

Issue 1
Fall 2019

THE ROAR JOURNAL

EMPOWERING VOICES FOR SOCIAL PRACTICE & INNOVATION



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DEDICATION TO DENISE HAST (THROUGH THE EYES OF PAULINE NICHOLLS)

The first issue of the ROAR Journal we dedicate to a clubhouse activist, the late Denise Hast. Denise was at first, a member of the Genesis Clubhouse in Worcester, MA, and later, a member of New York's Fountain House. She also worked, for a time, at Clubhouse International.

The title of our Journal, ROAR, is inspired by a group of members that Denise had been organizing before her untimely death. The group was created to increase member attendance at clubhouses and to strengthen member voices in the clubhouse world.

I interviewed Denise's best friend inside and outside the clubhouse world, Pauline Nicholls, in order to compose this dedication. Pauline is the wife of outgoing FH President Kenn Dudek and a clubhouse leader in her own right. She is currently a Nonprofit Management Consultant, but she has also served as a clubhouse director. Through CI, during a clubhouse accreditation, she first met Denise Hast. The two "fire-souls", as FH enthusiasts might call them, quickly became friends and remained so until Denise succumbed to cancer in 2016.

Denise, according to Pauline, was a loving mother and grandmother, and a loyal friend. She was intelligent ("smart, but not showy"), yet often misunderstood, reliable, but unafraid to speak up. She possessed tremendous empathy for her fellow human beings and had the unique ability to disagree with people, yet not alienate them.

Though Pauline and Denise could have surrendered to the traditional, hierarchical dynamic of recovery program staff (Pauline) and member (Denise), Pauline emphasizes that she and Denise were first and foremost friends, engaged in the type of "meaningful relationship" that clubhouses promote. Denise even had her own room in Kenn and Pauline's house. The two "BFF's" explored New York restaurants, put together furniture, traveled the world together and even climbed a Peruvian mountain.

"Denise," Pauline says, "embodied everything clubhouses promote: she led a recovered life, worked fulltime at CI, where she managed clubhouse accreditations, assisted FH Colleague Training Director, Alan Doyle in recruiting clubhouses for

colleague training, was a guide and mentor to many clubhouse members and staff and she was a respected activist in the clubhouse movement.”

I tossed Pauline an easy question about Denise:

“Did Denise engage in social practice?”

Fighting back tears, Pauline said, “All the time! She worked in the units, wrote for the newsletter, gave clubhouse tours, and was an ambassador for the movement.”

We hope that Denise, wherever she is, enjoys this first issue of ROAR. If she were alive today, she would undoubtedly be a member of our staff.

Craig R. Bayer, 6/13/19

LETTER FROM THE PRESIDENT

KENNETH J. DUDEK

Like many initiatives at Fountain House, this journal is a true grass roots effort from our members and staff. ROAR was conceived through The Center for Leadership and Education to create a place for our global community to discuss our way of working, which we have recently termed *social practice* (Doyle, Dudek, Lanoil, 2013). This inaugural issue aims to define and describe social practice so that we can all use a common language to describe the important work that we do each and every day.

As I wrap up my 28 year tenure as the President and Executive Director of Fountain House, I think it is very important to develop a platform for the voices of Fountain House members and staff as well as the thousands of kindred spirits around the world. I know this group brings a unique perspective not heard very often from either “peers” or “professionals”. At Fountain House we have come to understand that it is our challenge to find new ways to express our unique way of working. The burden is on us to communicate these ideas in a way that the professional world and the general public can understand and embrace. For example, we know we have an answer to trans-institutionalization and homelessness that is different from the dialogue often heard from the mainstream mental health community. However, if we continue to describe our model as “magic”, we undermine the professionalism that is required to sustain quality clubhouse programs and make it easy for governments and other entities to dismiss us as just a “nice place”. The mission of ROAR is to demystify our model and provide a platform for continuous education and innovation in our model for mental health recovery.

We honor Denise Hast and the countless clubhouse leaders who have passed for the contributions they have made to bring us to today. Moving forward, we all must take up the challenge to spread our work and confront the global mental health crisis by providing the world with a viable solution that we know works. Please join us by contributing to this ongoing dialogue, not just within our own clubhouse community, but throughout the world. Let’s raise our voices together and in doing so, make a positive change in the lives of people living with mental illness at every corner of the globe.

Kenneth J. Dudek
President, Fountain House



SYMMETRY
MAYBELLENE GONZALEZ

THE ORIGINS OF SOCIAL PRACTICE AT FOUNTAIN HOUSE

ALAN DOYLE

SUMMARY

Social practice is an innovation in social work know-how created by Fountain House New York for the recovery of people living with mental illness. At Fountain House social practice demonstrates on a daily basis the power of personal input, particularly the input of the members themselves, in the “creation of an opportunity-rich and relationally supportive social ecology” (Doyle et al., 2013) for recovery ends. The article that follows relates the event that launched the search for the term *social practice* in redefining its methodological approach; the historical context out of which the term evolved (i.e. the “total push” milieu therapy of the 1950’s), and the adoption of the term “social practitioner” to replace “generalist” as the framework to understand how Fountain House assists members to be able to live and thrive in society despite their illness.

THE PROBLEM

I first came to realize that Fountain House needed a new way to describe its approach to working with people suffering from mental illness from a student who was completing her practicum at Fountain House for a master’s degree in social work. I can still recall the morning she arrived for work confused over the public humiliation she faced from a class the previous night and the ridicule she encountered in relating the activities she engaged in at Fountain House. The descriptions of her work with members in arranging flowers and cleaning, normal responsibilities for a staff generalist, was met with incredulous derision as unprofessional and not reflective of rehabilitative techniques that would merit a graduate degree in social work. This was not the first time that basic clubhouse methodology had been

challenged by an academic institution. Early on in its history, Fountain House had partnered with Columbia University sponsoring a hands-on¹ training program for field practitioners in psychiatric social work. An annual internship program was introduced following the training program. The internship ended abruptly, however, a decade later when a newly appointed dean cancelled the practicum upon learning of the expectations for work at Fountain House (i.e. cooking and cleaning) that again did not measure up to the advanced nature of the professional expertise expected of a university graduate.

I felt this criticism from academics was misguided. To me, the remarks reflected how far the social work profession had shifted from its civil rights activism of the 1960's that I was familiar with. The profession appeared to be abandoning the tradition of community, street-level empowerment originated by the settlement house movement of the early twentieth century on which Fountain House was modeled.² Like others in the fields of social betterment during the latter half of the 20th Century, social work education was seeking to enhance its standing as a profession in the community possessing an expertise premised on technical rationality and scientific data to improve social integration in society (Schön, 1987). It adopted in this endeavor a staff *specialist* approach that had proved so successful in the medical profession in delivering health services. Here, people in need of treatments, such as those suffering from mental illness, were viewed as flawed and having specific deficiencies that could be reversed with the application of a targeted corrective techniques.

At the same time I realized that Fountain House needed a better way to communicate the substance of its approach than its *generalist* methodology. In contrast to the pervasive understanding of the work of the professional as a specialist, the generalist approach practiced at Fountain House described a more fluid understanding of the job of staff—one of not being restricted in their support for members by their training or location. Beard's formative and original work was a revolutionary act at the time. Beard and his field colleagues sought to include the patient themselves as actors integral within a therapeutic environment. He found however that for the approach to operate successfully the social structure of community-based social work had to be radically altered.

ACTIVITY GROUP THERAPY

Beard's approach stemmed from his observations decades earlier as a student intern for his degree in social work at Eloise,³ a psychiatric hospital located outside

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- 1 The program combined classes at the university in the morning with application practice at Fountain House in the afternoon.
 - 2 Note that the reference to "house" in its name alludes to the tradition within social work from which Fountain House evolved.
 - 3 A nickname for the Wayne County General Hospital, which, although named a general hospi-

Detroit City. At Eloise, Beard was part of a therapeutic team along with Goertzel, a psychologist, and Pearce, a psychiatrist. They practiced a novel approach in treating mental illness within the psychiatric profession at the time, milieu therapy.⁴ Concerned with the detrimental impact that the asylum environment had upon its patients, they expanded the dyadic relationship of the psychiatrist with their patient to include everyone in the hospital setting whom patients came in contact with: the social workers, the floor attendants, and even the other patients.

At Eloise, the team observed firsthand how the onset of mental illness had resulted in the total breakdown of normal human relationships of patients, devastating their personal lives with the loss of jobs, family, and friends and resulting in personal isolation and the loss of all social significance. They referred to the condition as “relationship failure.” Yet the team noted that, while their patients exhibited behaviors related to their psychosis, they demonstrated as well quite normal behaviors reflective of functions central to human interaction and relationships.⁵ They were aware that historically psychiatric patients appeared capable when they went off the hospital wards to work either in other areas of the hospital or on the grounds in farming. They noted the same results in their observations:

Yet when even the most disorganized, regressed patient was thoroughly and carefully viewed, we were able to observe various behavioral patterns, which though seemingly insignificant, were still quite appropriate and fundamentally intact.⁶

While these normal behaviors apparently went unnoticed by others at Eloise as they concentrated on the medical considerations of the illness, the team sought instead to make these areas of health and normalcy the focus of their work. In their opinion, the hospital environment only further reinforced the loss of identity and social significance that accompanied the onset of mental illness. In contrast, their task in the situation was to circumvent these dysfunctional behavioral patterns. In fact, they proceeded to consciously disregard expressions of the illness, rendering them “irrelevant” in their consideration of intervention strategies:

tal, operated as an asylum for the insane.

- 4 Beard alludes to *milieu therapy* in his seminal article (1958) where he describes the approach, Activity Group Therapy, as “similar in many respects to the supportive treatment of schizophrenics reported within the last decade by various professional workers in the field.” He later identifies this treatment as the “total push” approach (*Beard Unplugged*, 1978), a form of milieu therapy that attempted to structure the entire hospital community as an active force in patient treatment (Doyle et al., 2013). In England the approach was practiced as a *therapeutic community* (Jones, 1953).
- 5 The team referred to this core of normal functioning as “*residual ego strengths*.” It revealed their Freudian mindset where the working medical definition of schizophrenia was the absence of ego strengths.
- 6 Beard et al., 1958.

We sought to render his pathology irrelevant and meaningless in terms of the reality context of our relationships to him and to be equally irrelevant of the activity structure of the group.

They speculated that, since the patients retained normal areas of human reasoning, they could engage them on the basis of these areas of apparent health. Instead of relating with the patient in terms of a deficit, i.e. their illness, the team determined to relate in terms of normal interests, and “actively” engage them in the practice of milieu therapy. They concluded:

Our task was, therefore, to strive to relate exclusively to these behavioral patterns and to *utilize them actively* in the establishment and development of a relationship between the patient and his environment in the hospital

Here, Beard and the associates with whom he worked at Eloise introduced an innovative aspect to a psychiatric intervention: that of including the patient themselves as integral actors within the therapeutic environment. They invited the patients to join them as participants in the activity group therapy they were conducting on the ward. Ultimately the team concluded that engaging the patients in the reality of normal group activities had a therapeutic effect:

The patient’s new experience in participation with others on a basic reality level seems to promote a process or reinstitution of lost ego capacities.

For Beard moreover it was this initial insight that became the foundation principle of Fountain House: where the client would be perceived, despite their illness (their disability), not as deficient but as capable and that the capabilities they retained could be the key to both themselves and those with whom they associated in a recovery enterprise. Over the next decades, Beard and those that followed him proceeded to build its signature side-by-side approach, constructing a practice in which the member was to become an integral component in fostering recovery among people suffering from serious mental illness.

BUILDING THE FOUNDATION OF FOUNTAIN HOUSE

In moving from the hospital setting of Eloise to midtown Manhattan, it was this aspect of opportunity for peer involvement and member mutual support in the recovery process that appealed to Beard. Having a place within an urban environment he could expand his initial notion of professional-patient interaction within

isolated task groups into the activities of an entire day where the members would work alongside the staff of the organization, “side-by-side,” from nine to five, five days a week, like everyone else in New York City.

Beard accomplished this by radically rearranging the social structure of the patient and the professional with whom they worked within the clubhouse setting. He changed the profile of the member from one who was needy to the one who was needed, placing a value on member input, not for the flaws that needed remediation, but for the talents they could contribute. Concretely this called for understaffing the operation so that there were never enough staff to accomplish the activities of the day without purposeful involvement of the clubhouse membership.⁷ Imagine having a place of work without enough people to accomplish the tasks at hand. This is exactly what Fountain House called for. Member participation was also built into the daily planning of clubhouse workflow by requiring member participation in decision-making. No discussion could be held regarding program decisions or member issues without the input from clubhouse members.⁸ In fact member input was not just expected; it was essential if good decisions were to be pursued. As observed by Bradley (1997):

I think the quality and the thoughtfulness of the decisions we reach as a community is superior to decisions I reach alone in my office.⁹

Structurally Fountain House under Beard’s direction organized itself as a place for recovery in mental health that was operationally deficient without the contributing talents of its membership. In effect, Beard had secularized a therapeutic strategy in psychiatric recovery into a restorative place in society where the participants, members and staff side-by-side, collaborated in the important work of mental health recovery.

The creators of Fountain House understood that a place of work in and of itself is not an appealing enterprise—even work that is structured to guarantee a position for members in its operations. At Fountain House there was no inherent appeal of productive work devoid of human intervention. In addition to structural adaptations noted above, the opportunity for normal human exchange was considered essential to motivate active involvement of the clubhouse membership, particularly in a culture where “members choose they way they utilize the clubhouse, and the staff with whom they work” (Standard#3). Lanoil, an early administrator

7 As expressed in Standard #9: *Clubhouse staff are sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without the member involvement.*

8 As stated in Standard #8: *All clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed.*

9 Kevin Bradley, as director of Genesis Club in Worcester Massachusetts led the effort to have the practice of consensus inserted into the Standards (see #37).

at Fountain House, recounted how Beard explained the role of staff within such an environment as “completing the helping act” (Doyle et al.). He recalled how Beard used the example of helping a person who is a visitor to the city and asks a passing pedestrian for directions. He would relate: “You tell him to go two blocks, turn right, then go to the third light and make a right, and then at 46th Street go left, etc.” You could even draw the tourist a map. In Beard’s opinion, this is how a specialist acts in the situation: one who sees themselves as someone who knows something and provides the information, even drawing a map, for which another person is searching for a solution.

But *actively engaging* the person, which is the mark of a generalist, required more; it required completing the helping act. It meant taking the time to escort the visitor to where they wanted to go, saying: “Come on, let me show you the way.” As *generalists* Fountain House staff were expected to shift seamlessly organizing activities within the work day program, supporting member efforts at housing or employment and then moving to recreational activities in the evenings and weekends in completing the helping act. The message in the anecdote is aptly summarized in Standard #10:

Clubhouse staff have generalist roles. All staff share employment, housing, evening and weekend, holiday and unit responsibilities.

In other words, clubhouse staff are not to act like specialists within the organization; they are not restricted in their dealings with members in terms of the specialties they had been trained for (e.g. vocational evaluator, rehabilitation counselor, job developer) or the locations within the organization where that specialty is practiced. They take the initiative and personally accompany members on the way. Even when written information is available on how to perform the tasks at hand (i.e. the “maps” for the situations), members or staff are ready to stand at their sides and help members learn their responsibilities—as someone who would complete the helping act and be there for every step of the way. The role of clubhouse staff was designed with this highly relational environment in mind. As Vorspan (2000) summarized at the time: “The job of the clubhouse staff is simple. It is to take each opportunity to look into a member’s eyes and say: ‘I need you.’ Recovery does not happen simply in the doing of the work; it happens by doing work in the context of this real, human engagement.”

But completing the helping act was only the initial phase for staff in establishing a relationship with members. For Beard, completing the helping act was not an end in itself—where the member goes off on their way as related in the anecdote on asking for directions. Rather it was in gaining a member’s appreciation and trust in completing the helping act that staff responsibilities have only begun. A member’s expression of trust and sharing in everyday activities was the cue to pivot and

begin the process of integrating the member into the activities of a group. Or, as Madison, the current Fountain House Program Director, has contended, updating the recovery dynamic that takes place at Fountain House:

“I as staff need you, the member. But you do not need me. You need them.”

Engagement in normal human activities in participation with others, the “them,” he contends, in the words of Beard is the structure that isolates socially the patient’s symptomatology and promotes “a process of reinstitution of lost ego capacities.” Relying on his formative and favorable experience at Eloise, Beard had learned that, once staff established an initial relationship with the patient, they needed to shift in interacting with individuals and *relate to patients significantly and exercise the function of a real educator...* . In defining the role of staff as a generalist negatively, however—as one who does not act like a specialist—provided little if any guidance on how one was to accomplish such an injunction. Most importantly, how was a staff person to bridge the divide, for example, between the freedom of members to say NO and the imperative for active participation in the very activities that are considered essential to restoring meaning and directions in their lives. As Glickman has correctly posed the pervasive challenge facing clubhouse staff in his article of the same title: “What if nobody wants to make lunch?”

THE FLAW OF THE GENERALIST STAFF APPROACH

The real flaw in the generalist approach to the staff role that pervades clubhouse thought was that in defining the term by saying how NOT to act, it was considered enough to promote a personal sense of urgency and enthusiasm for the work to overcome the inertia and anguish that is a characteristic aspect of mental illness. In fact, it almost seemed that expertise itself, not how it was performed, automatically involved a professional reluctance to become fully engaged with members and thus disqualified applicable expertise as a serious topic for consideration.. As expressed by Hallinan and Nistico (1994) in an article included as required reading in clubhouse training, experts were presented as setting themselves up on a “pedestal,” “possessing skills, values, knowledge that are more effective and pure than those of lay people.” The ideal of side-by-side collegial work required only the enthusiasm of a layperson for the work at hand. Ultimately in clinging to defining the clubhouse staff role as a generalist, content with the passion of a person without the insight of expertise, robbed staff of know-how that could be helpful in enhancing collaborative rehabilitative relationship in working with members. One need only read Bradley’s article mentioned above on the importance of consensus as a social technique, an expertise that combines technical insight with passion and respect

for member agency, to understand the lapse in this mindset. It also exposed the clubhouse movement to the type of unwarranted criticism that was reflected by academics noted at the beginning of this paper.

SOCIAL PRACTICE AS A CONSTRUCT FOR COLLABORATIVE RECOVERY PRACTICE

It was at this point in my inquiry that I became aware of the approach of *social practice* from Marianne Kristiansen, a Danish researcher. She had conducted a study on the relational foundation of two clubhouse work units¹⁰ and their support for growth in member self-confidence and purpose. She explained that *social practice* was the best term she could find to get beyond understanding recovery as a unique process for each member. One needed to explore the entire social context in which the individual member recovers—the people involved, the members and staff, and the framework of their interaction to establishing purpose and personal motivation in engaging in clubhouse work. Member development, she observed, contains multiple aspects:

which are mutually bound. Theoretically then, my opinion is that work, people, social relationships, and context (i.e. structure for all activities) all go together like peas in a pod. (p. 65)

It was immediately apparent to me that the understanding contained in social practice—that member development and support for their recovery required an integrated understanding of work, people, social relationships and context—was the same insight that caught Beard’s attention in Activity Group Therapy and that became the formative conceptual basis in creating Fountain House. It was in social environments marked by collaborative, side-by-side work of members and staff in every day reality settings that had a positive effect upon member agency and recovery in mental illness. Likewise Kristiansen argued that social practice offered both a framework in which to structure interventions and the conceptual basis to understand the applicable principles and strategies in the social construction of groups and their effectiveness in supporting recovery in mental illness. Kristiansen even went further and contrasted the inconsistency in the emphasis on member development with the almost total lack of time given to collegial reflection among staff. Her research revealed that there was much usable tacit knowledge (Polanyi, 1963) that clubhouses could mine to apply when they find themselves “on a tightrope “

10 In *It Makes Sense* (2006), a study of the functioning of units in two established Danish clubhouses, Kristiansen observed how the various relationships (personal and professional) among the members and the staff on the units and the structure of the work of the day that frames those relationships promoted members’ ability to take charge of their own lives and develop self-confidence.

in their work balancing member choice and the necessity for social involvement. And such a reflective process should include the members as well. Since this first suggestion to replace the term generalist with the more descriptive expression of the actual expertise involved, Fountain House has adopted social practitioner as the name for those assuming its staff role. And now I am pleased that this first issue of ROAR is just the sort of exchange Kristiansen advocated that would promote collegial skills development and the progressive evolution of social practice in empowering members to assume purpose and direction in how to live and thrive in society.

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LOVE (by Eva Tortora)

**Beside me
I walk in faith
In thousands of roses
Toward the sun...**

**Today we spoke
Our own language
Little by little
Dancing in snow**

**Part of love
Is learning to dance in the rain
Being patient
To start slowly again**

**Sending to you
Roses and snow
Part of love is
Letting go**

**LOVE
EVA TORTORA**

DEFINING SOCIAL PRACTICE

DR. FRANCESCA PERNICE

The aim of this paper is to expand the definition and application of Social Practice as it applies to the “creation of an opportunity-rich and relationally supportive social ecology” (Doyle, Dudek & Lanoil, 2013, p.72) in the clubhouse setting. In this publication, Doyle discusses the origins of the term, which was borrowed from Kristiansen’s (2006) evaluation report of Denmark based Fountain House models. Traditionally, clubhouse staff are referred to as ‘generalists’ (Dougherty, 1994). Dougherty defined the generalist role on organizational theory and alluded to the clubhouse environment to fully describe staff roles. The practice the *generalist* embodies is characterized as ‘social practice’, however what *generalist staff* do is rarely explicitly discussed in the literature. We contend that Social Practice must occur within an intentional community setting, and like the term generalist, is not restrictive to clubhouses. In this paper, we aim to define social practice and redefine the role of generalist using the more descriptive term “social practitioner.”

DEFINING SOCIAL PRACTICE

Social Practice is a system of interventions in a community setting. The impetus for the introduction of the term *social* practice stems from the need to develop unified and shared language around the terms related to practice that utilize community methods in establishing health, recovery, meaningfulness, and belonging (Doyle et al 2013). An important move, therefore, is to define Social Practice in relation to practices occurring in clubhouse programs and environments. Social Practice is also aligned with the core principles and key practices of psychiatric rehabilitation. Specifically, it supports practices promoting full integration of people in recovery

into their communities, exercise their rights of citizenship, and accept the responsibilities of being a member of a community and larger society (Psych Rehab Association, Principle 6). As such, we define Social Practice as **a specialized form of therapy that uses the intentional community to assist people in their recovery**. The clubhouse is an ideal place to conduct social practice.

Social Practice addresses individual symptoms associated with serious mental illness and designs opportunities that assist individuals in their mental health recovery. Serious mental illness is recognized in the United States as a mental, behavioral, or emotional disorder that impacts our functioning and substantially interferes with or limits one or more major life activities (National Institutes of Mental Health). Serious mental illness typically involves a diagnosis of a schizophrenia spectrum disorder, Bipolar disorder, or Major Depressive Disorder. Across these SMIs, the constellation of symptoms typically associated are those that are most resistant to traditional medical or clinical interventions; that is, social practice addresses symptoms that are not directly addressed through medication alone, such as social isolation, social withdrawal, apathy, the absence of self-esteem or efficacy.

Social practice focuses on a community approach of assisting individuals recover skills, talents, a sense of belonging, and self-worth. Symptoms most often address include, but not limited to negative symptoms often associated with schizophrenia spectrum disorders, cognitive deficits associated with executive functions such as planning, decision making, and social support. Simply, social practice aims to integrate elements of the natural and human built environment to improve quality of life, access to social connections and support, and positive developmental trajectories in one's life. This is a broad definition encompasses both theory and method. Finally, we firmly believe that any activity defined as Social Practice be conducted only for the purpose of assisting people toward mutually agreed goals- otherwise it is deemed coercion.

Recovery. Our definition also explicitly mentions **recovery**, which requires context and explanation. The formal call of establishing recovery-based care in community mental health promulgated the development of 'recovery communities' however, Fountain House has long established itself as a community for individuals seeking to connect with others. Recovery as a concept in public mental health has evolved over the course the of the last 30 years (Deegan, 1988) and is often defined as a process or subjective experience in living with chronic mental illnesses, typically measured through qualitative studies. Professionals have described recovery as an objective outcome, with several instruments designed to assess recovery. The best way to address recovery from the perspective of social practice is through self-efficacy. Within the concept of Social Practice, recovery is defined both as a personal non-linear process and outcome—that is, as a proxy to 'self-efficacy'. For example, recovery can be self-defined as the process of regaining control over one's life in

a social environment, whereas a common outcome in clubhouse programs is the reduction in hospitalizations, independent housing and gainful employment. For example, clubhouse models utilize the structure of the Work Ordered Day (WOD) to explore opportunities that come along with clubhouse membership. Practices associated with the WOD are hypothesized to promote self-efficacy beliefs within an equalizing social structure known as *side-by-side*.

Intentional Communities. Intentional communities utilize a variety of naturalistic social environments to promote health change in individuals. Intentional therapeutic communities generally address social and cognitive deficits through interactions among staff and peers. The clubhouse model is a unique blended community of both mental health professionals and peers working together to foster a specific environment for recovery. Key features of an intentional recovery community are the elements of a “safe place”, the analogies of the presence of surrogate families, and socialization (Whitley, Harris, Fallot & Berley, 2008). Community participation is a key element in the recovery of persons living with severe mental illness (SMI) (Sanchez et al., 2016) as they are often faced with barriers to access to the community due to factors such as stigma and discrimination (Townley & Kloos, 2009). Clubhouses are intentional communities that offer 1 respite from isolation and opportunities to engage with other in activities while we seek to take on more meaning in the environment.

The intentionality of the group and associated activity offers opportunities for social exchange and mutually reciprocal support. The elements of Social Practice are predicated on the community setting; that is, it is based on using the community and the transformative relationships within that community to *draw out* those of us who seek to *withdraw* given negative symptoms often associated with psychosis. The intentional community environment provides the setting of a natural environment; yet something that we can control as a mechanism that allows people to be themselves in that very moment in time—to act as themselves. This allows one to grow and to become who they want to be because of starting in a safe place; a place they can be themselves. Thus, the pathology is circumvented by focusing on the healthy aspects of the self, or what is historically termed “ego-strength”.

FIVE ELEMENTS OF SOCIAL PRACTICE

Based on the key concepts of Social Practice noted above, there are five key methods to the practice within an intentional community. It is hypothesized that techniques must address at least one element of social practice to be effective in these settings:

1. Social Design
2. Relationship Development

3. Engagement
4. Continuous Assessment
5. Transitional Environments

People living with a history of mental illness or living with a serious mental illness may often experience a constellation of challenges and consequences associated with illness. For example, many of these common challenges include trust issues, social injustices and marginalization, low motivation, stigmatization, social isolation and alienation. The five foundational elements of Social Practice are practical ways to understand and address these common experiences. These are briefly introduced below along with a well-known clubhouse technique. The goal is to clarify and give ‘words’ to experiences found in settings that integrate social and physical environments as part of a therapeutic approach, such as clubhouse. Social Practice concepts and techniques aim to allow practitioners to connect to the “healthy part of the person” and identify their desires or goals, rather than existing skills. A set of core Social Practice elements are outlined and discussed with associated interventions or techniques below.

Transformational/Social Design refers to the engineering of the social and/or physical environment to facilitate a therapeutic process and develop *communitas* (i.e., *intense feelings of togetherness and belonging*; Turner, 1969) or sense of community (Sarason, 1974). Social design aims to direct members to the therapeutic opportunities in their environments. This participatory approach allows people to identify their own needs and collaborate with others to engage in mutual aid, thus addressing alienation and supports recovery. Social design includes creating social structures as well as designing the physical space so as to encourage exploration, engagement and even honor social withdrawing without going home. **Technique:** *social structures include house and unit meetings; physical space includes design of areas without signage so as to encourage social interaction.*

We also begin with the concept of Social Design as the basis of clubhouse philosophy. Social Design is based on the concept of *Transformational Design*, which is defined as the foundation of the clubhouse social ecology; it is the intentional human constructed environment that allows for engagement, interaction, as well as refuge. Doyle et al, uses the term transformational to draw attention to the interaction between humans and the environment that engender individual motivation, empowerment, and change.

“The complementary roles of transformational design and motivational coaching in social practice together create the positive practice results that ultimately define the community’s effectiveness in supporting the recovery and social integration of the membership.” (Doyle, et al., 2013, p. 109)

Engagement is a process of using the social environment to reach individuals with mental illness. Engagement also involves choice and control of how someone chooses to interact in their personal surroundings or interpersonal relationships. For instance, anxiety, poor social skills, interpersonal trust issues, stigma, lack of motivation or self-confidence can interfere with the capacity to interact with others or with an activity in meaningful ways. Methods of engagement refer to the ability to draw people in by utilizing a variety of techniques to help people establish connections to others and the social environment. In the social ecology of a clubhouse these methods may initially include making lunch, or sharing a common interest over coffee. Ongoing engagement is crucial as opposed to a single set of events. Connecting members to the environment allows for a variety of therapeutic effects to occur, such as reality-focus; feed-back; sense of connectedness; social connections; and opportunities to build skills and increased self-esteem. *Technique: Reach out as a form of on-going engagement*

Relationship Development is the assistance of members in developing a variety of social relationships and community connections. Consequences of SMI often leave many individuals without social connections or close friends and presents members with difficulties navigating or maintaining the different types of relationships. Factors like fear or distrust along with a limited social skillset could lead to continued isolation. The focus on relationship development directly combats isolation and loneliness by providing the opportunity to cultivate social networks and variety of connections through their environment. These can include transformative interpersonal connections such as friends and family, collegial, and societal relationships. *Technique: Side-by-side work*

Continuous Assessment refers to the ongoing observations of a person's strengths, needs, and challenges within a social context that allow for the development of individualized interventions. This may involve a combination of selecting from evidence-based practices, the individual's personal preferences, and the social practitioner's clinical expertise. Continuous Assessment gives a holistic picture of the individual that is not dependent solely on self-reflectivity, disclosure, memory, or verbal articulation (all things that can be severely impaired by serious mental illness). Creating opportunities of unmitigated observation creates a valuable and constant assessment, allowing for data to be gathered in real-time which allows for immediate modifications. *Technique: Unit Work*

Transitional Environments refers to creating access to places and spaces in society where mental health is not a priority of the environment (e.g., a job at a local business). Transitional environments assist people to safely shift from a therapeutic environment to natural settings (non-therapeutic). Using transitional environments

allows people to succeed in places they may have struggled with in the past. They offer opportunities to take risks, practice implementing new behaviors or attitudes, build confidence as well as test out non-helpful beliefs and increase self-efficacy. Further, it is an important element in organizing new narratives around the illness and identifying new roles. *Technique: Transitional Employment, supported education, attending meetings, speaking engagements.*

SUMMARY

The practices associated with the clubhouse model have evolved from both the members' lived experience as well as trial and error from professionals across a number of psychological and health related fields. These fields include social work (Jackson, Purnell, Anderson, & Sheafor, 1996), psychiatric rehabilitation, psychology (Raeburn, Schmied, Hungerford, & Cleary, 2014), psychiatry (Chen & Oh, 2018), and occupational therapy (Gregitis, Glacken, Julian, & Underwood, 2010). The term "generalist" took root in our model and has at times provided both clarity and confusion as to the work and roles in the model. Like other therapy system models, we believe that the social practitioner exerts a powerful and important force in the organizational environment through the development of meaningful relationships. We attempted to formulate the beginning stages of outlining greater understanding and clarity in our approach to Social Practice and how it applies to environments, such as clubhouse.

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NYC BASKET BICYCLE FLOWER

NOTES FROM THE ROAD

MEMBERS & STAFF CLUBHOUSE PELAREN, TRACY UREN, AND ANDERS RUDSTROM

Greetings and salutations from somewhere in this mad world. Welcome to Notes from the Road, a place for diversity; diversity of culture, mind, spirit, language, a place where people can share stories and perspectives from all over the world to help inform our communities and strengthen our movement.

In this first issue, we look at Social Practice. We have unique insights into some of what Social Practice means/looks like from members and staff at Clubhouse Pelaren in Finland, and Tracey Uren and Anders Rudstrom, a member and staff from the fabulous Fountain House Stockholm.

In Pelaren, we get a quick glance into the inspirational nature of their Social Practice and a sense of how important their Clubhouse culture is to their community and their idea of recovery. Tracey at Fountain House Stockholm is a dear friend and a strong Clubhouse advocate. She has worked with Clubhouse Europe and worked abroad doing a variety of Clubhouse work as well. Her piece is a wonderful expression of the possibility for members in her Clubhouse and how Social Practice in her Clubhouse facilitates these possibilities. Anders has a lovely piece cleverly titled “The Toilet Experience.” The Social Practice lesson comes from the title. It’s a really great story that not only illustrates the great work and culture they are creating at Fountain House Stockholm but also the point of Social Practice. Pay special attention to his last lines.

—Michael Hamlin, Fountain House

SOCIAL PRACTICE: CLUBHOUSE PELAREN PERSPECTIVE

MEMBERS AND STAFF AT CLUBHOUSE PELAREN

It all starts with the Work Ordered Day which makes strong relationships. Working side by side in the units gives us social connections, membership and hope. Together we share experiences, tasks and roles.

Strong relationships make a welcoming atmosphere with good friendships. It is wonderful to see members moving forward and sharing their moments of success. This gives you a strong sense of humility for both members and staff.

Being at Pelaren makes us feel valuable; we have friends. We get help when we need it, we have a place to go, our day has a goal. By sharing the preparation and enjoyment of meals together, we are showing that lunch is good and important.

First, we have cohesion and many members with a broad range of talents and personal goals. Next we have the positive WOD together with friendship and kind people who are there for you. The absolute best thing is that you are not alone and have peer support.

Our Social Practice comes with a sense of meaning, belonging and empowerment in the Clubhouse community with relationships between the continuous flow of human activity building across time and space.

SOCIAL PRACTICE: FOUNTAIN HOUSE STOCKHOLM PERSPECTIVE

TRACEY UREN

Having been a member for 13 years I have seen how Social Practice in our house has changed. Since I became a member Clubhouse Directors have changed and none of the staff that were there when I began are there now.

With experience I have learned that people move on, so even though I have found it very hard, I have learned that it is beneficial to get to know as many staff as possible. They all have different strengths.

Social Practice in our house I feel is based a lot on equality. I feel new members learn very quickly why there are not too many staff and that we members help run the house, working side by side with staff or other members. All the work is genuine work.

The house has changed a lot in that we have more members engaged in the day. Members start and finish projects needed to help improve the quality of the house. Members have a strong influence and we are heard.

I feel very supported by all staff backing me when need be and helping me learn to be more independent, which has given me self-confidence. This has helped me give back to new members and new staff if they need help.

I feel both staff and members can be transformational designers and motivational coaches.

SOCIAL PRACTICE: FOUNTAIN HOUSE STOCKHOLM PERSPECTIVE

ANDERS RUDSTROM

“Most of all, Fountain House is a process.”

When looking back on my years working as a staff member at Fountain House Stockholm, I first think of all the people that I've had the pleasure of meeting for the first time. Eight years ago, I entered the Stockholm clubhouse not knowing much more than a potential member doing the same. Some Mondays I have the humble feeling that this is my second day at work.

I would like to give you an example of how I make myself visible for the entire clubhouse when I get into work on a Monday morning. I call it *the toilet experience*.

At the morning unit meeting I start off by signing my name to the task of cleaning the first-floor toilets. There are two WC's on the office unit floor, both located near the reception area and entrance. Hopefully someone will sign up to do the cleaning with me. If not, people will see my name up on the whiteboard when they get in and join me later. I go up to the second floor where the kitchen unit resides. On the second floor is also where we keep the tools needed for cleaning. This gives me a chance to say hello to members and staff of the kitchen I haven't met yet. This will give me a picture of who's in the Clubhouse and give me an idea of who I can reach out to later that day for up-coming work tasks I know they will be interested in.

On my way downstairs with the cleaning bucket in hand I have a better idea of how this day will work out. Like I said in the beginning, I've been a staff at my clubhouse for eight years. I set up my bucket outside the toilet near reception. I talk to the people working the first hour of reception duty. I ask them of their plan for the day and perhaps their evening and share my idea of how I will schedule my time.

I get a partner for the cleaning by a member signing in that I meet at the reception desk. She starts cleaning the mirrors on the first toilet and I move on to the second one, but first I need to sit down with another member coming up the stairs and book a time later this week for a one to one talk about that member's problem with a difficult landlord that needs to be sorted out. My cleaning partner asks me to join her for a coffee break in the backyard. In the backyard I meet another group and more subjects are dealt with. We go back in to start the second toilet but before that, we are called in by the director sitting close by that needs our opinion on a completely different matter.

You could do this cleaning by yourself in 15 minutes and sometimes that is the case. On a good day this will take me two hours and involve hopefully over 10 people.



REALITY BEYOND DIVISION
MAYBELLENE GONZALEZ

THE TRUE BOTTOM LINE RESPONSIBILITY OF CLUBHOUSE STAFF

MEGAN KELLY, LMSW & SAMENE REID, LMSW

Generalist staff of Clubhouses (or working communities) have long been identified as having the bottom line responsibility with certain tasks of The Work Ordered Day. Things like getting lunch made and served to the house or printing the clubhouse newspaper fall under the guide of staff, but is making sure these tasks are completed the true bottom line responsibility of clubhouse workers? Or are these tasks core tools that workers utilize to accomplish their true bottom responsibility—helping members in their rehabilitation? The premise of this article is that the latter—helping members in their recovery—is the true bottom line responsibility of clubhouse workers, and we will define what that role is, exploring the various components of this responsibility.

In the book, *Fountain House: Creating Community in Mental Health Practice*, (Doyle, et. al.), the concept of social practice is introduced to the clubhouse community. However, how does social practice practically take shape in the clubhouse and what does that look like in the day to day workings? Doyle posited that the role of a clubhouse worker is social practice, and as such, they are social practitioners. No one, members or staff, come to a clubhouse with the notion that their reason for being there is task specific, be it publishing a newspaper or making lunch. Members come because they hope that the clubhouse will help them in their recovery and staff come because they want to help people with mental illness in their rehabilitation. The way staff help members in their recovery is through good social practice.

The role of a social practitioner is complex and multi-faceted in that it involves many working parts, significantly utilizing the use of self, the use of others in the community, and the use of environment. Social practitioners should be able to be

placed in any environment and assess how it can be used in the rehabilitation of members. They need to be able to use the authentic self in developing rehabilitative relationships with members, and leverage those individual relationships to help the member develop new and different relationships that will expand their network of support. The social practitioner can then use the information they learn about members to create opportunities for members, both inside and outside the clubhouse, promoting a full scope of their recovery.

As with everything done in a clubhouse, the hiring of a social practitioner is intentional and purposeful. Social practice can be broken down into several core components: engagement, building relationships, collecting data and doing interventions, and TE management. For a social practitioner to do good social practice, they will need to be able to utilize the various environments where they interact with members—the unit, the larger clubhouse, a TE placement, and beyond. Each of these environments presents a unique opportunity for social practice to take place.

ENGAGEMENT

Engagement is a key element to social practice as it helps to lay a foundation from which to do the other components of the model. In order to build relationships as well as collect data and do interventions, one must first engage with a member. As a staff worker, the unit and the clubhouse as a whole serve a valuable opportunity for membership engagement. Unit tasks, which often have been viewed as staff bottom line responsibility, serve as an excellent vehicle for engagement.

Engagement in unit work is at the very core of what John Beard talked about—the need to be needed. Asking a member for help with a certain task, which is crucial to the running of the program, not only gives him the opportunity to contribute but involves him in the community. One of the most rehabilitative things anyone can do for another, and in particular for someone with mental illness, is simply to include them. Inclusion is inherently valuable for people who have otherwise been isolated and overlooked.

Social practitioners should engage in a variety of unit work with a variety of members. This is not merely because staff need to get the work done, but is much more intentional. If a social practitioner is engaging in several activities with a diverse group of members, it should implicitly allow for members to be engaged with a greater choice of opportunities and with a larger community, expanding their social network and support. Although unit work is one of the social practitioner's most durable tools for engagement, it is not the only one. Transitional Employment, social programs, outreach, and decision making opportunities also serve this purpose.

If a staff is engaging the members well, members will seek them out in return; not only on unit or with clubhouse work, but with their own personal goals as

well. When social practitioners engage members on various activities and goals, members are more likely to try additional opportunities, such as TE or Supported Education. This learned ability to engage with opportunities translates into the ability to engage with opportunities beyond the clubhouse walls.

BUILDING RELATIONSHIPS

The clubhouse community has long discussed the importance of relationships between members and staff and how they differ from the more traditional relationships in the mental health world. However, when talking about social practice, it is important to further explore the relationship between the clubhouse worker and member, to explain what it is and what it does, not just how it differs from traditional clinical settings. The premise of relationships in the clubhouse is recovery. It is through the interaction of clubhouse members and staff that isolation is broken, connections are formed, information is gathered, and opportunities are offered. Relationships between staff and members within the clubhouse are often developed through staff engaging members in unit work and getting to know them in a supportive environment, but there is much more to these relationships than merely engaging members in work and getting to know them. Engagement of course, is often the genesis of clubhouse relationships, but good social practice expands beyond these basic relationships. It involves utilizing the relationship to help members in their recovery.

Key to fully using one's relationship with a member is motivational coaching, which involves leveraging the relationship to motivate members to reach their goals. Clubhouse Standards talk about members and staff working "side by side" and often it is understood as doing unit work together. However, good social practice involves members and staff working together "side-by-side" in various ways that help members reach their goals. The social practitioner transforms "side by side" work with a member to create motivation and momentum when the member doesn't have the momentum/motivation to do so for himself. It involves a Social Practitioner extending themselves and working alongside members in a variety of capacities. Social Practice also involves using one's relationship with a member to help them develop new and diverse relationships with others. These relationships can take various forms:

Member—Staff
 Member—Member
 Member—Group
 Member—Work place
 Member—School
 etc...

Good social practice is not solely contained in the unit. It involves staff utilizing their relationships to help members meet their goals beyond unit work as well as helping to develop a network of support. Staff can do this in a variety of ways, both inside and outside of the clubhouse. A member might want to go to work/school but seeking that out on their own may be intimidating. Doing it together increases the likelihood of initiating the process and the opportunity for success. Utilizing the clubhouse's social program as a tool where a staff can leverage their relationship to involve members in leading a workshop or by engaging with other members who are interested in the same activity/topic can connect members with similar interests. Going to the gym together (and both struggling through trying to figure out the machines together) can help normalize the struggles many of us have integrating wellness activities into our lives. Going to a school together to register or to take a tour allows the staff to safely introduce new opportunities as well as facilitate other relationships on campus, which may be vital to that member's success in a new environment. If a staff is unable to extend themselves in a particular way, then at the very least they need to make introductions to others (members or staff) who can help facilitate members in meeting their goals.

There are some pitfalls in the clubhouse community not talking about what good social practice is and what the role of our relationships are, and those pitfalls often stifle member recovery. For example, the over-dependence on one particular staff to meet the needs of a member, limits a member's network of support. Since rehabilitation occurs within community this over-dependence thwarts recovery. The over-dependence on a particular member to meet staff need does not provide an opportunity for a variety of members to engage in particular unit work with that staff, which prevents a staff from building new relationships and members from building relationships with other members. Often times a member will only do work for one particular staff and the staff come to rely on that. This has the potential for becoming an unhealthy clubhouse relationship because the focus of the relationship becomes more about meeting the needs of staff than it does about member recovery. Some staff do not extend themselves to help members meet their goals. Having a good rapport or sense of camaraderie is nice but isn't enough for good social practice, it's merely the foundation. A staff must use that rapport to motivate members to take the next steps toward their recovery.

COLLECTING DATA, DOING INTERVENTIONS

Data collection and member intervention may sound very clinical, even often avoided in the clubhouse world, but everything we do in the clubhouse is rehabilitative in nature. Therefore, these practices may be considered "clinical" to a certain degree, just not in the traditional sense of the word. As a social practitioner, it is expected that someone gets to know the members with whom they work is consid-

ered collecting data. What the worker does with the collected information is the intervention itself.

When working together on unit work, a social practitioner has the chance to observe many important things about a member that will help to influence their rehabilitative plan. Units are more than mere work spaces, they are opportunity centers for both members and staff. Units and unit work offer members a safe place to explore their work skills, a place where they are needed and their contributions are appreciated. But for staff it offers a unique opportunity, not available in traditional “clinical” settings, to collect data and do interventions. A staff will learn how a member works with others, if they tend to isolate, if they are able to complete tasks, if their symptoms are active while they work or if they interfere with the member’s ability to relate to the work or others, etc. This is all important information or data that can be used when working with a member on their goals and their rehabilitation. The information gathered should influence what type of unit work the staff engage the member in, when and which TE opportunities should members be encouraged to try, what a particular member should get involved in in the clubhouse before returning to school, etc.

Another opportunity for data collection and interventions occurs when a social practitioner works with a member on TE. The staff worker is seeing the member in a different environment and observes how they interact with others at the work place and with new work in a new environment. All of this is useful in helping a member in their recovery. If the placement manager is not the primary worker for the member on their TE placement, it is crucial to inform their worker of the data collected at TE. This information will be useful in planning the next steps after the member completes the placement. Likewise, the data collected on the unit, should be relayed to placement managers to help with the training and support needed for a member to successfully work on a TE.

The social program is another important environment for a social practitioner to collect data and use that information to formulate plans with members. Even grabbing a cup of coffee with a member is an opportunity to collect data that may inform future interventions. A good social practitioner will find these opportunities in every environment and every interaction.

If a staff worker is doing good social practice, he should be able to answer the following questions about all of the members with whom he works: How often are the members attending? What do they do when they are at the clubhouse? When they are not? What goal are they working towards? What data has he collected about each member that will be helpful to assisting the member towards this goal? How is the staff helping them to achieve that goal? What is the rehabilitative plan for each member? A social practitioner should constantly be asking himself these questions and be aware of the data they are collecting as well as what interventions they have implemented.

TRANSITIONAL EMPLOYMENT MANAGEMENT

Transitional employment management is an important piece of social practice. When we look at transitional employment traditionally, it has been looked at as a stepping-stone to get back into either employment or education. However, through the lens of social practice, transitional employment is an extension of the milieu in which social practitioners work within. It is different from the clubhouse units that are specifically engineered for the day-to-day therapeutic interactions. However, the extent of social practice extends to the transitional employment placement site. On transitional employment placement site, the level of control that the social practitioner has can be limited. However, social practitioners use this environment to work with the members to navigate the workspace, gain information; extend their relationship network of the member, and to expand upon the relationship that the clubhouse currently holds with the employer.

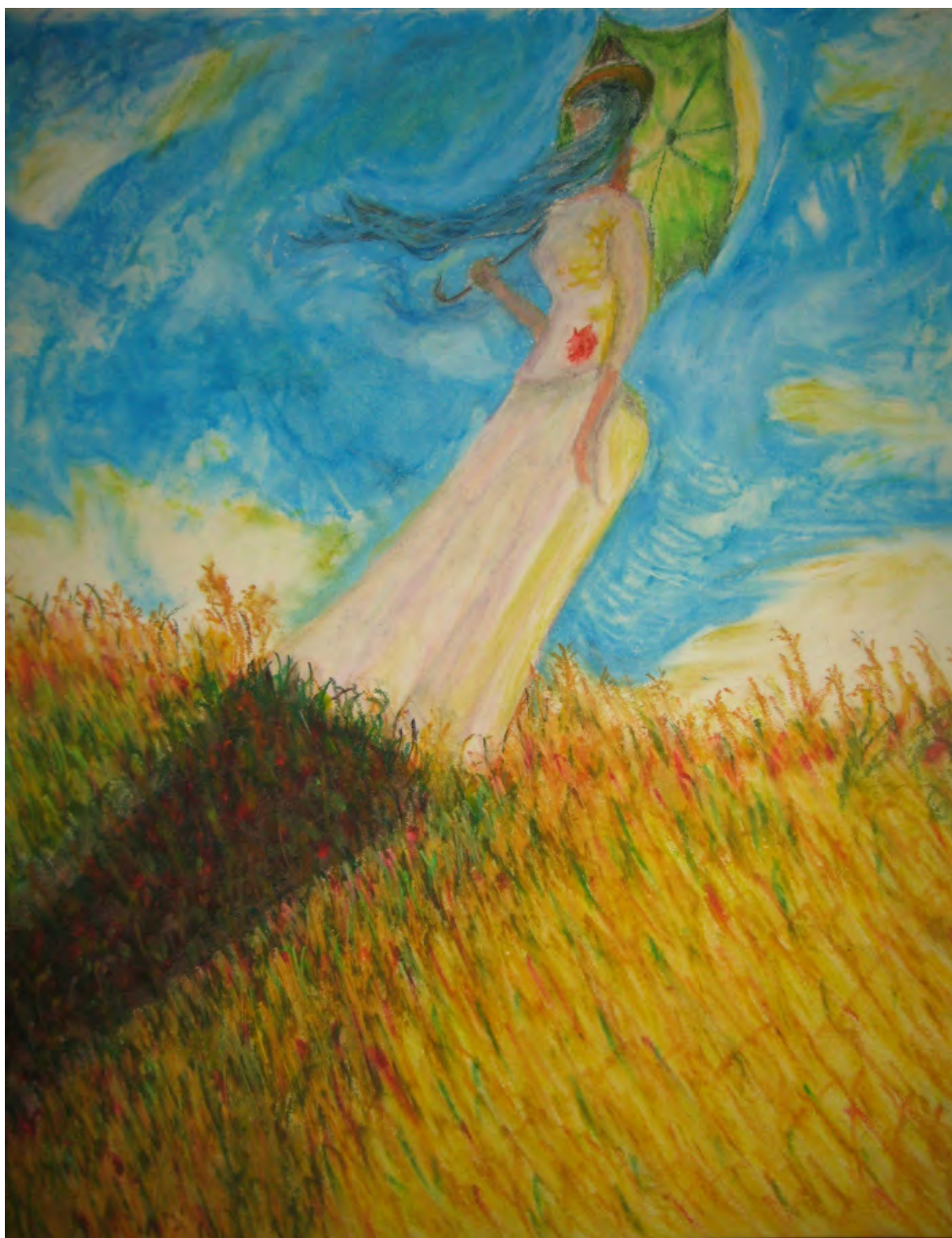
In the transitional employment milieu, social practitioners have to work to engineer the work environment to aid the member and to make the process a rehabilitative process. Being that the workplace is different from the clubhouse, there are some factors that are out of the control of the social practitioner. Therefore, the social practitioner has to come up with systems that help the member work within this uncontrolled environment. Social practitioners work with the members to guide them on a variety of things such as employment etiquette, interpersonal interactions, understanding the workplace culture, and any other thing that may occur on the job.

During the transitional employment process, the placement manager will be able to gain new information about the member that their social practitioner may be unaware of. The placement manager will be able to see directly how that member interacts with others in outside world, which may be different than the way that they work within the clubhouse. For example, a member may be very extroverted and outgoing in the clubhouse on the transitional employment they may come across as shy and introverted. Social practitioners are also able to obtain information about that member, through both the verbal and non-verbal interactions that happen during the hours of the shift. These interactions allow for the placement manager to strategize with the member on their plans for the future or a way to connect that member with their personal social practitioner to design a plan for the future or address any challenges that may arise.

Lastly, as part of the role of a placement manager, the social practitioner acts as a good steward of the transitional employment placement. They use the time that they are at the placement to develop relationships with the managers and various employees of the organization. They use those relationships to expand on potential opportunities for growth or expansion at the organization. Also, if something that arises that may jeopardize the position they can work with clubhouse to reestablish the ties that are needed to save the placement. When looking at the element

of transitional employment as part of social practice, social practitioners have this great tool at their disposal. When used in an optimal way, it can be of great value to the membership and an attribute to the clubhouse. Therefore, social practitioners must be intentional in the use of this tool and its ability to enhance the lives of the membership.

With member rehabilitation and recovery being the goal of clubhouse, the ability to properly explain the role of clubhouse staff is extremely important. Previously, the clubhouse community has spoken about the use of work to help move members forward with their lives, and this is true—work is a valuable tool in recovery—but it is not what clubhouse staff do. We use work, and other tools at our disposal within a variety of environments, the clubhouse being the major setting, to do social practice. Good Social Practice is not magic; it does not just happen. It is intentional and purposeful, and has successfully facilitated recovery for 70 years. With Doyle, et. al., introducing language to define our roles as social practitioners, it has created an opportunity for greater understanding of the very important role clubhouse staff play, the various components involved and how these components work with each other. The clubhouse community can now look beyond the work, continue more in depth conversations about our philosophy and model, better train our staff, and most importantly, continue to improve the recovery outcomes for our members.



WOMAN WITH A PARASOL
RIVKY GEE



I AM NOT ALONE.

DAVID MALATESTA

I know there are many of you, just like countless millions more, who suffer/have suffered from the symptoms of the scourge that is mental illness. There are those feelings of shame, humiliation and guilt. We feel that we are the cause and solely responsible for the problem, even though many try to convince us that we are not. Nevertheless, it is a real challenge not to believe it. There is the stigma that forces us to withdraw from those close to us, drop out of our social networks, and hide from our work colleagues. And then there is the pain from the noise we are forced to endure which is the deafening silence of isolation, trapped in a living, lonesome nightmare.

My story starts as a child, growing up in a dysfunctional family. I had a bitter, miserable, pill popping, alcoholic mother, filled with lies and emotional blackmail along with my violent father, who knew how to use his fists and feet on my sister and me. He was an uneducated Italian immigrant. A harsh upbringing and witness to many horrible things as a child himself, was probably not the right recipe for being a parent. However, through hard work and sacrifice, he became a very successful, self-made restaurateur and hotelier in England. Unfortunately, to his great disappointment, I was not the little Italian boy he had dreamed of. Was that my fault?

I remember one time, sitting next to my father in the car. I must have been about 4 or 5. I was just repeating everything he said while he was driving. Suddenly,

there was an incident on the road with another driver, that caused him to swerve and as we drove on, he swore in Italian. I did not have a clue what he was saying, I just repeated it. His reaction, was to stop the car and beat me for swearing.

Growing up there was little trust and protection. The consequences of crossing confused boundaries could be severe. It was no surprise then, one day when I was 13 years old at school, I tried to commit suicide, but I was discovered and saved. At home things only became worse. To this day I can still hear my father's voice, the countless times he told me 'You are rubbish, no good and when you are 18 I am going to throw you out, because then I will no longer be legally responsible for you, and I never want to see you again.' I did leave home, in fact I ran away without telling anyone, first to Denmark and then Norway, where except for a year in Germany, I have lived ever since.

Like many in my situation, I had a very low esteem, as such, my education had suffered. For a time, I had mixed with the wrong crowd and became involved in things which I am not very proud of. Things that even today, send me powerful pangs of guilt. This was the real world and I had to deal with it. Inside, I felt worthless, I was too scared to become emotionally attached to anyone, to build close relationships, for the fear of getting hurt.

I have never felt that I have ever been in the position where I would be able to offer the kind of security, stability, a good life to a child where it would be able to prosper, so I have purposely avoided becoming a father, or becoming emotionally attached to anyone who wanted children. The truth is, that I want my father's cursed genes to end with me. Is that right? Is that the way it should be? That is the way it is for me.

Sure, I have had success, taken my opportunities and missed others. I actually used my immense inferiority complex, to drive me back through adult high-school, and then on to university. I have achieved some amazing highs. Unfortunately, with the highs come the lows. And believing that one is all alone, I allowed myself to be swallowed up into the dark, depths of depression, with only the world of professional psychiatry, preventing me from drowning.

I arrived at the Clubhouse, Fontenehus I Oslo, with nothing, no hope, no will to continue. I had become a recluse, afraid to leave the house, with only my dear partner supporting me.

Of course, I was unsure, what is this place? What do they want? What and who lies behind it? Questions that could only be answered through my participation. I was afraid those first weeks. Yet I was welcomed so warmly. They genuinely seemed happy to see me.

It felt like I had been diving in the deep, and now I was able to slowly swim back to the surface, and take some deep breaths of fresh, clear air.

And by volunteering and taking part in a few easy tasks like washing the entrance hall floor, sitting on reception for 30 minutes, carrying the dirty coffee

cups up to the kitchen, I really did feel a sense of a simple structure in my mind that felt right. I had a sense of achievement that I was actually able to contribute something, to what I now know as the work-ordered day. For me, this really was meaningful work. And I was rewarded with a genuine, deep feeling of satisfaction. Though I was still too scared to go to the breakfast meetings, but at least **I knew that now, I was not alone.**

But I have to say here, that one of the most important things that kept me in the Clubhouse, was the fact that everything is voluntary. Had I felt in any way that I was been forced, or coerced to do something that I did not feel comfortable with, or obliged in any way to do something, that would have been my last day in the Clubhouse. And if that had happened, I really don't know where I would be today. When you do something in the Clubhouse, it is because you want to, and that is what is real, it comes from the heart, it is truly genuine, it feels right and you are always encouraged to try.

Officially, I am termed disabled and mentally ill. And in that world, where is the hope? Yet in the Clubhouse world, I am active, alive, and because there is always so much to do, I genuinely do feel appreciated. When I stop, and look back at my time in the Clubhouse, I am just amazed at many of the things I have done and achieved, by allowing the Clubhouse, to reach out to me.

One of the great Clubhouse pioneers, Susan Omansky said 'I need to engage in something from which I can derive my own sense of pride, accomplishment and self-satisfaction from the inside'. She is so right, and Clubhouse continuously offers me this type of engagement. Why? Because the Clubhouse is filled with so many opportunities, but the bottom line is, it is up to one to grasp these moments.

When I first walked in through Fontenehuset I Oslo's doors, I never envisioned that soon I would be a part of a team that was successful in developing our first website. We desperately needed pictures for our webpages that nobody seemed to want to take, so I ended up taking them myself. Soon, I became the unofficial Clubhouse photographer. Before Clubhouse, I never had the confidence to show my photographs to anyone, now in the Clubhouse they are both published and exhibited.

I was then asked to talk about the process of how we built the website, in a workshop about Clubhouse Relationships, at the European Conference in Stirling, Scotland. Next, I was asked to join an employment committee, which was responsible for hiring two wonderful members of staff. When a poster appeared on the Clubhouse notice board about Comprehensive Clubhouse Training, several people, both members and staff encouraged me to apply. After a lot of thought and discussion, would I be able to travel to London and be away from my partner and home for 3 weeks? Remember I was a recluse. Even my psychologist advised me against it. But in the end, I thought this was an opportunity that probably would never come along again, so I signed up and was chosen. But would I be

able to do it? After only two days at Mosaic Clubhouse, I had become so inspired, that I decided to completely immerse myself in the entire training experience. My self-confidence was given a massive boost, not only by how I was welcomed and received, but also by how the Mosaic community encouraged and allowed me to develop, while taking part in the discussions and their work-ordered day.

This really was a life changing event for me. Ask anyone who knew me after I returned. One staff member described it 'as if a light had been turned on inside me'. I could feel the extra step in my stride. In fact, I still do. Not long after, I was taken completely by surprise, when I was asked if I might consider applying for the Faculty for Clubhouse Development.

Now to be perfectly honest, my first reaction to this idea was incredulity. The notion was galaxies off my radar. At first, I did not respond, but after discussing it with a staff member and then the director, who both thought it was a great idea, I filled out the application. I now have the great privilege, honour and responsibility, of travelling to, and getting to know, other Clubhouse communities on accreditation visits. I also have the opportunity, of working closely with some truly inspiring, Clubhouse International individuals. And being a member of the Faculty, actually allows me to feel that I am now in a position, to give something back, to the Clubhouse community. However, I have to tell you this, being accepted for Faculty training, literary forced me to face and cross one colossal mental barrier.

Up until then, I had no problems working in any of the Clubhouse units, except for one, which I absolutely dreaded. The Culinary Unit. Now everyone knows that if you want to get to know a Clubhouse quickly, and what goes on there, go and spend some time chopping up vegetables in the kitchen. Which is an ideal place to be on an accreditation visit. Some people have a fear of spiders, mine was kitchens. This goes all the way back to my childhood and my father's catering profession. I cannot put into words the psychological terror that I went through, when I asked to join the culinary unit for a couple of weeks. And the courage I had to muster up, from where I really do not know, in order to show up to that first, early Monday morning kitchen unit meeting. At least they seemed pleased to see me. I immediately threw myself into everything, from the buying, chopping, cleaning, counting, laying, stirring, washing and wiping, I did it all. And you know what? I absolutely loved it.

What a personal victory that was for me.

And since my Clubhouse, Fontenehus I Oslo has now become Clubhouse International's 12th and newest international training base, it was only natural that I was asked to join the training team, which I just find so fulfilling. Yet, after all this and much more, I am the first to admit, that I still find a return to the world outside Clubhouse, and everything it entails, daunting. But by being a part of the Clubhouse, which just seems so good at encompassing and adapting to my needs.

I really can say it has given me the opportunity, to safely push my boundaries and comfort zone.

And now I am confident in the knowledge, that as long as I remain active in the Clubhouse, and continue to involve myself, there is always going to be hope.

And just like every other Clubhouse member, I know when I do well, the community will celebrate, and when things are tough, they will always be there to support me. I am not alone!



THE OTHER SIDE
RIVKY GEE

PARTICIPATORY ACTION RESEARCH

KEVIN RICE

INTRODUCTION

Persons with lived experience of mental health challenges have long advocated for research and knowledge about mental health to better reflect the realities of their own everyday lives. To these ends, persons with histories of mental illness are taking a more active part in studies conducted on them, seeking greater inclusion and representation through the direct participation of persons with lived experience on study teams and research projects (Case et al., 2014; Davidson et al, 2010). Particular settings within the mental health field that are especially well-situated for participatory research are community based organizations known as Clubhouses (Pernice-Duca, 2009; Pardi & Willis, 2018). Composed of persons with histories of mental illness (who self-describe as members) that participate and run the essential functions of the recovery community with staff support, the clubhouse model is uniquely congruent with the participatory research ethos of empowering the direct participation of community stakeholders (House, 1999; Doyle, Lanoil, and Dudek, 2013).

Capitalizing on this congruence, in 2017 a group of members of the original mental health clubhouse, Fountain House NYC, have been engaged in a Participatory Action Research (PAR) training and research project with partners from Yale University Program for Community Health and Recovery. The long-term goal of this project has been to develop a *member-led* evaluation component within Fountain House that can generate information to improve the quality of the clubhouse itself. Up to this point the project has featured members being trained in qualitative research methods, designing a qualitative research study, and conducting all aspects of the research study including conducting interviews, analyzing the content for common themes, and leading group discussions to create a report of the results.

Member participants described various reasons for initially joining the PAR project. Some members had a background in research, stating: “I was very interested that mentally ill people could research mental illness ourselves. We are the focus of the research, so why not be the drivers of the research? I had a research back-

ground before my diagnosis, and so this served as an opportunity to get back into this world.” Other members described wanting to be a part of the group because of its contribution in combating stigma: “I did not have any background in research, but I was interested in the class because I could develop my skills to become a researcher to help in the work of dismantling stigmas and create new opportunities for marginalized groups. So this was an advocacy endeavor for myself.” However, some members merely wanted to get involved in a stimulating project, not having any expectations at the beginning: “There was no expectation for myself in coming to the class. It merely served as an activity for re-engagement, to do something, because I was feeling that I wasn’t up to anything meaningful. All I knew is that I wanted to move on with something productive, to learn something.”

THE PROJECT

Two researchers from Yale University, Dr. Larry Davidson and Dr. Miraj Desai contributed their extensive expertise and background in conducting qualitative research in a PAR setting. Initial meetings were structured around discussing what members wanted to research in their own community of clubhouse. This was the *learning how* stage of developing the right questions to ask, which were determined by the members in what they deemed to be the most important things to know about the Fountain House community. The research team decided on the follow questions to compose a semi-structured interview:

- How has your life changed since coming to Fountain House?
 - How might your life be different now if you had never joined Fountain House?
- How do you relate to staff at Fountain House?
 - How do staff relate to you?
 - How do grievances get handled?
 - How do you find working side-by-side here different than other places?
- What do you hope to get out of Fountain House?
 - Do you see Fountain House more as destination or as a stepping stone?
 - Where would you like to be in two years?

Following the development of these questions, the PAR group was trained in conducting interviews in a focus group setting. It was important that the interviewers conducting the focus groups were members themselves, so that the member participants could relate to the interviewers based upon their having shared lived experiences with regards to the questions. Participating members needed to be comfortable with sharing their stories, the good and the bad. Interviews needed to be open ended, where participants were encouraged to share their experiences in

a story like fashion, and not yes/no. All interviews were recorded and then eventually transcribed for qualitative coding for thematic content. Qualitative coders were trained members reading each transcript sentence by sentence. Training occurred through the reading of previous PAR research as well as other example transcripts that were provided by the researchers from Yale. The goal of coding is to extract common themes within and across the various transcripts. It is also to condense typically lengthy transcripts into concise coherent narratives that can then be coded in order to identify the salient themes within each narrative. Salient themes and quotes were selected through consensus by member coders (at least 3 or more coders reading through the transcripts together).

THE FINDINGS

The first core theme identified was: **I would rather be at the clubhouse.** The contrast between life before Fountain House and life after was vividly conveyed by interview participants. Joining the clubhouse was a major milestone in participants' lives. It was a moment when the world opened up and life changed for the better, "a new hope". Life before Fountain House often involved day-to-day struggles, a sense of purposelessness, depression and isolation. As one person said, "[if I weren't here] I'd just be sitting around." The second theme identified was: **Needing more than just a place to go.** In addition to the overall expression of belonging amongst members of Fountain House, there was also a sentiment about needing more than just a place to go, that meaningful opportunities were required for deeper fulfillment, beyond just being there. Some felt Fountain House fulfilled this desire, whereas others felt it came up short, with initial positive experiences wearing off over time for some members. The third theme identified was: **It's hard to peg staff down,** wherein members spoke about a feeling of precarious accessibility to staff and support resources. Other members expressed having persistent experiences of staff unavailability, with many members explicitly speaking to staff being taken out of the house by impromptu TE responsibilities, making staff spontaneously unavailable. The fourth theme identified was: **I figured out how to navigate FH, what it can give, and what it can't.** Members often described a dynamic recovery journey in their engagement with Fountain House, in that over time they learned how to actively explore the supports within, manage the limitations of, and creatively contribute to the Fountain House community. Many participants echoed this agentic sentiment, speaking to their quest to be "proactive in [their] own health," where even though a person may not know one's way they were always accepted as they were and invited towards finding their niche in community.

What the results appeared to indicate is that Fountain House is not a singular experience. It appears differently to different members, and even for any individual member, its function and role in their lives can change over time. This is the first

main implication of the project's findings, that the meaning and role of "Fountain House" evolves over time for members, and in direct relation to a given member's needs, relationships, interactions, and modes of giving and receiving. In some cases, it is even less of a place as such, but a stable presence in one's life that members carry with them and know they can return to in times of need. Notably, members described their futures in terms of still being in relation to Fountain House, even if they anticipate those terms changing over time.

Many members described their initial draw to Fountain House as being due the clubhouse sense of community disrupting previously persistent experiences of loneliness and disenfranchisement, a finding consistent with other recent studies on the effects of community in the clubhouse model (Tanaka, Davidson, and Craig, 2018). However, this is not automatically the persistent case for everyone. Such experiences draw attention to possible revisions Fountain House may undergo for the sake of meeting the evolving needs of its dynamic membership. Indeed, some members described the transition of initial expansion and excitement upon coming to Fountain House as *slowing down* over time, leading to a sense of stuckness, boredom, or stifled creativity. In particular, members found that there were a range of experiences in the meaning and enjoyment of work, depending on the type of work, the background of the member, and the dialogue between the two. Members also differed with respect to their experience of staff engagement. Members can come to want more engagement opportunities with staff, particularly when staff are spontaneously called away to other obligations.

LOOKING FORWARD

With the successful completion of its training and completion of its first study, the Fountain House PAR group is now pursuing publication of its work in a peer reviewed qualitative research journal. Next steps have also included the incorporation of a qualitative research business as a Social Enterprise composed of trained Fountain House members contributing their skill set and lived experience to mental health research in the field at large. Such a research group would be unique, providing a heretofore missing perspective in formal qualitative research methods and mental health. Such a business will further expand the training base of future interested members, uplifting them into positions of skill and networks where they can meaningfully incorporate their lived experience of mental illness into mental health research through the creation of unique employment, education, and advocacy opportunities.

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GALLERY WINDOWS
MAYBELLENE GONZALEZ

WE ARE NOT ALONE, BUT HOW ARE WE CONNECTED? EXPLORING THE SOCIAL SUPPORT NETWORKS OF CLUBHOUSE MEMBERS

ANGELA CASTANO

INTRODUCTION

In the field of chronic mental illness treatment, the concept of Recovery has been discussed as a guiding principle. It is a belief that people living with Serious Mental Illnesses (SMI) can lead meaningful and successful lives, and that they can and should be in power of the processes involving their own treatment and growth. The concept of Recovery emphasizes the importance of social connections in facilitating more positive attitudes of hope, self-esteem, and attainment of meaningful roles in society, and it always comprises social elements, such as social support, social role, social connections or social exchange (Anthony 1993, Onken 2007). Based on this concept, psychosocial and community based rehabilitation models have developed and differentiated themselves from psychiatric treatment by focusing on the wider effects that the illness has on people's lives, instead of treating only the medical symptoms.

Clubhouses are a unique model of community-based rehabilitation. They are described as working social communities, that facilitate rehabilitation through socialization. People living with SMI who participate in clubhouses are called members, and their involvement in the community is voluntary and self-guided. The work of clubhouses is aimed at reaching goals, ranging from individual (finding a job, going back to school), community (preparing lunch at the clubhouse), and societal endeavors (fighting stigma). Members and a limited number of paid staff run the clubhouse jointly. Through working together, social connections amongst

members and between staff and members are created. In practice, this means that rehabilitation is not done within a one-on-one relationship from professional to patient or professional to group. Instead, the clubhouse focuses on promoting ties of mutual aid, akin to self-help programs (Beard, Propst et al. 1982, Pernice-Duca and Onaga 2009).

Previous studies have shown that social isolation and loss of meaningful social roles are two of the most pressing challenges persons struggling with chronic or severe mental health conditions face (Davidson, Shahar et al. 2004, McCorkle, Rogers et al. 2008, Pernice-Duca and Onaga 2009). Studies have further shown that persons living with SMI also struggle in developing quality social ties and structures (Umberson, Crosnoe et al. 2010), having smaller and less satisfactory social support networks, mostly comprised of health care professionals and family members (Pernice- Duca 2008). These ties are often unidirectional, with people receiving support but not feeling like they reciprocate support themselves (Davidson, Shahar et al. 2004). Such findings are alarming given the known negative impact of social isolation and the loss of close and important ties on mental and physical health (House, Umberson et al. 1988, Seeman 1996, Berkman, Glass et al. 2000, Kawachi and Berkman 2001). Studies have shown a correlation between larger and more satisfactory support networks and better quality of life indexes (Corrigan and Phelan 2004). Furthermore, the disabilities associated with serious mental illness are greatly due to social processes: the effects of the negative stigma surrounding the illness outweigh the impairments related to the medical symptoms (Hinshaw and Stier 2008, Jenkins and Carpenter-Song 2008).

THE STUDY

The present article summarizes a research study that explores the social world, and specifically the supportive ties, of persons with experiences of severe mental illness (SMI) involved in the Clubhouse model of community based rehabilitation. First we asked who constitutes the support system of members. Then we visualized and explored the network of supportive connections within a single unit, investigating the level of integration of members within this network. We then studied whether there was an association between participation in the clubhouse and the number and types of supportive ties nominated by members interviewed. Lastly, we focused on the reciprocity of supportive relationships for clubhouse members interviewed. This analysis of the organization was complemented by a few individual case studies, to provide a more comprehensive and nuanced understanding of the role of the clubhouse in people's social lives.

While gathering data for this study we were in the clubhouse during the work-week, assigned to a single unit as an intern doing usual work. We first conducted unstructured interviews and participant observation, around the theme of social

relations. With this insight we customized a structured interview based on the method developed by Manuel Barrera called the Arizona Social Support Interview Schedule (Barrera 1980, Barrera, Sandler et al. 1981, Johnson 2009) to identify and quantify sources of social support in the clubhouse. To map the structure of social connections, we used a social network analysis (SNA) framework (Luke and Harris 2007, Smith and Christakis 2008). We employed a standard name generator used in SNA, with the questions “who has helped you in the unit?” and “who in this unit have you helped?”. Within the scope of this work we utilized the network analysis measures of density, and two centrality measures at the individual level: degree and betweenness. Density gives us information about the cohesiveness of the group. Degree tells us the number of direct ties a person has within the network. Betweenness tells us the frequency with which an actor is in the path between two other people. We then looked for associations between the data from the Social Support Interview and the SNA measurements, and variables of membership (length of membership in years, and frequency of attendance), first using visual inspection of scatter plot diagrams, and secondly one-way analysis of variance (ANOVA). For the case studies, we used ego-centric networks, mapped through a free-list name generator based on Chris McCarty’s work (McCarty 2011).

FINDINGS

Supportive social network composition

Previous studies using different instruments to assess social support, had reported for people with serious mental illness, including clubhouse members, a mean number of 6 or less supportive ties (Meeks and Murrell 1994, Stein, Rappaport et al. 1995, Pernice-Duca and Onaga 2009, Pernice-Duca 2008). Our results showed that members nominated a median of 11 supportive ties, which means that 75% of people nominated more than 9 supportive ties. Previous studies on the composition of supportive networks amongst clubhouse members found that mostly family and friends were nominated as sources of support (Pernice-Duca and Onaga 2009). Therefore, we expected to have more people nominate non-clubhouse supports than clubhouse ones. However, the support system of members interviewed was found to be comprised of similar numbers of clubhouse and non-clubhouse supportive connections.

Given the emphasis of clubhouses on a partnership between members and staff, we further expected to have approximately the same proportions of staff and members nominated as sources of support. Our results demonstrated this, with members nominating roughly equal numbers of staff and members as providers of support. It is of consequence however to note that 16 out of 51, or 31% of interviewees, did not nominate any members at all. This number is higher than expected from

a peer-support agency, but not inconsistent with previous research (Pernice-Duca 2008). However, 22% of members interviewed (11 out of 51) nominated more than 4 members as part of their support system. Thus, individual variations are important in how many peers are part of the support network of those interviewed.

Structure of the network of supportive ties in a specific unit of the clubhouse

As far as a person's positioning in the network of supportive ties in a unit, theory based on the clubhouse principles tells us that everyone should have relatively similar positions of centrality overall. This would mean in this network based on the question "who has helped you?" that members and staff should be equally perceived as helpful, and that members should also nominate many peers as sources of support. However, members are encouraged to build a particularly strong bond with a staff of their choosing (as their worker), who will help them achieve their individual goals. Because of this, we expected all staff to have high in-degree centrality values (be perceived as helpful). Betweenness centrality was expected to be high for staff, as part of their job is to create connections. We also expected members to have high betweenness values, connecting each other through ties of support.

Centrality measures in the network contradicted the expectations based on the clubhouse discourse. Indeed, centrality measures, both in-degree centrality and betweenness showed a large disparity between staff and members, and also between members themselves. Staff had the highest in-degrees and betweenness, which makes them the most central in the network. This means that they are perceived as the most helpful, and are also the bridges that connect members to each other. However, some members did have high in-degree and high betweenness, which is why even when we removed the staff from the network analysis some connections remained. It would be very important for the clubhouse to determine how to learn from these members with central positions.

It is of relevance to note that during the interviews many people referred to the clubhouse as a source of support in itself. When asked who had helped them, people often answered "everyone!", "the clubhouse!", "we all help each other out". During the interviews we followed these answers with a request for a few concrete examples of particular people. It would be therefore interesting to explore to what extent the community itself represents a source of support in people's minds, and how important it is for recovery, compared to receiving support from specific people (Herman, Onaga, et al 2005; Biegel, Pernice-Duca, et al. 2013; Coniglio, et al. 2010).

Connections between social support, time of membership, and attendance rates

We explored the connections between variables of membership (years of membership and average days of attendance per month), and variables of social support (number of total ties, clubhouse, non-clubhouse, staff and members nominated).

Our aim was to study possible associations between these variables, to determine if the wide differences in the number of supportive relationships member reported can be explained by participation variables. The results we obtained showed no associations between how many supportive relationships a member reported, and how long they had been a member or how often they attended the clubhouse.

As far as positioning on the socio-centric network, we expected people who participate more to be more central: they would be better connected in the network of supportive relationships of the Unit. New members at first would be rather peripheral, but in time they would become more central in the unit. However, our findings refuted these expectations: there were no statistically significant mean differences for any of the centrality measures (in degree, out degree, betweenness) by average attendance per month or by years of membership.

These results show that variations in how helpful a member was perceived in then unit, how many fellow members he reported as supportive, or how much he connected people within the unit, are not related to how many years or how often he has attended the clubhouse. We do not discard the possibility that these results can be due to the categories we selected, or to the sample size. It might however be a proof that the rehabilitation process is very individual, and does not follow a particular pattern. Other variables that can explain the fluctuations in social support should be explored by further research. Furthermore, studies with a longitudinal design would be very relevant to understand how attendance and time of membership affect each individual's social support system. It would be very interesting to explore the same question focusing on new members and how their support system evolves in the first years of membership in the clubhouse.

Perceived reciprocity of supportive relations as reported by clubhouse members

Studies reviewed for this work about people living with SMI (including clubhouse participants) stated that in this population people often perceive their supportive ties as unidirectional, and that they receive more support than they provide. People are often socialized into "patienthood," where they are dependent of service providers (Meeks and Murrell 1994). We expected therefore low reciprocity of supportive ties. Based on the Clubhouse discourse however, we expected participation in the clubhouse community, with its strength-based perspective, would provide ample opportunities for people to also be providers of support (Coniglio, et al. 2010).

Results showed that the median number of overall people to whom support was provided is smaller than the number of people who provided support. Relationships within and outside of the clubhouse appeared similarly reciprocal, although non-clubhouse ties had a slightly higher number of reciprocal ties compared to clubhouse ties.

It is important to highlight that the members interviewed reported a median of 0 reciprocal ties to staff. Staff were therefore perceived as the most helpful within

the network, but this help was not seen as being reciprocated. On the contrary, relationships between members was shown to be more reciprocal. Although the figure was lower than expected within the model of mutual help, it is interesting to note that peer relationships were in fact perceived as more reciprocal than staff-member relationships. When asked whom they had helped in the unit, people nominated staff more often than members. It is interesting then to see that this result contradicts the reciprocity analysis, where we found that members reported very low reciprocal connections with staff. This can be due to the loose sense of “help”. Some people might have understood it as helping with unit work, which is most often delegated by staff. Interestingly, even though unit work is conceived as an opportunity for members to help out and use their strengths and knowledge for the greater good of the clubhouse community, it is not necessarily perceived as giving back or reciprocating the social support provided by staff.

CONCLUSION

The concept of Recovery places great importance on social connections, and potentiating the positive effect they can have on people’s lives and overall Health. In this article we wanted to shed some light on the role of the clubhouse in the process of Recovery. We explored the links between participation in the clubhouse and the social world of members - in particular supportive relationships. We explored how the theory and desired outcomes that underline the working-communities model operated in practice.

Results showed that members interviewed had a higher median number of supportive connections than previous research had found amongst people living with SMI. Interviewees’ supportive networks were composed of roughly equal numbers of clubhouse and non-clubhouse relations, and roughly equal numbers of staff and members. The analysis of the network of supportive relationships within a unit, based on the question “who has helped you?”, showed that the level of existing ties is lower than we would expect from a community of mutual support. The positioning of staff and members is different: staff are more central because they are perceived as being the most helpful in the unit, and also because they connect people that have not established a direct tie. As such, it would seem that staff make the community, to some extent: if we removed the staff many people would become isolates in the network. However, a few members were also relatively central, thus perceived as highly helpful in the unit, and acted as bridges within the network. It would be very important for the clubhouse to conduct further research and learn from them.

We found that time of membership and attendance rates were not associated to the total and the specific types of supports nominated. Thus, participation in the clubhouse does not explain variations in the number of supportive ties, whether

clubhouse or non-clubhouse related, which is consistent with previous research (Biegel, Pernice-Duca, et al. 2013). We also found that variables of participation in the clubhouse community were not associated to how helpful a person was perceived in the unit, how much help members reported receiving, or if members acted as bridges uniting the community as a supportive network. These results underline the very individual nature of the Recovery process. Further research through a longitudinal study design is required to understand (or negate) the influence of the clubhouse in promoting healthier social networks. However, these results also show that how often people choose to attend the clubhouse, or how long they continue to be active members, is not related to the support system they have within the unit, or the centrality in the network. This is corroborated by the results of the case studies: even those who are very peripheral in the network of a unit, and for whom the clubhouse is peripheral in their social worlds, still choose to attend.

We also studied if the supportive ties of clubhouse members were perceived as reciprocal, or on the contrary, as unidirectional. The results showed that members perceived the connections to staff as the most supportive, the most helpful, but also the least reciprocal. Relationships to members appeared more egalitarian on this basis, as it was more often reciprocated. However, results showed much less reciprocity than expected from an intentional community of mutual support. The network created by the perception of providing help to others is weaker (less dense and with many isolated people), than the network created by the perception of receiving help. For the clubhouse it would be important to acknowledge these results, first to reemphasize how important it is to promote peer support, second for staff to reevaluate if being very helpful in a unit might be creating more dependency than healthier reciprocal relationships. We found that helping a staff in the unit was associated to unit work, and was not perceived by interviewees as helping staff members in the same way staff helped them, and thus was not perceived as reciprocating.

Lastly, case studies showed that the organization can be central, auxiliary or peripheral in the social world of people, and that members use the clubhouse in different ways. Even when a person seems to be central in the clubhouse, it does not mean it is central in her /his life. In fact, the clubhouse community often appeared as an entity in itself, important to members as a source of support. We suspect that beyond the scope of this paper, the organization is for many not only a hub of resources or supportive relations, but, as someone put it during an interview, a “destination, both physical and mental”, a place where you “feel safe”. “You know that you’ll be safe because people know you”. It would be very interesting to conduct further research on this topic as well, to understand how people perceive and delineate the clubhouse community, and how they derive support from it, as opposed to from specific people as explored in this article.

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ABOUT THE ARTISTS

EVA TORTORA

I was already an artist, writer and plus size model. I've been in *OPRAH* magazine, *Goodhousekeeping* magazine, *Money Magazine*, and *Daily News* newspaper. My art was shown in a Dunkin' Donuts for eight months in Staten Island, and I have pictures of everything. I had heard of Fountain House. I didn't apply until seven years after I heard about it. I guess things happen when they are meant to happen, and things are just "meant to be". I was already a published artist and writer, but really grew at this program and loved every minute of it. Nonjudgmental, easy to get along with, honest, tough, real. Creative, inspiring, helpful, really there for you when you need them. I can say I'm truly inspired, and I literally hope to grow old with this program. In style, of course. In style and inspired.

RIVKY GEE

Rivky, a member of Fountain House, received incredible support during a time when she often remained mute, experiencing catatonic symptoms for almost a decade, diagnosed with a form of schizophrenia. "They spent time listening to me, asking me beautiful questions, like: "What are you good at?" Not, "what is your diagnosis, what are your symptoms?" Spending time flower arranging, piano playing and just simply eating lunch in a communal dining area helped me to eventually turn my attention upward, developing my awareness, altering the ideas of who I was, into something more hopeful, something completely different. Not the big looming beast of an illness that I already knew was there. I didn't need to know more of it. I consider them my second family."

Rivky's paintings have been sold to well-known collectors, like [Carl Hagberg](#), [Sheila](#) and [James Gray](#), former president of [Macy's](#). Her essays and artwork have

been in various publications like, **Harvard's** literary magazine, **The Mighty, Coffin Bell Journal**, among others, including scholarship residencies in The Hamptons, and a most wild adventure meeting **Dr. Patch Adams**, (a.k.a. Robin Williams film), and his "**Gesundheit!**" Institute for creative healing in medicine! Rivky spends most of her time as a Singer-songwriter playing with Cellist Brian Sanders, including her acting roles, Off-Broadway, **The Signature Theater, The Kennedy Center**, and stages featuring **Suzanne Vega**, and her song produced by **Grammy winning, Amy Lee of Evanescence**. Rivky was selected this year for the **New York Musical Theater Festival's** composers of 2019. www.rivkygee.com, Instagram: <https://www.instagram.com/rivkyisms/>

"I am drawn to Rivky by her raw talent. What I love about her as an artist is the strength in her vulnerability—absolutely beautiful. I can't wait to hear more from her!"

—Grammy winning, Amy Lee, Evanescence

SUSAN BAUS

When I first joined Fountain House I was a very isolated, sad, and depressed person. I have bipolar disorder and had been on various medications but it wasn't enough to keep me mentally healthy. I was in my apartment most of the time because I didn't want to go out. I began to use my computer skills to create scanned object digital collages, a technique I had developed in my isolation. A friend in my mood disorder group recommended I join Fountain House. I was skeptical but when I took the tour I knew definitively that this is what I needed in my life. Fountain House turned my life around. I joined the gallery and for the first time showed my creations to another person. The gallery director was very encouraging and I was invited to show some of my work. Since then I have become an artist who has had the opportunity to show and sell my art in many different venues. I moved upstate to Bethel, NY and was recently featured in a 3-person show at the Bethel Council of the Arts. I continue to come into the city once a week to keep active in Fountain House and the gallery. Fountain Hose remains my home community.



The Intentional Community

Recovering self esteem

Fostering a sense of belonging

Promoting self-efficacy

Working side by side

Providing a safe place to be oneself

Fostering a sense of community

Engagement, interaction and refuge

Developing social relationships

Practice continuous assessment

Setting up transitional environments