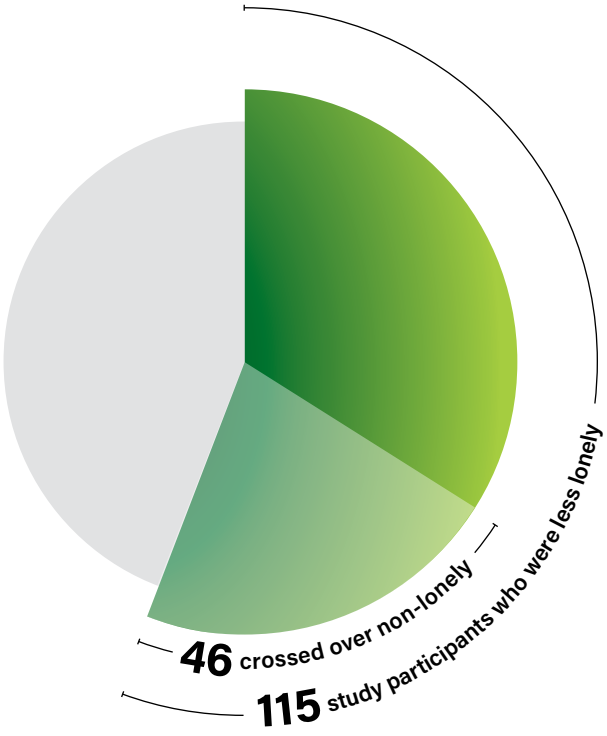
Research shows that clubhouses are associated with improved mental health, other positive life outcomes such as employment and education completion rates, and significant cost savings that flow from those outcomes, estimated to currently save the U.S . almost $700 million annually. Now, there is compelling evidence that clubhouses can impact one of the most critical health mediators: loneliness.

Researchers at Fountain House — the originator of the clubhouse model — recently analyzed shifts in loneliness among 206 clubhouse members . Baseline data was collected when they applied to join Fountain House's flagship New York City clubhouse, and follow-up data was gathered 1-3 years later, using the empirically validated and well-known UCLA Loneliness Scale that measures loneliness along a 9-point scale, in which a score of 6 or higher indicates the person is lonely.

Scores on the baseline survey showed evidence of elevated rates of loneliness among people living with a serious mental illness who were accepted to join Fountain House but had not yet engaged with programs. Of those surveyed, 73% of members identified as lonely, compared to a rate of loneliness in the general population of roughly 20%.

Even more significant, findings from the pre-post surveys indicate that the clubhouse experience alleviates feelings of loneliness for a majority of members. One hundred and fifteen of the 206 people studied (56%) were less lonely at follow-up, including 46 people (22%) who joined the clubhouse lonely and were no longer lonely at follow-up (i.e., scored 5 or lower on the survey).

Figure 1: Reduced Loneliness for Fountain House Members



In sum, the analysis provides compelling evidence that a social practice approach to recovery from serious mental illness enhances the well-being of individuals who are not only prone to being lonely but for whom loneliness leads to even worse life outcomes. The clubhouse environment represents a unique, holistic, and nonclinical approach to addressing the social symptoms and repercussions of serious mental illness that cannot be managed by medication alone. Future research by Fountain House aims to examine the interplay between Patient-Reported Outcome Measures (PROMs) and outcomes tied to health-related social needs.

In the context of a robust body of research documenting the wide-ranging and costly repercussions of loneliness — from elevated rates of cardiovascular disease to lower productivity and unemployment — these findings have implications for health care and other systems. Specifically, they suggest that systems for people living with serious mental illness should prioritize reductions in loneliness as an essential mediator of health and well-being, invest in nonclinical, community-based services that reduce loneliness and achieve other positive outcomes not possible with clinical treatment alone, and track community-based provider performance based at least in part on PROMs.

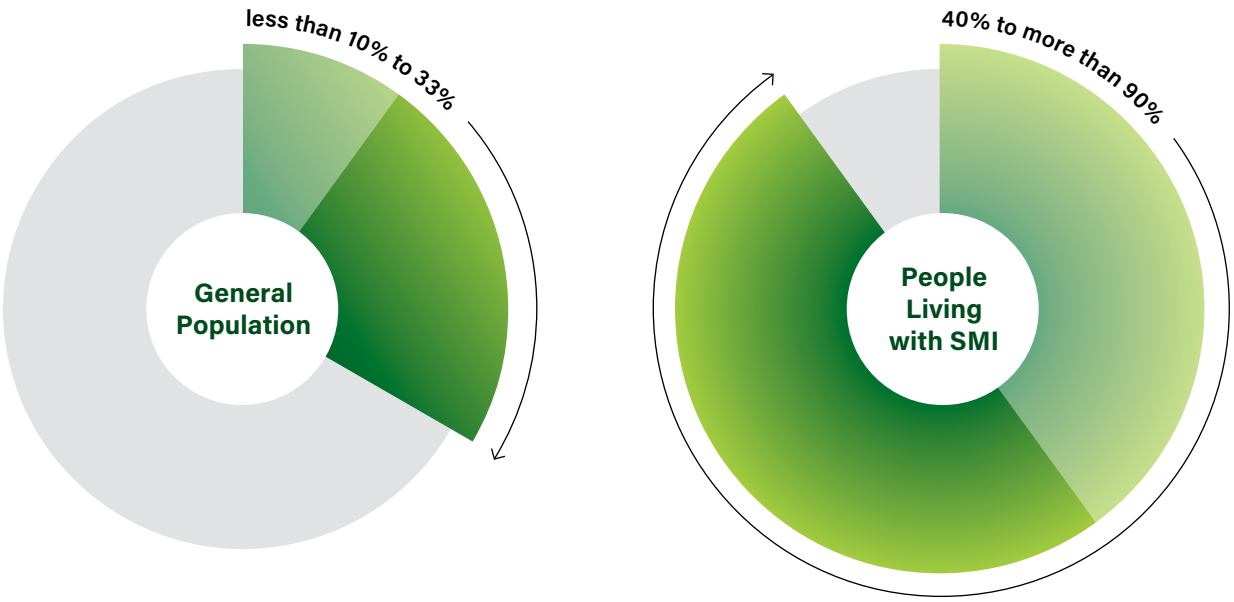
Cycles of Despair: The Link Between Loneliness and Mental Illness

By one common measure, roughly one in five Americans are lonely (Valtorta et al. 2016; Gallup 2020). A malady affecting at least 20% of the population is indeed an epidemic, as the U.S. Surgeon General reported in 2023, but one that pales in comparison to rates of loneliness among those living with a serious mental illness (Hawkley & Cacioppo, 2010; Mann et al., 2017).

People living with depression, bipolar disorder, schizophrenia, and other serious mental illnesses are 2 to 3 times more likely to be lonely than someone without a serious mental illness. Even during the COVID-19 pandemic when many Americans felt lonely, the rate among those with a serious mental illness was still 2 to 2.5 times higher (Heron et al. 2022).

Depending on the type of mental illness and how loneliness is defined and measured — different studies use different diagnostic tools and/or cutoffs — the rates and disparities in comparison to the general population can be even greater. One study, for example, found rates of loneliness as high as 94% among individuals with psychotic disorders (Badcock et al. 2015), while a study of people living with depression found a much lower but still troubling rate of 40% (Victor and Yang 2012). A 2023 study focused on the extremes of loneliness, found that people with a serious mental illness of any type were nearly 6 times more likely to be "severely lonely" than the population at large — a rate of 41% compared with just 7% (Nagata et al. 2023).

Figure 2: Comparing Loneliness Prevalence Rates



This well-established body of research also suggests a reciprocal dynamic in which loneliness functions as both a risk factor for mental illness and a consequence of it. The social isolation and disconnection that characterize loneliness create an environment that fosters the development or exacerbation of mental health problems. Individuals with serious mental illness frequently grapple with debilitating negative symptoms that interfere with daily life, such as the inability to initiate or engage in goal-directed behaviors, and lack of motivation to engage in social interaction, or a preference for solitary activities, which can lead to social withdrawal. This withdrawal is often further compounded by the stigma associated with serious mental illness and the fear of rejection. Consequently, the experience of being alone or feeling disconnected tends to intensify the symptoms of serious mental illness (Teo et al., 2015) perpetuating and reinforcing each other, creating a self-sustaining negative feedback loop.

This feedback loop can be observed in studies that have found prominent negative interactions and associations between loneliness and serious mental illness outcomes (Chrostek et al., 2016; Switaj, Grygiel, Anczewska, & Wciorka, 2014). A systematic review by Wang et al. (2018) found that loneliness and lack of perceived social support were consistently associated with more severe symptoms, lower remission rates, poorer functioning, and decreased quality of life across various serious mental illness diagnoses. A study directly comparing lonely and non-lonely individuals with psychotic disorders, a subset of serious mental illness, found that loneliness was associated with more severe cognitive impairments and worse symptom profiles, characterized by greater anhedonia—lack of interest; enjoyment; or pleasure from life's experiences, and thought disorders (Badcock et al. 2015).

A further study by Wang et al., (2020) found that individuals who reported higher levels of loneliness following a mental health crisis tended to report worsened symptoms and decreased quality of life four months later, with loneliness being a more significant predictor of those poor outcomes than other factors, including the size of the person's social network. Loneliness has also been observed in association with increased paranoia and decreased motivation, responses that in combination make it very difficult for people to connect with others (Chau, Zhu, & So, 2019; Michalska da Rocha et al., 2018). The result is a negative feedback loop of withdrawal, loneliness, and psychosis that lands many people in the hospital (Prince et al., 2018).

Situational factors also play a role. People living with serious mental illness are less likely to have steady employment and income, to be enrolled in school, or to have a stable home, undermining their already fragile sense of security and belonging and leading to heightened feelings of loneliness. (Caple et al., 2023). Moreover, because mental illness often emerges during adolescence or early adulthood, it disrupts both the processes of learning how to form and maintain healthy relationships and the development of a social network (Solmi et al., 2022).

Community As Therapy

Despite the well-documented link between mental illness and loneliness, conventional treatments rarely address loneliness as a crucial mediator of mental health (Badcock et al., 2020). Those that do tend to emphasize psychosocial skills training and cognitive-behavioral therapy to help people identify and change negative perceptions and other habitual thoughts that impede relationships (Cruwys et al., 2014; Erzen & Çikrikci, 2018; Masi et al., 2011; Meltzer et al., 2013). Such approaches have been noted as limited in their capacity to support persons experiencing the often severe social repercussions of mental illness. (Badcock et al., 2020, Lim et al. 2020, Mann et al. 2017). Recent reviews on loneliness interventions for mental illness similarly identify these limitations and call for interventions with more structured opportunities to connect with others and develop interpersonal skills through authentic relationships, building self-confidence, and cultivating a sense of belonging (Caple et al. 2023).

> ***I had to learn how to make new friends after the diagnosis. I didn't want to hide it, but it became a label for me. I would tell some of my friends, and afterwards they didn't come around as much as they did before. At Fountain House, I felt like I fit in. I was able to meet new people and didn't have to hide anything.***
>
> *—Minji*

Recognizing the importance of addressing these complex social needs for persons with mental illness, for over 75 years, clubhouses for people with serious mental illness have harnessed the power of a community of one's peers – experienced as part of a designed therapeutic environment – as the foundation for improved mental health and personal growth (McKay et al., 2018). Clubhouse methodology – called social practice [see sidebar "What is Social Practice?"] represents a unique holistic and nonclinical approach to addressing the social symptoms and repercussions of serious mental illness that cannot be managed by medication alone (Pernice et al., 2023).

What Is Social Practice?

Social practice is a term developed to represent the well-established psychological methods, theories, and principles that the clubhouse environment uses to enhance the social and emotional well-being of people living with serious mental illness (Pernice et al., 2023).

Clubhouses nurture the social-emotional competencies and metacognitive abilities (problem-solving and insight based on awareness of self and others) that make it possible to meaningfully connect with others (Rice et al., 2020, in particular: the ability to understand and relate to others through authentic social relationships, putting one's own feelings and experiences in perspective through community, collective insight, and communication through empathy (Milieu Therapy, Abroms 1969).

The clubhouse environment, with its collaborative work and decision-making processes, plays a pivotal role in fostering both self-efficacy and collective efficacy (Social Cognitive Theory, Bandura, 1986, 1989). This emphasis on collaboration promotes relationship building and cultivates autonomy through personal choice and self-directed decision-making, leading to feelings of competence and shared achievement (Self-Determination Theory, Deci & Ryan, 1985, 2008).

People who choose to join a clubhouse are not referred to as clients or patients; they are "members" who decide how frequently to visit, how to spend their time at the clubhouse, and how long to remain an active member – an emphasis on self-determination that is a feature of social practice and distinguishes clubhouses from day treatment programs and other models of psychosocial rehabilitation.

> ***I didn't fully understand what was going on when the symptoms first hit. I didn't have anyone to talk to and would isolate myself for long periods of time … I have so much support now. If I'm not at the clubhouse for a week, I'll have someone calling me, saying, 'We haven't seen you in a while, we miss you.' They really do care.***
>
> ***—Kirsten***

Members are essential to the day-to-day operations of the clubhouse: greeting visitors and answering phones, cleaning and repairing areas of the clubhouse, helping in the kitchen, facilitating meetings, assisting with community outreach, and more. A "Work-Ordered Day" at a clubhouse also features time for members to immerse themselves in activities and projects that feed their interests and activate their talents. The work itself yields a feeling of individual and shared accomplishment, and the fellowship underlying the work fosters a sense of belonging. Indeed, members often describe the clubhouse as a place where they "fit in," where they feel welcomed and supported instead of adrift and alone, and where they blossom socially and in other ways.

> ***I've been leading orientations for new members, which I love. I give tours and introduce people to the clubhouse while telling them about my own life experiences. It's a chance for us all to connect and feel like we're not alone.***
>
> ***—Russell***

With support and affirmation from their peers and guidance from trained professionals, members develop the social, emotional, and cognitive skills, and the confidence they need to thrive in this highly structured and supportive environment and in the world beyond the clubhouse doors (Kinn et al., 2018; Pernice-Duca et al., 2013). Many clubhouses run supported employment, housing assistance, and other programs that not only meet members' specific needs but also further expand their social network.

Evidence That Clubhouses Reduce Loneliness

While numerous studies have documented an array of positive outcomes associated with clubhouses (Beard, Propst, & Malamud, 1982; Coniglio et al., 2012; Battin et al., 2016; Doyle, 2013), none have measured their impact on loneliness. As part of a broader effort to collect and publish longitudinal data on key outcomes, researchers at Fountain House — which includes an active research unit comprised of approximately 100 clubhouse members and up to five staff — have begun to routinely survey clubhouse members using psychometrically validated instruments, including the well-known UCLA Loneliness Scale.[1] In alignment with prior uses of the UCLA scale, the researchers considered a score of 6 or higher on the 9-point scale to be indicative of loneliness, while a score of 5 or lower suggests the relative absence of loneliness (e.g. Steptoe, Shankar, Demakakos, and Wardle 2013 and Valtorta 2016).

Findings from this first wave of research reflect the experience of 206 people who were surveyed when they applied to become members of Fountain House's flagship clubhouse in New York City and again at follow-up after participating in clubhouse activities and programming. Fountain House began collecting loneliness data in mid-2019. The earliest match we have in this data set of people that had both a pre and a post survey is May 2020. Due to the COVID-19 pandemic, rapid changes to regular clubhouse program operations — moving first from a completely in-person program to a temporarily fully virtual program, and now to a hybrid in-person/virtual program — impacted data collection operations, resulting in a longer than anticipated collection period for this baseline set of research.

As part of the survey process, researchers also collected some basic demographic data. The study sample is split roughly equally between women (99) and men (95), with an additional 12 individuals answering the gender identity question differently.[2] Most people identified as White (72), Black (65), or Latino/Latina (37), with a much smaller number identifying as

1 In addition to loneliness, researchers collect self-reported data on quality of life and thriving, which both members and staff view as especially meaningful indicators of recovery.

2 The options were: "other gender," "non-binary," "transgender - identifies as male," "transgender - identifies as female," or "choose not to disclose."

Measuring Loneliness with the UCLA Scale

The UCLA Loneliness Scale consists of three simple questions:

1. **How often do you feel you lack companionship?**
2. **How often do you feel left out?**
3. **How often do you feel isolated from others?**

For each question, respondents select one of three possible answers:

- **A** **hardly ever** *(1 points)*
- **B** **some of the time** *(2 points)*
- **C** **often** *(3 points)*

The scale assigns a score to each response as noted above, yielding a total score that ranges from 3 to 9.

The UCLA scale is straightforward and easy to administer and provides a quick yet reliable measure of the extent to which an individual may feel socially isolated or disconnected, as opposed to measuring the person's actual number of social contacts and interactions. This is an important distinction. One can lead a life with few relationships and minimal social interaction and not feel lonely at all, while someone with dozens of friends, often surrounded by people can experience a profound sense of loneliness (Campaign to End Loneliness, n.d. and Hawkley & Cacioppo, 2010). In other words, how people perceive their relationships and social ties (or lack thereof) and how they make them feel, is what matters.

Asian (8). Additionally, 24 people selected "other" to describe their racial identity. The average age across the study sample is 45. The most common diagnoses are schizophrenia[3] (73), depression[4] (73), and bipolar disorder[5] (46), plus 14 people diagnosed with a personality disorder.[6]

Baseline Loneliness Scores

At the outset of the study, the average loneliness score across the study sample was 6.54 (median 6), indicating a significant level of loneliness. Indeed, 151 of the 206 people surveyed (73%) scored 6 or higher on the initial survey, compared to a rate of loneliness in the general population of roughly 20% based on multiple prior applications of the UCLA scale (Valtorta et al. 2016).

Figure 3: Baseline Loneliness Scores of UCLA Scale

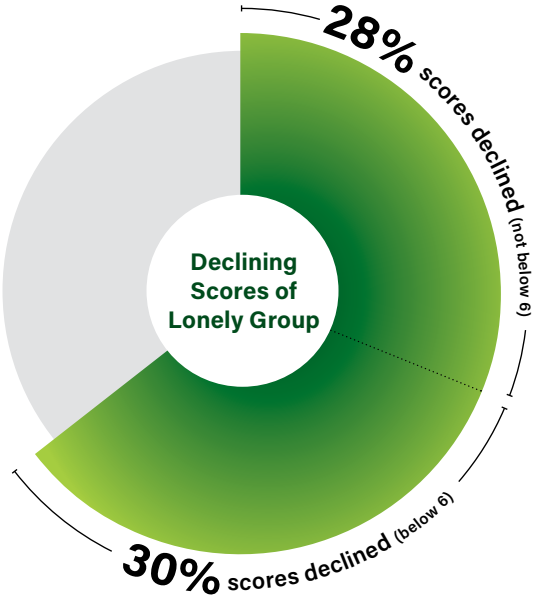
3 Encompasses schizophrenia, schizoaffective disorder, and schizotypal personality disorder.
4 Encompasses major depressive disorder, post-traumatic stress disorder, and generalized anxiety disorder.
5 Encompasses bipolar 1 disorder and bipolar 2 disorder.
6 Encompasses borderline personality disorder and narcissistic personality disorder.

Loneliness Scores After Participation in Fountain House

Overall, the subgroup of 151 people who started out lonely — scoring a 6 or higher on the initial survey — saw their average score drop by nearly a whole point, from 7.23 to 6.25 (a difference of 0.98).[7]

Even more meaningful in terms of individual outcomes, more than half (58%) of the subgroup of people who joined a clubhouse feeling lonely felt less lonely at follow-up. Specifically, 30% of people who scored 6 or higher on the initial survey had a follow-up score of 5 or lower, shifting them into the non-lonely category. An additional 28% of people who started out lonely saw their scores decline, by 1.53 points on average, but still did not score below 6.

Figure 4: 58% of Lonely Group Scores Declined



An analysis of variance suggests that gender, age, race, education level, history of homelessness, history of criminal justice involvement, or type of diagnosis were not associated with the change in loneliness scores a year later. This finding, coupled with the fact that a majority of the initially lonely members had lower scores at follow-up, indicates that clubhouses can foster a sense of belonging for a wide range of people.

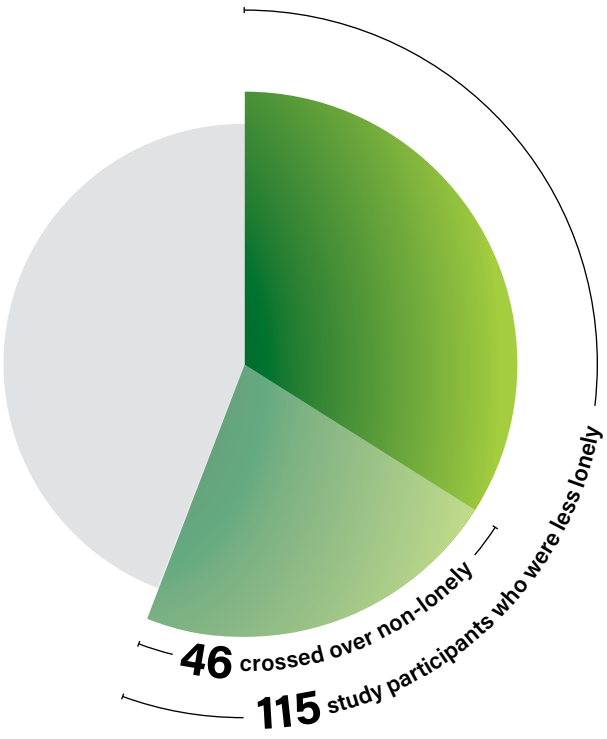
Not surprisingly, since loneliness occurs on a continuum, scores also decreased among many of the people who scored 5 or lower on the initial survey, putting them in the much smaller non-lonely subgroup. Specifically, 28 of the 55, more than half (51%) of this subgroup had even lower scores at follow-up, dropping 1.35 points on average.

7 This average for the subgroup overall encompasses those whose scores declined and those whose scores did not change or possibly increased.

We note that 16 people whose initial score placed them in the non-lonely category had somewhat higher scores a year later, typically pushing them over the threshold from not lonely to lonely. Specifically, their scores increased by 1.56 points on average, and 11 of the 16 scored 6 or higher on the follow-up survey. It is unclear why feelings of loneliness increased among these 16 people. It might be that they were less attuned to their loneliness prior to joining a clubhouse, they experienced major life changes, or they represent a possible cycling in and out of persistent loneliness that may occur over a person's lifetime, regardless of intervention. While loneliness cycles have been explored in the general and other populations (Qualter et al., 2015), further research and longitudinal tracking will help clarify how persons with serious mental illness move in and out of loneliness and what intervention, lifespan, or psychosocial factors precipitate or predict those trends.

Looking across both lonely and non-lonely subgroups, the majority of people studied, 115 of the 206 (56%), were notably less lonely at follow-up, including 46 (22%) who crossed over into the non-lonely category based on their answers to the follow-up survey.

Figure 5: Overall Clubhouse Effect



Fountain House researchers noted higher engagement from the loneliness analysis cohort compared to the typical clubhouse member. Future research will assess the impact of different variables on whether or not people are improving, remaining the same, or decreasing their loneliness, considering factors such as attendance dosage, specialized support engagement, membership length, or whether they are engaging more with virtual and online supports.

CASE STUDY

Exploring the Cost Savings of Reducing Loneliness

In his opening letter to a 2023 advisory on the epidemic of loneliness and isolation in the United States, Surgeon General Dr. Vivek H. Murthy, writes:

> *Loneliness is far more than just a bad feeling—it harms both individual and societal health. It is associated with a greater risk of cardiovascular disease, dementia, stroke, depression, anxiety, and premature death. The mortality impact of being socially disconnected is similar to that caused by smoking up to 15 cigarettes a day, and even greater than that associated with obesity and physical inactivity. And the harmful consequences of a society that lacks social connection can be felt in our schools, workplaces, and civic organizations, where performance, productivity, and engagement are diminished.*

What follows is a detailed catalog of these and many other ills. The takeaway: Anything that significantly reduces loneliness will have a positive ripple effect in a person's life and, in the aggregate, pay dividends for society.

Given high rates of loneliness among people living with a serious mental illness and wide-ranging negative repercussions, along with new evidence that clubhouses promote feelings of connectedness and belonging, researchers at Fountain House set out to assess the impact of clubhouses on one of the most common and financially costly health repercussions of loneliness: cardiovascular disease.

Recent research suggests that lonely people are 29% more likely to develop coronary heart disease and 32% more likely to have a stroke, two of the most common types of cardiovascular disease (Valtorta et al. 2016).[8] Their heightened risk has a deeply biological basis: The experience of being lonely — like any life stressor — raises cortisol levels, which over time trains the body to maintain elevated levels of cortisol. A constant stream of cortisol leads to high blood pressure, high blood sugar, and changes in blood fats, all of which increase the risk of cardiovascular disease (Paul et al., 2021; Henriksen et al., 2019).

Chronic stress also can cause inflammation and changes that physically weaken the heart and blood vessels setting the stage for a heart attack, stroke, or other debilitating or deadly cardiovascular event (Inoue et al., 2021). In addition, emerging research suggests loneliness, serious mental illness, and cardiovascular disease share some common genetic factors, all of which are more likely to be triggered by elevated levels of stress (Rødevand et al., 2021). When taken together, as the Surgeon General's advisory on the loneliness epidemic reported, "A synthesis of data across 16 independent longitudinal studies shows poor social relationships (social isolation, poor social support, loneliness) were associated with a 29% increase in the risk of heart disease and a 32% increase in the risk of stroke."

8 These values are derived from meta-analyses of longitudinal studies comparing individuals with poor social relationships to those with better ones (Valtorta et al., 2016).

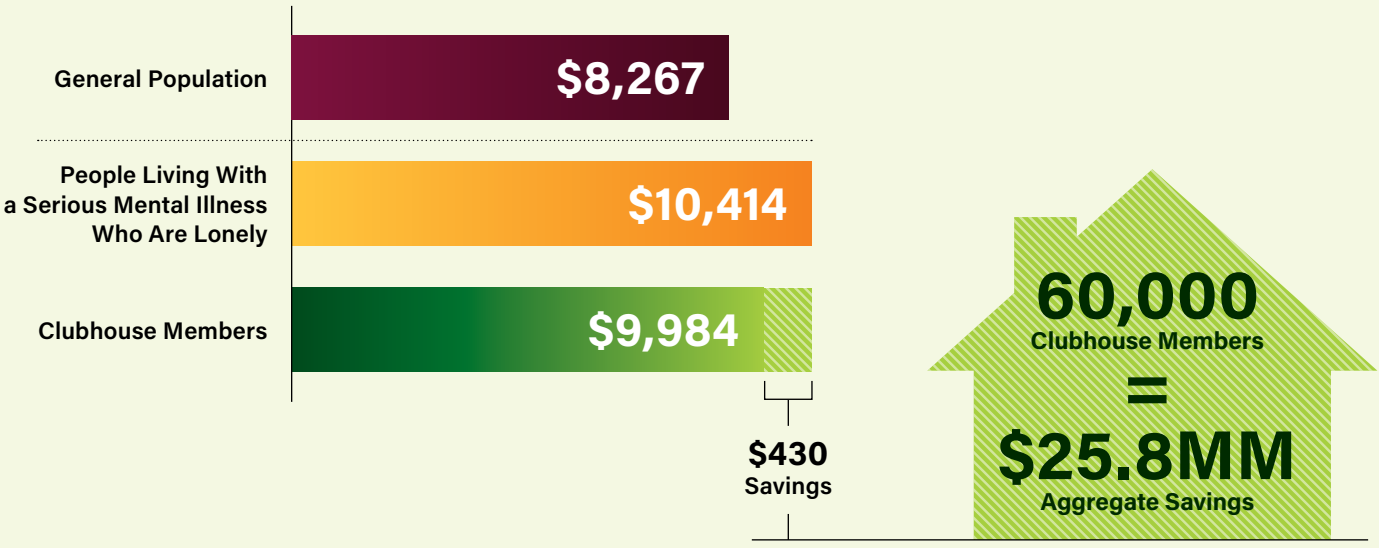
On average, Americans between the ages of 30 and 74 have an 11% risk of developing cardiovascular disease over a 10-year period (Yang et al. 2015).[9] More specifically, they have a 7.45% risk of developing coronary heart disease, a 2.1% risk for stroke, and a 1.5% risk for other cardiovascular conditions. Using cost estimates for treating these diseases adjusted for inflation (see Methodology), the average per capita costs associated with cardiovascular disease are $6,170 for coronary heart disease, $1,396 for stroke, and $701 for all other types of cardiovascular disease, for a total per capita cost of $8,267 (O'Sullivan et al. 2011).[10]

The risk among people living with a serious mental illness is roughly 1 point, or 10%, higher than among the general population (Daumit et al. 2020),[11] and as noted above, loneliness raises the baseline risk, leading to even higher per capita costs: $7,807 for coronary heart disease, $1,735 for stroke, and $872 for all other types of cardiovascular disease, for a total per capita cost of $10,414.

In this analysis, it was found that 22% of members moved from being lonely to not lonely. Given past research on the impact of loneliness on cardiovascular disease and associated costs, this loneliness effect suggests an average per-member savings of $430. If other clubhouses have a similar impact on loneliness, their collective impact would be more than $25 million based on reduced heart attacks and associated acute cardiovascular events.

Preventing cardiovascular disease is just one area of savings associated with clubhouses. Recent economic modeling by Fountain House suggests that clubhouses have an estimated total societal savings of $11,000 per person as a result of improved mental and physical health, increased productivity, and other positive outcomes. That's a savings of nearly $700 million annually across the 60,000 members (Usman and Seidman 2024) — savings that would grow exponentially if clubhouses served even 5% of the 15 million Americans living with a serious mental illness.

Figure 6: Per Capita CVD Costs



9 The risk is higher among men (14.6%) than women (7.5%), resulting in an average risk of 11.05%.

10 The dollar had an average inflation rate of 2.41% per year between 2011 and 2024, producing a cumulative price increase of 36.37%. This means that today's prices are 1.36 times as high as average prices since 2011, according to the Bureau of Labor Statistics consumer price index.

11 The exact rate is 12.1%.

Conclusion

Findings from this initial longitudinal study indicate that the Fountain House clubhouse experience alleviates feelings of loneliness for a majority of members. It provides compelling evidence that a social practice approach to recovery from serious mental illness enhances the well-being of individuals who are prone to being lonely and for whom loneliness typically worsens their mental illness and can lead to a range of other negative outcomes.

While this study is limited to one clubhouse in New York City, Fountain House is poised to begin collecting data across an additional 11 clubhouses in 7 states through the Fountain House United national network, research that should provide further evidence of the model's effectiveness. That research also will explore why the clubhouse experience benefits some members more than others in terms of enhancing feelings of connectedness and belonging. In particular, the question of dosage (i.e. frequency of visits and other measures of degree of participation) is ripe for exploration.

Future studies will include the collection and analysis of data related to quality of life and social drivers of health in addition to loneliness. This growing base of evidence on the impact of social practice, and clubhouses in particular, has implications for how healthcare systems support people living with serious mental illness. Even this initial study, for example, suggests that systems should prioritize reductions in loneliness as an important mediator of mental and physical health; invest in nonclinical, community-based services for their ability to reduce loneliness and achieve other positive outcomes not possible with treatment alone; and track provider performance based at least in part on data reported by the people participating in their programs.

Better outcomes for people living with serious mental illness are tied to the recovery of dignity, hope, personal agency, and a better quality of life—none of which are possible when people are socially isolated. As humans, we value ourselves in part because others value us and thrive in part with the support of others. Clubhouses provide an environment where those fundamental connections can take root and flourish.

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