Clubhouse as a Site of Social Inclusion for Mentally Ill Persons:

The Experience of Easy House in Taiwan


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Abstract

Mental illness is one of the major divisive categorization to classify people from each other, which functions to exclude certain people from self-determination of daily living, and subjugate oneself to medical professions’ decisions. Clubhouse, a long-recognized psychosocial rehabilitation model for psychiatric patients, has its roots in anti-psychiatry and mutual help movements, and thus is aimed to restore the subjectivity of mental patients through its special institutional and relational arrangements. In the normative level, the concept of social exclusion/inclusion will be adopted to analyze how the institutional arrangements of a clubhouse constitute a site of social inclusion for mental patients to capture the essence of clubhouse. In the empirical level, the experiences of Easy House will be analyzed to illustrate how the clubhouse principles are embodied to promote alternative subjectivity for mental patients. Participatory research is adopted as research design. Both written and oral Narratives of workers and members/patients are collected through a monthly gathering over a ten-month period. Findings show that a holistic view of human being is assumed in the everyday practices of clubhouse model to replace the subjectivity of patient which results from previous engagement with mental health system. Such process of replacement is not a one-time shot but a recursive and on-going one that requires persistence and reflexivity of workers to achieve such goal. We also find that the inclusive essence of clubhouse tends to be missed especially when current discourse on community-based rehabilitation defines ‘community’ in terms of physical location rather than a process of collective and resistant identity formation.
I. Introduction

Madness is an ancient but contested concept that varies in different historical moments. Despite of its variance, the mad/insane/mentally ill is one of the most powerful categories that disqualifies the signified individuals from participation in almost all decision-making of his/her daily life. In the light of classic works such as Goffman (1961) and Foucault (1965), the transformation of madness is revealed that a set of knowledge and techniques regarding madness has gained scientific status and institutionalized as a regulatory apparatus, a process which we call 'medicalization'. The mad man is now called 'mental patient' and the form of confinement has been shifted from 'Stultifera Navis' (the boat that conveyed the insane), asylum, mental institution, drug treatment and to community care, while there is only one thing that never changes, i.e. the constant division of the insane vs. the normal. Mental illness functions to subjugate one's autonomy to medical professions’ decisions. Yet, such discipline and regulation operate with constant resistance. The anti-psychiatry movement in the 60s, the consumer movement in the 80s and the survivor movement in the 90s, all mark the resistance to the destructive effects of medicalization on people with mental illness. Clubhouse, originated from a community social rehabilitation program called Fountain House in New York City, embodied a form of resistance to the medical discourse of mental illness.

Clubhouse, a long-recognized psychosocial rehabilitation model for psychiatric patients, has its roots in anti-psychiatry and mutual help movements, and thus is aimed to restore the subjectivity of mental patients through its special institutional and relational arrangements (Beard, 1982). The development of the clubhouse model strives to maintain a de-stigmatizing, empowering and supporting environment for mentally ill people. Instead of reinforcing the medical model of segregation, the clubhouse model intended to create a milieu — where mentally ill people or non-mentally ill people can work together, live together, and be respected as well as valued by the community of which they are a part (Michael, 1988). Clubhouse model initiates an alternative way to look at persons with mental illness. Clubhouse is unique in its dedication to reversing the effects of stigmatization through offering to program attendees membership status, valued roles, and a collegial relationship with program staff. The attendees are thus called 'members'. Hodosh (1998) identifies three generally accepted frameworks of this model: 1) successfully maintain an atmosphere in which
members are needed, 2) minimize functional hierarchies between members and staff, and, 3) operate in a manner which reflects a belief in the potential productivity of all members. In other words, in the context of medicalization of mental illness as a form of social exclusion, clubhouse is aimed to serve as a mechanism of social inclusion. Therefore, the concept of social exclusion/inclusion will be adopted in this paper to analyze how the institutional arrangements of a clubhouse constitute a site of social inclusion for mental patients to capture the essence of clubhouse. The experiences of Easy House will be analyzed to illustrate how the clubhouse principles are embodied to promote alternative subjectivity for mental patients.

The concepts and principles of clubhouse had already been introduced in Taiwan for more than fifteen years. Although it is well-known to some professional helping workers in mental health field, there was no effort made to start a clubhouse until the Eden Foundation established Fountain House in 2002. At this moment, there are four existing programs in Taiwan that claimed to be inspired by the clubhouse model. This paper is focused on the experiences of Easy House.

II. Research design

The purpose of this study is to explore the experiences in Easy House, and how these experiences illustrate the process of social inclusion from the perspectives of both member and staffs. In line with clubhouse principle of working with members, participatory research is adopted as research design. The research project was announced and invited voluntary participation from both members and staff. Focused group on a monthly basis over a ten-month period served as the public domain of dialogue. Dates of focused group meeting were scheduled in advance so members were aware of the event. The first author served as adviser and leader for the focused group. Two or three written or oral Narratives of workers and members were presented for group discussion to illustrate how personal narratives reveal the operation of clubhouse. Often narratives would induce other participants to share their stories. Through such cycles of collective narratives, both written and oral narratives were collected.

In addition of focused groups, a research team was established to collect and analyze data systematically. Semi-structured interview format was chosen to elicit in-depth information, using a flexible
interview style that acknowledges individual perspectives (Miniciello Aroni, Timewell & Alexander, 1990). The interview guide was used for exploration as a starting point but the respondents determined interview content (design flexibility), allowing them to introduce relevant themes not included in the initial interview guide. Three staffs were interviewed from May to June 2008. Participants were asked about their working experiences with mentally ill people. They also were inquired to reflect on the meaning of working in Easy House.

The study used a qualitative method based on thematic analysis of transcripts from semi-structured interviews in order to allow detailed exploration of participants’ views and experiences. Qualitative research lends itself to developing knowledge and understanding of people’s experiences, social contexts, and the meanings they ascribe to them, from their (emic) perspectives (Yuen & Fossey, 2003; Denzin & Lincoln, 1994).

The interviews were recorded on audio-tape and transcribed. Data were sorted into coding schema, from which themes emerged for analysis. Field notes and articles by participants were used to analysis too, but also reflected on salient themes immediately following each interview to assist data interpretation.

III. Research Findings

As social exclusion operates in multiple dimensions, the findings will be presented according to different aspects of exclusion that mentally ill persons face today. A holistic view of human being is assumed in the everyday practices of clubhouse model to replace the subjectivity of patient which results from previous engagement with mental health system. Such process of replacement is not a one-time shot but a recursive and on-going one that requires persistence and reflexivity of staff workers to achieve such goal. Four themes were identified: 1) voluntary membership in program arrangements to ensure member autonomy, 2) members’ subjectivity as a person rather than a patient; 3) member and staff relation as equal partners in a community to reverse the dichotomy of professional and client; 4) reshaping labor market as a collective to make work accessible to members. Difficulties and resistance from the existing mental health system were also discussed.
3.1 From Patienthood to Personhood: Voluntary nature of Membership

People with a history of mental illness are constantly under the medical gaze of examination in their intra-institutional journey. Being rejected under certain criteria of intake by service programs is so common for them that mentally ill persons start to believe that they have no say in their lives, which is well documented in Goffman’s analysis of total institution (Goffman, 1961). People with mental illness internalize the medical gaze (Foucault, 1977/1995) and assume the role of the sick. In other words, people with mental illness become a ‘patient’ through their daily interaction with the mental health system. To reverse the process of medicalization, a different set of social rituals and institutional arrangements is needed. First of all, people with mental illness are called ‘members’ rather than ‘patients’ to denote the idea that clubhouse belongs to them and they have a say in its daily operation. The first experience of ‘I have a say’ for members lies in the process of intake. Most psychiatric community-based programs, such as day care, rehabilitation programs or vocational program, are professional-driven and set certain requirements for their intake. However, people with history of mental illness are given the rights to decide if they want to become a part of the clubhouse.

The first thing is that as long as you are a qualified member, you can enter the clubhouse without any evaluation. We will not check whether they take medicine regularly or their illness is under control. Our only requirement is that you are a resident of Taipei County and have the document that proves your mental illness. We have to do that, because we are financially supported by Taipei County City. Under these two conditions, you can join whenever you want without the approval of professionals. (S1)

Access to services is not determined by the professionals. No referral, medical examination, or needs assessment is required, as “membership is voluntary and forever lasting.” (The first rule of ICCD, 2006) To become a member is member-initiated. A message of ‘Your words count’ and ‘you can decide’ is sent to members. Besides the restriction of being a resident of Taipei County, the mentally ill persons have the autonomy of being fully in charge. The willingness and motivation of the people with mental illness are
valued the most. No one is given up and excluded as “unqualified” persons. Everyone has a hope in clubhouse that everyone who wants to join has the chance to celebrate the beauty of being human.

Unlike other day care centre or community rehabilitation programs which exclude people who are not stable… The Easy House doesn’t want to repeat the same pattern. We emphasize that as long as you are willing to join, you can come. As a staff worker, I do not have the authority to choose my clients. I only have the obligation to accept the member’s decision. (S2)

For many professional social workers, zero-rejection on intake is threatening because that means professionals lose control over clients. Staffs in Easy House also experienced such worry but were aware that was a residual effect from the medicalization of professional training.

Easy House doesn’t want to repeat members’ experience of being rejected. Staff members then will have to jump out of the ‘bomb shell’ of intake criteria and be ready to face the consequences. In the beginning, you really felt the fear and worry about the uncertainty and unpredictability that you have internalized deeply in your mind. Then, you learn to know members through being with them. (S2)

To ensure members’ voluntary participation, members are given sufficient opportunities to ‘shop around’ in order to make an informed decision. The right to make decisions ensures a sense of belonging which leads to a community of solidarity.

After the application, they will become the “members to be.” We hope that these “members to be” will participate in our activities for twenty times… They will be exposed to a lot of different members. When they express that they like this place, finish their internship, understand the idea and structure of the house, and willing to join in, then we will welcome them and they can choose a group to join in… the feature of the clubhouse is that all the members need to participate in the policy making of this house. This enables them to have a sense of belonging to this place. (S1)

The principle of voluntary participation goes beyond the membership. Members also can decide when to come to and leave the clubhouse, which staff workers they want to work with, and which units they would
join. Members have autonomy in terms of deciding whether to accept the services or not. Once he decides to accept the service, he becomes a ‘member’. The people who come here are not to be treated, but to participate in the operation of the clubhouse. When people with mental illness are not seen as patients in need of intervention, there is no need for the professionals to ‘solve the problems’ or to ‘protect and train the patient’. People with mental illness are being regarded as “members” who are independent, self-sufficient, and can make contributions to the whole group. They are people who participate actively and have potentials.

In the clubhouse, you can try a lot of things that you haven’t tried before. After you becomes ill, sometimes others will tell you not to do the things that you used to do…for example, you are not allow to drive a car, or not allow to take care of your kids, etc. Because you are a patient, you have a lot of restrictions and have to obey…In Easy House, we try to deconstruct this concept, and we try to challenge. I think this is important.(S3)

However, the zero-rejection admission policy of Easy House was challenged by existing psychiatric programs. Social workers and nurses from day care were surprised that staff workers in Easy House did not supervise medication conformity daily to ensure the control of mental stability of members. The notion of knowing members as persons not as patients is alien and considered unprofessional. Insistence on the belief that members be treated as persons has been especially vulnerable during regular program inspection by the so-called experts on mental health. The paradigm shift from patienthood to personhood created conflict and anxiety for the director of Easy House who was in a position to defend its operation: ‘I don’t seem to be able to find appropriate words to tell them why we are doing it this way.’ In a system where there is insufficient community support for the mentally ill, the Easy House is at risk of becoming a dumping place for ‘the difficult patients’ by other programs. For example, case managers from vocational rehabilitation program who are under the pressure to find a place for people with mental illness have found the Easy House as an easy solution for their difficult cases.

3.2 From ‘You/I are Patient/Professional’ to ‘We are a Community’: Beyond the boundary of professionalism

In the model of clubhouse, there are two roles: staff and member. These two roles are indispensible to
each other in maintaining the operation of the clubhouse. In Easy House, there is no one who is in need of medical treatment. Most of all, staff workers do not make plans for members about their goals, but support members’ decision when and how they would change. In this way, members are constantly given a chance to have their lives back in their hands. The mechanisms of exclusion which medical power depends are consciously removed. The professionals no longer undertake the role of knowing-all professional but that of supporting friends. The relationship between doctor and patient is not the only possibility to help people with mental illness. The model of clubhouse is a new way of thinking in terms of how to treat these people. For staff workers, this is what they considered ‘real social work’:

I identify myself with the spirit and value of the clubhouse. I think it is real social work. You can develop a new model. This social work is based on the belief that people, no matter how ill they are, have the potential to contribute to the society…(S1)

This … changes the relationships between doctors and patients. I think that the model of clubhouse is more effective than treatments such as medicine, injection etc.(M1)

The staff worker no longer understands members through the categories of mental illness, but works with them and grows with them during the process. Relationships are established through accomplishing common goals by collaboration between staffs and members. They are partners who work together and face life together, as ‘Every member has the equal rights to participate in the affairs of clubhouse, regardless of his or her illness or ability. (Rule number four, ICCD, 2006)’

To ensure the sense of community and to reject the divisive effect of wages, work done in clubhouse will not be paid. In stead of waged labor, work is re-defined as activities that contribute to others’ lives and thus meaningful to members as well as others in clubhouse. Work done in clubhouse must reflect the needs of the community. The requirement of equal participation does not depend on the good will of staff workers but is ensured by the program design. The workload of each unit cannot be finished by staff workers, so that staff workers need members’ participation and assistance(Beard, 1982). In such arrangement, staff workers are
constantly looking for members’ strengths that will be of assistance. Such strength-based perspective is built into the clubhouse program, rather than a model of professional practices that does not ground in necessary material conditions. What members respond is a real need that makes real differences to others. It is the real relationship of reciprocity that members and staff workers establish trust and become a community. In Easy House, members and the staffs do these works together. By working together, the dichotomy of professionalism as professional vs. client is replaced by a collective subject as we. The substitution of ‘we’ with ‘you/I’ is critical in reversing the disciplinary relations in traditional programs of medical model. The relationship of imposed visibility upon patient by the professional gaze is substituted by a collegial relation of solidarity. Thus, clubhouse creates chances for both members and staffs to be together as a community. Clubhouse includes people with mental illness by creating a home for them to belong to.

One of the key feature of clubhouse is to involve members in the decision making process, including its daily operation, interior design, so they have a sense of belonging. Why do you have to work with members? It is because you will see their strengths. You look for members’ strengths that can be helpful to you. You are not there to manage them, but to depend on them to help you. I am not there to train them but to learn from each other. (S1)

The collegial nature of relationship between staffs and members is also liberating to professional social workers. Comparing with traditional social work setting, staff workers felt that they were free from the image of helping professional and can be a real person by expressing their weakness and their needs for help.

I may encounter things that are beyond my ability. I never expect myself to be the one to solve all the problems… I will share my problems with the group, so they can be understanding and be helpful… I can relieve myself from being Mr. Know-all. (S3)

In this sense, the practices of clubhouse are not case oriented but community-organizing approach. By living together, staffs and members are interconnected into a web of relationships of reciprocity and equality.
as persons. A staff considered clubhouse as a site to provide chances for bother members and staffs to care for and be cared by others. This principle of working together is fundamental to the operation of clubhouse that is applied to all activities. Easy House has been contracted with the government to provide outreach service to the mentally ill persons in community. Usually, outreach service is performed solely by professional social workers but Easy House turned it into an activity that staffs and members conduct the outreach together.

People feel autonomous and confident by giving. For members, outreach program provides opportunities for all to care for one another. That is one of the purposes for outreach program. (S6)

3.3 Reshaping the world of work as a collective to make work accessible to members

Given the essential role of work in contemporary society, work is the key in clubhouse to reconstruct members’ lives. Work is an alternative way to rehabilitation (Norman, 2006). However, work in clubhouse is defined differently from the mainstream society. Instead of waged job, ‘work’ means activities that are meaningful to others or that contribute to others’ lives. In that sense, members come to clubhouse to work, meaning members come to clubhouse to create changes in their and others’ lives. Therefore, work done in clubhouse must be responsive to the needs of the clubhouse community, not external needs. Work-ordered day provides the basic framework for members to engage with staffs and members. To be able to give and to contribute tends to enhance members’ self-confidence and their sense of belonging.

Yet, to create a self-sustaining community is not the goal of clubhouse. To be employed in labor market is the wish of many members but few can achieve that. Transitional employment is a kind of supported employment that clubhouse developed for people with mental illness (Bond, Drake, Mueser, & Becker, 1996). Its aim is to make job accessible to members who wish to work as much as possible. The way clubhouse eliminates the barriers for employment is to own employment opportunities in the name of clubhouse, dividing a full-time job into two part-time jobs for members to try for a limited period of time, usually six to nine months. In exchange, the clubhouse provides employers with on-job training and guaranteed absent-fulfillment by staffs. In such arrangements, clubhouse eliminates the barriers to employment for
people with mental illness, such lack of employment history, references, and stigma on mental illness by employers and co-workers. To ensure members the right to employment, transitional employment is characterized as something you will never fail. Members can try again and again until they find the transitional employment place that suits them. Clubhouse as a collective can remove the barriers by educating employers and co-workers, negotiating working conditions, adjusting work load to fit the members’ ability and integrating staffs into work placements as on-going support. Traditional employment then becomes a ladder toward independent employment to eliminate the exclusive mechanism of current labor market for people with mental illness.

VI. Conclusion

How clubhouse functions as an inclusive mechanism for people with mental illness? To sum up, clubhouse re-define mental patients as persons who are capable of contributing to others, regardless of the length of their mental history. The subjectivity of member is constantly renersoned in the daily opportunities to participate and to make decisions. The authoritative figure of professionals is transformed into staff as colleague and co-worker. The program arrangements of naming, membership, staff/member ratio, work-ordered day and transitional employment are aimed to reflect such philosophy. Transitional employment is a collective effort to provide a ladder between day program and independent employment, so members can build up their confidence. It shows that social exclusion of people with mental illness is multiple-layered. The view on inclusion should be visionary that provides hope and autonomy to people with mental illness rather than imposed from the perspective of the professional. Clubhouse is a sub-culture that tries to counter the medical discourse on mental illness. The essence of clubhouse is to make a process of collective and resistant identity formation possible.

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