ORIGINAL ARTICLE

PERCEPTION ABOUT PSYCHOSOCIAL INTEGRATION CLUBS FOR PEOPLE WITH SCHIZOPHRENIA IN LIMA, PERU

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ABSTRACT

Objective: To know the perception of users, caregivers and health professionals about the implementation, operation and satisfaction related to their participation in psychosocial integration clubs (PIC) for people with diagnosis of schizophrenia in two districts of northern Lima. **Materials and methods**: This study had a qualitative methodological approach. In-depth interviews and 3 focus groups were conducted with 21 participants including users, family caregivers, and mental health professionals. The information was collected in December 2018. We analyzed the perceptions of the implementation process and satisfaction of the club's users, their affective relationships and leisure, their link with families and socio-community networks, as well as the perceived limitations. **Results**: The perception of club's users, caregivers and mental health professionals was favorable regarding the implementation, functioning and satisfaction of the users, as an integrating and socializing role, through their active participation, social reintegration in normalizing activities with their community, the health network and in the strengthening of family ties. PICs are perceived as spaces for socialization that have a relevant meaning in the lives of users. **Conclusions**: Participants perceive PICs as a space for well-being and adequate use of free time, which contributes to the rehabilitation of the user's disease.

Keywords: Therapeutic Social Clubs; Schizophrenia; Mental Disorders; Leisure and Conviviality Centers; Community Integration; Recreation (Source: MeSH NLM).

INTRODUCTION

People with schizophrenia need comprehensive treatment that includes multiple interventions to improve their personal and family functionality and social and community reintegration. It is common for people with schizophrenia to have limited social networks, consisting mainly of caregivers and close family members [1,2]. Psychosocial integration clubs (PIC) for people with schizophrenia are community meeting places where users and people who are important to them interact. These are flexible community spaces that enable retraining in certain social skills and allow users to enjoy their free time through healthy leisure, a sense of belonging, and the reestablishment of social and emotional ties in the process of psychosocial rehabilitation [3,4,5].

Since 1983, in North Lima, the National Institute of Mental Health (NIMH) "HD-HN" implemented the PIC model for people with schizophrenia. These were weekly, open meeting spaces [6], with the accompaniment of mental health and psychiatric specialist nurses and

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technical staff, where the capacity and autonomy of patients was encouraged to develop interactive and interdependent relationships [7] through a variety of leisure activities, based on respect, tolerance, solidarity and support. Thus, meetings were held in sports fields, parishes or communal premises [8]. The PICs were initially implemented in seven community mental health services of healthcare centers of the first level of care, located in the districts of Independencia and San Martin de Porres [9]. In 2014, some clubs were merged and currently there are three. After 34 years, the PIC model is still active and in force [10,11]. With the creation of community mental health centers, within the framework of the mental health reform in Peru, PICs have been implemented in Metropolitan Lima and other regions of the country [12], led by nurses and social workers.

People with severe mental disorders (SMD) represent 0.5% of the country's population and have the least possibility of social inclusion and social and labor reinsertion, due to the stigma and discrimination in the society [13]. In addition, there is a scarce availability of rehabilitation services for this group of people, these services are concentrated in Lima and with reduced attention capacity. Except for rehabilitation services in psychiatric hospitals, psychosocial rehabilitation centers have not yet been implemented in the community [13,14]. Likewise, PICs are a resource for users within their community, given the shortage of rehabilitation centers, however, there are few of them.

In our country, funding for mental health remains scarce, despite the fact that the Mental Health Law [15] declared as a national priority the establishment of public policy on mental health and the creation, strengthening and implementation of the community mental healthcare model, where users should receive effective rehabilitation, insertion and family, labor and community reintegration. This study aimed to determine the perception of users, caregivers and health professionals on the implementation and functioning of PICs for people with schizophrenia in two districts of North Lima, Peru.

KEY MESSAGES

Motivation for the study: Psychosocial integration clubs (PIC) have been established as environments that contribute to the rehabilitation of people with schizophrenia. However, there are few qualitative studies that address the perceived benefits of PIC participants.

Main findings: PIC users perceive their participation in a favorable way, comparing the clubs to a "second home" and a place where they "can make friends". The perception of the linkage of the PICs to families and socio-community networks has been partially favorable.

Implications: More PICs could be implemented throughout the country, establishing their regulatory framework and informing people diagnosed with schizophrenia and their caregivers that it is a rehabilitation alternative in their community.

MATERIALS AND METHODS

Study design

The methodology was qualitative, descriptive, analytical and interpretative, focused on the application of in-depth interviews (IDI) and focus groups (FG). This research was based on the psychosocial rehabilitation theory and the model of care for people with disabilities, within the framework of the reform of mental health services and the community model. The study variables were three: the perception of the user, the perception of the caregiver and the health professional in the subjective appreciation of implementation, and the functioning and satisfaction of their participation in the psychosocial clubs.

Participant selection

Convenience sampling was used by the mental health facilitator teams that intervened in the PICs of North Lima. Users attending the Renato Castro de la Mata (RECAM), Amigos de la Santa Cruz (ASCRUZ), and Nueva Esperanza (NE) PICs; their family caregivers; and the nurses who accompanied the process of implementation and operation of the PICs were proposed to participate in this study. Said participants had participated in PICs between 1983 and 2017. Twenty-one in-depth interviews were conducted: 6 with nurses, 5 with family caregivers of members and 10 with PIC users. Also, 3 focus groups with 6 relatives, 8 users and 5 nursing professionals. The study was carried out in December 2018.

Inclusion criteria included users who attended the PIC for at least one year, with a diagnosis of schizophrenia, over 18 years of age and clinically stable, as well as family caregivers and nurses who participated in the CIP for at least five years.

Data collection

A general data collection form for all users participating in the PICs as of December 2018 was used to record

sociodemographic aspects extracted from the club program database to characterize the users of the different PICs at the time of this study.

Three focus groups were conducted with users, family caregivers and nurses, respectively. A team of researchers, advised and evaluated by experts, prepared the question guides for the FG and the IDIs (Annex 1).

The researchers, with training in qualitative research, systemic therapy, community mental health and interventions in rural populations, carried out the interviews. In addition, they had experience in previous studies with semi-structured interviews and FG with people with mental disabilities and health personnel. Previously, PICs users were informed of the importance of knowing their perceptions about the PICs, the methodology was explained to them, and they were asked for their consent to record the audio and participate in the study. During the interview, we ensured that the interviewer had no previous relationship with the participants to avoid bias. The use of clear, concise and simple language was taken into account, providing an atmosphere of trust so that they could express their ideas. Time was also vital, since in some cases the participants narrated their experiences in a more leisurely manner, so measures were taken not to interrupt the course of the person's narrative. Users were treated cordially and respectfully at all times. The data were collected in a single session in the community spaces where the PICs took place. In the case of the nursing staff, interviews were carried out in the NIMH "HD-HN". The interviews with the participants reached the saturation point for the proposed analysis.

The FGs were held on the same premises as the PICs, with trained personnel to moderate and observe the study, who were provided with a notepad. The methodology was explained to the participants: answering the questions in the survey and then the next participant would introduce him/herself and provide his/her comments. The FGs were recorded and transcribed for analysis. The FGs and IDIs lasted approximately 90 minutes.

Data analysis

For the analysis and processing of the data, we considered the research dimensions, the coding and elaboration of memos, the unification of codes, the cleaning of qualitative data, the construction of the book, the cloud storage and the code matrix in the Atlas Ti 8.0 software, as well as the preparation of the citation report and six thematic maps. In addition, 34 specific codes were created for each category, through the process of reading and analyzing the IDIs; these codes involved a total of 393 citations.

Ethical aspects

The Institutional Research Ethics Committee (IREC) of the NIMH "HD-HN" approved the study, with official code INSM-480-18. Participants voluntarily signed the informed consent form before participating in the FG and IDI. The confidentiality of the information was preserved, their names were replaced by codes and information that would facilitate their identification was omitted in order to protect their identity.

RESULTS

Regarding the characterization of the participants, as of December 2018, we found that 61.6% of the users had a disability card, 88.4% had a diagnosis of paranoid schizophrenia, 53.9% had more than 20 years of illness, 57.6% had coverage by the Seguro Integral de Salud (SIS), and 42.4% had coverage by EsSalud. Likewise, 73.1% of the participants did not report relapses during the last 2 years of permanence (Table 1).

User participation in the PICs in North Lima was 100% voluntary and 79.0% were referred to the club by a psychiatrist (Table 2). Regarding the characteristics of nursing professionals, all were female, with an average of 27 years of experience in community work, with a specialty in mental health, psychiatry and the role of PIC facilitators.

On the process of organizing the PICs

The perception regarding PIC organization was that PICs were significantly linked to the participation of the users within their community. In the collected narratives (Table 3), we found that the formation of the clubs began as an additional psychosocial intervention to the follow-up program for users diagnosed with schizophrenia. The users profile included being clinically stable, residing in the same area where the club operated, having a family member and being referred in most cases by the psychiatrist or another health professional in the area:

Around the years '85, '86 (...), a follow-up program for users with severe mental illness was created (...). Then, this program included several lines of intervention, home visits were made to see their family contexts and to see how they were trained in the skills they had lost, such as daily living activities: (...). That, plus the pharmacological treatment, gave us an indicator that he had less relapse. That is to say, he remained stable, but that was not enough... he had to be socially integrated... That is when the psychosocial integration clubs were set up. So, all the users were grouped together one day a week and recreational activities were mainly carried out (nurse 1, 55 years old).

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Table 1. Sociodemographic and clinical characteristics according to users of psychosocial integration clubs in Northern Lima, 2018.

Sociodemographic and clinical characteristics	Total (n = 52)		Renato Castro de la Mata Club (n = 24)		Nueva Esperanza Club (n = 14)		Amigos de la Santa Cruz Club (n = 14)	
	AF	%	AF	%	AF	%	AF	%
Age (years)								
18- 20	1	1.9	0	0	1	1.9	0	0.0
20-39	9	17.3	2	3.8	4	7.7	3	5.8
40-49	14	27.0	6	11.6	5	9.6	3	5.8
50-59	24	46.1	15	28.8	3	5.8	6	11.5
60 or more	4	7.7	1	1.9	1	1.9	2	3.8
Gender								
Male	30	57.7	16	30.8	10	19.2	4	7.7
Female	22	42.3	8	15.4	4	7.7	10	19.2
Education level	0		0					
Primary school	6	11.5	2	3.9	2	3.8	2	3.8
Secondary school	38	73.1	17	32.7	10	19.2	11	21.1
Higher Technical Institute	0		0		0		0	
Incomplete university	8	15.4	5	9.6	2	3.8	1	1.9
Marital Status	0		0					
Single	48	92.3	24	46.2	11	21.1	13	25.0
Married	2	3.8	0	0	1	1.9	1	1.9
Cohabitant	1	1.9	0	0	1	1.9	0	0.0
Widowed	1	1.9	0	0	1	1.9	0	0.0
Current residence								
San Martín de Porres	37	71.2	23	44.3	0	0	14	26.9
Cercado de Lima	1	1.9	1	1.9	0	0	0	0.0
Independencia	12	23.1	0	0	12	23.0	0	0.0
Comas	2	3.9	0	0	2	3.8	0	0.0
Certification of disability	0		0					
Yes, they have	32	61.6	19	36.6	10	19.2	3	5.8
No, they don't have	20	38.4	5	9.6	4	7.7	11	21.1
Time of illness								
1 to 5 years	1	1.9	1	1.9	0	0	0	0.0
6 to 10 years	7	13.5	1	1.9	3	5.8	3	5.8
11 to 20 years	16	30.7	4	7.7	6	11.5	6	11.5
Over 20 years	28	53.9	18	34.7	5	9.6	5	9.6
Psychiatric diagnosis								
Paranoid schizophrenia	46	88.4	22	42.3	10	19.2	14	26.9
Other schizophrenias	6	11.6	2	3.9	4	7.7	0	0.0
Insurance type	0		0					
SIS	30	57.6	10	19.3	9	17.2	11	21.1
ESSALUD	22	42.4	14	27.0	5	9.6	3	5.8
Armed forces	0	0	0	0	0	0	0	0.0
Private	0	0	0	0	0	0	0	0.0
Pharmacological treatment	0		0					
Currently taking medication	51	98.1	23	44.3	14	26.9	14	26.9
Did not continue with medication	1	1.9	1	1.9	0	0	0	0.0
Frequency of relapses in the last 2 years of club attendance	0		0					
No relapse	38	73,1	20	38,5	11	21,1	7	13,5
1 relapse	8	15.4	1	1.9	1	1.9	6	11.5
2 relapses	4	7.7	2	3.8	1	1.9	1	1.9
More than 2 relapses	2	3.8	1	1.9	1	1.9	0	0

AF: Absolute frequency

Table 2. Characteristics of user participation in psychosocial integration clubs in Northern Lima, 2018.

Characteristics of user participation in clubs	Renato Castro de la Mata Club (n = 24)		Nueva Esperanza Club (n = 14)		Amigos de la Santa Cruz Club (n = 14)	
	AF	%	AF	%	AF	%
Voluntary participation						
Yes	24	100	14	100	14	100
No	0	0	0	0	0	0
Method of referral to the club						
By medical recommendation	16	67	11	78.6	13	92.9
Recommendation from friends/family	8	33	3	21.4	1	7.1
How the user attended the 1st day of club meetings						
Attended with a relative	10	42	7	50.0	2	14.3
Attended alone or with a friend	14	58	7	50.0	12	85.7
Length of time involved with the club						
1 to 5 years	5	20.8	3	21.4	7	50.0
6 to 10 years	1	4.2	6	42.9	3	21.4
11 to 15 years	4	17.0	4	28.6	1	7.1
Over 16 years	14	58.0	1	7.1	3	21.4
Frequency of club attendance						
4 times per month	14	58.4	10	71.4	7	50.0
Twice per month	6	25.0	3	21.4	6	42.9
Once per month	2	8.3	1	7.1	1	7.1
Less than once per month	2	8.3	0	0	0	0.0
How the user attends club sessions						
Attends alone	22	91.7	13	92.9	13	92.9
Attends with a companion	2	8.3	1	7.1	1	7.1
Reasons for non-attendance to the club						
Studies	1	4.2	0	0	1	7.1
Dependent job	2	8.3	1	7.1	4	28.6
Job in sales	4	16.6	2	14.3	0	0
Helps or cares for a family member	3	12.5	1	7.1	3	21.4

AF: Absolute frequency

(...) Well, the psychologist at the health center suggested me to be in a meeting of guys like me, when my illness just came in... The guys were communicative... They were more people and I started to understand all this schizophrenia stuff, and I started to listen to them and I liked it... and ... I stayed in the club (user 3, 42 years old).

In the collected narratives, respondents mentioned that the nursing staff provided continuous awareness sessions to the family and the user, called "member", achieving a link, and they in turn responded by joining the club: the "member", attending, and the caregiver, motivating the former to participate. In this way, a triple bond was generated: "family-member-nurse", which had an impact on the continuity of the PIC:

The link between the family and the club happened also because the nurse provided empathy and friendship to the member and the family (...). Friendship is knowing the mother, what happened with the father (...). All this helps the nurse to bond with them. So that is also very positive. That is what a community nurse is (nurse 1, 55 years old).

(...) For example, for the family, it has not been easy either... We went to the home and the user was sleeping until eleven in the morning and the family said "he'd better sleep so he doesn't bother" We had to first explain to the family that he was a human being who needed to develop, what the pathology consisted of... Going to the club helped them a lot in their grooming, in their personal presentation (...) (nurse 5, 64 years old).

Implementation and operation of the PIC

The participants pointed out that the implementation and operation of the PIC was carried out through joint work

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Table 3. Perceptions of members, family caregivers and health professionals on the organization of psychosocial integration clubs in Northern Lima, 2018.

Category	Testimony
Creation of psychosocial integration clubs	*When I saw that he was recovered and no longer had many acute symptoms, that is, when he was no longer very psychotic, full of hallucinations; then, he was invited to participate in the club.... the doctor or the nurse would be asked to send him to the club* (nurse 1, 55 years old).
Organizational structure of psychosocial integration clubs	*(...) I went for a consultation at the healthcare center... a nurse gave me an interview, and then she invited me to the club and I went (...) I went periodically, because on Thursdays I went to play ball at the Institute... on Wednesdays I went to the healthcare center, from time to time* (user 10, 41 years old).
Admission	*(...) the family is an ally... The primary caregiver was usually the mother. But, if we were able to convince this person of the benefits they can have by going to the club, they are going to do everything they can to get them out of the neighborhood* (nurse 5, 64 years old).
Raising family awareness	*We have raised awareness in the community, because the community has a stigma towards the user (...) so we generally, in the community we have always walked with the users, talking and people saw that; they no longer saw him as they did at the beginning: "He is going to do something to me, he is looking at me wrong, he is going to throw stones at me". Even when we went into some stores, we told him that he was in treatment and that he was a good guy, so as not to keep arousing that fear and rejection of the user* (nurse 3, 63 years old).
Raising awareness among community institutions and the community in general.	*Therefore, political advocacy has always been done with these community actors, because if they changed priest or mayor, we had to sensitize them again, which sometimes helped a lot, because we got some resources* (nurse 1, 55 years old).

between the users and the nursing professionals, who jointly established healthy leisure activities and coexistence rules, which were carried out and respected at the same time:

We used to program activities for the psychosocial clubs and, for example, we were going to celebrate Christmas, so we needed to prepare chocolate with panettone, which is a classic, right? We made it possible for the users themselves to have autonomy and independence and they themselves went and collected donations from the bakeries (...) in addition, they made their own wall newspapers, celebrated members' birthdays (...) (Nurse 5, 64 years old).

According to their accounts, the participants noted that the clubs had two types of allies: strategic and conjunctural. The former were those that had supported them on a regular basis, such as non-governmental organizations, including Caritas Peru; local parishes; grassroots organizations, such as soup kitchens, among others. Conjunctural allies were institutions that gave occasional support, generally companies that sought to establish their social responsibility. Likewise, users and family members generated their own income in order to self-finance their recreational activities:

(...) The health center had a large piece of land and told us that we could work that land... What did we do? As most of the members were migrants or children of migrants, we began to work the biogardens. A small plot of land was assigned to each user... We coordinated with someone from the Ministry of Agriculture at the time... They trained the users on how to prepare the land for planting... When they saw it green and beautiful, they were motivated (smiles) (...) (nurse 5, 64 years old).

PIC users participated in various recreational activities, such as walks, practice of various sports, handicrafts, among others, in order to enjoy healthy leisure and learn to use their free time, feel good and useful again, as well as socialize with their peers. However, since the clubs' creation, the interviewees perceived that the clubs had scarce human resources, consisting of two people (nurse and nursing technician), who had periodically received institutional and self-funded training in order to accompany the "members" in the face of possible relapses, crises, family conflicts, applying different strategies and techniques, such as motivation, active listening, empathy, home visits, psychoeducation, healthy leisure and specialized counseling (Table 4).

Affective relationships and leisure as rehabilitating agents of the PICs.

Both the health team and the users agreed that the clubs are spaces for socialization in which relationships of camaraderie, understanding and dialogue are developed. For the users, the clubs are their "second home", their "house" and even "everything in their life"; they feel satisfaction for being in a space where they can establish friendly and affective relationships, where they can find "friends", "a family", can have relationships and maintain an active sexual life:

It helped me first to socialize... I had no friends before... I was sullen... I was very introverted... quiet... very dull... no strength (user 10, 54 years old).

(...) The club means everything to me, because it is a distraction and an improvement... because there, being with my peers, we share ideas... the nurses also help us and so... we talk... we share and I feel calm and I feel happy (smiles) (user 2, 56 years old).

Table 4. Perceptions of the implementation and operation of the psychosocial integration clubs in Northern Lima, 2018.

Category	Testimony
Of the implementation process	*(...) every user of the club who was undergoing treatment was visited every month at home and we found that the user was sleeping until eleven o'clock... We saw the medication, then we told the family that the user could not be confined to a space, and you have to help... Then, the family helped to move him, until the user came alone to the club* (nurse 5, 64 years old).
	(...) In the last two years, the admission has been mostly from the community follow-up program in which the users have been stable regarding their health (nurse 4, 29 years old).
	Empathy was good. Do you know what helped? It helped that the nurses who started this program, we were young people, so we had a very casual language among young people, so it was a space for joking, joking, joking, feeling good, and that established that bond (nurse 1, 55 years old).
	Well, in our case, we had to be always actively listening to our users.... Sometimes they would come and say: "My mother told me this". The other one would say: "She didn't want to bring me", in other words, they trusted us and came to give us their complaints (nurse 3, 63 years old).
	We worked on psychoeducation for the family, which is a technique that not only has to do with the theoretical and cognitive content, but also that the person who is very emotionally charged can express what he/she feels (...) (nurse 5, 64 years old).
	(...) the creativity of the nurse to provide materials, often recycled, or any type of material that allows recreational work with the users had great influence (...) (nurse 5, 64 years old).
Of planification	*(...) the users actively participated in the planning of activities, they said: "What are we going to do? All year long! What are we going to do? What are we going to do? What are we missing?" (...)* (Nurse 1, 55 years old).
Rules of coexistence	*We made the rules of coexistence because when users came for the first time, they sometimes had negative behaviors, for example, they became irritable, interrupted another member, laughed or made fun of others, didn't they? So, we moderated: "Wait your turn, please, let your partner finish talking, and you talk", these are rules that we are all going to respect, and we all agreed to get along well, to be happy and content* (nurse 3, 63 years old).
Of the strategic allies	*(...) Later, with the glass of milk program from the municipalities, users often did not have anything to eat, or because of the medications they were taking, they were anxious to eat, so when we organized the club, we made breakfast and shared it with the patients* (nurse 3, 63 years old).
	(...) For example, in the Municipal Office for People with Disabilities they are now organizing courses, workshops, they are teaching how to read... because we have users who do not know how to read... they have also helped us to update their ID cards that some of them did not have (...). INABIF has also helped with food for our users... Another political ally was the education sector, in the sense that there were teachers who taught them how to play soccer (nurse 3, 63 years old).
Of the financial resources	*(...) However, Helen, my partner (from the club), contacted a poultry store and they donated chickens for Christmas and to share* (user 3, 42 years old).
	(...) they did it among themselves, they gave their quota every day... ten cents, they collected and it was enough for the mazamorra and cake, we used a lot of social assistance at that time (...) (nurse 1, 55 years old).
	Yes, I remember that we used to organize raffles, we organized ourselves with the members themselves and also we, the professional team, donated and asked institutions to provide us with gifts (...). (Focus group, nurse)
	Yes, we were funded by the Institute with transportation for all the trips, according to the calendar of the year, in the summer, to go to the beach (nurse 1, 55 years old).
Of training for the healthcare team	*The basic training on rehabilitation of the person with schizophrenia was on psychosocial rehabilitation, by a social worker, who came from the United States, the Cayetano Heredia Peruvian University was more specific to what was group training and did psychoeducational work with people with mental illness (....). I am a family therapist, for example, I have training in family and systemic therapy, I am a therapist in gestalt therapy, I am a biodancer, that is, I trained in various therapies to work with different pathologies* (nurse 1, 55 years old).
	In reality, the training was permanent; in various aspects including group interventions (...) (nurse 5, 64 years old).

Another important component of satisfaction perceived by users, family members and health professionals are the leisure and free time activities chosen by them (Table 5). These activities allowed users to interact with each other and with the health team, the latter perceived as an empathetic team that encourages and accompanies them, which generates a gradual rehabilitation process in the members and their reintegration into the community. The activities were related to the practice of sports, such as soccer or volleyball, collectively chosen outings to places outside Lima, dances and board games such as cards, throwing darts, bingo, among others.

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Table 5. Perceptions on affective relationships and leisure as rehabilitative agents in psychosocial integration clubs in Northern Lima, 2018.

Category	Testimony
Affectivity	*I like jokes, making jokes with each other and the girls followed us, girls are capricious (smiles)... Each one had their ideals, didn't they? they said: "I want to marry a white boy" (laughs)* (user 10, 54 years old).
	What I enjoy about the club is the company of everyone. Teresita, a pretty brunette, doesn't pay attention to me (laughs). Another one, Rocío, tells me: "No, I'm too much of a woman for you" (laughs) (user 10, 54 years old).
	Whether she is a woman or a man, she or he should come with their father, so that they can get called down, because there are many who are very flirty and there are other girls who like other things (user 10, 54 years old).
	Well, the first positive aspect was that the user felt active, had friends, fell in love... Well, there were also some difficulties (...) They fell in love and sometimes went into the bathroom to have sex (nurse 1, 55 years old).
	The positive part, as I said, is that they felt that it was a space where they could feel very sociable, affectionate... Everyone loved them, nobody threw them out, nobody rejected them, so it was a space of affection, and also where they could show their positive side. Whoever was good at something did it.... There were guys who made beautiful letters, wrote or drew, so they brought out all the good things they had (nurse 2, 55 years old).
	I think that fundamentally there is social support, where they can share with people who have the same characteristics, they feel that there they can be free, that they can make a joke, so I think that these things have strengthened the club a lot (nurse 2, 55 years old).
	To be in the club means that I have developed a lot of patience, tranquility, because I am also a little bit choleric, I get bitter, but not so much, my choleric side comes out, my laughing and cheerful side comes out more, (smiles) so, the club means everything to me, because it is a distraction and an improvement... because being there with my companions we share ideas... The nurses also help us and so we talk, we share and I feel calm and I feel happy (user 2, 56 years old).
Leisure	
	I socialized, because I went to birthdays, to the party, holiday dates, we did drawings, painting, therapy, we walked there, inhalation, exhalation, what it means to be assertive, we talked about communication, presentation, cleanliness, a lot of nice things, and above all the presence of all my friends (user 10, 54 years old).
	For me it is a day to relax, to chill as they say (she smiles). Yes, it's the only day I can relax, I leave my granddaughter and say "I'm going to my club, I'll be right back" (smiles) (user 2, 56 years old).
	So, he would come alone, until one day I said to myself: "I'm going to go and get to know the place" (...) I used to play with the mothers of the volleyball club... I liked to participate and collaborate (...) I programmed myself, because I have two children here. I remember that my son was not playing at the beginning and I saw him stressed, I had nowhere to take him (family member 3, 55 years old).
	(...) there is a routine: I arrive at three o'clock, say hello, we start playing darts, monopoly, bingo, sapo, which is a game I played with my uncle (smiles).... My uncle has his lumber shop... We do all that; we play and it relaxes me a lot (user 3, 42 years old).

It has helped me because in the club we participate, we do dynamics, games, talks (...) That has helped me to be looser, more emotional. Sometimes, for example, on Mother's Day I participated by singing, I like to sing! (smiles). I also get distracted there because they have taught us to knit, to make little cards (user 2, 56 years old).

My daughter seems to be more confident... she does her chores as if she wants to do them on her own... And we, little by little, have let her do the housework... Then, when I am sick, my daughter takes responsibility for the kitchen and she has learned to cook (smiles) (family member 2, 66 years old).

Linking PICs to families and socio-community networks

The perception of the linkage of PICs to families and socio-community networks has been partially favorable (Table 6). Some families perceived that their family member made better use of their free time and was not idle at home, and that they showed satisfaction in being able to interact with their family and carry out domestic activities. In other families, social stigma, exhaustion due to caregiving and little interest in the user's rehabilitation process persisted:

Few family members attended when there were problems in Independencia... We had to go from the health center to the community center. Family members were asked for a meeting and did not attend (user 6, age 40).

Also, they offered us handicraft workshops for family members... Not only the patients had to learn, they said, and sometimes we family members were the ones who enjoyed these workshops the most, we felt more relaxed... so, I think it is a good initiative that we participate together: family members and patients (family member 1, 55 years old).

The linkage of the clubs with the community was also partial, as it required constant sensitization of authorities and socio-community networks due to prejudice and stigmatization perceived as a barrier that required permanent intervention:

Table 6. Perceptions regarding the linkage of psychosocial integration clubs to families and socio-community networks in Northern Lima, 2018.

Category	Testimony
Members' relationship with their families	*(...) the family has become more and more active, not only in seeing that their family member participates but also in participating in the activities that are organized as a club...I think that this is one of the most positive things that has happened with certain families, they have understood the importance of the space for the family* (nurse 1, 55 years old).
	Families are also integrated into the club. For example, the sisters of one user learned work activities, participated in the field trips and helped the children (user 1, 55 years old).
	Parents attend the meetings... they talk... they ask: "How can I help?", treat their child, my father treats me like that, my father is a little bit rude, he calls me conceited, my father loves me a lot, he has understood me (smiles) (user 1, 53 years old).
	Well, only with the exception of my nephew, who comes here and is 21 years old, he puts a lot of pressure on me that I have to go to work early, that I have to earn money, he pressures me and sometimes insults me, so I don't think it is appropriate (user 5, 58 years old).
	Yes, my husband has been invited to a talk at the end of the month, and to talk about me, because my husband does not participate with me... I tell him: "I am going to go to the club, to my therapy"; he says: "Don't go, you are just going for the heck of it". He is a bit negative (user 2, 56 years old).
	Of course, we always listened, we did not interrupt until they finished. Then we told them if you say that they have scolded you, they have hit you, what is the reason? we began to explore, what for, to visit the family with knowledge and be able to educate them, and also the user (user 3, 63 years old).
	(....) Teresa helps at home making tamales, a series of things, but her family mistreats her... the visit helped to discuss the patient's situation with her family, but she also needed a lot of help and understanding, because they say: "You are of age and do not contribute" (Focus Group, nurse).
	Every day I fight against my family, my sister wants to throw me out of my room, she is the owner; she does not let me work as an ambulant, I have my sewing machine, my machines, it does not work because she breaks the plug, she spoils it saying that I can't, I am patient (Focus Group, user).
	(...) Since my father was there, he would hit us with the belt and take off his shirt (user 6, 55 years old).
Links between clubs and social and community networks	*The stigma was not only from the family, from the healthcare center's office, but also from the staff, they were very afraid, they thought they were going to destroy or misuse things, in short. The stigma was notorious* (nurse 5, 64 years old).
	(...) I went to talk to the person in charge of OMAPED to tell her what I thought: "You are also the ones who support us in labor issues", and she told me: "Indeed, private companies had as a regulation that a minimum percentage, 10% of workers should have some kind of disability, but they opted more for physical disability: 'I prefer a person who has no arms than a person with mental disability who can have a crisis' (...)" (nurse 4, 29 years old).
	For example, if someone insults you, you can't respond in the same way, you have to appease him (...). The other day I was singing and dancing in the market because I liked the music, and a man came and I stood next to the one speaking the Gospel and he said to me: "You are mocking me, here come many little fools who stand next to me" (user 1, 53 years old).
	The community knows that there is a club; socially there is a whole stigma that has to do with information, the profile of people with schizophrenic disease, so how can we get people and communities to integrate these patients? (...) (nurse 6, 45 years old).
	Because sometimes my husband does not participate with me (...) But the lady has been talking to him for a while, and because of that, he tells me: "You are going to go to your therapy, you are going to your mental health", then when we have a walk and he is already worried, he tells me: "What are you going to take?" Since I am a person who suffers from diabetes, he worries about what I am going to eat (user 2, 56 years old).
	(...) The club is in the health center... but there is still this stigma. The former boss had allowed us to use the auditorium, but now that they changed the boss, they remodeled the auditorium and moved us to the patio... We wanted to return to the auditorium... We filed documents, the guys themselves filed documents, and they gave us a negative answer... We could not use the area for the club (crestfallen) (...) (nurse 4, 29 years old).

DISCUSSION

The PICs implemented by the Collective Health Department of the NIMH HD-HN began in 1983 with clinically stable users, who were managed autonomously by a board of

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directors elected by themselves from among all the members. These PICs are meeting places where various recreational activities are carried out, making good use of their free time and leisure. This study reports the favorable perception of users, caregivers and nursing professionals in the first PICs in the country that contributed to the promotion of socializing spaces and inclusion in normalizing activities within their community and territorial health network.

The results showed the absence of PICs in other services of the health system (Essalud, armed and police forces, private sector), in spite of being mentioned as a priority at an intersectoral level within the framework of the current community mental healthcare reform and with the participation of users [16].

It is noteworthy that 73.1% of the users who participated in the PICs had not relapsed in the last two years. Abelleira [17] reported that family support, social support, free time and leisure activities are protective factors that contribute to reduce the possibility of relapse, since affective bonds of trust and mutual gratification are generated. This rehabilitative approach is like a "school for life" [18] where it is evident that community-based interventions and psychosocial rehabilitation contribute to clinical improvement and relapse prevention. Chung *et al.* [19] also noted that family members perceived positive affective changes, improved behavior, positive attitude and increased social interaction.

Raeburn *et al.* [20] mentioned that users highlighted the increase in confidence, acceptance and hope through supportive relationships with others who shared their experience in a normalized environment. This experience is analogous to the implementation of several clubs in Brazil and Chile, where that the interaction was "meaningful, as a living space, which restores the longed-for normality to the members" [4].

The accompaniment of the members by specialist mental health nurses, who have provided continuous comprehensive care, is noteworthy. Bernal [21] mentioned the relevance of quality care focused on the problems and needs of the users. Angulo [4] made visible the importance of the participation of mental health teams from the public system, in addition to the participation of corporations, foundations or groups of users and family members.

The club users perceived that the PIC is a space for meeting and healthy socialization, where they feel free to express what they want, because they are among friends, they feel listened to, supported and understood regarding to their disease and with others, which gives them wellbeing and satisfaction. This coincides with Larizgoitia-Jauregui [5], who mentions that the clubs encourage participation and the exchange of opinions between members and professionals, who use facilitation techniques. Tur [22] also showed that, in users with SMD, after carrying out leisure and free time activities for three years, the users achieved a progressive interest towards enjoyment; greater satisfaction, according to the degree of independence and self-esteem; and interpersonal relationships increased and improved and users showed more care in their grooming and personal image.

Regarding sexuality, the users and the health team perceive that there are expressions of physical attraction in the clubs, like being comfortable with another person and empathy, as would be developed in other socializing spaces of life; thus, consolidating strong affective bonds with rehabilitative potential, that make the user feel loved and accepted in the personal and social sphere. Thus, having social support contributes to clinical stability, emotional well-being, positive perception of the affective environment and improved perception of quality of life [23]. On the other hand, according to Kring and Coponigro [24], the sexuality of the person with schizophrenia may be affected by the presence of negative symptoms associated with restrictions in the expression of emotions, as well as the presence of some difficulties in the perception of future pleasurable experiences. However, Verhulst [25] highlights the importance of expressing affectivity during the course of the illness and the rehabilitation process, with interpersonal relationship problems, lack of social skills and impaired social functioning being the main barriers to falling in love and healthy sexual interaction. Regarding the perception of family bonding and their participation in the clubs, some testimonies mention that family support to the users was partially positive and they perceived social stigma. Inglott [26] emphasizes that family support is essential in psychosocial rehabilitation programs for people with mental disorders, and is influenced by caregiver overload and high family stress.

Likewise, we found that the family and users were unaware that schizophrenia was a medical disease, and there was evidence of discrimination and social stigma towards the users, who were even treated with violence and disqualified or denied their participation in the club, as it was perceived as a "waste of time". This negative role of certain families is a significant barrier to the rehabilitation of the user [27,28]. Muñoz [29] highlights the presence of self-stigma in people with mental illness and in the family members themselves, associated with feelings of shame, guilt and behaviors of concealment of the person with disability from the community social environment. The families, in principle,

expressed their needs for information and support, but were not always willing or available to go to the health services network.

The linkage with the socio-community networks of the members could be related to community, family and individual ties [30,31]. The PICs in northern Lima have developed all three dimensions, some more than others. These clubs are considered as a space that builds relationships that promote social articulation and citizen participation in various instances of debate on the future of the community, involving professionals, family members and people with mental disabilities. The clubs have managed to link up with some socio-community organizations that provided logistical support, such as the use of premises or donations. In the clubs of other countries, greater community participation and involvement has been achieved [24], as well as greater development of community ties and local cultural, social and artistic development [32,33].

Regarding clubs' limitations, the narratives described the lack of logistic resources for operation and functioning, the lack of adequate infrastructure, barriers related to the socioeconomic condition of the users who lived in poverty, the lack of money for transportation, the scarce involvement of the first level of healthcare centers with the users of the club, which is associated with social stigma and discrimination by the health personnel themselves, in addition to the scarce awareness of community organizations. A qualitative study [34] showed limitations perceived by users with mental disorders in sheltered homes, centered on budgetary and administrative barriers that limited spending on transportation and compliance with activities related to the users' leisure and rehabilitation plans. Our study had limitations inherent to the design of qualitative studies, such as the representativeness of the actors' perceptions. This does not allow us to make inferences, but it does allow us to understand the historical process of the implementation of these measures for the social integration of users within their community.

In conclusion, the meaning and benefits perceived by PIC users, despite socioeconomic and infrastructure limitations, reveal a favorable impact, because users perceive that the club generates a group atmosphere where they develop long-lasting bonds of friendship, satisfaction with the enjoyment of healthy leisure and a progressively greater participation and integration into community life, without restrictions.

It is recommended to continue with quantitative and qualitative studies to understand the contextual, cultural and social factors of each community that are associated with dropout or continued participation in PICs, as well as to understand the availability of standardized socio-community resources, level of community empowerment and the process of their implementation in the community mental health centers of all the integrated health networks in the country. It is necessary to invest more resources in community therapeutic programs for people with mental disabilities, improve and implement PICs in each locality, establish the national regulatory framework and provide free services to users within the framework of universal insurance and the current community mental health reform.

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