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Nine ways that clubhouses foster interpersonal connection for persons with severe mental illness: Lessons for other types of programs

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ABSTRACT
We highlighted ways in which clubhouses promote togetherness in order to highlight lessons in togetherness that can be learned by non-clubhouse programs. Using three hour-long focus groups (N = 20), we found that clubhouses promote closeness through work, repeated interaction between members, a non-judgmental environment, evening and weekend activities, social skill enhancement, power equalization between staff and members, sharing of similar experiences, flexibly structured activity, and staff outreach after absence. Other types of mental health programs (e.g., day treatments, certain residential facilities) can grow in these nine ways in order to foster closeness between people and prevent relapse or other adverse consequences.

The provision of meaningful relationships is the core ingredient of clubhouse programs (Clubhouse International, 2016; Raeburn, Halcomb, Walter, & Cleary, 2013). But which clubhouse features are most central in promoting interpersonal connection? Is it the work-ordered day that fosters closeness between people, for example, or is it the availability of evening and weekend activities? Or perhaps the non-judgmental environment is key, or the opportunity to share similar experiences with peers. Based on focus groups and a review of published literature, we sought to elucidate the ways in which clubhouses help people with severe mental illness (SMI) to connect socially. Other types of mental health programs (e.g., day treatments, drop-in centers, some self-help centers, certain residential programs) can then learn lessons in togetherness in order to foster closeness between people. Our intent is to help these other types of mental health programs to maximize potential for interpersonal connection (i.e., by learning from the clubhouse model). Such closeness can combat loneliness, which increases vulnerability for a wide
variety of negative outcomes (e.g., relapse, inpatient stay, cognitive decline, suicidality, illness, death: Cacioppo, Hawkley, & Thisted, 2010; Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Ellwardt, Aartsen, Deeg, & Steverink, 2013; Hawkley & Cacioppo, 2010; Heinrich & Gullone, 2006; Hosseinbor, Ardekani, Bakhshani, & Bakhshani, 2014; Stickley & Koyanagi, 2016; Stravynski & Boyer, 2001; Wilson, Krueger, & Arnold et al., 2007). We hypothesized that some clubhouse features (e.g., the work-ordered day; evening and weekend activities) are especially salient in promoting meaningful interpersonal connection.

**Background: What is a clubhouse?**

With over 300 programs in more than 27 countries worldwide, clubhouses share several characteristics (Clubhouse International, 2016). First, clubhouse members and staff share equally in the tasks of running the organization. In “work-ordered days,” tasks range from bathroom cleaning to the hiring of new personnel. Second, in relation to all important clubhouse operations, there is consensus-based decision making. Members play key roles in making key agency choices (e.g., hiring of new staff). Third, every effort is made to place clubhouse members in the paid labor force, through supported, transitional, and independent employment programs. Fourth, education and housing assistance is available, and crisis intervention is offered. Finally, there are always evening and weekend activities, and clubhouse members and staff work together as colleagues in order to forgo the clinical distance of most other mental healthcare. Clubhouses are a solution to the social isolation and stigma that can accompany SMI, and the social support provided in clubhouses promotes recovery and overall well-being (Carolan, Onaga, Pernice-Duca, & Jimenez, 2011).

In a recent systematic review of clubhouse literature, McKay and colleagues (2016) suggest that clubhouses are better than other types of programs in promoting social relationships, even though other mental health programs reach for the same goal. Clubhouses are especially effective in welcoming people and providing opportunities to meet others, and relationships develop among peers who: (1) collaborate on shared tasks; (2) share personal experiences, knowledge, and advice; and (3) depend intimately upon one another and look out for each other (Coniglio, Hancock, & Ellis, 2012). Clubhouse members have a place to go every day and to be with other people in the same place, and in that place there is constant interaction, ongoing opportunities to meet new people and develop friendships, and daily practice in developing social skills (Carolan et al., 2011; Herman, Onaga, Francesca, SuMin & Ferguson, 2005). Clubhouses combat isolation by building a community where social relationships can grow and staff members make every effort to help such relationship develop in the work-ordered day (Chen, 2016; Herman et al., 2005).

The International Standards for Clubhouse Programs (2016) call specifically for the development of meaningful interpersonal connection by: (1) providing
outreach to members who are not attending, becoming isolated in the community or hospitalized; (2) engaging members and staff together in the work-ordered day, and side-by-side in the running of the clubhouse; (3) organizing the clubhouse into work units, where unit meetings are held to foster relationships as well as to organize and plan the work of the day; (4) having recreational and social programs during evenings and on weekends, where holidays are celebrated on the actual day they are observed; and (5) holding open forums with procedures that enable members and staff to actively participate in decision making, generally by consensus, regarding governance, policy making, and the future direction and development of the clubhouse.

What is it about clubhouses that promote closeness? In relation to other types of mental health programs, what lessons can be learned?

**Method**

We held three hour-long focus groups (N = 20, with 6–8 members in each of the three groups) at Fountain House, the very first clubhouse. Founded in 1948, Fountain House now helps about 1,300 people in New York City to find employment, enhance education, get housing, improve health, avoid hospitalization, and build social networks. For our focus groups, Fountain House members agreed (voluntarily) to join our study, and then participated in the groups on the very same day. Some people arrived late for the three groups and some people left early. We did not have access to charts, so demographic and clinical information about focus group members is unavailable. The Fountain House population is 60% male, 42% White, 11% ages 18–29, 20% ages 30–39, 17% ages 40–49, 27% ages 50–59, and 24% ages 60 and over. In order to collect data, three of the authors together facilitated each of the three focus groups. We audiotaped and transcribed each group. The hour-long groups centered on ways that people with SMI get close to others and form relationships in regular encounters (e.g., daily, weekly, biweekly, monthly). We needed only one question in order to gain in-depth information: “What works well, and what has made it hard to form close relationships?” We offered examples of what might work well in forming close relationships (e.g., sharing activities with other people at Fountain House), and what might have made it hard to form close relationships (e.g., symptoms getting in the way). After the on-the-spot recruitment of focus group members, the researchers met with members in a conference room, asked permission to record the proceedings, and collected written informed consent. For this analysis, we examined ways that clubhouses foster closeness.

**Data analysis**

In four stages, we used grounded theory to understand focus group themes and patterns (e.g., Lingard, Albert, & Levinson, 2008). In the first stage, one researcher
examined themes and patterns in one focus group, a second researcher examined themes and patterns in the second focus group, and a third researcher examined themes and patterns in the third focus group. We determined that saturation was achieved when the three researchers began to note the same themes and patterns.

In the second stage of our analysis, each of the three researchers examined themes and patterns in all three focus groups. In the third stage, a doctoral student in social work synthesized all of the information into a single document by: (1) grouping together themes and patterns that emerged in all three of the focus groups and (2) creating a taxonomy of the underlying content. In the fourth stage, the first author (a professor of social work) further synthesized the findings. This process was guided by a seven-stage content analysis (e.g., Hsieh & Shannon, 2005). First, we broke the data apart while categorizing the different concepts. Second, we gained familiarity of the data with repeated reviews. Third, we noted codes of preliminary themes and patterns in the margins. Fourth, we numbered and categorized each code into a classification system. Fifth, we merged together the common themes and patterns. Sixth, we reexamined and related the categories to each other. Seventh, we linked direct quotes to the data.

We concluded that there was nine Fountain House features that foster interpersonal connection, and sought to quantify this connection in a follow-up study.

**Quantifying closeness in a subsequent study**

Fountain House members \((N = 150)\) participated in a follow-up study that was part of a larger investigation on social network formation (the creation of interpersonal connection). In relation to demographic characteristics, the follow-up sample was similar to the Fountain House population (sample: 61% male, 54% White, 13% ages 18–29, 18% ages 30–39, 15% ages 40–49, 29% ages 50–59, 25% ages 60+; Fountain House population: 60% male, 42% White, 11% ages 18–29, 20% ages 30–39, 17% ages 40–49, 27% ages 50–59, 24% ages 60+). In addition to containing information on interpersonal closeness, the follow-up interview included questions on a wide variety of other factors (e.g., social network, loneliness, mental health, recovery assessment, substance abuse). All participants in the follow-up study had SMI and they spoke English. We trained a doctoral student in social work to administer the survey by reviewing the interview questions and by holding mock interviews. In our convenience sample, participants were recruited to be in the study if they were available on days of data collection. In other words, we came to Fountain House and recruited members to be in the study on the very same day. As part of the follow-up study, we asked Fountain House members to indicate the extent (on a 4-point Likert-type scale, from 1 = very true to 4 = not true at all) to which they agree that nine features promote closeness to other people. The nine features were taken from focus group findings. Table 1 shows the clubhouse features that promote togetherness.
### Table 1. Nine clubhouse features that promote interpersonal connection.

<table>
<thead>
<tr>
<th>Clubhouse Features that Promote Closeness</th>
<th>Percent Reporting True or Very True (N = 150)</th>
<th>Mean (from 1 = very true to 4 = not true at all)</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work at Fountain House helps me to get close to other people</td>
<td>94</td>
<td>1.56</td>
<td>0.74</td>
</tr>
<tr>
<td>Repeated interaction with other people at Fountain House helps me to get close to other people</td>
<td>93</td>
<td>1.62</td>
<td>0.75</td>
</tr>
<tr>
<td>The non-judgmental environment at Fountain House helps me to get close to other people</td>
<td>89</td>
<td>1.61</td>
<td>0.83</td>
</tr>
<tr>
<td>Evening and weekend activities at Fountain House help me to get close to other people</td>
<td>88</td>
<td>1.72</td>
<td>0.88</td>
</tr>
<tr>
<td>Improving my social skills at Fountain House helps me to get close to other people</td>
<td>88</td>
<td>1.65</td>
<td>0.84</td>
</tr>
<tr>
<td>Being on an equal footing with staff at Fountain House helps me to get close to other people</td>
<td>86</td>
<td>1.69</td>
<td>0.94</td>
</tr>
<tr>
<td>Being able to share similar experiences with others at Fountain House helps me to get close to other people</td>
<td>84</td>
<td>1.76</td>
<td>0.90</td>
</tr>
<tr>
<td>Absence of rigid structure at Fountain House helps me to get close to other people</td>
<td>83</td>
<td>1.72</td>
<td>0.96</td>
</tr>
<tr>
<td>Staff outreach to me when I am absent from Fountain House helps me to get close to other people</td>
<td>79</td>
<td>1.92</td>
<td>1.07</td>
</tr>
</tbody>
</table>
and the extent to which clubhouse members agree that each feature fosters closeness. Written informed consent and Institutional Review Board (IRB) approval was obtained for both the focus groups and the follow-up study.

In the sections that follow, we use our focus group findings and published results from other research on clubhouses to illustrate the nine features of clubhouses that promote interpersonal connection (closeness). We rely on findings from other studies when such findings complement our own, and we highlight lessons in togetherness that can be learned by non-clubhouse programs.

**Results and lessons for other programs**

**Closeness factor 1: Work in clubhouses**

Each day the clubhouse members work alongside of staff in order to develop relationships and build skills in areas such as reception and administration, meal preparation, and building maintenance (Raeburn et al., 2013). Working together builds interpersonal connection. One Fountain House member stated as follows:

> You want to encourage people who seem like they’re not connecting as much as they should, or they feel like they can’t connect. You want to encourage that through participation in the work, and the social interaction maybe will follow. You see . . . the work is the conduit.

Similarly, from Coniglio and colleagues (2012, p. 158):

> Around the work-ordered day, you get to know people. After a while, you know who you can trust . . . . They take a while to trust you but once they do trust you, they trust you. With a drop in centre, I couldn’t imagine that you’d get the same amount of trust with people. They’re just dropping in, saying hello and having a cup of tea and going.

Importantly, this last statement contrasts the work-centered togetherness in clubhouses with the lack of connection in some other types of mental health programs. Without turning into clubhouses, non-clubhouse programs could also offer work- or task-related projects. That is, similar undertakings could be shared among members (e.g., meal preparation; cleaning) in order to reap the benefits of interpersonal connection (e.g., preventing relapse by counteracting isolation).

**Closeness factor 2: Repeated interaction**

Repeated interaction helps promote interpersonal connection in clubhouses. As one individual put it, “You see the same people every day, and eventually you start to talk to them and become friends.” Sharing the same activity repeatedly, where such activity is chosen carefully, is important:

> I was attracted to the research unit because they had all the computers, and everyone looked busy, so I thought this would be the perfect atmosphere for me,
because you know, I’m not that social. But you know, *when I kept coming* … [I would] develop friendships (italics added).

Or:

Before I came to Fountain House I wasn’t like making as many friendships and then I came here and the more I came here, even just going to lunch every day and talking to people and it could be very causal. Could be what’s your favorite song, what’s your favorite movie, and they usually play the radio. So you know, say whose singing, kind of like name that tune, so I found *the more I come here the more social I am* (italics added).

Thus, it is repeated exposure to the same people and activities that brings clubhouse members closer to one another. Efforts in other types of mental health programs (e.g., day treatments) to bring the same individuals together repeatedly in the same activities (e.g., by keeping cohorts of people together across undertakings) can counteract the social isolation that can lead to hospital stays or other unwanted outcomes.

**Closeness factor 3: A non-judgmental environment**

Interpersonal connection is promoted when mutual understanding between clubhouse members prevents unwanted judgment:

I like to socialize at fountain house because people don’t judge you at fountain house like they do outside . . . . When I was in high school they’d make a big deal about me being in Bellevue, at the time there. They called me a nut and stuff like that, you know, mental patient . . . I couldn’t socialize with anybody outside of fountain house. They’re too judgmental.

Or:

Some people . . . when they hear you have mental illness they don’t want to associate with you anymore. But at Fountain House it’s different, they’re more accepting. Cause you know, I tried to get relationships outside of fountain house. But I wasn’t successful because . . . . I have mental illness. But at fountain house . . . . [there is not] as much judgment like outside of fountain house. Cause outside of fountain house they say . . . “you’re like that guy who shot kids in Connecticut,” you know . . . you’re gonna kill kids or something like that.

Thus it is important in non-clubhouse programs to promote a non-judgmental environment. Such an environment cannot be assumed. Someone with major depressive disorder, for example, might negatively evaluate someone else with a disorder such as schizophrenia. According to one Fountain House member: “At first I thought that people . . . [with] different diagnoses would be hard to talk to and I would have to be on guard . . . that someone would harm me. Then I just found out that it wasn’t the case.” Tolerance must be learned in some cases, even among staff that might find certain
expressions of mental illness to be off-putting (e.g., mistrust; agitation). Non-clubhouse programs must always strive for a non-judgmental environment that encompasses both consumers and staff in order to promote closeness and prevent isolation and potential relapse.

**Closeness factor 4: Evening and weekend activities**

According to the International Standards For Clubhouse Programs (2016), recreational and social programs must be available on evenings and weekends. Such nontraditional hours help many clubhouse members to get close to other people: “Fountain House helps me develop friendships . . . [in] evening and weekend programs . . . [with] social activities such as parties, and activities like crocheting, watching a movie, board games, karaoke, and dances.” Similarly, one member has “a special group on Friday nights . . . [for] making friends . . . [My group] goes to the diner . . . . Before that we go to nursing homes to keep people still involved in Fountain House.”

Or:

Because of Clubhouse I have that extended network after hours . . . . And I’m lucky that I’ve got friends . . . . Seeing everyone on the weekend is very different because they’re still your friends and you can talk to them about things. They’ll be there for you. (Coniglio et al., 2012, p. 158)

Thus evening and weekend activities in non-clubhouse programs could enhance opportunity for togetherness. After all, risk of loneliness runs especially high outside of normal working hours (weekdays 9–5 when more structure is often available), and loneliness increases risk of relapse and a wide variety of other adverse consequences (e.g.: Cacioppo et al., 2010, 2006; Ellwardt et al., 2013; Hawkley & Cacioppo, 2010; Heinrich & Gullone, 2006; Hosseinbor, Ardekani, Bakhshani, & Bakhshani, 2014; Stickley & Koyanagi, 2016; Stravynski & Boyer, 2001; Wilson et al., 2007).

**Closeness factor 5: Improving social skills**

One of the roles of clubhouse staff is to help members to develop social skills, and interpersonal connection begins to develop. According to one staff member:

If you’ve been in the hospital or isolating at home for a really long time, you don’t know what to talk to people about. I think showing people what small talk looks like, and when you get to know somebody how you engage with your peers, is really important . . . . When somebody comes in the morning on Monday you ask “What did you do on the weekend?” It’s like really small things like that. (Chen, 2016, p. 5)

The process of completing work together on a daily basis also builds social skills while developing togetherness: “We work on hard and soft skills while you develop actual skills . . . . It’s twofold, you actually learn tools while
building relationships and working on social skills” (Chen, 2016, p. 6). Other programs (e.g., certain residential facilities) can reach out more often to engage the more isolated consumers in shared activities or tasks in order to develop social skills, and hold more formal social skill training groups.

**Closeness factor 6: Members and staff on equal footing**

Clubhouse staff makes every effort to reduce hierarchical distinctions with members, for such distinctions often create clinical distance. A peer role is pursued instead (Chen, 2016). According to one Fountain House member:

> I think overall...[staff] do a very good job of integrating with the members in terms of collaborating on all tasks and... even integrating in social activities. I think they do a very good job relative to most other places you see where there is a more strict boundary. And we have a social program and the staff are always involved.

Or as another Fountain House member put it: “[At] Fountain House you can’t even tell the staff from members. Fountain House is like a bridge—the more you are able to come out of the world of mental disability and rub shoulders with people who are abled, the more you are abled, it heals you.”

In a study by Chen (2016, p. 9), one Fountain House member contrasted these power-equalizing relationships with the clinical distance found in traditional mental healthcare: “It almost never happens [elsewhere] and it is hard to even imagine a psychiatrist going to you and saying 'Hey, could you help me set my VCR?' but we do that every day.” Or as another club-house member said about staff: “They try to help you out. I don’t know if you would consider them friends or people close to you, though, but I consider them friends. I feel like they are my friends” (Carolan et al., 2011, p. 220).

There is little evidence that the clinical distance found in most mental healthcare promotes positive outcomes, whereas the experience of these clubhouse members suggests that absence of distance has beneficial effects. Non-clubhouse programs can learn from this experience and try to minimize power differential in order to promote healing connections. Rapport between staff and consumers may improve in the process, and strong rapport leads to a care satisfaction, intervention adherence, and a wide variety of other positive outcomes (e.g., Duncan et al., 2003; Leach, 2005). Staff may need to be trained and supervised differently in order to help overcome a long-standing medical model tradition of power gap.

**Closeness factor 7: Sharing similar experiences**

Similarity between clubhouse members promotes closeness. As one club-house member put it: “I just like to be around here. Just to be with other people, socialize with other people who have problems similar to yours,
people that understand you” (Carolan et al., 2011, p. 129). According to another clubhouse member:

We do have the same issues with our illness or some of the same issues, side effects of the mental illness and all kinds of things to do with mental illness. And if you didn’t meet with other members then you wouldn’t get to talk about side effects so it’s really helpful to have friends who are going through the same thing. (Coniglio et al., 2012, p. 157)

Or according to a Fountain House member:

There are programs in Fountain House, outside of the work ordered day, social programs that I get involved with. I get involved more here than I do outside of Fountain House. I’m involved in a music group. I’m part of a band. I do a lot of socializing with the people in the group. It’s a common interest and activity.

In addition to sharing interest in activities (e.g., music groups), sharing experiences relating to symptoms or treatments of mental illness seems to be especially important in bringing clubhouse members together. Non-clubhouse programs can offer psychoeducation or other venues that allow consumers to share psychopathology-related experiences (e.g., depression support groups).

**Closeness factor 8: Absence of rigid structure**

According to the International Standards For Clubhouse Programs (Clubhouse International, 2016), there are no agreements, contracts, or rules intended to enforce member participation. Fountain House members report that this lack or rigidity helps promote closeness with other people. Members don’t want a total absence of structure (which could result in isolation), but flexible structure is appreciated because it draws people together:

I feel more comfortable socially interacting when there is some amount of structure to the environment but … [not] a definite structure. I’ve developed my [own] structure, where I come in, and I’m comfortable working on certain projects. I look forward to it, and I like it. There are certain things I do. Like work on the newspaper, I edit, as much as I can, I proofread, I work on the literary magazine. That’s my structure. And most members do that. If they want to, they can create their own structure to whatever extent they want … I’m comfortable with it … Just the right amount that will also allow social interaction.

Rigidly structured environments, on the other hand, do not seem to be as conducive to making social connections:

There was a day program I was in. That was rigidly structured. But I think that defeated any hope of social interaction. It was so rigidly structured in terms of “we will have this talk on the hour,” and “this next talk in another hour.” It wasn’t really conducive to social interaction. At least not conducive to helping me be social. At all. The only thing that finally helped really was this environment.
Thus the lesson for non-clubhouse programs is to provide just the right amount of structure, where too little will promote isolation and too much may repel consumers who may not feel up to participating at certain times or in some events. The idea is to promote togetherness without causing care disapproval by applying too much pressure to attend. It could prevent isolation and relapse.

**Closeness factor 9: Staff outreach**

According to the International Standards For Clubhouse Programs (Clubhouse International, 2016), all clubhouses should provide outreach to members who are not attending. Outreach brings people back to the agency, and this in turn promotes closeness that would have been lost with more absence. According to one clubhouse member:

> Sometimes when you have errands to run or you have a lot of activities at home with doctors, with therapists, with your own family, you tend to forget about . . . well, I have tended to not have visited as often. But when I get those calls, I’m back here within a week . . . . I’ve never seen any place where they call you up and are concerned about you or not showing up or whatever.

Absence of outreach or follow-up seems to have the opposite effect, in relation to making social connections: “I was in a day program at Mt. Sinai, and lots of times . . . [in] mental health organizations . . . . it’s just like Vietnam in a way. It’s like body count.” The lesson for non-clubhouse programs is obvious; it is important to follow up when consumers are absent. The absence disrupts connection, and relapse could follow.

**Discussion**

Given that relationship-building is the core ingredient of clubhouses (Clubhouse International, 2016), we delineated the nine clubhouse features that are most central in promoting interpersonal closeness. Other types of mental health programs can integrate many of the nine features in order to combat the social isolation that can lead to relapse or other adverse consequences. In relation to these other mental health programs, certain types of agencies (such as day treatment programs, drop-in centers, some self-help centers, certain residential facilities) seem especially poised to integrate some of the nine features because of the ongoing contact between consumers, and between staff and consumers. Other types of programs (e.g., outpatient clinics; assertive community treatment) have too much of a one-on-one focus to make use of the nine togetherness-promoting features, or the interpersonal contact is too sporadic or time-limited.
In relation to work in clubhouses, people who might otherwise remain isolated can be enjoined by sharing job activities. Many such activities require togetherness by their very nature; it might take a group of people to complete some tasks. Trust tends to develop over time and with such trust comes togetherness. Day treatments, drop-in centers, some self-help agencies, or certain residential programs may wish to emulate this work-related togetherness by having staff and consumers contribute jointly to completing agency tasks. It builds rapport between staff and consumers, and it brings consumers together in healing relationships that might not otherwise form.

In work and in all other shared activities, it is the repeated interaction in clubhouses that draws members together. Simply seeing the same people everyday at lunch, for example, goes a long way towards promoting togetherness. Other types of mental health programs could strive to bring the same people together each day rather than mixing individuals in various activities. Perhaps cohorts of people can be kept together, and together they can join various groups or activities rather than enlisting individuals to participate. Of course, this runs the risk of having people in each cohort who might not get along. Or all of the people in the cohort may not wish to participate in the same activity. However, the option to change cohorts or belong to more than one cohort could always be open.

The non-judgmental environment in clubhouses brings people together, and this too can be maximized in other types of mental health programs. Sometimes it must be developed, for even consumers judge each other when symptoms or mental illnesses seem foreign (Prince et al., 2017). There is often a strong bond when someone with depression relates easily to someone else with depression, for example, but there can be less of a bond when someone has depression and someone else has schizophrenia, for instance. Non-judgmental attitudes cannot be assumed, especially when people with one type of mental illness are placed in close proximity to someone with another type of mental illness; the shared understanding must be developed. Even some staff, especially those that are new to the field or to the agency, may hold certain judgments that must be addressed (e.g., around people with borderline personality disorder). Supervision and training can be helpful under these circumstances.

Other types of mental health programs can also incorporate evening and weekend activities (when possible), for such activities bring people together in healing relationships, and risk of loneliness runs especially high outside of normal working hours (weekdays 9–5). Loneliness increases vulnerability for a wide variety of negative outcomes (e.g., relapse, inpatient stay, cognitive decline, suicidality, illness, death: Cacioppo et al., 2010, 2006; Ellwardt et al., 2013; Hawley & Cacioppo, 2010; Heinrich & Gullone, 2006; Hosseinbor, Ardekani, Bakhshani, & Bakhshani, 2014; Stickley & Koyangi, 2016; Stravynski & Boyer, 2001; Wilson et al., 2007).
Efforts to build social skills must also be developed, for we found that such efforts bring people together in clubhouses. Opportunities for practicing social skills and promoting interpersonal connection can be maximized by enjoining consumers as much as possible in shared activities or tasks or conversations (as in clubhouses). This means that the tendency for some consumers to remain isolated even in the presence of others must be counteracted whenever possible. Of course, people who feel more comfortable being alone must be respected, but staff and consumers can try to draw the more isolated individuals into shared undertakings or chats so that social talents can grow in ways that promote restorative connections. Staff can also offer social skill training groups. Interpersonal ability and togetherness can then grow simultaneously and help buffer against stress or loneliness or other adversity that can lead to relapse or other unwanted outcomes.

Our focus groups demonstrated that clubhouses bring people together by reducing power differential between staff and members, and other types of mental health agencies can learn from this program feature. In short, programs can reduce power imbalance. If consumers of mental healthcare can learn to get close to providers instead of learning to maintain distance, then perhaps consumers could also learn how to get close to people more generally (Prince et al., 2017). It has somehow become ingrained in most mental healthcare that clinical distance is necessary or curative. Perhaps this is a holdover from psychoanalysis, where too much intimacy disrupts transference. Or perhaps the distance is seen as beneficial because it allows for more objective clinical decision-making among providers who can respond thoughtfully to consumers instead of reacting impulsively. But there is little hard evidence that distance is always necessary or beneficial, and clubhouses dispense with it to the point where staff is even encouraged to socialize with members even outside of normal working hours (9–5 weekdays). This does not harm the members. To the contrary, it brings members closer to staff and closer to each other in ways that counteract the isolation that can worsen symptoms. It builds rapport in the process, and strong rapport leads to a service approval, care adherence, and many other positive outcomes (e.g., Duncan et al., 2003; Leach, 2005). Training and supervision of staff may need to change.

Sharing similar experiences brings clubhouse members closer to each other as well. In particular, opportunities to discuss shared symptoms can promote interpersonal connection. Members are drawn together when they can chat about depression, for example, or side effects of medication. Psychoeducation groups would address this need in other types of programs. Similarly, support groups around a common mental illness or symptom (e.g., anxiety) would serve the same purpose. Conversations about shared symptoms or interests can also happen quite organically (without structure), so programs can bring consumers together simply by offering as many
opportunities for connection as possible in evening or weekend programs, for instance, or in activity or task-oriented groups.

We found that presence of flexible structure in clubhouses counteracts tendency to isolate, while rigid structures (i.e., those not allowing non-attendance on certain days or times) were repellent to some people who simply felt that they could not participate for whatever reason (e.g., symptom exacerbation). Thus other types of mental health programs need just the right amount of structure, without erring on one side (too little structure, which can result in isolation) or the other (too much structure, which can result in too much pressure or care dissatisfaction). When consumers fail to attend structured activities, we found that outreach to absent individuals brings clubhouse members together. Without the gentle encouragement of staff to attend, absent members might otherwise remain disconnected from the program. Other types of mental health programs can offer similar outreach so that consumers remain close to each other without falling off the radar. Clubhouse members discussed how other programs could fail to notice absence, or at least fail to follow up on it.

Our study was exploratory, and we were unable to collect demographic or clinical information about the people in our focus groups. In addition, the sample size was small, and there may have been recall errors in our self-report data. Furthermore, we studied only one mental health organization with only one type of mental health care in only one urban location. However, we drew from clubhouse experiences described in other published studies. There may be more than nine ways that clubhouses promote meaningful interpersonal connection, for not all such ways may have been uncovered in our support groups. Other clubhouse programs might promote togetherness in different ways, and other studies also investigated social connections in clubhouses, and this is why we pulled from such other studies. We are not trying to magically transform non-clubhouses into clubhouses, but there is no reason why other programs cannot emulate clubhouses in certain ways in order to promote connections that can counteract a relapse-risking tendency to isolate.

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**References**

