Mental ill-health and experiences of work in a 'working community' in Scotland.

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Abstract

Within capitalist societies, active participation in paid employment is often considered an indicator of good mental health and wellbeing. Many support services for individuals with diagnoses of severe and enduring mental health conditions are focused around assisting these individuals to attain and retain paid employment. Despite this, in 2019 only 28.5% of individuals categorised as having a diagnosis of a 'mental illness or other nervous disorder' were in paid employment in the UK. This thesis explores the experiences of work and employment for individuals who have a diagnosis of a mental health condition and attended a 'working community' service in Scotland. This working community encourages its service users to participate in 'meaningful work' and prepare for entering paid employment in order for these individuals to achieve 'mental health recovery'. I explore the space of the working community as an alternative to other welfare-to-work and supported employment approaches.

Enlisting an emancipatory epistemology that aims to privilege the voices of individuals with diagnoses of mental health conditions, in this thesis I present a detailed account of the space of the working community and the experiences of those working within it. Utilising a qualitative multi-method research approach, I collected data through a year-long, in-depth ethnography as an observant participant in conjunction with semi-structured interviews and documentary analysis. I engage with literature from the geographies of mental health and beyond to conceptualise 'community' and 'care' and am informed by mad studies and critical disability studies to challenge exclusionary narratives of 'mental health recovery' which infer that obtaining paid employment inevitably improves mental wellbeing. This thesis offers a careful consideration of both the positive and negative aspects of work and employment for individuals with diagnoses of mental health conditions and examines the issues faced by these individuals in finding and keeping paid employment within a neoliberal society in which their potential productive capacity is undervalued. Through this, I contribute empirically to the geographies of mental health by adding a detailed ethnographic account of a space of work for individuals diagnosed with mental health conditions, and conceptually through providing a critical consideration of the term 'recovery'.

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Author’s Declaration

I hereby declare that, except where explicit reference is made to the contributions of others, this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Eleanor Nichola Martin

List of Abbreviations

ADA-WOD – Average Daily Work-Ordered Day Attendance

CEO – Chief Executive Officer

CMHT – Community Mental Health Team

DoH – Department of Health

DWP – Department for Work and Pensions

ESRC – Economic and Social Research Council

ICCD – International Centre for Clubhouse Development

IPS – Independent Placement and Support

PAR – Participatory Action Research

NHS – National Health Service

NHSGG&C – National Health Service: Greater Glasgow and Clyde

NIMH – National Institute for Mental Health

OECD - Organisation for Economic Co-operation and Development

ONS – Office for National Statistics

SEMHC – Severe and Enduring Mental Health Condition

TE – Transitional Employment

TEP – Transitional Employment Placement

WANA – We Are Not Alone

WOD – Work-Ordered Day

1 Introduction

1.1 Working for Better Mental Health?

Individuals diagnosed with long-term mental health conditions comprise a group that is one of the least likely to be in paid employment. In the UK, only 28.5% of individuals who were categorised as having a diagnosis of a 'mental illness or other nervous disorder' were in paid employment in 2019, compared to an average of 53.2% of all 'disabled' individuals and 81.8% of 'non-disabled' individuals between 2013 and 2019 (Office for National Statistics (ONS), 2019a). In 2016, the UK Conservative government published '*Improving lives: the work, health and disability green paper',* that declared the intention to help more disabled individuals to get into paid employment, because there was compelling "evidence that [participating in] appropriate work can bring health and wellbeing benefits" (Department for Work and Pensions (DWP) and Department of Health (DoH), 2016:6). The evidence to which this green paper refers is a 2006 report commissioned by the New Labour government's Department for Work and Pensions entitled *'Is work good for your health and wellbeing?',* that stated:

> "Employment is generally the most important means of obtaining adequate economic resources, which are essential for material well-being and full participation in today's society; work meets important psychosocial needs in societies where *employment is the norm*" (Waddell and Burton, 2006:vii; emphasis added).

In a capitalocentric society (Gibson-Graham, 2006), in which money is required to purchase essential goods and services to fulfil basic needs, it follows that being employed on a sufficient wage to satisfy these needs is associated with better health than living on the "manifestly inadequate" payments of state welfare benefits alone (Council of Europe, 2013:107). Moreover, in societies where paid employment is the 'norm', work is linked to social status, one's personal identity, and perceived value by others in society (Sage, 2018). Being perceived positively by others can impact our health and wellbeing, as it may improve our own self-esteem and self-perception (Boyce et al., 2008), and by conforming to societal 'norms' such as undertaking paid employment, we are less likely to be 'othered' as marginalised subjects (Foucault, 2004). Individuals with diagnoses of long-term mental health conditions have historically been

stigmatised as having a "tainted, discounted" identity (Goffman, 1963:11). The nature of this stigmatisation today may differ from the stigma of 1960s, nevertheless discrimination pervades in the realm of work and welfare in relation to disabled people (Heap, 2015). Individuals with diagnoses of mental health conditions are vilified for being deemed 'undeserving' recipients of disability welfare benefits (Ryan, 2019), and at the same time are excluded from many forms of paid employment as they are deemed 'unreliable' or 'unproductive' workers in comparison to their non-disabled counterparts (Gleeson, 1999). Therefore, the kind of jobs that are most frequently available to individuals with diagnoses of long-term mental health conditions are low-paid, intensive in their physical labour requirements, with few employment rights, and greater precarity in contractual terms (such as short-term or zero-hours contracts) (Buhariwala, Wilton and Evans, 2015). This low-paid work is limited in the material improvements to health and wellbeing it can bring, as it does not provide the individual with much income to purchase items to fulfil one's basic needs. These low-paid, labour-intensive, precarious jobs are associated with an increase in stress and experiences of mental distress, to the extent that undertaking this work can have a greater detrimental impact on mental health and wellbeing than remaining unemployed (Chandola and Zhang, 2018). Therefore, the "devalorization of the labor power of people with mental illness" has entailed that the potential advantages that may be gleaned from undertaking paid employment, such as a greater income and a less-marginalised social status, are harder for disabled individuals to achieve than non-disabled individuals (Evans and Wilton, 2019:96).

The *'Improving lives'* green paper can be viewed as a textual representation of the suffusion of neoliberal ideals within political discourse in the UK over the past forty years (Peck, Theodore and Brenner, 2012). These ideals have 'normalised' the notion that each individual must take responsibility to make an "entrepreneur of himself [sic]" through engaging in productive labour, and the idea that the individual should find a sense of purpose and fulfilment through undertaking this labour (Foucault, 2008:226). Despite the uncertainty that engaging in employment can actually improve health and wellbeing for individuals with diagnoses of long-term mental health conditions beyond fulfilling material needs, this neoliberal narrative means that both welfare

policy and mental health care and treatment in recent years has increased focus upon getting these individuals into paid employment (Piggott and Grover, 2009). The seemingly entrenched notion that work 'can bring health and wellbeing benefits' means that paid employment is now strongly associated with 'mental health recovery' (McWade, 2016). The term 'recovery' will be examined in depth in the body of this thesis so I will not linger over it here, but within this context we can broadly consider 'recovery' to mean living with as little 'distress' as possible (Brown and Kandirikirira, 2007). The notion of living a 'meaningful life' is an important trope within mental health recovery discourse, as such the concept of undertaking *meaningful* work is strongly associated with 'achieving' recovery (Hooker et al., 2020). Whilst some individuals may find meaning in their paid employment, the precarious work that disabled individuals are more likely to be undertaking reduces opportunities for 'meaning-making' (Noack and Vosko, 2011). Establishing strong social connections and feeling included are also associated with 'mental health recovery' (Leamy et al., 2011), therefore individuals are encouraged to participate in 'mainstream' employment, where it is anticipated that they will form social connections with 'non-disabled' individuals. However, research has demonstrated that the reality of paid employment for disabled individuals is that they tend to experience further exclusion in 'mainstream' employment (Hall, E., 2004). Nevertheless, successive UK governments over the past three decades have implemented a 'welfare-to-work' approach to welfare benefit policy (Sunley, Martin and Navitel, 2006), demanding that an increasing proportion of disabled people must undertake work-related activity in order to receive welfare payments (Stafford, 2005).

We need to remain critical of any approach to social welfare that connects wellbeing with productivity, as productivity is linked to socially 'normative' values about the capacity an individual has to function (Frayne, 2019). However, whilst being critical of the societal values surrounding paid employment and mental health 'recovery', I acknowledge that living in a society where employment is valorised (Weeks, 2011) means that work is going to be "a pertinent navigational construct through which [mental health] service-users order their lives" (Laws, 2013:344). Therefore, it is very important to understand the views that individuals with diagnoses of long-term mental health

conditions hold about work and employment; their experiences of it, both positive and negative; and their own hopes and expectations regarding work and mental health recovery. Previous research has identified that there can be positive outcomes of working for these individuals:

> "Work situations provided an opportunity to distance oneself from problematic areas of life, and to engage with others on tasks unrelated to illness. Work as an activity provided a sense of belonging tied to socially valued roles rather than diagnostic categories and individualized pathology. These roles and responsibilities helped engender routine, regularity, and predictability in everyday life" (Evans and Wilton, 2016:80).

Therefore, there clearly can be benefits for these individuals in undertaking some forms of work, particularly in the opportunity to move away from difficult parts of one's life that may be associated with mental distress. Furthermore, many 'care and treatment' services for individuals are focused upon work training, employability, or supported employment (Hall and McGarrol, 2012). Consequently, many individuals with diagnoses of long-term mental health conditions do participate in employment-related activity: because they desire to, because they feel compelled to, or just because that is the focus of the service they are engaging with. As mental health recovery is an entirely personal experience, and 'work' and 'employment' can be very different experiences for different individuals, in this research I have chosen to engage with a service, a mental health 'Clubhouse,' in which there are a variety of work experiences to be had and which represents one 'pathway to employment' in the UK social welfare landscape. In trying to understand the impact that work and employment has on individuals with diagnoses of long-term mental health conditions, I have attempted to foreground the knowledge and experience of these individuals, the users of the Clubhouse, who form the focus of this thesis.

In response to the neoliberal retrenchment of state services in the UK from 1980s onwards (Peck and Tickell, 2002), and following the process of psychiatric deinstitutionalisation at around the same time, many third sector organisations have emerged to provide 'community care' for individuals with diagnoses of long-term mental health conditions. One such organisation is 'The Club' (a pseudonym), in Glasgow, Scotland. The Club is based in the West End of Glasgow and is a service for individuals with diagnoses of 'severe and enduring' mental

health conditions, who are being treated under secondary mental health services within the Greater Glasgow and Clyde NHS health board area (The Club, 2012). The Club is a day service for these individuals and promotes 'recovery' from diagnosed mental health conditions by broadly following a Clubhouse model of psychosocial rehabilitation. This is an internationally recognised model of 'treatment' for individuals with diagnoses of mental health conditions (Jackson, 2001). Its underlying premise is that of the 'working community', in which individuals work together in a non-clinical space in order to maintain and sustain the building and organisation (Doyle, Lanoil and Dudek, 2013). Beginning in 1940s as a group of former psychiatric patients in a building known as 'Fountain House' in New York City, the growth of the organisation meant that by 1980s the Clubhouse had achieved recognition by the National Institute for Mental Health (NIMH) in the USA as a method of reducing hospital recidivism for the former psychiatric patients who attended the service (Beard, Malamud and Rossman, 1978). The principles that had been developed over several decades within Fountain House were distilled into a set of guidelines called the 'Clubhouse International standards', informally known as the Clubhouse 'model' (Karlsson, 2013). The histories and geographies of Fountain House, the development of the Clubhouse model, and the Clubhouse International standards will be examined later in the thesis. However, by way of introduction, I will briefly outline a few key elements of the model here. As Clubhouses are created outwith clinical treatment spaces, their service users are referred to as 'members', as they hold a 'membership' at the Clubhouse. I shall use the term 'member' throughout the thesis to refer to the service users of The Club. The four core principles of the Clubhouse model upon which the Clubhouse International standards are based are that members shall have:

> "1) a right to a place to come; 2) a right to meaningful work; 3) a right to meaningful relationships; 4) a right to a place to return" (Raeburn et al., 2013:376).

Clubhouses serve as spaces for members to attend when they choose, where they can voluntarily participate in work tasks within the house, and also have the opportunity to participate in a supported employment scheme known as the Transitional Employment Placement (TEP) programme (Valkeapää, 2019). They are able to attend the Clubhouse for the rest of their lives, as membership is lifelong, distinguishing the Clubhouse model from many other short-term

treatment or rehabilitation programmes (Clubhouse International, 2018). Another distinguishing feature is the nature of staff and member relationships within the Clubhouse. These relationships are very different to traditional clinical relationships between psychiatric treatment professionals and patients. The intention of the Clubhouse is to 'flatten' the staff and service-user hierarchy that usually exists in spaces of mental health care and treatment (Tanaka, 2013). Therefore, paid staff and unpaid members work alongside each other in maintaining and improving the community and space of the Clubhouse, by undertaking: cooking, cleaning, administrative tasks, financial services, and any other tasks or services required (Mowbray et al., 2006). These various work tasks are structured temporally alongside meetings and activities within the house and so the programme of activity in the Clubhouse is described as the 'work-ordered day' (Craig, 2013). The Club encompasses all these Clubhouse features and is the primary field site for this research. Its histories and geographies will be explicated within the methodology chapter, and indeed throughout the thesis, but as an organisation that structures its programme around work, both paid and unpaid, it engages with the neoliberalised discourse that presents work as a means of achieving mental health recovery. At the same time, as a 'working *community*' it is an important space outwith mainstream employment for individuals to potentially experience social inclusion. As such, it is an ideal space in which to observe and interrogate the complex relations between work, recovery, care, and community.

1.2 Terminology

Before I situate this thesis within the geographies of mental health, outline the key concepts, research objectives, and overall structure of this thesis, I must clarify the meanings that I am ascribing to two key terms. In attempting to investigate the forms of 'work' that individuals with diagnoses of mental health conditions might find meaningful, I am cautious not to put a strict definition on the term 'work'. Gorz (1989) delineates three different understandings of work: work in the economic sense, work for ourselves, and autonomous activity. The first of these may be roughly equated to paid employment, which is the prevailing understanding of the term 'work' in Western neoliberal society (Frayne, 2015). Work for ourselves may be understood to be the 'maintenance work' we need to do as individuals to sustain ourselves and our loved ones

outwith our paid work. In relation to individuals living with mental ill-health, this 'maintenance work' may include the 'recovery work' these individuals undertake to gain and maintain mental wellbeing (Laws, 2013). Finally, 'autonomous activities' are the things that we do for the pursuit of meaning or pleasure. Clearly, these categories are not necessarily mutually exclusive, as one may find pleasure or meaning in an activity that is undertaken as paid labour. In this thesis, in considering work 'in the economic sense' I will clarify this as '*paid*' work, labour, or employment. Beyond this, I elect not to define the term 'work' more strongly other than to say that it as an activity that an individual chooses to undertake, with the caveat that this 'choice' is not always freely made and can be strongly influenced by networks of power that the individual finds themselves within (Foucault, 1995). In this definition, the work may not always be 'meaningful' for the individual, though it may be life-sustaining in some way, and any meaning derived is inherently personal and individually defined (Leufstadius et al., 2008).

This research pertains to individuals with 'diagnoses of mental health conditions'. This phrasing is used to recognise that diagnosing an individual with a mental 'illness' is a complicated and controversial act (Wykes and Callard, 2010) in terms of the 'treatment' they may go on to receive: medically, socially, and culturally. Diagnostic categories are not relevant within this thesis, other than to state that in order to become a member of The Club one must have been diagnosed with a mental health condition that is considered 'severe and enduring' (The Club, 2012). As such I have chosen to use the term 'individuals with diagnoses of severe and enduring mental health conditions' (SEMHCs) in the broader context, and 'members' when writing specifically about the Clubhouse. In addition, I refer to 'madness' or 'mad individuals' in my consideration of the histories of work in relation to mental health care and treatment. I have done this following Foucault's (2006a) juxtaposition of 'Madness' to 'Reason', indicating that an individual deemed 'mad' was considered a 'non-normative other', prior to the construction of diagnostic categories. Using this terminology, I aim to acknowledge the experiences of individuals who live with extreme distress, whilst being conscious that there is not "a certain standard way of being human" (Laing, 1960:27). Throughout this thesis I will make reference to 'disabled individuals' as some of the material I reference concerns a broader

group of people than those with diagnoses of SEMHCs. I will use the term 'disabled individuals' rather than 'individuals with disabilities' as an acknowledgement that individuals are disabled principally by the structures of society, though their embodied health experiences are also very important (Barnes and Mercer, 2005). Through doing this I hope to signify that not all individuals with diagnoses of SEMHCs consider themselves to be 'disabled', but almost all are subject to some form of disabling power from wider societal structures.

1.3 Situating this Research

Prior to outlining the conceptual underpinnings that structure this thesis, I am going to provide some disciplinary context. My academic background is that of social geography, as such, this thesis is largely informed by and intended to contribute to the body of research within mental health geographies. I am going to provide a brief overview of the development of the sub-field of mental health geographies, before locating my research within this discipline, and the main contributions my research can offer to the geographies of mental health. Throughout this thesis I also pull on a number of interdisciplinary threads to build my arguments. The most significant of these threads are disability geographies literature related to work and employment for disabled individuals, psychosocial rehabilitation literature within psychology for research and theory related to the Clubhouse model, and critical disability studies and mad studies literature for critical perspectives on mental health 'recovery'. However, at various points throughout the thesis I also engage with research from: medical and feminist sociologists, feminist political economists, organisational psychologists, social historians, medical humanities scholars, and psychiatric survivor researchers. Additionally, I engage with literature from other areas of human geography including political, economic, feminist, emotional and affective geographies.

As a concise overview, I intend only to demonstrate the broad development of the subfield of mental health geographies, therefore this review is not exhaustive, and largely does not engage with work within related fields such as disability geographies, carceral geographies, or psychoanalytic geographies. Philo (2005) identifies the first mental health geographies research commencing

in 1960s as statistical 'spatial epidemiology' that considered the spatial distribution of individuals diagnosed with 'mental disorders' within urban areas using quantitative methods (see Timms, 1965; Giggs, 1973, 1986; Dean and James, 1981). As statistical modelling has developed significantly since 1960s, quantitative research considering individuals with mental ill-health and the life-course is still a thriving strand of the geographies of mental health (Lowe, DeVerteuil and Moon, 2014; see Propper et al., 2005). Contemporary research in this field continues to contribute to quantitative social science with the use of 'cross-classified multi-level modelling' that demonstrates the importance of understanding social and ecological factors that impact mental (ill-)health at a number of spatial scales (Prior, Jones and Manley, 2020; Griffiths and Jones, 2020).

Qualitative mental health geographies research began in earnest in late 1970s, initially in a North American context (Jones, 2001). This work focused upon the social geographical impacts of the closure of the psychiatric asylums, and the relocation of these individuals in wider society (Smith, 1975; Dear, 1977; Wolpert and Wolpert, 1974). Following this, research identified the spaces of the mental health service dependent population among 'psychiatric ghettos' and local community attitudes to the siting of mental health facilities in these areas, both in North America (Dear and Taylor, 1982; Dear and Wolch, 1987) and elsewhere, such as the UK (Moon, 1988) and New Zealand (Joseph and Kearns, 1996). At a similar time, research concerning the historical geographies of psychiatric asylums provided an historical context to the geographies of mental health (Philo, 1989; 2004) and demonstrated that community opposition to mental health facilities was not a new phenomenon (Philo, 1987a; 1987b). Research concerning the historic and contemporary spaces of care and treatment for mental ill-health has continued into the 21st century, including research considering the repurposing of old asylum sites (Kearns and Joseph, 2000; Moon, Kearns and Joseph 2015; Parr 2008), and the geographies of spaces for mental health care and treatment in a community context (Milligan, 2000; Curtis, 2010).

In the past three decades mental health geographers have become concerned with what McGeachan (2017:4) describes as "experiential worlds." This research has focused upon the embodied, emotional and lived experiences of those living

with mental ill-health, utilising qualitative methods such as ethnography, in-depth interviews and focus groups that help to bring "more sharply into view the faces and voices of people with mental health problems" (Parr, 2008:11-12). Much of this research has focused on the issue of social inclusion or exclusion for individuals with diagnoses of SEMHCs, as these individuals have frequently been marginalised within society due to their status as mental health service users. Some research has examined the relation between mental ill-health and poverty in experiences of exclusion (Wilton, 2003, 2004a). Other research has considered the significance of the remoteness of a community, and the lack of service provision available in rural areas (Parr, Philo and Burns, 2004). Some researchers have explored the possibility of inclusion and exclusion within potentially more 'inclusive' mental health settings based in the community (Pinfold, 2000; Parr, 2000), and the possibility of experiencing inclusion in community settings with a focus upon other pursuits such as art or gardening (Parr, 2006; 2007). There has also been consideration of the 'delusional', 'mad', or 'magical' worlds inhabited by some individuals diagnosed with SEMHCs (Parr, 1999; Laws, 2013; 2016). Further research has also taken inspiration from feminist science studies and the more-than-representational turn in human geography to gain new perspective on the subjective experiences of individuals with diagnoses of SEMHCs, in relation to the 'technology' they engage with to manage their mental ill-health (such as psychiatric medications) (Flore et al., 2019) and how individuals' affective engagement with spaces may impact their perception and experience of mental health 'recovery' (Duff, 2012; 2016).

This thesis is primarily concerned with the lived experiences of individuals with diagnoses of mental health conditions, and therefore relates most closely to research considering the 'experiential worlds' and everyday lives of individuals with diagnoses of SEMHCs. However, I also draw upon research considering the historic role of the asylum and the process of psychiatric deinstitutionalisation, firstly in contextualising the history of mental health care and treatment in the UK, and in understanding the space of the Clubhouse. There has been a small amount of research within mental health geographies concerning the realities of work and employment for individuals with diagnoses of SEMHCs, with a particular focus on social enterprises in Canada (Evans and Wilton, 2016, 2019; Buhariwala, Wilton and Evans, 2015). Additionally, Parr, Philo, and Burns' (2005) exploration

of a Training and Guidance Unit for individuals with diagnoses of SEMHCs in the Highlands of Scotland provides an insight into experiences of employment training in a rural context. Laws (2013) research into perceptions of different forms of (paid and unpaid, real and imaginary) work for individuals with diagnoses of SEMHCs in the northeast of England demonstrates that 'work' often means much more than 'paid employment' for these individuals. Whilst not within the subfield of mental health geographies, Ed Hall's (2004, 2005, 2010) work within disability geographies considering the complex relation between work and social inclusion and exclusion for people with learning disabilities in Scotland has also offered valuable theoretical insight to my thesis. All this literature has conceptually influenced my thesis by demonstrating the complex relationship between work and mental health, that there are both positive and negative things to be gained from working, and that 'paid employment' is not always conducive to social inclusion. My own research further contributes to these discussions in the following ways. By drawing on critical disability studies and mad studies literature, I have been able to develop a more critical examination of mental health 'recovery' than has thus far been demonstrated within most mental health geographical research. In examining an unstudied space within mental health geography – the mental health Clubhouse, I am able to provide a picture of a unique space that aims to facilitate mental health 'recovery' through work activities. Finally, as a medium-term ethnographic study I am able to contribute a high level of observational detail about the social and spatial relations of the Clubhouse, and the complex lives of individuals with diagnoses of SEMHCs. This methodological contribution and its theoretical underpinnings will be further explicated in the methodology chapter.

1.4 **Key Concepts**

In the next chapter, I mobilise academic literature from mental health geographies as well as some of the aforementioned subdisciplines to engage with and develop a contextual and historical background to the relationship between work and mental health. Rather than presenting this literature in a traditionally abstract geographical literature review format, this conceptually informed historical rendering enables me to provide an applied contextual understanding of the relationship between work and mental health and to 'set the scene' for

the later empirical chapters. The reasons for presenting the literature in this way are threefold:

- To demonstrate that there is historical precedent of using work as 'treatment' for mental ill-health in a UK context outwith the Clubhouse model of psychosocial rehabilitation, and to introduce the model in greater detail
- To track the changing UK policy context regarding mental health, work and welfare over the nineteenth and twentieth centuries
- To illustrate that there have been multiple and changing uses of the term 'community' within mental health care and treatment in the UK over the past seventy years.

Following this 'contextualisation' chapter I provide a shorter and more traditional literature review chapter of two of the key concepts within this thesis, 'care' and mental health 'recovery'. I am now going to briefly explain the theoretical underpinnings of the main concepts that I deploy and explicate in the contextualisation chapter and engage with throughout the empirical chapters.

In considering the relationship between work and mental health care and treatment, my research has been informed by the critical philosophies of Michel Foucault, particularly in relation to the disciplinary mechanisms of institutions such as psychiatric asylums. Foucault theorises that Western society can be understood through the analysis of power relations; this power is "exercised rather than possessed" (Foucault, 1995:26) and can be both repressive and productive. This means that mechanisms of power can simultaneously constrain certain actions and relations and also facilitate the production of other relations and knowledges. One relation of power exercised throughout society is 'disciplinary power'. Foucault (2006b:22) argues that within institutional spaces the apparatuses of disciplinary power are concentrated and therefore easier to identify as "the visibility of [disciplinary power] is only found in the obedience and submission of those on whom it is silently exercised." The architectural organisation of space is one such mechanism as it requires individuals to move and behave in certain ways. Foucault's (1995) examination of Bentham's panopticon demonstrated how the design of carceral institutions could be used

to further constrain behaviour. All 'inmate' spaces of the panopticon could be seen from a central watch tower, but inmates were not able to see whether the watch tower was occupied by a guard. Therefore, the continuous possibility of surveillance encouraged the inmates to constantly modify their behaviour.

Another disciplinary mechanism common to institutional spaces is the strict regulation of time, through timetabling activity. This exerts disciplinary power by regulating individuals' time, however Foucault (2006b:47) explains that it does more than this through the "occupation of the individual's time, life, and body." Therefore, in addition to occupying the individual's time, the disciplinary power of timetabled *work* operates by requiring individuals to commit their body and mind to tasks, and so depletes their energy and reduces their capacity for thought and resistance (Foucault, 2006a). In relation to the asylum and the 'mad' individuals within it, this exhaustive occupation of the mind and body prevents the individual from dwelling on their 'madness' (Foucault, 2006b). The disciplinary power of time is also noted by sociologist Erving Goffman in his examination of psychiatric asylums and is considered one of the key features of 'total institutions': "all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next" (Goffman, 1961:6).

Foucault (2008) further develops his theory of power through the concept of 'neoliberal governmentality'. Neoliberalism is a contentious and broadly-defined term, that may be conceptualised as "both a political discourse about the nature of rule and a set of practices that facilitate the governing of individuals from a distance" (Larner, 2000:6). Foucault advanced the notion of 'neoliberal governmentality' as a set of processes and practices enacted by the state to control or govern subjects, wherein the 'state' is not a singular government or entity, rather an assemblage of institutions and actors whose role it is to:

> "modify… sources of finance, modes of investment, decision-making centres, forms and types of control, relationships between local powers, the central authority and so on" (Foucault, 2008:77).

In this context, we can consider the 'subjects' that are being governed as being constituted by and through power relations. This understanding of subjectivity maintains that the 'subject' is both subjected *to* the processes of

governmentality, but also is subjected *by* these processes, meaning the subject is created through them:

> "categorizing the individual, attaching him [sic] to his identity, imposing a law of truth upon him which he must recognize and which others have to recognize in him" (Foucault, 1983:212).

Therefore, individuals living within a neoliberal society are not only regulated through the processes of neoliberalisation that may be acting upon them, these individuals also construct their own understandings of themselves through the principles of neoliberalism, and attempt to hold themselves to these standards (Allen and Guthman, 2006). In this co-constitution of power, it is no longer just discipline upon the individual that dictates their behaviour, it is also 'biopower', which Foucault (1978:14) describes as "an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations." As Scher (2020:290) explains, biopower "lies in a specific mode of rationality: state control is maintained by promoting life." What this means is that rather than controlling populations by threatening them with punishment (or death), biopower is pervasive in its control by dictating to individuals how to live their lives. Hence the population are expected not only to conform to neoliberal norms, but to reinforce these 'norms' through striving to conform and to be recognised in this conforming identity.

This understanding of the formation of the subject in relation to neoliberal biopower is fundamental to another key concept of my thesis: the 'ideal neoliberal productive subject'. I engage with the ideas of sociologist Nikolas Rose, who takes Foucault's notion of the 'governable subject' and examines the ways that neoliberal governmentality has created a 'productive subject':

> "The productive subject is to be governed as a citizen, as an individual striving for meaning in work, seeking identity in work, whose subjective desires for self-actualization are to be harnessed to the firm's aspirations for productivity, efficiency and the like" (Rose, N., 1999a:244).

Rose explains that the recognition of workers not just as productive of capital, but as productive of their own subjectivity means they are constructed as 'consumers', who are responsible for 'choosing' their own route to fulfilment:

> "The worker is an individual in search of meaning, responsibility, a sense of personal achievement, a maximized 'quality of life', and hence of work. Thus the individual is not to be emancipated *from* work, perceived as merely a task or a means to an end, but to be fulfilled *in* work, now construed as an activity through which we produce, discover, and experience our selves" (Rose, N., 1999b:103-104, emphasis original).

The productive subject is therefore seeking "to make an enterprise of their own life, investing in their human capital in order to fuel the consumption that will produce their own satisfaction" (Houghton, 2019:623). The problem with this is that by framing this subjectivity and consumption as a set of 'choices', it entails that unhappiness, distress, and non-conformity are personal failings on the part of the individual, rather than as a result of systemic structural marginalisation of certain subjects or groups. Furthermore, it suggests that all individuals will be able to achieve their 'satisfaction' through working 'productively'; as we will explore throughout this thesis, for many individuals with diagnoses of SEMHCs this is often not the case.

The neoliberal subject is problematic in the way that individuals are expected to be able to fulfil their needs and desires through productive labour and capitalist consumption (Rose, N., 1999b), rather than through the state provision of welfare; but it is also problematic as the neoliberal subject is portrayed as autonomous, independent, and rational (Goodley, 2014). Therefore, individuals who are perceived not to match up to this 'rational' subjectivity are automatically 'othered', creating a binary between 'us' (the productive neoliberal subjects) and 'them' (the unproductive others):

> "'Us', then, are the able, engaged citizens, or the ideal neoliberal type, who actively engage in and contribute to the neoliberal project … These engaged and compliant citizens are then pitted against those who fall outside the categories of 'engaged' and 'compliant' – 'them'. 'They' are those who cannot or choose not to become 'active' or 'compliant citizens': they are the 'scroungers'" (Runswick-Cole, 2014:1124-1125).

This division between those seen as 'engaged' or 'compliant' and those who cannot or will not engage and comply has been created and enacted by societal processes of neoliberalisation (Goodley and Runswick-Cole, 2015). The inherent

assumptions about what an 'engaged' neoliberal subject 'should' be has been identified by critical disability scholars as 'neoliberal-ableism':

> "Under neoliberal-ableism, the rationality of the market is paramount; the ideal citizen is an adaptable citizen, indeed he is an able individual (note the deliberate gendered/ableist positioning of the subject here) who is caught up in and complicit with the demands of late capitalism" (Runswick-Cole, Lawthom and Goodley, 2016:257).

The neoliberal assumption is that the disabled individual will be 'adaptable' to the 'rationality' of free market capitalism, even if one is not considered to have a 'normative' mind or body, and the expectation that one will be 'rational' is a constraining power upon the individual. Firstly, this entails that the individual fits within certain physical and mental 'norms' that enable them to participate in 'productive labour'. Secondly, neoliberal-ableism assumes that in being 'adaptable', the individual takes personal responsibility both for their normativity and their productivity (Türken et al., 2016). The reality for many disabled individuals is that under the constraints of neoliberal capitalism, they do not have the economic or social capacity to be 'adaptable'. Furthermore, the assumption that disabled individuals have the desire to adapt to the 'norms' required to become a 'productive subject' is in itself ableist (Bates, Goodley, and Runswick-Cole, 2017). Critical disability scholars have noted that being labelled with a diagnosis of a SEMHC often also leads one to be labelled as 'irrational' and therefore more likely to be cast as the 'Other' under neoliberal-ableism:

> "There is no doubt that some disabled people – for example, those with the labels of mental illness or severe cognitive impairments (note the definitive quality of these scientific and psychiatric categories as really outside of the humanist rational register) – risk being depicted as the real Others of neoliberal-ableism: inherently defective, useless, unproductive" (Goodley, 2014:57).

The key problem of this neoliberal-ableism is that it does not attend to the potential desires or decisions of the disabled individual, as the assumption is that under neoliberalism, everyone will desire to become productive neoliberal subjects who are autonomous and independent. However, writers within critical disability studies remain hopeful that neoliberal ideals can be resisted, adapted and altered by individuals and organisations:

> "we remain optimistically attached to the idea that opportunities exist to work the spaces of neoliberalism and for disabled people to re-shape, re-fashion and resist the processes of neoliberalisation" (Runswick-Cole and Goodley, 2015).

In the empirical chapters I will consider the ways in which The Club both conforms to and resists neoliberal-ableist assumptions and processes as a third sector organisation, and the ways that members within The Club negotiate their own paths towards, or away from neoliberal subjectivity.

1.5 Research Objectives

In approaching this research I have attempted to address four broad research objectives that allow me to give voice to the experiences of individuals with diagnoses of SEMHCs, whilst offering critical commentary in relation to a space of supported employment and mental health 'recovery'. These objectives are:

- To explore a Clubhouse 'working community' as an alternative approach to 'welfare-to-work' and supported employment schemes
- To investigate the varied experiences of work and employment of individuals with diagnoses of SEMHCs
- To provide a 'lively and nuanced' geographical account of a space of 'community care'
- To critique established discourses of work and employment in relation to mental health recovery.

These objectives are addressed in the rest of the thesis, which is comprised of a contextualisation chapter, a literature review chapter, a methodological chapter, three empirical chapters and a concluding chapter. A more detailed structure of these chapters is outlined below.

1.6 Chapter Outline

Chapter 2 is separated into four main parts. The first section considers a brief history of 'work' in relation to the treatment of mental ill-health in the UK, beginning with 'moral treatment' at the start of the nineteenth century and finishing with industrial therapy in the mid-twentieth century. This section mobilises Foucault's ideas about disciplinary power that I have outlined and

takes insight from the work of 'asylum geographers' and social historians. The next section uses mental health and disability geographies research to consider the term 'community' in relation to mental health care and treatment; examining the rise of 'therapeutic communities' following the Second World War and the notion of 'care-in-the-community' that emerged after psychiatric deinstitutionalisation began in earnest in 1980s. The next section considers welfare-to-work and supported employment policies and programmes in the UK over the last three decades. Finally, I provide an historical and geographical overview of the first mental health Clubhouse, Fountain House, in New York, USA, from its inception until the creation of the Clubhouse model of psychosocial rehabilitation. This chapter provides a geographically situated history of work in relation to the treatment of mental ill-health and identifies the well-established but not uncontested understandings of 'community' in relation to mental health, which allows me to explore theorisations of community as 'relational'. This relational understanding of community will be utilised in the empirical chapters.

Chapter 3 is a literature review structured conceptually and comprises two sections. The first section considers the term 'recovery' and the way that this has been mobilised within mental health care and treatment discourses, engaging with literature from psychology and psychosocial rehabilitation studies, before offering a critical examination of this term with the use of literature from mad studies, medical sociology and critical disability studies. The next section explores the nebulous term 'care' and the various ways in which this has been conceptualised and mobilised within human geographical literature, considering the work of feminist geographers, health and disability geographers, and emotional and affective geographers. This literature review aims to presents 'care' as a useful conceptual lens through which to consider mental health communities. In understanding care as a network of affective, practised and 'ethical' relations, I am able to use this concept in conjunction with 'community' in my examination of The Club in the empirical chapters.

Chapter 4 is the methodology chapter and begins with an introduction to the common qualitative methods used within geographies of mental health research. I explicate the methods I used in collecting my data: ethnography, documentary analysis, and interviews; then I explain my method of data coding and analysis. I examine the formal ethical procedures undertaken in planning the research, and

the practicalities of enacting these procedures within the actual fieldwork process. I present my epistemological position in relation to the research, considering the significance of my own personal politics and experiences in the framing and undertaking of this project, and exploring the notion of the messiness of the fieldwork process and the importance of acknowledging this in the written outputs of the research. After this I present an introduction to the broad histories and geographies of my main field site, The Club. Finally, I provide a very brief overview of my two micro-ethnographies at two additional field sites in London and Orkney. This chapter provides insight into the data collection process that has enabled me to provide a very rich and detailed account of The Club throughout my empirical chapters.

Chapter 5, the first empirical chapter, considers members' experiences of attending and working within the space of The Club, and how these experiences are shaped by the space and structure of the Clubhouse. I explore the space of The Club in depth, to understand how work tasks are created and then allocated to members, engaging with organisational psychology literature. I explain the process of allocating tasks to members, and how these tasks along with the meetings and breaktimes of the house serve to temporally structure members' time within the work-ordered day. Using a Foucauldian framing of power, I consider how these structural tools are used to constrain members temporally and inform their actions through the structure of work. I contemplate what may be defined as 'work' in the Clubhouse through an examination of some of the Clubhouse International standards and think about how this work may be constructed as 'meaningful' for members. I reflect upon member experiences of undertaking work and creating a routine within the Clubhouse. I conclude with an examination of a tool used by the Clubhouse model that is intended to make members feel recognised and their work valued: the 'need to be needed', referring to psychosocial rehabilitation literature concerning Clubhouses. This chapter provides comprehensive spatial detail of The Club that presents the material and conceptual context for understanding the Clubhouse as an alternative space for work.

*Chapter 6, t*he second empirical chapter, considers how both 'care' and 'community' are realised within the space of The Club. In examining how community may be intentionally facilitated in this space, I evaluate the

Clubhouse International standards in relation to 'Clubhouse identity', explore members' understanding of the Clubhouse model, and consider how these impressions shape the experience of the community within The Club. I think about how community is facilitated in The Club through the 'doing-in-common' of work tasks, and how working together can help to build relationships and form a shared identity within the membership. I then scrutinise the formation of caring relationships within The Club, in relation to the shared experience of mental ill-health between members, and how the care that may be experienced in these relationships differs but overlaps with the care relations between members and staff. I consider the limits to the community and the care that may be offered to members before concluding by interrogating the decision-making process within The Club. I suggest that The Club may be understood as a space of 'controlful care' in which disciplinary techniques are enacted to maintain the community and ensure the space remains safe and caring for all within it. In considering both community and care as 'relational' processes, I am able to use this chapter to conceptualise the Clubhouse as a lively and ever-changing space that relies upon its membership to maintain the 'caring community' atmosphere.

Chapter 7, the final empirical chapter, appraises the Transitional Employment Placement programme within The Club. I once again use the Clubhouse International standards as a framework through which to understand the way that the Clubhouse represents 'paid employment'. I employ this framework to consider the manner in which The Club presents TEPs to members. I explore member attitudes towards TEPs and paid employment more generally, including a consideration of the types of work that members find meaningful and valuable. I examine the notion of the 'productive subject' as a problematic figure that is perpetuated through the pervasiveness of neoliberal capitalism in Western society, once again using a Foucauldian framing of power to structure this argument. I think about how the ethos of the Clubhouse encourages members to become autonomous productive subjects, and how the TEP programme both reinforces and subverts this by encouraging members to undertake time-limited paid work that is highly supported by Clubhouse staff. As The Club offers members support regardless of whether they are a 'productive subject', I consider it to operate as an 'interstitial space' between 'mainstream employment' and more institutional spaces of mental health care and

treatment. I analyse the aspects of paid employment that The Club members find valuable to their 'mental health recovery' and think about how we can consider the TEP programme as a means of achieving these goals without requiring the individual to become a 'productive subject'. This chapter offers a critical review of the TEP programme as a form of supported employment that can be a positive experience for the individual, whilst attempting to frame this outwith neoliberal recovery discourses.

In *Chapter 8,* the conclusion, I reflect upon the research process and thesis as the product of this process, outlining my principal arguments again in relation to my research objectives and identifying what I believe are the broader research contributions this thesis offers to the geographies of mental health, Clubhouse research, and broader understandings of work for individuals with diagnoses of SEMHCs. I state and explain the three specific academic contributions this thesis adds to the sub-field of the geographies of mental health: theorising the 'interstitial spaces' of community mental health care and the 'in-between identities' of service users of these spaces, advancing an 'emancipatory' geography of mental health, and critical considerations of care, community, and control. I conclude with a consideration of the future role of work in mental health care and treatment in Scotland.

2 Contextualising ‘Work’ and ‘Community’ in the Treatment of Mental Ill-Health

2.1 Introduction

This chapter evaluates the implementation of ‘work’ in relation to mental health care and treatment in the UK from the nineteenth century until the present day, engaging with Foucault’s theorisation of power in relation to psychiatric institutions. I start from this point to demonstrate the influence of growing industrial capitalism upon the relationship between work and mental health treatment. Utilising literature from social history, medical humanities, and mental health geographies, I examine the conceptualisation of the term ‘community’ as it pertains to mental health care and treatment. I begin by sketching a brief history of ‘moral treatment’ at the Retreat in York from 1796, exploring how work was used to ‘constrain’ the ‘mad’ (Foucault, 2006a). I reflect on the influence of moral treatment upon the construction of the public psychiatric asylum system, as the legacy of ‘work-as-treatment’ evolved over time due to the expansion of the asylum system and as industrial capitalism influenced the understanding of ‘patient work’. Moving to the twentieth century, referencing literature from occupational therapy and social history, I consider the emergence of the practice of occupational therapy in private mental hospitals and Scottish Royal Asylums, tracing how the ‘constraining power’ of work endured, despite the framing of occupational therapy as ‘therapeutic’ work. After this, and with reference to the work of historian Vicky Long and geographer Jenny Laws, I appraise the introduction of industrial therapy within mental hospitals alongside the creation of sheltered workshops for disabled individuals that were being set up in the wider community.

In the next section of the chapter, I briefly consider the notion of the ‘reformist’ therapeutic community as a new and theoretically ‘less institutional’ form of mental health care at a time when mental hospitals were beginning to be criticised for their treatment practices within public discourse. I examine how these communities still operated within a disciplinary framework that worked to ‘normalise’ the ‘patient’. Following this, I scrutinise the process of psychiatric deinstitutionalisation in the UK using research from mental health geographies and examine how this led to many individuals with diagnoses of SEMHCs being a

‘community presence’ through living in the community, whilst still experiencing marginalisation and social exclusion (Wiesel and Bigby, 2014). I consider the perceived failures of ‘care in the community’ and the move to transform ‘community presence’ into ‘community participation’ through encouraging individuals with diagnoses of SEMHCs to get into ‘mainstream employment’. I acknowledge the role of third sector organisations in creating spaces of genuine social inclusion for these individuals and contemplate recent calls from mental health and disability geographers to frame the ‘voluntary sector’ and ‘disability geographies’ through a ‘relational’ lens in order to glean an understanding of the mutable nature of community and inclusion within these spaces (DeVerteuil, Power and Trudeau, 2019; Hall and Wilton, 2017). I advance an understanding of community as ‘relational’ and ‘practised’ (Pratt, K., 2013) that I will utilise in the empirical chapters in my examination of The Club as a space of ‘community care’.

Next, I use research from mental health and disability geographies to examine UK welfare-to-work policy over the last twenty-five years, broadly from the introduction of New Labour’s New Deal for Disabled People onwards. I explore the ‘incentivising’ and ‘punitive’ approaches to welfare payments, how the former created a discourse of ‘responsibilisation’ for individuals to get back into work (Rose, N., 1999a), and the latter punished those who were not able to become ‘productive subjects’ by introducing increasingly harsh sanctions on benefit payments. I examine the introduction of widespread assessments to test the ‘work-readiness’ of disabled individuals, and how these deemed an increasing number of disabled individuals to be capable of becoming ‘productive subjects’. Finally, with reference to mental health geographies literature, I consider the range of ‘supported work’ schemes that have emerged alongside but often separate from these policy initiatives. I appraise multiple approaches: ‘train-and-place’ schemes, such as Training and Guidance units; ‘place-and-train’ schemes, such as Independent Placement and Support (IPS); and lastly social enterprise approaches, that sit in between these other approaches. I consider the merits and disadvantages of these approaches, whilst noting that the ‘preferred’ method of supported employment in Scotland is ‘place-and-train’ (Scottish Government, 2010), and the recommended model for individuals with diagnoses of SEMHCs is IPS (Drake, Bond and Becker, 2012).

In the last section, I look beyond the UK context of welfare-to-work and mental health care and treatment, to explore the origins of the Clubhouse model of psychosocial rehabilitation in the USA, the rehabilitation model upon which The Club is based. I begin by sketching a brief history of the original Clubhouse, Fountain House in New York, from the former psychiatric patient movement that founded it, through to the long leadership of the executive director John Beard, a social worker. I consider Beard's notion of 'normalcy' and how he envisaged Clubhouse members leading 'normal' lives through participation in paid work (Beard, Schmidt and Smith, 1963). I then examine the expansion of Fountain House into an international movement, and explicate some of the Clubhouse International standards, the guidelines for organisations attempting to replicate the 'Clubhouse model'. I provide an overview of some of the key elements of the Clubhouse model, in particular the work-ordered day, which is the programme through which activities and meetings are structured within the Clubhouse. Finally, I summarise the notion of Transitional Employment Placements (TEPs), the paid supported employment programme that is a key element of the Clubhouse model.

2.2 The Constraining Power of Work in the Historic Treatment of Madness

2.2.1 From 'Moral Treatment' to the Public Asylum System

The social construction of 'work' in relation to the 'treatment' of 'mental health problems' in a Western context has changed over time in terms of what this work entails, and the potentially 'curative' power the work is expected to have. However, I intend to demonstrate that regardless of form or intent, all these constructions of institutional or 'prescribed' work are used to constrain individuals in one way or another. Whilst there is not a smooth or linear narrative regarding work in relation to the treatment of madness, I will provide a roughly chronological account, starting around the time of the emergence of industrial capitalism in the late eighteenth century in the UK, up until the accelerated rise of neoliberal capitalism in the late 1970s and early 1980s. A much deeper examination of the relationship between work and mental health from this period to the present day will be provided later in this chapter. Although a thorough consideration of the impact of 'social class' upon each

patient's experience of 'work treatment' is beyond the scope of this short overview, I must acknowledge that the treatment conditions for working class patients were of course much worse than for those in fee-paying institutions. Nevertheless, I wish to demonstrate that regardless of class or type of institution, the various theories of 'work treatment' are designed to constrain, discipline, and 'normalise' mad individuals, by creating "a small, miniature, simplified, coercive society in which the maxim, 'he who wants to live must work', would be clearly revealed" (Foucault, 1995:122). Through this account I do not intend to suggest that there are never any positive outcomes for 'mad' individuals undertaking work (though of course the form of work, working conditions, and one's autonomy in choosing to undertake the work are all important factors in achieving any positive outcomes), rather I am demonstrating that all of these forms of work-as-treatment are ways of placing the individual in distress as a patient needing cured, a problem needing solved, an abnormality needing normalised. Taking a Foucauldian framing of power, I recognise that power can be "facilitative" as well as constraining (Sharp et al., 2000:2) and that even in an inherently institutional space there is the possibility of 'resistance' (Goffman, 1961; Wilton, 2004b). Therefore, I acknowledge that these *constraining* apparatuses that I refer to cannot be disentangled from the potential positive or 'therapeutic' aspects of work, nor from any individual's relief of distress, or their individual autonomy to resist the constraining power of work.

William Tuke's Retreat, opening in 1796, was not the only institution that asserted that work could have a 'moralising' effect on mad individuals (Freebody, 2016), but as one of the best known, its practices have already been the consideration of much critical scholarship (Foucault, 2006a; Scull, 1979; Edginton, 1997). The Retreat became well-known in the early nineteenth century as an example of a place where the 'mad' could be 'cured' and was visited by several high-profile figures in prison and asylum reform, following the publication of Samuel (William's grandson) Tuke's (1813) '*Description of the Retreat'* which offered explanation of the theory of moral treatment (Doerner, 1981). In the past individuals considered 'mad' were likened to animals, chained up, and restrained; 'moral treatment' was deemed an innovative approach as for the first time it was considered possible to 'cure' madness (Foucault, 2006a).

The intention of moral treatment was to 'restore reason' in the individual through the disciplining of the mind and body (rather than physically restraining) through the pursuit of work (Bing, 1981). The guiding principle of the Retreat was to "encourage the individual's own efforts to re-assert his powers of self-control" through work (Scull, 1979:425):

> "Work was of primary importance in the 'moral treatment' that was practised at the Retreat. In itself, work has a power to constrain which was superior to all other forms of physical coercion, as the regularity of the hours, the demands it made on attention, and the obligation to achieve a result removed what would otherwise have been a harmful liberty of thought, fixing patients in a system of responsibility" (Foucault, 2006a:485).

The work undertaken by 'patients' at the Retreat was largely manual labour: farm work, gardening, or tending the stables for men and laundry and sewing work for women (Digby, 1985; Edginton, 1997). This work had the 'power to constrain' in several ways. Firstly, in occupying the individual mentally and physically it encouraged them to "think about something else" rather than the 'introspection' involved in thinking about their 'madness' (Foucault, 2006b:248). Whilst this may not 'cure' the individual, we can consider that during some of the time individuals were working they were not focusing upon the parts of their character that had been deemed 'undesirable' by others. Secondly, in order to undertake these work tasks, a certain level of 'self-discipline' was required, that encouraged the individual to govern themselves (Driver, 1993). This meant that the individual practiced the regulation of their own behaviour, rather than learning through being punished for 'deviant' behaviour. Thirdly, work provided discrete activities around which a timetable could be formed to constrain the individual temporally (Goffman, 1961). Undertaking "regular daily activity was seen as conducive to less disturbed behaviour" (Hall, J., 2016:314) and in this way constrained the times in which 'mad behaviour' could take place.

The Retreat was not a medical space, but the principles of 'moral *treatment*' opened up the possibility of the 'medicalisation' of madness within the public asylums of the mid-nineteenth century (Paterson, 2010), as the notion of *treating* madness meant that medical knowledge could "insinuate itself within the moral impulse of the asylum" (Philo, 2004:489). The Lunacy Act (1845 England, 1857 Scotland) led to the construction of public county or district

asylums, to serve local populations. The encroachment of industry on urban areas meant that 'madness' as a newly 'curable' ailment had been reframed as a disease of environment as much as a crisis of rationality. Therefore, much like the Retreat, county asylums were built in rural areas, as asylum advocates saw the "spreading urban industrial landscape of gloomy tenements and smoky factory chimneys" as a possible cause of madness (Philo, 1987a:404). In addition to trying to keep patients in a place less desperate than the workhouse (though plenty of 'mad' individuals did remain in these spaces) (Driver, 1993), 'madness' was not conducive to industriousness and economic productivity, therefore moving 'deviant' individuals out of the site of industry was imperative (Moon, Kearns and Joseph, 2015). Furthermore, it enabled these individuals to be placed in purpose-built spaces that were designed for discipline (Piddock, 2007). The organisation of space "guarantee[s] the obedience of individuals, but also a better economy of time and gesture" (Foucault, 1995:148). Many asylums were constructed in a manner that enabled the 'patients' within to be watched at all times by ward supervisors and 'alienists', the medical experts within asylums that were the predecessors of psychiatrists (Chaney, 2016). Purpose-built asylums could be designed in a manner that enabled maximum surveillance of patients with fewer staff. The notion of being watched constantly and judged upon individual conduct, particularly 'mad' behaviour, was designed to alter the way the individual behaved (Foucault, 1995).

With the broad expansion of the asylum system in the nineteenth century, whilst the work was retained, the principles of "affective conditioning guided by 'benevolent theory'" (Charland, 2007:62) were instead overtaken by a capitalist ethic:

> "By the late nineteenth century, the principles of moral therapy were still widely celebrated, but the feasibility of implementing them in the large-scale public institutions that emerged all over Europe was restricted. Patient work, however, was more easily retained as a cornerstone of institutional management of the insane and an income spinner" (Ernst, 2016:7).

In the large public asylums, 'patient work' was no longer balanced with rest and worship as it was in the Retreat (Laws, 2011), rather it was used as a means of reducing the costs of the asylum: "there can be no doubt that the resulting farm and garden enterprises [of asylums] were designed with an economic objective

in mind" (Philo, 1987a:407). This work therefore constituted any task that might be required to keep the asylum running and was not confined to tasks deemed 'restorative' to the individual's character. There also grew a focus on the notion of 'malingering', shirking one's civic and moral duty to work. Whilst the term gained popularity in society more generally due to the invention of worker insurance schemes, the term also became common in asylum journals:

> "In three key medical journals (J*ournal of Mental Science, British Medical Journal and The Lancet*), the number of articles containing the term [malingering] soared from less than thirty in 1851 to nearly 300 in the first decade of the twentieth century. Similar levels of increase occurred in textbooks and newspapers" (Chaney, 2016:284).

The prevalence of this term, indicating concern from asylum specialists that mad individuals may be 'malingering' from work, demonstrates the societal expectation of the late nineteenth century that even those deemed 'mad' should feel ethically compelled to work.

2.2.2 Occupational Therapy

In 1930 the Mental Treatment Act heralded the end of the 'asylum' in name, as institutions for the treatment of mental ill-health became 'mental hospitals' (Eyles, 1988). Work-as-treatment found its way into these newly defined spaces through 'occupational therapy' (Crouch and Alers, 2014). As the name suggests, it was intended as a therapeutic measure and in a British context early occupational therapy drew inspiration from the Arts and Crafts movement that had gained momentum in the UK at the end of the nineteenth century and that was burgeoning in the United States in the early years of the twentieth century (Reed, 2005). Many of the individuals now considered 'early pioneers' in the field of British Occupational Therapy spent some time studying or observing at North American occupational therapy centres before bringing the practice back to the UK (Paterson, 2007). Occupational therapy was a technique initially developed and practiced largely in private, fee-paying mental hospitals in England, and similarly in the Royal Asylums in Scotland. Therefore, the type of 'occupation' that individuals were expected to undertake would have been work considered 'suitable' for middle class patients. This work often involved handicrafts, artistic pursuits and creative writing (Hocking, 2008). An early and well documented regime of occupational therapy in the UK took place at

Gartnavel Royal Hospital in Glasgow in the early 1920s, under the auspice of psychiatrist David Henderson (Morrison, 2017). In an early journal paper on the subject Henderson (1925:66) stated that through occupational therapy "good habits are substituted for bad ones." This indicates that the practice of occupational therapy was based upon judgments about what was considered appropriate behaviour, and that certain forms of conduct were to be discouraged. The aim of occupational therapy was to restore equanimity to the individual and stressed "the importance of using occupation to rebalance and habituate activities between work, leisure and self-care" (Pentland and Pentland, 2015:249). Firstly, this reveals that patients were considered 'unbalanced' in their lives and that their distress could be reduced by introducing some stability through 'occupation'. It also promoted focus on 'self-care', though it may not have been phrased in this manner at the time. Once again, this suggests an expectation that the individual should take responsibility for their 'care' and for forming their own 'good habits' of behaviour, despite the fact that they are under a treatment regime in an institution. Finally, disciplining the timing of activities for the individual yet again plays an important role in treatment (Goffman, 1961). In occupational therapy, "detailed planning of the activity programme for individual patients" was undertaken to achieve the "overall goal of totally overcoming the problem of the refractory patient" (Hall, J., 2016:320). This constraint through timetabling is demonstrated by this classification of occupational therapy by the 'Board of Control', the health ministry's regulatory organisation for mental institutions in England and Wales in the first half of the twentieth century. The Board emphasised that occupational therapy encompassed a whole host of activities:

> "The varieties of this treatment may be classed as (1) occupational, as by the use of the utility departments of the hospital and of handicrafts; (2) recreational, as by drill, country walks, shopping, dancing, music, games and reading; (3) social, as by visits by and to friends" (Board of Control, 1933:27).

The 'arts and crafts' type activities that I have indicated were common in early occupational therapy practice would be included under 'handicrafts' in the 'occupational' category. However, that 'recreational' and 'social' activities are also included as part of the treatment regime of 'occupational therapy' suggests

that these other leisure activities are to be regulated as ‘good habits’, in an attempt to provide a disciplined ‘treatment’ structure at all hours of the day.

2.2.3 Industrial Therapy

After the Second World War, a large number of individuals returned to civilian life disabled physically and psychiatrically from their participation in the war effort (Anderson, J., 2011). With a significant proportion of the working-age population disabled in one way or another, it was economically imperative that adjustments were made so that some of these individuals could become ‘productive workers’ (Bennett, 1996). The Disabled Persons (Employment) Act 1944 provided impetus for the formation of the Disabled Persons Employment Corporation Ltd (later known as Remploy) by the Ministry of Labour (Barnes, 1991), that created sheltered workshops in which some of these newly disabled individuals could find employment, though the focus was upon physical disability and individuals that were already living in the ‘wider community’ (Hyde, 1998). The passing of the Mental Health Act (1959) was formal political recognition that ‘mad’ individuals did not need to be permanently institutionalised, after a shift in the medical understanding of the methods of treatment for psychiatric patients. It was suggested that those individuals once deemed permanently ‘mad’ could be ‘treated’ with antipsychotic medications and discharged into the community (Valenstein, 1986; Gronfein, 1985; Gleeson and Kearns, 2001). Therefore, the conceptual focus of work in mental hospitals shifted from ‘occupation’ to ‘preparation for employment’. It was understood that these individuals could become economically productive, however whilst the discourse around treatment might have changed, the reality in mental hospitals was quite different. Firstly, patients that had been institutionalised in the long term had difficulty adjusting to a new environment where they were expected to be productive (Long, 2016). Secondly, these patients were often actively excluded or discouraged from taking part in industrial therapy schemes as they were considered ill-suited for ‘work rehabilitation’ by the administrators overseeing the running of the industrial therapy units (Jones, K., 1993).

There was not a single model or form of industrial therapy, as it was enacted in multiple ways in different locations. In some instances, factory units were constructed within the grounds of psychiatric hospitals; in other cases, patients

were permitted day release and attended off-site factories to work as labourers (Laws, 2011). The work involved would often be "repetitive, monotonous work" (Long, 2013:748) that involved assembling, or disassembling, the same items over and over for several hours, several days a week (Barnham and Hayward, 1995). The work was usually paid, though the wages were lower than those paid to an equivalent non-disabled worker (Long, 2013). Industrial therapy units that were not on the site of psychiatric hospitals, such as the sheltered workshops operated by Remploy, were usually created for those who were physically disabled, and those with learning disabilities (Hyde, 1996) but these workshops were often not well-equipped to deal with the specific needs of individuals classed as having 'psychiatric disabilities' (National Association for Mental Health, 1959). The high-profile psychiatrist Maxwell Jones petitioned the Ministry of Labour to set up his own Remploy-style workshop within a psychiatric unit, however the Ministry were resistant to this idea as they deemed individuals with 'psychiatric disabilities' to be less productive than other workers (Jones, M., 1968). The work of industrial therapy units and sheltered workshops was intended to have a constraining power, focusing on occupying the individual and the quality of production, rather than a focus on 'rehabilitation':

> "Industrial therapy provided an explicitly disciplinary environment and uniform repetitive monotonous work to which people had to adapt. The quality of the finished article was paramount and the subjective experience of the worker irrelevant" (Long, 2013:749).

The monotonous work was considered a way of 'filling time', and therefore was used to constrain the hours that individuals had to focus on their 'madness' (Laws, 2011). Industrial therapy units would bid for contracts to manufacture items for competitive mainstream businesses; therefore, a certain level of productivity was expected from individuals, requiring them to adhere to certain behavioural norms in order to fulfil orders (Long, 2016). Getting these individuals to take on more responsibility, and to behave as though it was a 'real job' was encouraged by industrial therapy advocates (Imlah, 2003) despite the fact that these individuals were poorly paid, their productive capacity devalorised (Jones, M., 1968) and they were expected to revert to their 'patient identity' once they had returned to the hospital ward (Goffman, 1961). Eventually, a reduction in manufacturing and industrial production nationwide caused rising unemployment levels and made many of the industrial therapy

units economically unviable (Bennett, 1996). Furthermore, pressure from successive governments to close former asylum sites (Moon, 1988) meant that by the 1980s many of the in-house industrial therapy units had closed. The closure of psychiatric institutions did not mean the end of 'work-as-treatment' for individuals with diagnoses of SEMHCs. However, this 'treatment' is now enacted in different ways, due to the acceleration of processes of neoliberalisation in 'Western' countries and the 'roll-back' of state-run mental health services, and roll-out of public-private partnerships in mental health care and treatment that this has entailed (Peck and Tickell, 2002; Milligan and Fyfe, 2006). These more contemporary geographies of work in mental health care will be considered later in the chapter.

2.3 Contextualising 'Community' in relation to Mental Ill-Health

2.3.1 'Reformist' Therapeutic Communities

In 1959, the Mental Health Act gave local authorities in England and Wales the approval to create 'community-based' (as opposed to institutional) services, and in 1962 the Ministry of Health announced the decision to close most of the country's mental hospitals (Boardman, 2005). In spite of this, widespread deinstitutionalisation did not occur until 1980s. During these intervening years, when institutional mental health care had fallen out of favour, therapeutic communities were one response to the criticisms of the 'failures' of institutional care (Whiteley, 2004). The term 'therapeutic community' encompasses an extremely varied set of locations, practices and approaches; however, they all arose from a general assertion that mental health care and treatment required overhauling from the legacy of 'the asylum' (Clark, 1965). In the UK, these different experiments in community can be largely split into two categories: those led by 'reformist' psychiatrists that wanted to improve psychiatric practice, such as Maxwell Jones; and those led by 'anti-psychiatrists', who attempted to eschew psychiatric practice completely, such as David Cooper (Cooper, 1967). It is the former 'reform' communities that I will focus upon here, as these are tied more closely to the psychiatric institutions that instigated 'work-as-treatment' that I discussed in the previous section (Jones,

M., 1952), and in general they served a larger patient population than the 'radical' communities.

One of the earliest British therapeutic communities developed after the Second World War and throughout the 1950s was at the Belmont Hospital in South London, led by Maxwell Jones (Crossley, 2006), who also introduced an industrial therapy unit onto this site at a similar time to serve some of this population. Another 'reformist' community established in 1955 within a mental hospital was the Claybury Hospital led by Denis Martin (Martin, 1968). The approach taken in the reformist therapeutic communities of the 1950s and early 1960s was seen as a step away from 'traditional' psychiatric practice as it focused upon the patient as an individual rather than on the disorder that they had been diagnosed with (Jones, M., 1968). In this sense therapeutic communities led the way in what was later to be understood as the 'person-centred' approach that is frequently used in twenty-first century mental health care and treatment (Curtis et al., 2009). Based upon research conducted at Belmont Hospital, Rapoport (1960) defined four key characteristics of the therapeutic community: democratisation, each member shares power and responsibility for decisions; permissiveness, deviant behaviour is tolerated; communalism, experiences are shared openly; and reality confrontation, behaviours are reflected back onto the individual. I shall briefly examine how these characteristics functioned within the communities and the ways in which these communities both diverged from and maintained the disciplinary apparatuses utilised in the asylum.

If the impetus for these therapeutic communities was a move away from the 'institutional discipline' engendered by the mental hospital (Foucault, 2006a), we can consider this a partial success, as the 'unlocking of the asylum doors' allowed some patients more freedom to come and go (Clarke, 2004). However, the threat of being moved to a locked ward if one became too 'agitated' (Martin, 1968) was a possibility that meant that the principle of 'democratisation' could not be fully realised. Whilst Maxwell Jones (1952) tried to include patients at Belmont in the discussions on the ward, 'democratisation' more frequently meant that the psychiatric nurses (who previously would just act on the treatment orders of the psychiatrist) were given more opportunity to voice their opinions (Bhurruth, 2015). Patients would still not necessarily have any say over their treatment, meaning they could be moved to other wards

without their consent (Wilson, 2012). However, acknowledgement by reformist psychiatrists that the hierarchical structure of decision-making within mental hospitals was not conducive to a 'therapeutic environment' for the patient (Foucault, 2006b) demonstrates a determination to move away from some of the disciplinary apparatuses of institutions. Efforts to remove the hierarchical structure within the therapeutic community was also a goal of 'communalism', which was intended to create a 'community spirit':

> "reformist psychiatrists wanted to create a genuine 'community spirit'. This characteristic… is linked to the importance given to communication, to commitment in relationships and to communal pursuits, not to mention the steps taken to reduce the distance between patients and the medical team by suppressing traditional attributes of authority" (Fussinger, 2011:150).

This involved removing institutional formalities, such as doctors' white coats, and patients and staff referring to each other by first name. It also meant that most discussions were undertaken as a group, including group therapy sessions (Mills and Harrison, 2007). Whilst the promotion of social interaction was a positive aspect, the notion of communalism also entailed a form of 'responsibilisation' (Rose, N., 1999a), as individuals were expected to take responsibility for the social functioning of the community, and to mediate their own behaviour within it.

The characteristic of permissiveness appears to contradict the principles of communalism, as the countenance of 'deviant' behaviour could be antithetical to the formation of a 'community spirit'. However, in the 'reformist' therapeutic communities, this permissive licence related more to the relaxation of rules in terms of the strict disciplining of the patient's time (Goffman, 1961) and the consent to verbally express their thoughts and feelings in a 'democratised' setting:

> "the rules of everyday life: tidying and cleaning rooms, rising time and participation in communal activities were all domains in which rules were softened or at least applied differently from previously" (Fussinger, 2011:154).

Any behaviour that might be considered destructive either to oneself or to the broader community was usually not permitted and may result in the individual

being removed from the community and into another ward (Martin, 1968). Therefore, behaviour was less constrained than in the asylum, however patients were still expected to conform to the 'norms' of the community, and some behaviours were still marginalised as 'abnormal'. Furthermore, the technique of 'reality confrontation' was also designed to constrain the individual's 'mad' behaviour, by reflecting this behaviour back onto the individual for them to see the 'madness' of it themselves. This is reminiscent of Foucault's (2006a:499) description of 'mirroring' in moral treatment where "mirrors were positioned in such fashion that eventually the mad could not fail to see themselves for what they were" and so the madness becomes "imprisoned in its own gaze." The 'communalism' of group therapy and discussion sessions enabled patients to discuss each other's behaviour, encouraging patients to empathise with each other and modify their behaviour accordingly. This promoted a certain kind of 'normalisation' whereby 'madness' was pointed out and shown to be irrational. This confrontation could temper some of the 'deviant' behaviour that may have occurred as a result of the permissive licence that patients were given.

Kennard (2012:110) notes a successful therapeutic community requires "a psychological tendency within individuals to behave towards others in a certain way." The therapeutic community approach assumes that individuals will have the 'psychological tendency' to participate in group discussions and take on constructive criticism about their behaviour and furthermore be willing to modify their behaviour for the benefit of others. However, some individuals experiencing extreme mental distress may find it difficult to function in a co-operative environment. The conceptualisation of 'community' that 'reformist' therapeutic communities offered was therefore one that prioritised co-operation and communication, but also an 'exclusivity' that required a certain level of functioning and form of behaviour in order to participate (Whiteley, 1979). These high expectations related to patients' psychological tendencies and behaviour, coupled with the increased number of patients being discharged into the 'wider' community due to the gradual 'wind down' of mental hospitals in 1960s and 1970s (Moon, Kearns and Joseph, 2015), meant that many of these reformist therapeutic communities had ceased operation by 1970s. Examining therapeutic communities has enabled me to highlight some of the problems of trying to foster a 'community' inorganically, which is significant in a study of a

mental health Clubhouse, which is also an 'intentional community'. The problems experienced by those practitioners in maintaining these communities meant that new solutions for care were sought, opening up the opportunity for new conceptualisations of 'community'.

2.3.2 Care in the Community

The seed of psychiatric deinstitutionalisation in the UK was planted in early 1950s due to the rising costs of the National Health Service (NHS) (Moon, 1988), at a time when the 'welfare state' was burgeoning (Boardman, 2005). However, the slow progress to close these institutions, in part due to a lack of adequate community welfare provision to support long-institutionalised individuals (Cornish, 1997) meant that the era of 'care in the community' took place during Thatcher's Conservative government administration, when policy-making influenced by the ideals of neoliberalism entailed the 'roll-back' of state funding for public services (Peck and Tickell, 2002). The Mental Health Act (1983, Scotland 1984), whilst creating specific legislation giving power to psychiatric services to detain individuals without consent, also reinforced the notion that individuals with diagnoses of SEMHCs had rights as patients, and created the impetus to treat most patients that were not in 'acute crisis' outwith psychiatric institutions. As mental hospitals began to close from mid-1980s onwards (Jones, J., 2000), the NHS and Community Care Act (1990) was introduced that cemented the role of the state as 'enabler' rather than 'provider' of these services (Milligan, 1998). This led not only to the retrenchment of state funding for services, but also the reduced responsibility for planning these services as well:

> "[community] care is no longer viewed as the prerogative of public services. Legislation has sought to promote a multi-agency approach, elevating the independent sector through a renewed emphasis on private and voluntary provisioning" (Milligan, 2000:192).

This created a dearth of even, adequate provision of community services for newly deinstitutionalised individuals, and many services were provided by third (voluntary) sector organisations (Fyfe and Milligan, 2003). These services were required to compete for scarce state-offered funding, whilst government institutions could avoid taking responsibility for the quality of care offered by

the services, leading to a "para-state apparatus comprised of multiple voluntary sector organizations" described as a 'shadow state' (Wolch, 1990:xvi).

The process of deinstitutionalisation and the growth of 'shadow-state' care services produced a new focus on the concept of community in relation to mental health care and treatment (Milligan, 1999). As Pinfold (2000) has noted, the closure of mental hospitals entailed the loss of a sense of belonging to a community for many individuals who had resided within these institutions, one that was not necessarily replaced by attending services in the 'wider' community. Therefore, we might conceptualise the relation between deinstitutionalised individuals and wider society as 'community presence' (Wiesel and Bigby, 2014). This entails the locating of mental health services and service users within 'wider society', without this inevitably engendering the 'social inclusion' that had been a principal intention of policies of deinstitutionalisation across 'Western' countries (Kearns, 1990; Wilton, 2004b). The lack of national guidance or infrastructure in organising the care and treatment of individuals with diagnoses of SEMHCs in the community led to a "patchwork quilt… of community services that evolved throughout the 1980s and 1990s" (Power and Hall, 2018:307). Furthermore, the requirement to compete for funding led to an overlap of provision in some service areas and a lack of provision in others, with poor communication between services (Nelson, Lord and Ochoka, 2001). One of the starkest variations over geographical location was the difference in service provision between urban and rural areas, with services in rural communities frequently being sparse (Philo, Parr and Burns, 2003).

This 'patchwork' provision and lack of cohesive care strategy led to the New Labour government declaring the 'care in the community' project a failure on their election to government in 1997 (DoH, 1998). Their response to this perceived failure was to increase the emphasis upon 'community participation' over 'community presence' (Wiesel and Bigby, 2014), primarily through encouraging disabled individuals to participate *economically* by engaging in 'mainstream' employment (Roulstone, 2000). Whereas the initial move to deinstitutionalisation might be understood as "a policy shift that has sought to transform rather than introduce a sense of community within supported-care regimes" (Gleeson and Kearns, 2001:77), the move to 'participation' through mainstream employment elided 'community' with wider 'society' without

acknowledging the impact of smaller-scale communities and their potential to foster social inclusion. The specific strategies, policies, and realities of this new 'welfare-to-work' focus will be explored later in the chapter, however, it is important to understand that the political ambitions and legacies of these policies produced and continue to produce expectations of 'community participation' that frequently do not match up with the experiences of 'feeling part of a community' as a disabled person. Often these individuals may feel socially excluded in exactly the spaces they are 'supposed' to feel a sense of inclusion, such as the workplace (Hall, E., 2004; Wilton and Schuer, 2006). At the same time as New Labour's welfare-to-work scheme was being rolled-out, third sector organisations of various kinds were creating spaces of inclusion for individuals with diagnoses of SEMHCs: in community garden projects (Parr, 2007), art projects (Parr, 2006), community centres (Conradson, 2003a), spaces of faith-based organisations (Parr, 2000), and even on old asylum sites where these former spaces of discipline were reconfigured for 'community care' (Parr, 2008). Usually targeted specifically at those with diagnoses of SEMHCs, these services offered spaces where individuals were able to 'be themselves' on the premise that there was 'mutual understanding' between individuals. Therefore, these 'exclusive' spaces for individuals with diagnoses of SEMHCs potentially offered greater social inclusion than the wider community, though the realities of the social relations within these spaces are extremely complex and inclusion for all was certainly not the case in all these spaces (Parr, 2000; Conradson, 2003a).

2.3.3 **Conceptualising Community**

The sense of 'community' that an individual may experience is mutable and "social inclusion and exclusion are fragmentary and relational, 'entangled' within each other in particular ways and in particular contexts" (Hall, E., 2005:108). It is this 'fragmentary and relational' nature of social inclusion that makes it difficult to create a singular conceptualisation of community, that leads some to frame community as local and small-scale rather than as a complex set of relations (Studdert and Walkerdine, 2016). This is further complicated by the ever-more constraining mental health policy that was increasingly encroaching on 'patients' living in the wider community at the time that these spaces of social inclusion were being forged. The Mental Health (Care and Treatment)

(Scotland) Act (2003, enacted in 2005) introduced the notion of community-based compulsory treatment orders, a similar notion was introduced in England and Wales a couple of years later with the Mental Health Act (2007). Prior to this, patients could only be treated against their will whilst under a detention order as an in-patient at a psychiatric hospital. These new policies meant that patients could now be compulsorily treated whilst living out in 'the community', an intrusion of disciplinary institutional logics within the spaces of community care.

The term 'community' remains ambiguously defined within geography and broader social science disciplines, as well as within broader policy discourse (Valentine, 2001). Therefore, I wish to briefly outline how I am going to use the term throughout the empirical chapters. The complex nature of the relationships between multiple actors at multiple scales; between the state and the third sector, between healthcare professionals and 'patients', and the variety of spaces and services in which these interactions take place, lead me to favour a 'relational' approach in conceptualising community. Geographers have recently considered the possibilities of a relational approach in conceptualising both the third sector (DeVerteuil, Power and Trudeau, 2019) and disability geographies (Hall and Wilton, 2017). The first of these papers takes a neo-Marxist approach that asks us to consider third sector organisations as assemblages comprised of multiple actors:

> "with each body having capacity to act but within the constraints of other (institutional) relations, including structures, rules, hierarchies, finances, technologies and places" (DeVerteuil, Power and Trudeau, 2019:922).

The fluctuating affective capacity of each of these bodies to act means that there are various and changing opportunities to both follow and resist the 'structures, rules and hierarchies' of neoliberal governance (Bondi and Laurie, 2005). The second of these papers asks us to conceptualise spaces that disabled individuals visit and inhabit in a way that:

> "resists the static classification of such spaces as either inclusive or exclusionary, recognizing that the way they are inhabited and interpreted within the context of specific relational networks will help determine their meaning and status" (Hall and Wilton, 2017:732).

Therefore we can view 'community' spaces for individuals with diagnoses of SEMHCs as places that are potentially 'enabling' in their relational capacity for social inclusion (Duff, 2011) whilst also constantly under constraining institutional relations of neoliberal governance (Fyfe, 2005). Acknowledging the struggle for agency that people with diagnoses of SEMHCs and navigating neoliberal processes face (Chouinard and Crooks, 2005), it is nevertheless the actors within these third sector spaces that ultimately determine the nature of 'community' that is created. The experience of a feeling of community is unique and personal to each individual within the space (Conradson, 2003a), though these individual feelings are often connected to broader relational affective 'intensities' that are less consciously 'felt' (Anderson, B., 2009). Therefore, we may understand how these intensities of community are created and experienced through examining the practices of working together and relating to one another within 'community' spaces. Geographer Kathryn Pratt (2013:178) suggests that the practice and the place of the community are co-constitutive: "togetherness is constituted through practice… Practices, likewise, emerge in continual relation to material and immaterial becomings of particular sites." This understanding of the co-constitution of practice and place are significant in considering a place such as a Clubhouse, which is a "place-based intervention approach" to mental health care and treatment and is focused on the *practice* of work (Jackson, 2001:40). Therefore, we can think of the community being formed by a "doing-in-common" (Pratt, 2013:180) of tasks within the same space and working towards the same goals.

2.4 Welfare-to-Work and Supported Employment in the UK

2.4.1 Welfare-to-Work

The neoliberal-ableist assumption that all individuals want and are able to strive towards their productive neoliberal subjectivity (Goodley, 2014) provides context for the political rhetoric that states that 'work is good for individual health and wellbeing' (DWP, DoH and Health and Safety Executive, 2005). This has led to the increased popularity of 'workfare' style policy-making and reduction in welfare provision over the past four decades, but particularly since the election of the New Labour government in 1997 (Peck and Theodore, 2001). One of the most pervasive shifts that the New Labour government enacted was

to move from a "rights-and-entitlement approach" to a 'no rights without responsibilities' welfare-to-work approach (Peck, 2001:262). This sought to place the onus of responsibility for reducing social deprivation onto those already experiencing poverty, as expressed in Labour's 1997 election manifesto:

> "The best way to tackle poverty is to help people into jobs – real jobs. The *unemployed have a responsibility* to take up the opportunity of training places or work" (Labour Party, 1997:19, emphasis added).

Whilst this statement was not specifically targeted at disabled individuals, it demonstrated a social contract approach (Giddens, 2000), that aimed to reduce dependency on welfare benefits by incentivising individuals to work in 'real jobs' which we can understand to mean jobs that feel 'meaningful' and pay a living wage (Sunley, Martin and Navitel, 2006). The notion of 'responsibility' also indicates the expectation that unemployed individuals will take up their neoliberal subjectivity, as they 'seek to make an enterprise' of themselves (Foucault, 2008). The New Labour government was the first UK administration to introduce a welfare-to-work scheme specifically aimed at disabled people, the New Deal for Disabled People (NDDP). Creating a specific work programme for disabled individuals was deemed necessary due to reduced government provision to Remploy sheltered factories and workshops from 1985 onwards as the previous Conservative administrations had attempted to reduce spending on public services (Hyde, 1998; 2000). The NDDP programme was a voluntary scheme aimed at individuals living on incapacity related benefits who wanted to get into work. This scheme involved 'job brokers' who could come from private, public and voluntary sector organisations to place disabled individuals into work (Edwards, 2010). The rhetoric of the New Labour government in relation to the NDDP was that disabled individuals had been kept out of mainstream workplaces due to a lack of opportunities that presented better prospects than living off welfare benefits; and that with a greater variety of work opportunities, workplace accommodations, and better pay, almost all disabled individuals would be able to become 'productive subjects' (Roulstone, 2000; Stafford, 2005). However, participation in the NDDP scheme was low, in the twelve months ending May 2006 only 3.1% of eligible participants had taken part in the scheme (Stafford et al., 2007). Significantly, the demographic data collected about participants in the scheme stated that they were "less likely to have a mental health condition" (Francis et al., 2008:20) suggesting that individuals

with diagnoses of mental health conditions were often either unwilling or unable to participate in the scheme. The neoliberal 'responsibilisation' approach (Rose, N., 1999a) adopted by New Labour meant that the NDDP:

> "focused on the actualization of individual capacity with little attention given to the labour markets and workplaces into which disabled people are obliged to enter" (Wilton and Schuer, 2006:193).

A suggested solution to the low participation rate in NDDP by individuals with diagnoses of SEMHCs was to increase the length of contact time between job brokers and participants (Lewis et al., 2005), but for many disabled individuals, New Labour's promise of 'real jobs' was out of reach, and the work that was available was often unsuitable, unfulfilling, and poorly paid (Barnes and Mercer, 2005).

In addition to the 'incentivising' approach to get individuals into paid jobs they found meaningful; the past twenty-five years of welfare policy have entailed a political shift towards a 'punitive' approach. This approach has reduced the number of individuals that are eligible for welfare benefits without being required to participate in some form of welfare-to-work scheme (Piggott and Grover, 2009). Prior to 1995, an individual's claim to 'being disabled' was assessed by the individual's GP, and disability welfare benefits were offered on the provision of a sick note. Furthermore, a claimant's fitness for work was assessed on their ability to return to their previous job (Burchardt, 1999). The first move towards the 'creeping conditionality' of welfare benefits for disabled individuals occurred when John Major's Conservative government attempted to formalise this process with the introduction of the 'All Work Test' (Dwyer, 2004). In this assessment, some disabled individuals were now subject to an occupational health examination, and were assessed on their capability to undertake any paid employment, not only jobs in the trade that they were skilled in. This is indicative of a concerted move towards a discourse that expects all individuals to strive towards their own neoliberal subjectivity (Houghton, 2019). In the year 2000, the New Labour government renamed this test the 'Personal Capability Assessment' in the Welfare Reform and Pensions Act (1999).

The ‘Freud Report’ commissioned by the DWP in 2006 to assess the first decade of New Labour’s welfare-to-work policy determined that more targeted support needed to be offered to the ‘least advantaged’ individuals and this support should be outsourced to private contractors (Freud, 2007). The report also reinforced the ‘responsibilisation’ discourse of the then incumbent government by continuing to “associate a lack of paid employment with individual failings encouraged by the provision of relief” (Grover, 2007:543). The response to this was to determine whether those receiving disability benefits were ‘deserving’ of such ‘provision of relief’ unconditionally or whether they would be required to undertake some form of work-related activity to ‘earn’ their benefits. The Employment and Support Allowance Regulations (2008) dictated that individuals with disabilities be tested as to whether they are fit for work through a Work Capability Assessment (WCA) (Beatty and Fothergill, 2018). The WCA constitutes two parts, a questionnaire and an in-person medical assessment. The ‘Capability for Work’ questionnaire involves a twenty-four page form that asks probing questions about one’s health, from mobility, to continence, to whether one is “behaving appropriately” (DWP, 2017:17). The medical assessment is a face-to-face examination, undertaken at a health centre or at the individual’s home. Based on this short assessment the individual is placed into one of three categories: fit for work; unfit for work but fit for work-related activity, or; unfit for work or work-related activity (Gulland, 2017). It is only if the individual is placed in the final of these three categories that they are exempt from being required to undertake work, employment searches or skills training. The proportion of disabled individuals that are exempt from the WCA is much smaller than in prior work capacity tests, indicating that a greater proportion of disabled individuals are now deemed to have the potential to become ‘productive subjects’. Crucially, having a diagnosis of a SEMHC is no longer considered a reason to exempt an individual from a WCA (Osborne, 2008). Therefore, whilst some disabled individuals are still exempt from welfare-to-work conditionality in receiving welfare assistance, the proportion of individuals that continue to qualify as disabled *enough* to remain eligible for unconditional welfare support is decreasing (Grover, 2015; Ryan, 2019). In England and Wales, and initially in Scotland, WCAs were carried out by private firms, in a demonstration of the total entrenchment of ‘roll-out’ neoliberalism within the welfare system (Peck, Theodore and Brenner, 2012). In Scotland, the performance of WCAs by private

firms was abolished in April 2017 in response to much criticism from the mainstream media and general public (Independent, 2017).

The end of the NDDP came with the election of the coalition Conservative-Liberal Democrat government in 2010, and the 'Work Programme' and 'Work Choice' schemes were introduced alongside the new welfare benefit Universal Credit (Woods-Waters, 2012). The Work Programme was intended to be a 'universal' welfare-to-work programme, though the requirements for participation also varied depending on age and disability. Work Choice, a voluntary scheme, was intended for disabled individuals with 'more complex' issues. The lack of clarity on what constitutes a 'complex' issue meant that a large number of individuals who may consider themselves disabled were enrolled on the Work Programme (Scholz and Ingold, 2020). Furthermore, the Work Programme specifically targeted groups that had been unemployed for over nine months and were considered "harder-to-help" such as those claiming Employment and Support Allowance, a benefit designed specifically for individuals out of work due to illness or disability (National Audit Office, 2014:29). At the same time as requiring a greater proportion of individuals to participate in work-related activity, the coalition government also began imposing harsh benefit sanctions upon individuals for an increasingly long list of 'infringements' (Dwyer, 2017). This meant that individuals could have their benefit payments stopped for not attending work-related appointments or activities such as job interviews, and these measures have been implemented with little consideration for the concomitant impacts of disability and poverty on individuals' capacity to undertake work activity or to attend appointments (Dwyer et al., 2020; Wright, Fletcher and Stewart, 2020). With the Scotland Act (2016) and the Social Security (Scotland) Act (2018) the provision of some welfare benefits in Scotland became the responsibility of the devolved Scottish Government, along with responsibility for the provision of employment support. This has led to the creation of the 'Fair Start Scotland' employment scheme which is voluntary for disabled individuals, the provision of which has been contracted to local authorities, third sector organisations, and public-private partnerships across the different regions of Scotland (Scottish Government, 2020a). The longer-term impact of this devolved responsibility on the provision of welfare in Scotland in relation to employment for disabled individuals remains

to be seen, and as the new Social Security Act only came into effect at the end of my fieldwork period, its impacts are not within the scope of this thesis.

2.4.2 Supported Employment

Alongside these policy initiatives, a wide variety of 'supported work' schemes have emerged in the UK in the past forty years, to support disabled individuals into paid work (Hyde, 1998). Some of these schemes are operated through third sector organisations, tendering for 'state' funding; other schemes may be run by private businesses as part of a 'corporate social responsibility' initiative; and some of these schemes are run as social enterprises (Pollard and Tjoa, 2020). Supported employment is an umbrella term for many different workspaces and activities that are designed to cater for individuals with disabilities including: physical impairments, learning disabilities and mental health problems (Weston, 2002). Ridley et al. (2005) delineate the approaches to supported work into two broad categories: 'employment support' and 'supported employment'. 'Employment support' describes a 'vocational rehabilitation' or 'train and place' approach, whereby disabled individuals are offered different forms of training to prepare them for the workplace (Butcher and Wilton, 2008). This training or support is not always paid but may be the kind of activity that is required in order to receive 'conditional' welfare benefits and is therefore compensated in this way. The day-to-day operation of the Clubhouse model (that will be explicated in the next section and in detail in the first empirical chapter) has been described as a train-and-place style model of 'vocational rehabilitation' (Modini et al., 2016), as it offers the opportunity for work-related activities but is not in a 'mainstream' workplace and the work is not paid. These 'employment support' approaches were criticised by the New Labour government for the 'segregation' of disabled individuals from mainstream workplaces, claiming that this segregation was a cause of social exclusion for these individuals (Social Exclusion Unit, 2004). The Scottish Government (2010:4) framework for supported employment states that supported employment placements "should be in an integrated workplace," indicating that 'train and place' approaches continue to be less favoured from a policy perspective. However, research has demonstrated the continued marginalisation of disabled individuals within 'mainstream' workplaces in a Scottish context and has indicated that a greater level of 'social inclusion' for these individuals may be found in spaces with other

disabled individuals (Hall, E., 2004; 2005; 2010). Philo, Parr and Burns' (2005) research of Training and Guidance units in the Highlands of Scotland reinforces this perspective. Training and Guidance units are spaces that individuals with diagnoses of SEMHCs can "access for training and learning activities designed to prepare them for (re-)entry into the labour market" (Philo, Parr and Burns, 2005:778). These spaces were significant for the feelings of 'social inclusion' of participants living within an 'emotionally reserved' rural community (Parr, Philo and Burns, 2005). Furthermore, the realities of the Highlands' employment landscape means that there are frequently not enough jobs available for disabled individuals to find work within mainstream workplaces, making the Scottish Government's desire that all supported work should take place in 'integrated workplaces' difficult to realise.

The second category of work support identified by Ridley et al. (2005) is 'supported employment'. This approach can be understood as a form of 'workplace accommodation' or 'place and train' approach, whereby the individual is supported to find a job in 'mainstream' employment, then support and accommodations are offered in the workplace to enable the individual to undertake the job (Saloviita, 2000; Wilton, 2004b). As the work takes place in mainstream workplaces, this form of supported employment is almost always paid and this renumeration is in addition to or in place of welfare benefits. The preferred 'place and train' approach for individuals with diagnoses of SEMHCs is known as Independent Placement and Support (IPS) (Drake, Bond and Becker, 2012; Centre for Mental Health, 2017). Whilst this method can initially be very costly and time-consuming, there is evidence that it is twice as effective at placing individuals into 'competitive' employment than traditional supported employment schemes (Drake and Bond, 2008). IPS is often integrated with or connected to local mental health services; it offers intensive support to the individual, seeks to quickly find them a job that matches their skills and preferences, and then provides support in the workplace tailored specifically to the individual (Rinaldi, Miller and Perkins, 2010). The Clubhouse Transitional Employment Placements (that will also be explored in the next section and in depth in the final empirical chapter) are a form of 'place and train' support, in that Clubhouse members are offered placements in mainstream work environments and then trained in the specific tasks of the role whilst in the paid

placement (Dorio et al., 2002). The labour-intensive and costly approach of a 'place and train' model such as IPS means that sometimes the individuals who are considered most likely to 'succeed' in finding and maintaining employment (who are usually considered to be the 'least disabled') are favoured as participants in these schemes (Hall and McGarrol, 2012). In Scotland, there are multiple agencies that manage supported employment for disabled individuals. In the West of Scotland, a well-established supported employment service for individuals with diagnoses of SEMHCs is an IPS service run by a national mental health charity and many of these services are located within community mental health teams (CMHTs), which are NHS Scotland services, and the service is funded by NHS Greater Glasgow and Clyde (NHSGG&C) (Public Contracts Scotland, 2020).

A third approach to supported work is to employ disabled individuals within social enterprises. Broadly defined, social enterprises are businesses whose profits are reinvested into the enterprise to fund the social objectives of the organisation (Mansfield and Gregory, 2019). If the 'social objective' of these enterprises is to create an inclusive workplace for disabled individuals, these spaces of work can offer flexible 'workplace accommodation' that is frequently not possible in 'mainstream workplaces' (Evans and Wilton, 2016). This approach attempts to remedy the issue of 'segregating' disabled workers whilst still offering a 'buffer' from the neoliberal expectations of mainstream workplaces that encourage one to become a 'productive subject'. Social enterprises have greater operational freedom as businesses, rather than the restrictions that third sector organisations often face in tendering for state funding (Amin, 2009), this enables them to subvert some of the neoliberal-ableist ideals of 'responsibilisation' and 'normalisation' (Bondi and Laurie, 2005; Goodley, 2014). These workplaces can provide opportunities for disabled individuals to participate in the 'wider community', as many enterprises comprise both disabled and non-disabled workers, and frequently are businesses that have 'customer-facing' job roles that involve interaction with the 'general public' (Buhariwala, Wilton and Evans, 2015). Therefore, social enterprises can offer the benefits of 'segregation': flexible work, an 'understanding' workplace and colleagues, and a feeling of social inclusion. At the same time social enterprises offer some of the experiences of working in 'mainstream' employment, such as

potentially higher wages and the opportunity to mix with non-disabled individuals (Wilton and Evans, 2016). As such, the position of social enterprises between the 'train and place' model and the 'place and train' model locates them as 'threshold spaces' or 'interstitial spaces':

> "the position of these enterprises on the threshold between real and therapeutic work is precisely why they have the capacity to unsettle the disabling division of labor" (Evans and Wilton, 2019:99).

The Club runs a café as part of a joint social enterprise with a housing association (explored briefly in the methodology chapter and in detail in the final empirical chapter). The Community Café (a pseudonym) enables The Club members on Transitional Employment Placements or in a supported employment role to interact with the 'wider community'. However, creating an inclusive environment for disabled individuals by engaging with the practices of a neoliberal capitalist system that has traditionally marginalised these same individuals can be fraught with difficulty. Trying to maintain a productive business whilst not pressuring workers to be 'productive subjects' is a problematic task, and as with IPS, the individuals that are more likely to be offered these supported employment positions may be those that are considered to be 'less marginalised' or 'less disabled' workers (Buhariwala, Wilton and Evans, 2015).

2.5 The Clubhouse Model

2.5.1 The Histories and Geographies of Fountain House

I have provided a detailed contextual history of work in relation to mental health care and treatment in a UK context from the rise of industrial capitalism until the present day. I am now going to contextualise the Clubhouse model of psychosocial rehabilitation, which emerged in a North American context. Whilst the backdrop of twentieth century Western capitalism was similar in the USA as in the UK context, the process of psychiatric deinstitutionalisation commenced almost three decades earlier in the USA than in the UK (Marshall, 1982; Dear and Wolch, 1987). In 1944, some former patients of the Rockland State Mental Hospital in New York City formed a mutual support organisation known as We Are Not Alone (WANA) as there was limited care or support for individuals with

diagnoses of SEMHCs within the 'wider' community at this time (Robbins, 1954). The mission of WANA, as well as supporting ex-patients living in the community, was to prepare currently hospitalised individuals for discharge (Anderson, S., 1998). In 1948, with the support of a wealthy benefactor, they were able to purchase premises, which they named 'Fountain House'. Once the building had been purchased, the Fountain House Foundation was instituted, with a board of directors comprised mainly of medics and wealthy advocates. In an attempt to establish staff and member parity, an ex-patient only board was also created, known as the Fountain House Fellowship. Fountain House determined that all service users at the house would be known as 'members' (Gorman et al., 2018) and initially Fountain House focused on educating members with 'life-skills' and functioned as a social space (Doyle, Lanoil and Dudek, 2013). Towards the end of 1940s, a Professional Advisory Committee was established at WANA, comprised of mental health experts working alongside the board of directors and an occupational therapy programme was established at Fountain House in 1949 (Anderson, S., 1998). Not long after this, with assistance from the Department for Vocational Rehabilitation, a programme that provided training in clerical skills was established.

In 1955, a social worker named John Beard was appointed executive director of Fountain House (Goertzel, Beard and Pilnick, 1960). Prior to joining Fountain House, he worked on a psychiatric ward in Michigan, and began to develop a methodology for 'mental health recovery', called 'Activity Group Therapy'. This approach involved Beard maintaining one-to-one interpersonal contact with patients, learning about and helping to develop patients' interests outwith their illnesses. Once these connections had been established, patients would be encouraged to undertake activities together in groups, with a focus on improving their strengths, rather than treating their illnesses (Beard, Goertzel and Pearce, 1958). This focus upon 'strengths' outwith the 'pathology' of illness automatically places all elements of an individual's personality and behaviour on a binary of strength or deficit, suggesting that at least some of the individual's character is 'undesirable' (Harper and Speed, 2012). After some time, Beard considered the possibility of finding employment for his patients. He managed to secure an agreement with the local supermarket to employ patients for a few hours a week; he did this by agreeing to stay with patients while they worked

shifts, and ensure that all the work was completed (Flannery and Glickman, 1996). Beard believed strongly in the power of work to 'normalise' individuals with 'psychiatric disabilities' and he adopted this approach in his role at Fountain House:

> "Work was also a normalizing factor for Beard. 'Normalcy' represented a powerful word in Beard's vocabulary… There was nothing unusual about going to work" (Doyle, Lanoil and Dudek, 2013:ch.2, para.14).

This emphasis upon 'normalcy' once again infers that at least some part of the individual with a diagnosis of a SEMHC is 'undesirable', as they are considered to be 'abnormal' until they engage in work. In contrast to the original principles of WANA, that posited that mental health recovery could be achieved through self-governance (Flannery and Glickman, 1996), Beard believed recovery could be achieved by working together to improve the conditions and functioning of the house. Beard changed the core functioning hours of the Clubhouse from the evening to daytime 'working' hours, and created two core member working groups, one dedicated to decorating and improving the interior of Fountain House, and a second involved in administration and clerical work for the house. Social activities were now encouraged to be external from Fountain House, and fully member-led (Beard, Schmidt and Smith, 1963). These changes were not wholeheartedly welcomed by the Fellowship, who began to feel their views were being neglected. One of the concerns of the Fellowship related to the introduction of the new work programme, they felt that it was forced, unpaid labour (Anderson, S., 1998). The Foundation board saw the Fellowship as being troublesome and enabling some members to wield too much power over the rest of the membership (Fisher, Beard and Goertzel, 1960). In 1956, it was decided by the Foundation board and staff that the Fellowship had become disruptive and needed to be dissolved (Karlsson, 2013). The Fellowship members were ejected from Fountain House during a meeting, and the locks to the building were changed overnight by staff (Anderson, S., 1998). Beard's ultimate goal was to achieve overall inclusivity, but to accomplish this, he believed that some members needed to be excluded and for decisions to be made by himself alone. He now had the freedom to reconstruct the programme of Fountain House without obstruction, and he continued to develop the day programme to prepare members for employment:

> "The [programme] utilizes the daytime hours at the Clubhouse for the purpose of helping the members establish and strengthen primary work habits and motivation for productive work, employment and eventual financial independence" (Beard, Schmidt and Smith, 1963:508).

This quotation further demonstrates Beard's desire for members' 'normalcy' through participation in work, as well as a desire to see members becoming economically 'productive subjects' (Rose, N., 1999b). By December 1956, a nine-to-five working routine had been established, with social events taking place on evenings and weekends (Anderson, S., 1998). In the summer of 1957 lunches began to be served in the House every day, being prepared, cooked and served by members under the guidance of staff.

Beard's next step was to introduce formal employment placements. Fountain House arranged placements with local businesses to allow members to engage in temporary employment. Members were selected for placements by Fountain House staff. The staff established criteria for individuals to fulfil before commencing an employment placement: this involved the member being pro-active in the day work programme at Fountain House, getting on with other members, and an assessment from the house psychiatrist was required to determine whether the individual was ready for employment (Anderson, S., 1998). To begin with staff would work alongside members when they first started out on placements to help them to train and to provide reassurance that members were on the right path. Most of the placements available were messenger roles, administrative roles, or factory jobs; they were all entry level, to be accessible to as many members as possible (Doyle, Lanoil, and Dudek, 2013). If a member was unable to attend their placement one day, a Fountain House staff member would cover the job until the member could return or another member could be recruited for the placement. Initially, these placements were organised informally, and there were no contracts between employers and Fountain House. However, by the end of 1959, twenty-two Fountain House members had successfully completed what had come to be known as Transitional Employment Placements (TEPs) (Beard, Schmidt, and Smith, 1963).

The process of psychiatric deinstitutionalisation, that was in full swing in the USA in the mid-1960s (Taylor, 1988) meant there was a greater demand for Fountain House membership. As the service grew, a purpose-constructed building for Fountain House was erected across the street from the original building. The membership of Fountain House grew significantly, and the closeness of a small community and feeling of inclusiveness waned. The staff realised that in order to maintain this intimate feel, smaller communities would have to be developed within Fountain House (Goertzel, Beard and Pilnick, 1960). These smaller communities became known as 'units' and were each ascribed different functions (Singer, 2002). By early 1960s, it became apparent that in order to survive in the mental health treatment field, Fountain House would have to demonstrate its success outwith its own front doors and attempt to teach its methods to others. The Social and Rehabilitation Services, a government agency, were searching for ways to engage the new and growing population of formerly institutionalised individuals in the community (Flannery and Glickman, 1996). After the move to the new building, several research studies were conducted by the Social and Rehabilitation Services and the National Institute for Mental Health (NIMH) to determine the true efficacy of Fountain House in promoting recovery and reducing hospital readmission. Although the results of these studies did not show a significant reduction in hospitalisations, they were able to demonstrate that individuals who joined Fountain House shortly after being discharged from hospital, and who remained engaged in the programme were less likely to be re-hospitalised and would be in hospital for a shorter time (Beard, Malamud and Rossman, 1978). These results were enough that in 1976, Fountain House received a five-year grant from the NIMH to formally introduce a national training programme to reproduce the Fountain House philosophy and methods (Karlsson, 2013). By 1980, over three hundred representatives from mental health care and treatment centres had participated in the training programme, and there were seventy-seven Fountain House-style programmes across the USA.

2.5.2 The Clubhouse Model

In 1980, the first 'international seminar' concerning the 'Fountain House' model was held in Pakistan, by the third seminar in 1985 in New York the term 'Clubhouse model' had begun to be used. By the fifth seminar in 1989, the

Clubhouse 'standards' which are used to "define essential elements" of what makes up a Clubhouse were introduced (Karlsson, 2013:12). A 'Clubhouse Expansion Project' that was designed to construct a "framework which transcended the leadership at Fountain House for strengthening and transmitting Clubhouse culture" (Anderson, S., 1998:175) eventually developed into the International Centre for Clubhouse Development (ICCD) in 1994. The role of the ICCD was to ensure Clubhouses across the globe were following the new Clubhouse standards, and an accreditation process was developed to ensure this. The Clubhouse standards relate to eight different principles: membership; relationships; space; work-ordered day; employment; education; functions of the house; and funding, governance, and administration. The Clubhouse model was not designed as an all-encompassing solution for mental health recovery and rehabilitation, it is intended to be used alongside other methods of treatment (Propst, 1992), therefore these standards are not designed to cover all aspects of mental health 'recovery'. These standards are reviewed every two years by accredited Clubhouses, to ensure they are still globally relevant and broadly applicable (Macias et al., 2001). The organisation once known as the ICCD is now called 'Clubhouse International' and will be referred to as such throughout the rest of this thesis.

For a potential Clubhouse to become accredited by Clubhouse International, the organisation is required to complete a form called a 'Clubhouse Profile Questionnaire'. This is a lengthy form that includes many sections that relate closely to the Clubhouse standards such as: organisation characteristics (origin, location, population served, budget), membership (number of members, referrals, and member characteristics), staff, space, work-ordered day (units, meetings), employment (numbers, types), education, functions of the house, and funding, governance, and administration (McKay, Yates and Johnsen, 2007). On the completion of the Clubhouse Profile Questionnaire, applicants that are considered likely to be successfully accredited are visited by a Clubhouse International representative and are required to undergo an inspection. Successful candidates receive an accreditation for either one or three years, depending on how compliant they are with the model (Moxley, 1993). If many changes are required for model compliance, a one-year accreditation will be awarded, so that the necessary changes can be implemented and another

inspection take place the following year. A three-year accreditation is the standard award given to Clubhouse compliant organisations. Organisations can gain and lose accreditations for a variety of reasons, including non-compliance, or a lack of membership fees paid.

To conclude this section, I will consider just a few of the key characteristics of contemporary Clubhouses as 'working communities' that are pertinent to the research objectives of this thesis. As I indicated in the introductory chapter, there are four principles or 'fundamental rights' for members attending Clubhouses: "the right to a place to come, the right to meaningful relationships, the right to meaningful work, and the right to return" (Staples and Stein, 2008:186). The Clubhouse is a "place-based intervention approach" (Jackson, 2001:40) which means that the Clubhouse has its own space outwith clinical mental health treatment spaces. This prevents any activity associated with 'treatment' occurring within the space, such as medication clinics or therapy groups. Furthermore, membership to the Clubhouse is voluntary, as are attendance and participation in any activity. Therefore, members have 'a place to come' where they are not required to talk about their 'illness', nor required to participate in activities if they do not want to, but are around other individuals who may have had similar experiences as them in relation to their mental health. The choice to participate, and to meet other individuals that one may have shared experiences with provides the opportunity to begin to form 'meaningful relationships' that are not focused on clinical encounters. Furthermore, as membership to the Clubhouse is lifelong, meaningful relationships are able to form over a longer time and makes the Clubhouse a "place to return" (Raeburn et al, 2013:377). Lifetime membership means that once a member has joined and been inducted into the Clubhouse, they are free to come and go as they please from the Clubhouse for the rest of their life, regardless of their level of mental health 'recovery'.

In fulfilling the 'right' of 'meaningful work' for members, the Clubhouse continues to draw on the ideas of John Beard's original day programme at Fountain House that prepared members for employment. The programme within Clubhouses is now known as the 'work-ordered day'. This concept structures the day within the Clubhouse, by dictating that the activities of the Clubhouse should primarily focus on "undertaking the tasks that are essential for the

running of the Clubhouse" (Craig, 2013:122). The work-ordered day assumes that individuals gain and regain skills and working habits by contributing to wider projects and by working alongside paid Clubhouse staff and other Clubhouse members (Jackson, 2001). The Clubhouse is open for 'normal' working hours (usually between 9am and 5pm) and staff and members work together to run the house: through preparing and cooking meals; cleaning and maintaining the house; undertaking any clerical, administrative, or business-related activities; and anything else that is required to 'maintain and enhance' the Clubhouse (Propst, 1992). The paid staff at the Clubhouse are 'generalist practitioners' whose main task it is to engage members in the work of the work-ordered day (Dougherty, 1994). This work is intended to be 'meaningful' for members because members can see how their work contributes to the broader community of the Clubhouse. To encourage members to attend, the Clubhouse is purposely understaffed, so that the paid staff alone cannot complete all the tasks of the work-ordered day without the help of members (Kinn et al., 2018). Therefore, the Clubhouse can only function with the assistance of members, so their presence is required in the Clubhouse frequently. Members are encouraged to undertake work tasks by staff, then when they have completed the task, staff will tell the member that their work is valued and required in the Clubhouse, and that they should continue to return to the Clubhouse to complete the task again in the future. This contributes to the member feeling a 'sense of mattering' (Conrad-Garrisi and Pernice-Duca, 2013) because their presence has been acknowledged, their work has been recognised and valued, and their presence has been requested again in the future. Within the Clubhouse model, this experience of a sense of mattering for the member is known as the 'need to be needed' (Doyle, Lanoil and Dudek, 2013).

The final Clubhouse element that is pertinent to this thesis and is also strongly drawn on Beard's principles for Fountain House, is the Transitional Employment Placement programme. This is a form of supported employment programme that operates within the Clubhouse and is exclusively for Clubhouse members. The idea of the TEP programme is to prepare members for returning to 'mainstream' employment' in 'competitive' workplaces in the future (Torres-Stone et al., 2016). The TEP programme is operated entirely by the Clubhouse, but placements are in 'mainstream' organisations and not held on the site of the

Clubhouse (Macias et al., 1999). The placements are part-time and time-limited, usually six to nine months in duration (Henry et al., 2001). Placements are intended to be 'entry level' so that members do not require extensive training to undertake the work (Clubhouse International, 2018). The placements are paid at the 'going' rate for an equivalent 'mainstream job' and always at least at minimum wage (Macias et al., 2006). The placements are managed by Clubhouse staff and there is 'guaranteed coverage' on placements, meaning that Clubhouse staff will cover the work of the placement if a member is unable to attend (Valkeapää et al., 2019). Finally, there is a high level of support on these placements with staff accompanying and supporting members on placements for as long as the member needs before they can attend independently.

2.6 Conclusion

I have presented an historical and geographical background to the landscape of mental health and work in the UK, in order to provide a social, economic, and political context within which my field site, The Club, can be understood. I have also offered a brief summary of the history of the Clubhouse model of psychosocial rehabilitation, to contextualise The Club within the specific framework upon which it was developed. This contextualisation chapter has provided a broad overview of the histories of work and employment in relation to the treatment and care of individuals' mental ill-health in the UK from the nineteenth century until the present day with reference to Foucault's framing of power relations. It has also offered various conceptualisations of the term 'community' in the context of mental health care and treatment, from the perspective of mental health practitioners, and then engaging with literature from mental health and disability geographers, acknowledging that this term is mobilised in different ways, and often in relation to discourses that encourage individuals with diagnoses of SEMHCs to get into 'mainstream' employment to become 'productive subjects' (Hall, E., 2004). These discourses are bound up in the ideals of neoliberalism and an individual's participation within a community is therefore linked to one's neoliberal subjectivity (Foucault, 2008).

The notion of 'work' in these 'mainstreaming' narratives is mobilised differently to the 'curative' power of work as configured in moral treatment in the early nineteenth century, however both of these forms of work impose 'normativity'

upon the individual and indicate that these norms can be achieved with 'self-discipline' (Foucault, 1995). This idea that the individual must take personal 'responsibility' to behave 'normatively' will be explored further in the next chapter in relation to discourses concerning 'recovery' from mental ill-health. This imposition of 'normativity' is also reflected in John Beard's promotion of the idea of 'normalcy' as a desirable outcome for an individual in Fountain House, that was also explored in this chapter. The Clubhouse model of psychosocial rehabilitation was developed from the practices and experiences of Beard's work at the original Fountain House Clubhouse, and now operates across the globe, with Clubhouses following a set of thirty-seven standards agreed upon by Clubhouse International. Beard's philosophy that the individual diagnosed with a SEMHC may achieve 'normalcy' through undertaking 'meaningful work' shares political undertones with the rhetoric which inspired the New Deal for Disabled People in the UK, through encouraging 'social inclusion' through paid employment.

It is possible for individuals to resist some of the 'normalising' discourses of neoliberal-ableism that are pervasive both in social policy and in mental health care and treatment spaces (Wilton, 2004b; Goodley, 2014) and this can be facilitated within certain spaces that act to 'buffer' some of the processes of neoliberalisation and provide room for individuals to assert agency (Bondi and Laurie, 2005). In relation to mental health care and treatment and *work*, these spaces might be third sector organisations, such as The Club, alternatively they might be social enterprises. Both types of organisation have the capacity to subvert neoliberal-ableist processes in various ways and become inclusive spaces for individuals with diagnoses of SEMHCs (Goodley and Runswick-Cole, 2015), whereas mainstream workplaces may still be marginalising. Understanding governmentality as an approach to 'power' that recognises power can be as 'facilitative' as much as it is constraining (Sharp et al., 2000), I acknowledge that 'work' within spaces of community care can have both positive and negative impacts upon individuals and their experiences of social inclusion or exclusion, and these experiences are often entangled. As such, I am deploying 'community' as a relational concept, that may be experienced differently by various individuals in various places and may be understood through relational practice between individuals in spaces of 'community care'. In the following

literature review chapter I will examine how ‘care’ has also been conceived relationally with reference to feminist science and technology studies and more-than human geographies, and therefore these concepts can be understood to overlap and intertwine within spaces of community care.

3 Conceptualising ‘Mental Health Recovery’ and ‘Care’

3.1 Introduction

In this literature review, I problematise the way that the term recovery has been conceptualised within psychosocial rehabilitation literature, drawing on the work of critical social scientists and academics within mad studies and critical disability studies to evidence my argument. As an alternative to ‘recovery’, I draw on theorisations of ‘care’ from human geographers to provide conceptual framing to understand how Clubhouses can be caring spaces that may *enable* recovery (Duff, 2016) without engaging with narratives that promote individualisation. The first section of the review attempts to trace the origins of ‘recovery’ in relation to mental ill-health, from the psychiatric survivor movement to its adoption in psychology, and then widespread use in mental health services and third sector organisations. I examine the evolution of the notion of ‘personal mental health recovery’ within psychology and psychosocial rehabilitation literature and explain the ‘CHIME’ framework for mental health recovery that was conceptualised by psychologists (Leamy et al., 2011). CHIME is an acronym standing for: connections, hope, identity, meaning in life, and empowerment. I examine these concepts and demonstrate that they are often used to mobilise a discourse of ‘responsibilisation’ that attempts to move the individual diagnosed with a SEMHC towards fulfilling their neoliberal subjectivity by engaging in paid employment (Rose, N., 1999a). However, I also acknowledge that this framework can be used in ways that are helpful and personally meaningful to individuals in distress and recognise that for an individual living within a neoliberal capitalocentric society (Gibson-Graham, 2006), living a ‘normal’ life may be what they desire in their personal mental health recovery.

In the next section, I discuss the term ‘care’ as it has been conceptualised within human geography. I consider feminist geographical perspectives of care which examine the hidden geographies of care that are usually undertaken within the home, traditionally by women. Following this, I explore the ‘ethic of care’ as understood by feminist scholars, and explain how this can help to frame ‘care’ as a concept that demonstrates the relationality and interdependency of all individuals, in opposition to the notion of a ‘rational autonomous subject’. I

consider that care has previously been conceptualised as temporally and spatially bounded (Bowlby, 2012) to certain phases of life and particular spaces. At the same time, I highlight that there are specific spaces *for* care, such as hospitals and care homes, and examine health and disability geographers' research that considers the operation of care at a variety of scales. In these 'caring' spaces, care may be experienced differently by different individuals, depending on their relations to: the space, others within the space, and the practices undertaken within the space (Conradson, 2003a). Mental health geographers concerned with disciplinary power have explicated that the caring relations within these 'caring' spaces exert different amounts of power upon different individuals, and to some extent may exert a level of 'control' upon some individuals as a form of 'controlful care' (Philo and Parr, 2019). I consider that care is both emotional and physical labour, that may be expressed as caring *about* and caring *for*. Finally, examining research from geographers studying 'affect', as well as feminist science and technology scholars, I think about how this emotional work may be understood to have an affective capacity in a relational understanding of care, and how we need to consider care as affective, practiced, and 'ethical' to gain a broader understanding of the relational landscape of care (Puig de la Bellacasa, 2017).

3.2 Problematising 'Recovery' in Mental Health Treatment Discourse

In the introduction to this thesis, I expressed that recovery broadly means living with as little 'distress' as possible (Brown and Kandirikirira, 2007), however it is a "polyvalent concept" (Pilgrim, 2008:299) that has been variously defined and interpreted by different mental health interest groups. Although defined differently across psychology, it has been generally accepted as a 'useful' term within psychosocial rehabilitation literature (Anthony, 1993; Davidson et al., 2005). Some third sector organisations have adopted and worked on a broad conceptualisation of the term helping individuals to "live a good life, as defined by the person" (Scottish Recovery Network, 2015:np). Some psychiatric survivor activists have acknowledged the broad aims of recovery as being laudable but reject the term as it is currently understood as "it has been corrupted by neoliberalism and capitalism" (Recovery in the Bin, 2016:np). Psychology literature acknowledges that the term originated from the psychiatric survivor

movement in the USA and was introduced to mental health treatment discourse in 1980s (Anthony, 1993), and has since been adopted and adapted in multiple ways. This has included the distinction between 'clinical' and 'personal' recovery by some psychologists (Slade, 2009). With clinical recovery the outcomes and 'success' of recovery is determined by clinicians, entailing a clinical gatekeeping of who is 'able' to recover. With personal recovery these outcomes are theoretically determined by the individual themselves, suggesting that anyone is able to recover. Medical sociologists have criticised this dichotomy for obscuring the 'normalising' aspects of personal mental health recovery that has been presented by policy discourse (see DoH, 2001; McWade, 2016).

The rhetoric of personal recovery also places the responsibility for 'recovery' onto the individual in distress. Recovery has been described as changing the power relationship between service providers and service users, 'empowering' service users to take control of their own mental health recovery (Gale and Grove, 2005). However, this implies that mental health service users are able to take control of their lives, which is inherently at odds with the notion of compulsory detention and treatment that are in place under the Mental Health (Care and Treatment) (Scotland) Act 2003. Recovery is often measured (in both clinical and personal frameworks) by the individual's reduced reliance on various mental health and welfare services (Harper and Speed, 2012) and outcomes tend to focus on the 'independence' and 'autonomy' of the individual. Therefore, services following a recovery model may focus upon aspects that are likely to make individuals less reliant on welfare, such as supporting them towards finding paid employment. Critical scholars in 'service user' research have argued that this view of recovery disguises the fact that nobody is ultimately autonomous or independent of support from other individuals (Rose, D., 2018).

3.2.1 Defining Mental Health Recovery

Pat Deegan (1988:11), an American psychiatric survivor-scholar and psychologist, uses the term 'recovery' to distinguish the "lived or real life experiences of persons as they accept and overcome the challenge of the disability" from the term 'rehabilitation', which she defines as the "services and technologies" that are available for individuals with diagnoses of SEMHCs. Deegan highlighted the

significance of recognising the individual in distress as an 'active subject' in the process of recovery from mental ill-health; as opposed to the traditional 'therapeutic encounter' where the psychiatrist or clinician has absolute power over the treatment of the patient (Goffman, 1961). Deegan goes on to state that this lack of agency is perpetuated by a dichotomous relationship between clinicians and patients, whereby clinicians cast themselves as 'normal' and cast patients as 'abnormal':

> "too often staff attitudes reflect the implicit supposition that there is the 'world of the abnormal' and the 'world of the normal'. The task facing the staff is to somehow get the people in the 'abnormal world' to fit into the 'normal world'. This creates an us/them dichotomy wherein 'they' (the disabled) are expected to do all of the changing and growing" (Deegan, 1988:18).

The dichotomy Deegan highlights is one outlined by Foucault (1995; 2004) in his historical analysis of institutions. He argues that these spaces enacted a form of 'normalisation' as control, by which individuals were disciplined using various techniques to strive towards a particular way of behaving, which was considered the ideal 'norm'. This is problematic because it suggests that the individual with a diagnosis of a SEMHC has to change themselves in order to 'fit in' with the rest of society, rather than society making changes to accommodate these individuals as they are. This places all the responsibility for 'recovery' onto the individual in distress, as they are the one expected to 'change and grow'. I have commenced this discussion of recovery with Deegan's work because the founder of the Center for Psychiatric Rehabilitation at Boston University, William Anthony (1993) credits psychiatric survivors (including Deegan) with introducing the idea of 'personal recovery' into wider mental health discourse. Despite his admission that the notion of 'personal recovery' came from the psychiatric survivor movement, it is psychologist Anthony's (1993) paper on recovery that is one of the most quoted in academic work on 'personal recovery' within psychiatric rehabilitation literature (Rose, D., 2014), having been cited over four thousand times overall to date (Google Scholar, 2020):

> "Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development

> of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993:15).

Anthony takes many of the ideas that Deegan (1988; 1993) identifies as core elements of recovery, such as: recovery is an individual and subjective process, recovery is not necessarily associated with an absence of symptoms, and recovery for the individual requires the support of others. However, in adopting many of Deegan's ideas, Anthony (1993) shifts the onus of responsibility for enacting them from a 'collective' responsibility between service users, clinicians, and services, solely onto the individual in mental distress, as he describes it as the individual's responsibility to 'change one's attitudes'. This is precisely the stance that Deegan expressed concern about in her argument against 'normalisation', that the individuals with diagnoses of SEMHCs should not be 'expected to do all of the changing and growing'. Critical social scientists and mad studies scholars have argued that the shift from collective responsibility to individual responsibility is a symptom of the 'mainstreaming' of recovery (Rose, D., 2014) meaning that it has become "deeply embedded with both the economic and social imperatives of contemporary neoliberalism" (Howell and Voronka, 2012:5). In the case of recovery, shifting responsibility from the collective to the individual both encourages the individual to draw upon their own resources to 'recover' rather than be a 'drain' on state-funded mental health services, and encourages the individual to strive for a personal subjectivity that enables them to be a 'productive subject' (Rose, N., 1999a).

3.2.2 Clinical Versus Personal Recovery

Within psychosocial rehabilitation literature, the framing of recovery as 'personal' to the individual is set up in opposition to what has been termed 'clinical recovery', when the recovery 'achieved' by an individual is "rated by the expert clinician, not the patient" and the form this recovery takes is not variable between individuals (Slade, 2009:35). Clinical recovery is criticised for expecting individuals to work towards "conforming to social norms" (Slade, 2009:50), with the suggestion that personal recovery does not do this, which mad studies scholars have argued "locate[s] 'personal recovery' as an adjunct to clinical recovery, and this complementarity avoids recovery being seen as inherently contested" (Harper and Speed, 2012:13). Medical sociologists have also criticised this psychological framing of recovery for proposing that 'personal

recovery' provides agency to the individual over their own recovery and standing as a companion to clinical recovery it "can be defined in such a way as to retain medical expertise and make individuals responsible for their own recovery" (McWade, 2016:63). Though Deegan (1988) advocates for a form of personal recovery that does not involve the individual in distress having to take all responsibility for their recovery, Anthony's (1993) paper suggests that the individual goes further than taking an 'active role' in their recovery, they are now solely responsible for their own wellbeing, regardless of the structural economic and social circumstances they may find themselves in (Lemke, 2001):

> "The meaning of recovery in this sense involves the person's assumption of increasing control over his or her psychiatric condition while *reclaiming responsibility for his or her own life*, a life that previously had been either subsumed by the disorder or taken over by others" (Davidson et al., 2005 emphasis added).

> "For the individual, it means having or developing a belief in oneself, *taking control over one's life*, having choice, self-confidence, the courage to take calculated risks and *to take appropriate responsibility for failures* as well as successes – in a nutshell, to have power" (Craig, 2013:125 emphasis added).

This narrative of individual responsibility is repeated in numerous quantitative, qualitative, and systematic review studies of mental health recovery within psychosocial rehabilitation literature (see Repper and Perkins, 2009; Oades, Slade and Amering, 2008; Piat et al., 2009; Noiseux and Ricard, 2008). I have selected the quotations above as these psychologists have also conducted research concerning Clubhouses and the Clubhouse model (Tanaka, Craig and Davidson, 2015; Craig, 2013; Tanaka and Davidson, 2015). This framing of recovery is already prevalent within mental health services, including Clubhouses, but it is also pervasive in the academic research concerning Clubhouses. Therefore, when 'recovery outcomes' are measured in a research study of Clubhouses, it will be most likely in relation to this particular discourse of recovery. This is significant, as I will draw on some of this Clubhouse research within my empirical chapters.

3.2.3 The 'CHIME' Framework

Leamy et al. (2011), a team of psychologists, conducted a systematic review of the literature surrounding 'personal recovery' in order to construct an empirically-based framework for this concept. Research papers included in the review were those that had a 'framework' or succinct summary of recovery, that was not explicitly clinical recovery; and were primarily published in psychiatry, psychology, psychosocial rehabilitation, mental health nursing and social work journals and texts. The framework they created is known as 'CHIME' and its principles are: "connectedness; hope and optimism about the future; identity; meaning in life; and empowerment" (Leamy et al., 2011:449). These rather vague terms have been identified by social policy scholars as not being strongly defined (Beresford, 2015), to support the idea that this is a framework that can be adapted for individual use, and as such places the onus of responsibility for recovery onto the individual, hence 'personal' recovery (McWade, 2016). The neoliberal processes which shape this framework, and encourage a striving towards individualism and productivity (Rose, D., 2018) are specifically warned against by Deegan in her initial examination of the 'lived experience' of recovery, as particularly harmful for individuals with diagnoses of SEMHCs:

> "For some psychiatrically disabled people, especially those who relapse frequently, these traditional values of competition, individual achievement, independence, and self-sufficiency are oppressive" (Deegan, 1988:17).

Deegan's paper was not included in the systematic review conducted by Leamy et al. (2011). Using a 'narrative synthesis' approach, the authors of the review identified that 91% of 87 studies reviewed considered 'personal responsibility' a key aspect of achieving mental health recovery (Evans and Wilton, 2019). The authors acknowledge that the review "favour[ed] individualistic over collectivist understandings of identity" (Leamy et al., 2011:450) citing 'cultural difference' between the UK and the USA (where many of the papers in the review originated) as the reason for this. Although the authors of this paper acknowledged some limitations of the 'CHIME' framework, it was created for future 'recovery-oriented research and practice', suggesting the authors intended it to be applied in mental health care and treatment settings. The 'CHIME' framework is now an accepted model for personal mental health

recovery in the UK and beyond, and The Club (2019:4) states that the "programme at The Club is built around the expressed needs of the membership and with a focus on the CHIME recovery model."

I am going to briefly consider the potential meanings of each aspect of the 'CHIME' framework, and how these may play out in a UK mental health care and treatment context, with reference to literature from health and disability geographies, critical disability studies and sociology. Connections, or social contacts, can potentially have a positive impact on mental wellbeing, if these relationships involve positive interactions (Wilton and Evans, 2016). However, facilitating social inclusion is sometimes equated with getting individuals to participate in paid employment, and as we explored within the previous chapter, for many disabled people paid employment is frequently an experience of social exclusion rather than inclusion (Hall, E., 2004) because 'normative' expectations of a productive worker require individuals to adjust to the workplace rather than making workplace adjustments for disabled people (Roulstone, 2015). Hope, as "the conviction that the future may be different from the present" (Anderson and Fenton, 2008:77) can again be a positive aspect of 'living well', assuming that individuals are able to pursue the goals that bring them hope. Whilst hope in itself is not problematic, the "recovery movement interprets [hope] in a particular way and it is with an ideological slant" that assumes that an individual's hopes in life will align with neoliberal ideals of productivity (Rose, D., 2014:217). If individuals have other hopes for their recovery, they may struggle to achieve these within the 'CHIME' framework.

Identity usually relates to how we are perceived by others (Goffman, 1956; Butler, 1988). Identity as a sense of 'self' is something that is continually needing to be worked upon, as we create ourselves as subjects in relation to our social and cultural context. This is more problematic for an individual with a diagnosis of a SEMHC, as their diagnosis as a 'label' suggests a 'spoiled identity' that can negatively impact the way in which they are perceived by others (Goffman, 1963), and therefore they need to strive for a 'normalised' identity outwith their identity of 'mental patient'. Individuals are often directed to forge this new identity through attempting to enter paid employment, in order to take on a 'worker identity'. This identity might be framed as becoming a 'productive subject' who is "an individual striving for meaning in work, seeking identity in

work" (Rose, N., 1999:244). This is similarly reflected in the next aspect of 'CHIME', in finding purpose and meaning in life. In order to access certain mental health services, individuals are expected to behave in particular ways, and choose 'recovery goals' that lead one towards becoming an economically productive subject. Critical social scientist Diana Rose (2014:217) describes this succinctly as the 'mainstreaming of recovery' and provides the example of the 'policing' of goals, saying "you cannot decide to go to bed for a month." Furthermore, the capitalocentric nature of Western society (Gibson-Graham, 2006) means that entering mainstream paid employment is considered a successful means by which individuals may achieve mental health recovery (Buhariwala, Wilton and Evans, 2015):

> "The ability to engage in meaningful activities such as work was also seen as an important aspect of recovering from mental illness" (Jacob et al., 2017:55).

The above quotation is taken from another review of the academic 'recovery' literature within psychology. The uncritical equation of work with meaningful activity, without establishing why work should be meaningful or under what circumstances it can be meaningful, perpetuates the notion that all forms of work may be conducive to mental health recovery. This is perhaps to be expected, as feminist political theorists have noted that work "is one of the most stubbornly naturalized and apparently self-evident elements of modern and late, or postmodern capitalist societies" (Weeks, 2011:43). However, the notion of 'finding meaning' can be important for individuals with diagnoses of SEMHCs, as long as this meaning is not wholly dictated by mental health services and professionals, or by a requirement to get into paid employment. Occupational therapists have argued that what is 'meaningful' cannot be stated as a singular definition as meaning is entirely personal and subjective:

> "the meaningfulness of an occupation can only be perceived and expressed by the individual who performed the occupation at that point in time and in his or her specific context and life" (Leufstadius et al., 2008:28).

Therefore, what is meaningful to an individual may include paid employment, particularly in a society in which paid employment is "idealised as a source of prestige, independence and dignity" (Frayne, 2019:123). The social and

economic status provided by this employment may enable the individual to overcome some systemic oppressions they may be living under, such as the stigmatised identity of 'mental health service user' (Goffman, 1963), even though such an identity should not be stigmatised in the first place.

The final strand of the 'CHIME' recovery framework is 'empowerment'. The multiple structural oppressions under which many individuals with diagnoses of SEMHCs live as outlined by mad studies scholars, which include but are not limited to: "biomedicalism, raci[sm], sanism, sexism, ageism, heterosexism," cissexism, and classism (Morrow and Weiser, 2012:28) mean that any kind of genuine "redistribution of power" (Harper and Speed, 2012:15) to these individuals is likely to improve their lives and overall wellbeing to some extent. Unfortunately, 'empowerment' within the 'CHIME' framework is usually presented as an individual endeavour, wherein the individual takes personal responsibility to 'take control' of their recovery, as in the 'responsibilisation' discourse (Rose, N., 1999a), and therefore this framing of 'empowerment' does not tackle broader societal inequality.

3.2.4 **Striving for Recovery**

As the 'CHIME' framework is so prevalent as a structure for personal mental health recovery in the UK and in Scotland in particular (see Scottish Recovery Network, 2015), there is some value in attempting to understand the ways in which recovery *might* play out through these aspects. There are ways in which all aspects of 'CHIME' can be achieved that do not require that individuals strive to become a productive neoliberal subject, such as searching for personal meaning through activities that are not 'paid employment'. Furthermore, as recovery is highly individual and personal, whilst I have been critical of the discourses of 'responsibilisation' and 'normalisation' that run through 'CHIME', there may be some individuals who find enacting their recovery in this way to become a 'productive subject' is conducive to their mental wellbeing, particularly in a society where having a diagnosis of a SEMHC does leave one at greater risk of discrimination and poverty, as noted by critical disability studies scholars:

> "practices which might be deemed as deeply normative (working, earning money, shopping, marriage) remain desirable for many people (disabled or not disabled). Being poor and wanting more money might smack of a neoliberal-ableist subjectivity to those of a crip persuasion. To others it is a matter of life and death" (Goodley, 2016:201).

In writing for the Scottish Recovery Network, Brown and Kandirikirira (2007) highlight that whilst a 'normal' life may be what some individuals find meaningful, the notion of 'feeling normal' is not the same as *being normal*. Therefore, what feels normal for the individual could be something entirely 'unreasonable' within 'larger society', and what 'recovery' means for an individual likewise might not *appear* recovered to mental health care and treatment professionals:

> "Recovery need not mean 'being normal' but accepting your madness and making the most of it when you can often because you have the first-hand experience allowing support to others when in similar distress. This is the basis of real peer support… This is not to say that 'normality' is not a goal of many – the situation is complex" (Rose, D., 2018:737).

For the purposes of the empirical chapters in this thesis, there will be times when I make specific reference to certain discourses or literatures of 'personal mental health recovery', particularly the 'CHIME' framework within psychology (Leamy et al., 2011). However, more broadly, when I write of 'recovery' in relation to my research participants, it will be however they self-identified with the concept, if they did at all. In some cases, this may include a desire to be 'normal', or to get into paid employment. In thinking about how to counter neoliberal-ableist discourses of recovery, I am now going to conceptualise the term 'care'.

3.3 **Conceptualising Care**

Geographical research has had an increased focus upon care since the turn of the twenty-first century, with several edited collections being published in geographical and social science journals including several special editions in *Social and Cultural Geography* considering: the 'spaces, practices and experiences' of care (2003), the 'care of the body' (2011), 'gendered spaces of commoditised care' (2013) and 'placing care in times of austerity' (2018).

Additionally, there have been special editions considering 'postcoloniality, responsibility and care' in *Geoforum* (2009), the 'ethics of care' in *Ethics, Policy and Environment* (2010), 'troubling the geographies of care and control' in *Area* (2019), and 'stretching the boundaries of care' in *Gender, Place and Culture* (2019).

Care has been within the remit of health geography for some time, "in ways that go beyond matters of [health care] access and provision" (Parr, 2003:212). Some of this work has been considered in the contextualisation chapter in relation to 'care in the community' (Milligan, 2003) and focuses on the configuration of practices of care in institutional settings (Cornish, 1997), and attempts to reconfigure this care for community settings (Parr, 2000; Conradson, 2003a). Outside of this research, feminist geographers have taken inspiration from other feminist social scientists to understand 'care work' as something that has been firstly ignored, then undervalued in its productive potential. Geographers have considered the commodification of care work and the lived realities of this for those providing the care (Pratt, 2012) and those receiving it (Hall, E., 2009). Feminist geographers have also focussed on thinking through the nature of care relations between individuals, highlighting our responsibility as geographers to centre care, as a challenge to neoliberal autonomy (Lawson, 2007). Geographical work has considered the spaces of care, which can include institutional spaces of care (Milligan, 2005) to more informal or non-institutional (Conradson, 2003a) to private spaces such as the home (Williams 2002; Brown, 2003). This work has opened up a number of debates, including the nature of care as public or private activity (Cox, 2013a), the implementation of care as a form of control (Philo and Parr, 2019), and attempts to attend to the emotional and affective aspects of caring (Puig de la Bellacasa, 2017).

3.3.1 Care Work

The concept of care has been of interest to feminist geographers as the *work* of care has traditionally been hidden, ignored, or devalued within discourse that encourages the formation of individual neoliberal subjectivity and promotes the notion of a 'rational autonomous individual' (who is traditionally white, male and heterosexual) (Brown, 2003). Feminist geographers have contended that 'work' has been conceptualised as labour that takes place in male-dominated

workplaces and has ignored the labour that takes place within the space of the home:

> "a gendered division of labour is not only a key feature of the organization of unpaid work in the home and the locality but is also a fundamental feature of the organization of production, albeit taking different forms at different times and in different places" (McDowell, 2004:148).

Traditional hetero- and mono-normative gender roles that delineated men as 'breadwinners' and women as 'homemakers' within a household led to this 'gendered division of labour', whereby only the labour that appears to be economically productive (male labour) is seen as 'work' (England and Lawson, 2005):

> "Caring is 'given' to women: it becomes the defining characteristic of their self-identity and their lifework. At the same time, caring is taken away from men: not caring becomes a defining characteristic of manhood" (Graham, 1983:18).

This binarism not only devalues the work that takes place within the domestic sphere, but also elides the fact that many women, and especially working-class women, have long participated in productive labour alongside undertaking the work of the home (Cockburn, 2005). The work of the home entails caring for the space of the home and those within it, which includes but is by no means limited to cooking, cleaning, and childcare (McKie, Bowlby and Gregory, 2001). Feminist scholars have described this work as 'reproductive labour', arguing that this work of the home is not only just as valuable as the 'productive labour' of male workers but is in fact essential to it, as those undertaking economically productive labour are only able to behave as 'productive subjects' because they and their home space is cared for (Hochschild, 1983).

Feminist geographers have been particularly interested in the way that reproductive labour, which has traditionally been unpaid, has been 'commodified' and 'outsourced' to other individuals who are paid for this labour (Cox, 2010). Several geographical studies have focused on the experiences of female transnational migrants moving to undertake domestic work, such as Geraldine Pratt's (2012) research with Filipina women working as nannies in Canada and Rosie Cox's (2011) research of au pairs and nannies in the UK. This

care work is still highly undervalued and underpaid, as the "gendering of care work is closely linked to the devaluation of care" (Bondi, 2008:249):

> "The commoditised provision of care muddies the boundary between public and private, revealing their problematic relationship. It also exposes the political nature of the public/private divide—a division which is clearly implicated in gender inequalities but also produces and is produced by unequal relations of class and ethnicity" (Cox 2013a:492).

The multiple intersectional inequalities that still 'devalorise' the productive capacity of marginalised groups means that this undervalued care work is undertaken mostly by working-class women, women of colour, and migrant women (McDowell, 2009). However, postcolonial geographers have also called for a greater focus on the transnational migration of 'professional' care workers to challenge the "simplistic representation of migrant women from the Third World as being almost exclusively incorporated into First World households" (Kofman and Raghuram, 2006:297). This call has been answered to some extent by geographical research considering the caring work of transnational migrant nurses in the UK (Batnitzky and McDowell, 2011; England and Henry, 2013). This research has demonstrated that even in 'professionalised' roles such as nursing, the care work that these workers do is undervalued and underpaid, and these workers experience "discrimination in a combination of overt, covert and systemic ways" (England and Henry, 2013:570). Therefore, it is imperative to move towards an understanding of care that works against political and economic processes which "preserve inequalities of power and privilege, and… degrade 'others' who currently do the caring work in our society" (Tronto, 1993:101). To increase the value placed upon care work, we need to have an understanding of care that emphasises the interdependent nature of care relations between individuals.

3.3.2 Care Ethics

Geographers have taken inspiration from other feminist scholars in developing a 'care ethics'. A feminist ethic of care was developed in order to counter the notion that the boundaries of human morality should be pre-determined from a set of un-contextualised principles or rights:

> "These boundaries require that morality be derived from human reason in the form of universal principles that are abstract and formal. They require that the social and political connections to morality not be counted as central to morality itself. They require that morality be rigidly separated from personal interest" (Tronto, 1993:27).

Carol Gilligan (1982) first used the term 'ethic of care' to argue that 'ethical behaviour' should be based upon caring relations, as opposed to a set of pre-defined morals determining what is 'just'. However, Joan Tronto (1993) argues that 'moral responsibilities' and a sense of care for others can and should work alongside each other. Significantly, Tronto's work is intended to refute the notion that any moral decision is made wholly rationally or as an autonomous individual. Instead, we should consider the individual being held within a contextual set of dependent relations tied up in place and with multiple human and non-human others:

> "Moral life is not a distinct and autonomous realm of human endeavor; it arises out of the ongoing practices of a group of people. Morality is always contextual and historicized, even when it claims to be universal" (Tronto, 1993:62).

This argument states that we cannot rely solely on a set of moral principles to guide our ethics, as these principles do not account for intersectional difference, or situational context. Therefore, centring the concept of 'care' can help to guide us morally, based upon the notion that by caring for the humans, non-humans, and environment around us, we will act in a way that is morally responsible (Tronto and Fisher, 1990):

> "Feminist care ethics assert the absolute centrality of care to our human lives: we are all in need of care and of emotional connection to others. We all receive care, and throughout our lives, many of us will also give care. In short, care is society's work in the sense that care is absolutely central to our individual and collective survival" (Lawson, 2009:210).

Focusing upon care as a set of interdependent relations demonstrates that all individuals are care-givers and care-recipients in various ways, at different times and in different spaces (England, 2010). This notion that we are all 'needy' can be used to counteract the fallacy that any individual is truly autonomous or independent (Popke, 2006):

> "to require care is to have a need; when we conceive of ourselves as autonomous, independent adults, it is very difficult to recognize that we are also needy… we prefer to ignore routine forms of care as care is to preserve the image of ourselves as not-needy" (Tronto, 1993:120).

Geographers have engaged with the feminist 'ethic of care' because it "helps us to embed relational thinking across proximity and distance" (Raghuram, 2016:515). Geographers have used the notion of a relational care ethic to consider care at a variety of scales, from intimate care (Brown, 2003), to local and neighbourhood care (Conradson, 2003a), to transnational caring relations (Datta et al., 2010), as well as understanding our caring relationships with non-human others (Donald, 2018; Ginn, 2014). Furthermore, an ethic of care is a "way of theorising spatial relations in an ethical register" (Raghuram, 2016:515), thereby providing an ethical framework upon which geographers can think about 'responsibility' (Massey, 2004):

> "Care ethics foreground the centrality and public character of care activities and so reframe responsibility. This reframing involves challenging neoliberal market logics that intensify the marginalization of care by expressing (seemingly) everything in terms of personal responsibility or competition between communities. Care ethics calls attention to the ways in which neoliberal discourse, government policy, and laws have effectively privatized responsibility rather than politicized it" (Lawson, 2007:3).

I am engaging with the term 'care' within this thesis to counter the trope of the autonomous individual striving for neoliberal subjectivity (Staeheli and Brown, 2003) that has become pervasive within discourses of personal mental health recovery and has been encouraged through welfare-to-work policy in the UK in recent decades. In doing this I hope to engage with a "wider social ontology that opens the possibilities for a relational response to intersecting oppressions" (Lopez, 2019:834). Furthermore, I wish to demonstrate the ways that care is enacted relationally between individuals within the space of the Clubhouse.

3.3.3 Spaces of 'Controlful' Care

The "devaluing of any form of dependency within our society" (Cox, 2013b:494) means that the concept of 'care' has been 'relegated' to specific spaces (hospitals, hospices, day centres, care homes) and temporalities (childhood, old

age, an acute illness phase), in order to 'bound' it, and to deem it as something that is only for 'dependent others' (Bowlby, 2012). Of course, some individuals may be more reliant on 'formalised' care than others, and these individuals are often those that are found in 'care spaces' such as residential care homes. Mental health geographers have noted that over the second half of the twentieth century, the 'spaces of care' for individuals with diagnoses of SEMHCs have moved from the (relatively enclosed) asylum (Pinfold, 2000) into the 'wider community' (Milligan, 2000). In moving from an 'institutional' to 'community' model of care in mental health we can understand care as relational and unbounded but still inherently *spatial*. Therefore, we can identify sites where formalised care takes place to be 'nodes' within a greater landscape of care:

> "landscapes of care refer to the complex embodied and organisational spatialities that emerge from and through the relationships of care," (Milligan and Wiles, 2010:740).

Feminist geographers have intimated that 'care' operates within a 'relational landscape', therefore we can imagine it to function at a number of scales, from the individual, to the community, to national frameworks, and international networks (McEwan and Goodman, 2010; Massey, 2004). In spaces dedicated to the care of individuals with diagnoses of SEMHCs, care can be viewed as action between individuals, these individuals are interacting in a wider 'caring space', that in turn is implicated in a wider network of care (including other care spaces, healthcare providers, the home and familial care), and these are subject to best practice guidance and legislation to ensure they "contain the right sort of care" (Parr, 2003:219). What the 'right' sort of care may be is of course not fixed, and while it may be legislatively informed by care guidelines and limited by financial constraints, it is neither provided in a single way or experienced equally by every individual:

> "care is woven into the fabric of particular social spaces and communities, at times supporting individuals and facilitating their well-being; at times breaking down and leaving significant gaps; and often requiring very significant amounts of effort" (Conradson, 2003b:453).

The work of geographers has thus been helpful in explaining how places of care-giving are constructed in specific social, cultural, and spatial formations,

meaning each place will offer a distinct form of care. Furthermore, care is not experienced equally, and what may be a caring space for one individual may be the opposite for another (Conradson, 2003a). These relational experiences of care are entirely contingent not only upon the space but on who is within the space giving or receiving the care and the "interpersonal interaction between" them (Conradson, 2003a:518). Furthermore, spaces designed for care-giving are exclusionary in various ways, either by design or in practice. In a hospital environment, only those who are deemed sick enough to require treatment are 'entitled' to care, therefore excluding those who are deemed to be 'well' (Andrews and Evans, 2008). Other spaces may be intentionally exclusionary to some in order to protect (and therefore care) for others. In Parr's (2000) study of a community-based mental health drop-in service, individuals would occasionally be excluded from the drop-in for 'deviant' behaviour, indicating that the provision of care and access to caring environments can be contingent upon individuals obeying the rules of the space and conforming to certain behavioural norms. Therefore, care relations are highly complex and imbricated in "both brutal and more delicate and subtle relations of power" (Bowlby, 2012:2102), in terms of one's ability to access care, and the form that this care takes. In acknowledging power-relations, we must consider the ways in which care can be both "constraining and facilitative" (Sharp et al., 2000:2). This is particularly prescient in spaces of care for individuals with diagnoses of SEMHCs, given the institutional history of treatment for 'mad' individuals:

> "To speak of care and control as entirely different processes is thus in error: rather, each folds into its other… engendering institutional spaces conditioned precisely by this deep doubling of care-and-control logics," (Philo, 2017:26).

Philo is referring specifically to an institutional space, however these 'care-and-control logics' have carried over into the community-based forms of mental health care and treatment, and whilst these logics unfold in different ways, it is still true that "care can exert control and… control can often succeed in igniting care" (McGeachan, 2019:201). Therefore, a deinstitutional community space that is not connected to compulsory mental health treatment or the criminal justice system may be conceptualised as a space of "controlful care" where "low-level mechanisms of control" are enacted in various ways (Philo and Parr,

2019:245). This spatialised interpretation of care and control will become important in the examination of The Club in the empirical chapters.

3.3.4 Care as Practice

Geographers have also interrogated the practice of care. Conradson (2003a:451) has conceptualised care as both "physical and emotional labour", highlighting that care does not take a singular form and is both felt and practiced. This attention to both physical and emotional labour has become increasingly important in a deinstitutionalised landscape of care, where care is delivered in a variety of ways, in a variety of settings, has become ever more commodified (Cox, 2013a; Power and Hall, 2018), and individuals in receipt of care now have greater control over the kind of care they can access (Hall, E., 2009). We can understand the physical practices of care as caring *for,* and the emotion involved in undertaking this care as caring *about:*

> "'caring for'—that is, tasks of care—as well as 'caring about', which refers to emotional investment in another person's problems and concerns. Clearly the two are related but 'caring about' does not necessarily lead to 'caring for' while 'caring for' can occur without 'caring about'. However, the experience of 'caring for' often leads to 'caring about' someone. Caring can involve both practical and emotional care, often simultaneously" (Bowlby, 2011:606).

Many feminist geographers have researched the *practiced doing* of care (Atkinson, Lawson and Wiles, 2011), as indicated in the first section of this review of care, considering the 'hidden' work that takes place within the space of the home (Cox, 2013b; Pratt, G., 2012; McDowell, 2009). Care may be embodied practice that occurs through physical proximity, such as cooking for another person (Johnston and Longhurst, 2012). Practices of care can also take place at a distance, through telecommunication and more traditionally through letter writing (Longhurst, 2013). As care takes on many forms in many different spaces, it can be carried out for a number of motivations: love, fear, duty (including contractual obligation) (Green and Lawson, 2011), and the 'physical' care cannot be separated from the notion of the 'emotional':

> "Emotions are part and parcel of caring – they are both necessary and inevitable elements of 'good' care but are also central to 'bad' care… the emotionality of care means that the possibility for a carer or the

> cared for to exploit, manipulate or give pain to the other is inherent in care relationships" (Greenhough, 2010:135).

In more formal 'spaces of care' the immediate motivation to provide care is usually a contractual obligation, staff in these spaces are paid to provide a service of care. This contractual obligation already frames the emotional interpersonal relation between care-giver and receiver, if the staff member does not enjoy their job, or they feel undervalued and are underpaid for the care they undertake, this will impact their emotional relation to the care (Milligan, 2005). Moreover, giving and receiving care may be a 'better' experience for both parties if they feel that the other person is 'likeable' or friendly (Bowlby, 2011). Therefore, the emotional relation one has with care is vital to the way that care is experienced, and can have influence upon the 'care and control logics' within the space:

> "Emotional work is thus seen to represent a mechanism through which order can be maintained… Such a mechanism employs elements of both nurture and control" (Milligan, 2005:2107).

Milligan, like Philo (2017) is referring to an institutional setting, and the way that care is practiced in a deinstitutionalised space of care is more blurred (Milligan, 2003). Practices of care, such as making a cup of tea, do occur in spaces of community care such as drop-in centres, but 'personal care' tasks, such as bathing and clothing do not occur in these spaces and the individual practices of care may be harder to identify. Therefore, in attempting to characterise the way that care is enacted and experienced in a space of 'community care', I favour a relational approach that enables us to examine the practices in conjunction with the emotions associated with these practices, whilst acknowledging that both of these sit within broader frameworks of power that shape the way that care can be undertaken and experienced (Milligan and Wiles, 2010).

3.3.5 Care and Affect

Feminist science and technology studies scholar Puig de la Bellacasa (2017) invites us to take the physical and emotional aspects of care and situate them in an ethico-political framework that enables us to understand care relationally,

but also identifies when these practices (caring for) or emotions (caring about) are not quite enough to constitute care on their own:

> "affectivity – not necessarily positive – is part of situations of care, as oppressive burden, as joy, as boredom. Staying with these tensions exposes that vital maintenance is not sufficient for a relation to involve care, but that without maintenance work, affectivity does not make it up to care and keeps it closer to a moral intention, to a disposition to 'care about', without putting in the work to 'care for'" (Puig de la Bellacasa, 2017:5).

The practice of care is not always enough to 'make it up to' care, the emotional intent must also be present, even if this emotion is not 'positive'; conversely one can care about someone else without acting upon this feeling to undertake a care practice. In formalised care spaces, both of these formations are possible, though it is perhaps more likely that a paid care-giver will care *for* the recipients of care, without necessarily caring *about* them. In attempting to 'stay with the tensions' of care, particularly in research that studies a space of 'community care', I want to consider the notion from feminist scholars which suggests that emotions may also be understood relationally as coalescing within spaces of care:

> "emotions do things, and they align individuals with communities—or bodily space with social space—through the very intensity of their attachments" (Ahmed, 2003:26).

This communal 'emotion', not individually expressed, may be considered 'affective'. The notion of 'affect', particularly in its relation to emotion, is by its very nature difficult to define in written terms, as it is "beyond… epistemological certainty" (Dewsbury, 2009:23).

Geographers considering affect have taken insight from non-representational theories which pay attention to embodied practice (Thrift, 2008; Bissell, 2010) and the body's "force for existing, capacity for being affected" (Deleuze, 1988:128):

> "Nonrepresentational theories… encourage us to think of spaces and places in terms of their enactive composition through practice… to find ways of making more of the affective qualities of these spaces… the important question is how to cautiously reaffirm experience as a

> source – however modest – of conceptual, empirical, and ethico-political experiment" (McCormack, 2013:xi).

Although the critical philosophies of Foucault are seen by some non-representational geographers as 'averse' to the notion of affect (Thrift, 2006), Ben Anderson (2010) engages with Foucault's (1978) conceptualisation of biopower to demonstrate how affect is a "condition for subjectivity" (Anderson, B., 2017:2). As biopower is understood to be processes that both promote conformity and encourage the subject to be recognised as 'normative', then "the abnormal is fabricated as a threat that must be corrected or regulated" (Anderson, B., 2010:32). This 'threat' is then expressed as a collective 'affect', which is not quite a 'feeling', but more a 'pre-conscious' intensity:

> "intensities that are only imperfectly housed in the proper names we give to emotions (hope, fear)… it is the very ambiguity of affective atmospheres – between presence and absence, between subject and object/subject and between the definite and indefinite – that enable us to reflect on affective experience as occurring beyond, around, and alongside the formation of subjectivity" (Anderson, B., 2009:77).

As these intensities or 'affective atmospheres' are experienced, such as a 'fear' of a non-normative 'Other', this affect then works to continually (re)constitute the power of conformity, as those who are considered to be 'normative' attempt to demonstrate their 'normative subjectivity' to those around them. Ben Anderson (2014) uses Foucault's (2006a) description of a communal 'great fear' of a 'sickness' as a collective affect, that led to the social construction of the concept of 'madness':

> "Suddenly, in the space of a few years in the mid-eighteenth century, a fear emerged. It was a fear formulated in medical terms, but deep down it was animated by a whole moral mythology. People were in dread of a mysterious sickness that apparently emanated from houses of confinement and was soon to spread throughout the cities" (Foucault, 2006a:355).

This fear is indicative of an 'atmosphere' through which "a represented [subject] will be apprehended and will take on a certain meaning" (Anderson, B., 2009:79), such as an individual being inscribed as 'mad'. Affect, then, can be a means of trying to discern power relations within a space or a population, and how these power relations influence the construction of a 'normative' subjectivity. This is not to suggest that affects *are* power, rather they occur

alongside power, they are constituted by power and they in turn constitute it. However, as "affect always exceeds understanding and conceptualisation […] it precedes signification and the formation of meaning" (Bissell, 2010:82), affective atmospheres can be difficult to discern, therefore I do not wish to overstate their potential in determining power relations. They may serve as an indication that power is being exerted, rather than providing an insight into exactly how the power is being expressed or experienced.

In bringing the discussion back to care, I want to think again about the 'ethic' of care and the possibilities of affective atmospheres in relation to care:

> "A care-centered theoretical perspective is thus premised on a *relational* conception of subjectivity, which stands opposed to the autonomous rational subject of individual rights and responsibilities" (Popke, 2006:506, emphasis in original).

If identity is constructed 'relationally' (Massey, 2004), and individual subjectivity is formed through our relations to other people, spaces, and structures of power; then a space in which one feels cared *for* and *about* is more likely to create a 'positive' sense of identity. It is not that care *is* the affect, rather care is the relation, and the affective atmospheres are formed with and through these relations. Therefore, in a space where care is felt (both given and received) and practiced, this atmosphere may be one that is experienced positively (such as something close to 'hope' or 'love'). Of course, in spaces where practices of 'controlful care' are exercised, these relations are more complex, and an atmosphere of 'hope' may co-exist with an atmosphere of 'fear' (fear of the 'Other' and fear of becoming the 'Other').

Criticism has been levelled at studies of 'affective' geographies by emotional geographers as eliding the importance of the emotional geographies of individuals (Tolia-Kelly, 2006). In attempting to understand care as relational, I choose to shift my focus to the affective, as it might be more successful in elucidating "the ways more collective emotional experiences contribute to the (re)creation of space and place" (Little, 2019:211), particularly in considering the practices of caring *for*. At the same time, I acknowledge the importance of emotional geographical work in influencing these understandings of affect (see Anderson and Smith, 2002; Bondi, Smith and Davidson, 2005) and that in trying

to “pin down” either emotion or affect definitively I would not be doing justice to either of these “fuzzy concepts” (Bondi and Davidson, 2011:595). Nevertheless, in trying to understand the relations of care (controlful and otherwise), the concept of affect can help to represent the parts of fieldwork that often seem ‘unrepresentable’ or ‘indefinable’. Furthermore, in trying to understand how members navigate their own identities and constitute their subjectivities: as Clubhouse members, as ‘patients’, or as workers and productive subjects; understanding the ‘atmospheres’ of the Clubhouse can elucidate the social and spatial relations that inform these subjectivities.

3.4 **Conclusion**

‘Recovery’ has a particular significance both within mental health discourse and the Clubhouse model. It has been engaged with differently by various interested parties; from psychologists, to third sector mental health organisations, to psychiatric survivor activists. In coming from ‘psychiatric survivor’ roots (Deegan, 1988), recovery was soon theorised within psychology and psychosocial rehabilitation literature (Anthony, 1993), and placed within a ‘responsibilisation’ framework (Rose, N., 1999a) that expected the individual in distress to take all responsibility for recovery, to become a ‘normal’ member of society. The notion of normalisation is inherently problematic, by suggesting that an individual needs to ‘recover’, this infers there is something ‘wrong’ with them, that casts them as abnormal (Foucault, 2004). However, I also recognise that individuals with diagnoses of SEMHCs do experience extreme distress and there can be a very real desire to be ‘normal’. We can find recovery to be productive as a concept when we do not strongly define what ‘normal’ is or what personal meaning in life might be (Rose, D., 2018). Unfortunately, welfare-to-work policy has meant that achieving this ‘normalisation’ is often presented as returning to ‘mainstream employment’, which as we have previously explored, can be very difficult for many disabled individuals. The ‘CHIME’ conceptual framework for personal mental health recovery has been adopted by third sector organisations in the UK, including by The Club. ‘CHIME’ encourages an ‘individualist understanding’ of recovery (Leamy, et al., 2011), that also infers individuals with diagnoses of SEMHCs should take responsibility for their own mental health recovery.

In trying to think beyond the notion of 'normalisation' I conceptualise the term 'care'. Examining geographical considerations of 'care work', I have evaluated research that demonstrates that the labour of care has been undervalued within Western societies which value individualism, rationality and autonomy (England, 2010). Therefore, through adopting a feminist ethic of care (Tronto, 1993), I have attempted to offset the neoliberal 'responsibilisation' narrative of recovery by indicating that no individual can be an 'autonomous rational subject' (McWade, 2016; Lawson, 2007) and therefore each individual's potential to become a 'productive subject' is tied up in the care relations that they participate in. In understanding 'care' as relational, I want to demonstrate that all individuals are dependent upon one another to some extent, therefore, to be cared for is 'normal' (Bowlby, 2011). Within a space such as a Clubhouse, the care that takes place is not necessarily identifiable as individual practices (though of course these do occur), rather it is through the 'affective atmospheres' within the space that care may be elucidated. Furthermore, these affective atmospheres may help to illuminate the processes of power that are taking place within the space, including processes of 'controlful care' (Philo and Parr, 2019) that regulate the behaviour of individuals in an effort to keep them safe. In understanding the Clubhouse as a space of 'community care' and a 'working community', the 'normalisation' discourse of recovery frequently comes into tension with this atmosphere of care. This shall be explored in the context of The Club in the second empirical chapter. Through this literature review my aim has not been to 'replace' the term 'recovery' with the notion of 'care', rather I hope to demonstrate through the empirical chapters that thinking of the Clubhouse through caring relations rather than through individualised notions of recovery may help to better demonstrate the positive impact The Club has upon the lives of its membership.

4 Methodological Framework and Fieldwork Methods

4.1 Introduction

Human geographers have embraced qualitative methods as these techniques are "attentive to the ways people make sense of the places they inhabit and to their understandings of the meaning of action" (Hay, 2020:1). Qualitative methods are intended primarily to uncover subjective meaning, rather than to take any quantifiable measurement. There have been multiple reviews of the use and application of different qualitative methods in the *Progress in Human Geography* journal over the past two decades considering methods such as: interviews (Dowling, Lloyd and Suchet-Pearson, 2016; Hitchings and Latham, 2020a), ethnographies (Hitchings and Latham, 2020b), more-than-representational methods (Dowling, Lloyd and Suchet-Pearson, 2017; 2018), participatory research (Davies and Dwyer, 2008; DeLyser and Sui, 2013) archival research (Dwyer and Davies, 2010); and broader methodological considerations such as positionality (Crang, M., 2003), and methodological rigour (Crang, M., 2002; 2005). Qualitative methods may now be said to dominate the discipline of human geography (Hitchings and Latham, 2020a), as such I am going to consider the use of these methods within the geographies of mental health specifically, which utilises methods that are widely adopted across human geography, but also attends to the specificities of undertaking research with individuals with diagnoses of SEMHCs.

Although many of the early studies in mental health geographies built upon the quantitative spatial epidemiology work of early twentieth century sociologists, research considering the experiential geographies of mental health has favoured qualitative methods as:

> "Attention to the lived experiences of those with mental health problems… [is] necessary in order to articulate how the story of madness and illness is not simply, or just, one of exclusion, subjectification and outsiderness" (Parr, 2008:12).

Engaging with qualitative methods involves the collection and analysis of 'textual' data, wherein the textual refers to that which is not numerical, such as

written, visual, or audio and video material (Rose, G., 2016). Research methods may include but are not limited to: interviews, focus groups, ethnography and participant observation, archival and documentary analysis, videography and photovoice. These methods are considered valuable for research with 'marginalised' groups such as individuals with SEMHCs or disabled individuals because they "facilitate the elucidation of subjective meanings attached to social circumstances" (Wilton, 2004a:30). Moreover, these methods can 'centre' the individuals at the heart of the research and contextualise them as "embodied, as thinking, as feeling, as acting and as more than just a container for information about geographical patterns and relationships" (Parr, 1998a:343).

Parr (1998b:30) explains that a variety of adaptable techniques and methods need to be adopted within research with individuals diagnosed with SEMHCs to "be responsive to different ways of self-representation (on the part of the respondents) and their different 'ways of being' in time and space." One such method of attending to these ways of being that I adopted in my research was to undertake in-depth interviews with participants. Health geographers have noted how in-depth interviewing can "reveal the [participants'] relationship to the complex layering of environment, through their accounts of illness experience" (Dyck, 1999:121) and is therefore appropriate in a geographical research project, where consideration of individuals' perceptions of and relationship to space and place are paramount. Interviews have also been used by disability geographers for "building narratives of the everyday geographies" (Hall, E., 2004:300) allowing the researcher to create a detailed and complex picture of the lived experiences of these individuals. However, geographers researching mental health have also implied that interviews need to be undertaken with caution, to centre "on the individual and their socially, as opposed to medically focused world" (Pinfold, 2000:203), as many individuals diagnosed with SEMHCs may have much experience at participating in medical 'interviews' with a variety of 'psy-professionals'. Therefore, researchers are at risk of reminding the individual of previous negative experiences (if these medicalised interviews were so) or of eliciting primarily 'medicalised' narratives of the experiences of individuals, rather than their personal views of their social and spatial worlds (Parr, 1998a).

Other methods often adopted by qualitative social scientists researching the lives of individuals diagnosed with SEMHCs are ethnographic techniques, including participant observation. Knowles (2000a, 2000b), a sociologist, who undertook ethnographic work with individuals with diagnoses of SEMHCs in Montreal, Canada, explains how ethnographic work can help to 'fill in the gaps' of everyday life that are not elucidated through conversation:

> "Ethnographic observation revealed the gap between practice and talk; between living and telling stories about life… there are things that remain unsaid, not because they cannot be said, but because they are not said. Instead they are embedded in the habitual, the taken-for-granted background assumptions of living, which are beyond narrative. Living is essentially a practical activity: it is 'done' rather than reflected upon and hence not necessarily told as narrative" (Knowles, 2000a:17).

As ethnographies are in-depth studies concerned with the relations between people and place, in addition to filling in the 'narrative gaps' in the lives of participants, they can also offer rich descriptions of environments, and the ways that people interact in these spaces. Estroff (1981), an anthropologist who conducted a long-term ethnographic study in a Program for Assertive Community Treatment for individuals with diagnoses of SEMHCs, in Madison, Wisconsin, USA explains that ethnographic methods centre the research participants as the experts in the field of study:

> "The anthropological fieldworker customarily attempts to learn and to reach understanding through asking, doing, watching, testing, and experiencing for herself the same activities, rituals, rules, and meanings as the subjects. Our subjects become the experts, the instructors, and we become the students" (Estroff, 1981:20).

This is significant for research with marginalised groups, such as individuals with SEMHCs, as the subjective meanings and experiences of these individuals are often overlooked. Considering research participants as the 'experts' in the topic of research reminds the researcher to constantly 'centre' participants in the research throughout ethnographic work, where there are a lot of data to record, and a lot of activities to be distracted by. Parr (1998a, 1998b, 2000), a geographer, who undertook both overt and covert ethnographic work in a variety of semi- and non-institutional spaces for individuals with diagnoses of SEMHCs in Nottingham, England, explains that attempting to fill in these 'narrative gaps'

through observation and participation may require “geographic research practices being messy, evading neat, organizing frameworks and not progressing according to a tidy developmental model” (Parr, 1998b:29). This reflects my own experience of attempting to undertake ethnographic work within the Clubhouse, and the ‘messiness’ inherent to this research will be explored later in the chapter.

In this chapter, I will outline the methods of data collection and analysis I adopted to address my research questions. I detail the qualitative methods I used in conducting my fieldwork: ethnographic participant observation, documentary research, and one-to-one semi-structured interviews with members and staff. I explain the practicalities of carrying out these methods in the field, and the decisions I made in deciding when it was (in)appropriate to deploy one or more of these methods at certain times or with certain individuals. I then describe the methods of analysis I used to interpret meaning from the data that informs the upcoming empirical chapters. Following this, I detail the formal ethical procedures this research was subject to, the practicalities of mobilising these procedures in the field, and the decisions undertaken to maintain an ethical approach throughout the fieldwork and broader research process.

The next section will consider my epistemological position as a feminist social geographer attempting to conduct in-depth multi-method qualitative research at a field site. In deference to the messiness of the process, I will do this by writing through the ‘doing’ of fieldwork, exploring a methodological mishap that occurred early in the process. I weave my ethical anxieties, and the formal and informal means by which these were managed and alleviated through this section. Ethical concerns are inherently tied up in my own positionality, which in turn informs my epistemological framing. Attempting to ‘rationalise’ qualitative social science ethnographic fieldwork into a linear narrative does not do justice to the complex relations that make up the field, nevertheless I will attempt to disentangle some of the conscious decisions I made and the consequences these had from the wider processes taking place in the field.

After this I introduce my research field site, The Club. I will consider the histories and geographies of the space, follow its progress to becoming a Clubhouse accredited with Clubhouse International, and review their status as a

third sector organisation, and the way they are funded. I explore the growth of the membership over the years, evaluate the criteria for membership, and how this is influenced by the impact of being a 'shadow-state' service (Wolch, 1990). Some diagrams of the site are included at the end of the section to provide a visual spatial representation of The Club. I determine how the work units are organised within the Clubhouse, what each unit is responsible for, and how this influences the work-ordered day. Finally, I briefly consider the Transitional Employment Placement programme that The Club operated.

Following this, I provide details about the two short field visits undertaken at sites outwith The Club. Whilst I do not consider this research project a multi-sited ethnography, as the other visits were so short, the data collected on these visits offers a means of comparison, that demonstrated other potential possibilities and configurations than the realities in The Club. These visits showed how a Clubhouse ethos might operate in environments with different populations, spatialities, and employment opportunities to The Club. These visits also helped develop my understanding of the Clubhouse model and its implementation in a UK context. I conclude with a reflection about the lasting impact that fieldwork can have on the researcher, and the importance of this in the evolution of a doctoral project from its initial conception to its completion. The uncertainty that lies in many aspects of undertaking qualitative fieldwork can be difficult for researchers, but it is this mutability that continues to enliven social science research.

4.2 Methods

4.2.1 Ethnography

Ethnographic methods comprise a range of field techniques, that derive from "an extended, detailed, immersive, inductive methodology intended to allow grounded social orders, worldviews and ways of life gradually to become apparent" (Cloke et al, 2004:188). While specific methods may vary, there is consensus that for research to be considered ethnographic, it must consist of an extended period of participant observation wherein "the researcher spends considerable time observing and interacting with a social group" (Herbert, 2000:551). With the cultural turn in human geography it was conceived that the

more-than-representational might best be understood through performative practice and material representation itself (Lorimer, 2005). To this end, Thrift (2000) suggested a refiguring of ethnographic methods from 'participant observation' to being 'observant participant', in order to enliven the ethnographic into practice. This is a move from passive witnessing to active partaking. While my epistemological framing is not led by more-than-representational theories, I consider them to figure "as a background hum, asking questions of style, form, technique and method, and ushering in experimental kinds of response" (Lorimer, 2008:556). It would be remiss not to acknowledge these particular geographies in my understanding of how humans interact with each other and non-human subjects in a more-than-human world. I do not privilege my own visceral experiences of being and working in The Club, nor the materialities and agencies of the non-human subjects in the space because my epistemological aim of conducting emancipatory research leads me to prioritise the voices of my participants. However, the acknowledgement of my own flesh inhabiting and interacting with the space of The Club is important in re-affirming my subjective position as part of a method that provides an "intersubjective" understanding of one's research (Watson and Till, 2010:121).

My ethnographic approach in The Club involved much more than just observing. I often took on work tasks, both in my anxious desires to facilitate the work-ordered day, but also to glean a better understanding of what The Club is and what the work-ordered day does. Participating in the work also better facilitated observation and conversation with members, it was much easier to see what was going on in the kitchen if I offered to help with lunch preparation. This participation also helped to better focus my conversations with participants, both in formal interviews and informal conversations. This active participation in work tasks did not take the place of questioning members on their own personal experiences of work tasks. For example, I would not assume that I intersubjectively understood what it would be like for a member to work at the till at the café, rather working on the till myself allowed me to tailor my questions to members about their experiences of working on the till. Participating gave me a better (though of course still subjective) frame of reference within which to interpret members' responses, but it did not help me predict what those responses might be. Offering myself up for participation also

meant being able to ask members to show me how to do certain tasks, allowing rich descriptions from their perspectives of how certain work tasks should be done. Finally, a willingness to 'get stuck in' allowed me to ingratiate myself with members and staff better and alleviated my fears about disrupting the work-ordered day.

I conducted my ethnographic fieldwork as an observant participant between July 2017 and August 2018. For the first two months of fieldwork, I attended The Club one day a week, for members to become familiar with my presence in the Clubhouse. From September 2017 onwards, I attended The Club three days a week, from approximately 9am until 4pm, covering the work-ordered day. I focused most of my time in the upstairs of the house, where the work and learning unit is located, but I also used the downstairs space to attend meetings and for working in the kitchen. Overall, my ethnographic fieldwork constituted over nine hundred hours of 'observant participating'. For ethical reasons, I made the active decision not to record everything that I observed during my fieldwork period, this will be explored further in the consideration of research ethics later in the chapter. I created a 'field note form' that I used as a guide each day for writing up notes. A blank copy of this form can be found in Appendix A at the end of the thesis. This form provided tick boxes, to allow me to note quickly which regular meetings or groups had taken place within the structure of the work-ordered day, and an area to lay out anything that was noteworthy or outwith the usual structure for that day of the week. After this, I listed a set of headings, under which I could write notes pertaining to the subjects of my research objectives. These headings (including 'education', 'relationships', 'recovery') may be thought of as etic categories, these are broadly descriptive terms related to the research objectives for the project that were introduced by the researcher prior to the start of fieldwork (Crang and Cook, 2007). Beneath these headings was the slightly forbidding heading 'other comments' in which I wrote any other observations or descriptions of events that did not directly fall under any one theme heading but seemed important to note. This area was also where I would note down my own emotional reflections of fieldwork. Beyond the cathartic experience that this provided it is also important in an ethnographic account to take note of our emotions and understand the ways in which this might shape the fieldwork process and interpretation of the data collected

(Vannini, 2015). In a research project such as this, conducted over an extended period and considering 'sensitive' topics, this reflection is essential.

4.2.2 Documentary Analysis

In addition to my time spent participating in and observing the work-ordered day, a portion of my time at The Club was spent trying to unearth the history and workings of the space. Much of this data was used to sketch out the histories and geographies of The Club. Whilst some of this was achieved through oral history in casual conversations, and some through the 'doing' of the participation in the work-ordered day, much of the specific data, particularly related to available TEPs and membership was gleaned through a thorough search of both soft and hard format documentary data contained within The Club. The Club has a wealth of material, ranging from a member produced newsletter to minutes from meetings, to house policy and procedure documents. I did not set aside a single time or day each week to complete this work, rather as I got into the 'rhythm' of my ethnographic fieldwork I became better attuned to which times of day there would be a lull of activity and therefore I might be able to do this work. Early in the morning, or at the end of the day were prime hours to search for and read through these materials, as there were fewer members in the Clubhouse to interact with. I did not undertake a specific form of analysis or coding when approaching this documentary work, rather it was a close reading that took place during ethnographic fieldwork, taking note of key historical events, and data that was pertinent to TEPs. As such, most of this data is not explicitly referenced throughout the empirical chapters, rather it is 'written through' the text in the descriptions of the space and processes of The Club. We may consider this work to be a "make-do method" providing a contextual landscape for the other methods (Lorimer, 2010:258).

Ogborn (2010:92) has argued that "any place where such records are kept so that they may be used as sources of information is thought of as an archive." Unlike many 'traditional' archives, the body of documentary data to which I had access was not curated, and whilst much material within it was historical, it was still 'live'; having meeting minutes and various other documents added to it on a daily basis. As Cloke et al. (2004) have noted, a frequent issue with accessing 'non-official sources' of documentary data is that records are often incomplete,

with documents both paper and digital being lost, or incorrectly filed. This was a common experience in my documentary analysis. Meeting minutes provide a particularly pertinent example of the variety of quality, style, and indeed presence of such documents in the 'archive'. Meetings were a staple of the work-ordered day, and minutes were meant to be kept at each meeting. Minute-taking was considered a work task and therefore offered up for members to undertake. I was not aware of a 'house style' for minute-taking, or of a guide or training for minute-taking and different members and staff would take minutes in a variety of fashions, from very limited notes to incredibly detailed accounts. After each meeting, handwritten minutes were placed in a document tray to be typed up at a later date. Typing was also a work task for members to undertake. Members would take the handwritten minutes from the tray and proceed to type them on a word-processor. Frequently these members would not have attended the meeting that the minutes related to and would sometimes misinterpret some of the handwritten minutes due to difficulties in reading handwriting. Often if I was in attendance at a meeting, I would offer to take the minutes, this would prompt me to follow the meeting closely to better record the details in my field notes later.

This is only a single example, but this issue was endemic with a lot of documentation that was produced in-house. The digital filing system was also somewhat unclear, which was something that The Club was trying to address during my fieldwork period. Documents that were created for usage outwith the internal workings of The Club were more likely to be complete. The Club policies, annual reports, and the newsletter were far less fractional, though there was still not a full historical record of these. Documents dating from before the early 2000s were rarer, in part due to a lack of computer access within The Club from this time, some may also have been lost during the move to the current premises. Despite the gaps, this documentary information helped to colour the landscape of The Club for me and informed my understanding of the space in my fieldwork and in the writing process.

4.2.3 **Interviews**

Interviews have been a staple method in geography for decades, though as McDowell (2010) notes, our approach to conducting them, the kind of data we

hope to elicit from them, and most particularly the importance of researcher positionality in the interview has moved to privilege individual stories and acknowledge the role of the interviewer in the representation of these stories. As a 'conversation' between researcher and participant, we can consider the knowledge produced throughout the interview process to be co-constructed (Crang, M., 2005). The interviews I conducted with The Club members and staff were semi-structured, I had a prepared list of questions to ask participants related to my broader research objectives. For the most part these questions did not need to be asked in a specific order, and I allowed the interview to move onto other topics that participants raised, or I might ask additional 'unscripted' follow up questions. Employing a semi-structured interview technique was intended to elicit more specific and targeted responses related to my research questions than was generally possible in seemingly more 'natural' ethnographic encounters.

Once a member had agreed to be interviewed, I would take them to the '1:1 room' within The Club (see Figure 2 later in the chapter), explain the purpose of my research and what the interview would involve. I asked participants to read an information sheet (see Appendix B) or I offered to read it out loud to them. I explained that my questions to them would be asking about their experiences of work within and outside The Club, and their experiences of being a member. I clarified that everything they told me would remain confidential, they would be assigned a pseudonym to remain anonymous, and that they were able to withdraw from the research at any time, during or following the interview. They could also choose not to answer any questions I asked if they felt uncomfortable discussing certain topics. I requested if they would agree to the interview being audio recorded and asked them to sign a consent form (see Appendix C).

Using interview schedules (see Appendices D and E) helped to alleviate my own anxieties as a researcher-in-training (Petersen, 2011) but adopting a semi-structured approach hopefully reduced anxiety on the part of participants, as the interviews remained informal. I would begin with a few 'easy' closed questions to begin with to get a conversation flowing, such as: "how long have you been a member of The Club?" Once my participant and I had both 'landed' into the space of the interview I would ask open-ended questions allowing for a greater level of depth to the discussion. Not every question was asked of each

participant, I directed questions based on previous answers, to delve further into topics they had begun to elaborate on and omitting questions that they had answered already through a previous response. Other elements directed these interviews as well, time being a significant factor. In general, I would let the participant speak for as long as they wished but where interviews ran to nearly two hours in length, I attempted to direct my questions in order to bring the interview to a close. In other cases, I would know that the member or staff member had only a limited time to talk to me, and so I tailored the interview schedule to ask a few 'key' questions, usually related to experiences of work, working, and TEPs for members, and questions concerning the running of The Club and TEP supervision for staff.

I conducted twenty formal semi-structured interviews with The Club members, seventeen of these were audio recorded and transcribed, three were only recorded by note-taking during and immediately after the interviews. I am not going to provide a list of anonymised interviewees and their demographic data, such as age or ethnicity, as I believe this could leave some of the participants vulnerable to personal identification. All participants ranged between twenty and seventy-five years-old at time of interview, fourteen were male and six female. Whilst this does not represent an even gender split, it more closely represents the demographic of The Club, that had a significantly greater proportion of male members than female at the time of my fieldwork. Throughout my empirical chapters I will refer to participants by their pseudonyms and indicate how long they have been a member at The Club. Where it is important to the discussion, I may include other details concerning their work histories and current work status. There were several frequent Clubhouse attendees that I chose not to ask to participate in an interview, as I was not certain that I would be able to attain genuine 'informed consent' from them. I will elucidate my process of obtaining and maintaining informed consent in greater detail in my discussion of ethics later in the chapter. This decision may mean that my project neglects to attend to the voices that are already most marginalised, however as a doctoral student, where I am myself still tentatively negotiating the 'how-to' of qualitative research, I felt this was the most ethical course of action. For members that I considered 'vulnerable', I felt that I could not guarantee that the benefit of taking part in my research would

outweigh, or at least balance the potential harm that could also occur in the course of an interview. There were some individuals that I deemed 'too vulnerable' and therefore "ethically out of reach" (Parr, 2001:165). I am aware this is problematic in a research project that aims to amplify the voices of marginalised individuals.

Reflecting on my interviews now, I believe I made the correct decision in choosing not to interview the individuals I deemed 'vulnerable'. Not only would I probably have been unable to do these individuals justice through this research if they were not verbal communicators, some of the interviews that I did undertake elicited emotional responses from my participants. The questions asked throughout the interviews were not intentionally emotionally provocative, however, they did require individuals to consider their personal histories, which for many members was traumatic. If members did become upset, I would allow them the space to pause and would ask if they wanted to stop the interview. In every case, members were content to pause briefly, or we would spend some time discussing what had upset them before continuing with the interview. Compounding the potential emotional issues of this research, using interviews to prompt conversations about employment is inherently complex. Parr and Stevenson (2014) discuss the intricacies of interviewing families of individuals who had been reported as missing; not only is this topic of discussion highly emotive for participants but the notion of the interview itself is bound up in complex emotions, as families will have already endured the process of police interviews. I was conscious of discussing topics such as the anxieties members experienced in relation to job interviews in the context of a research interview. However, the relatively informal nature of my interviews, in conjunction with the fact that all participants had met and had spoken at length with me prior to participating in a research interview helped to alleviate this potential issue.

In addition to these interviews, I had multiple hours of conversations with members as part of my ethnographic fieldwork, including those who took part in interviews but also many others. Two members, who were regular and long-standing attendees, offered valuable insight into The Club, and of living with a diagnosis of a SEMHC in Glasgow. While these individuals are not quoted directly, nor will I refer to them explicitly throughout the empirical chapters, their contribution needs to be acknowledged. I also conducted semi-structured

interviews with four staff members of The Club, two male and two female, all of these were audio recorded and all participants anonymised as much as is possible. The policy of 'purposely understaffing' the Clubhouse (Kinn et al., 2018) meant that finding times that staff were available to be interviewed was difficult, and some of these interviews took place outwith the hours of the work-ordered day, and outside of the Clubhouse in my office at the university. I focused my interview recruitment on full-time staff members, who all had some connection to the work and learning unit, as this was most pertinent to the questions I wanted to ask of them.

4.3 Data Analysis

As I move to consider the processes of analysing and interpreting my data, I must acknowledge that these processes began long before the 'official' analysis stage of the thesis writing process. Geographers have argued against traditional linear understandings of thinking about, collecting, and making sense of data; instead suggesting that "we analyse and interpret from the minute we decide to tackle a particular research topic, and bring with us an outsize range of baggage prior to even reaching that point" (MacKian, 2010:159). I have already mentioned some of the 'etic' themes that have shaped this project from its conception. In addition to these, processes of data 'sifting and sorting' were already taking place in the course of data collection:

> "Field-noting is an ongoing sense-making process. It is a process of creative writing based on first-hand experience. It involves attempts to tie together minutiae of theoretical and empirical detail gleaned in and between the different locales of a project's expanded field" (Cloke et al., 2004:218).

The nature of doing such deep ethnographic work at a single site meant that I was undertaking this sense-making for many months before I sat down to 'do the analysis'. I felt that I had a clear grasp of my data and initial ideas for themes and concepts to be constructed and explored, but I welcomed the opportunity to refresh my memory by transcribing interviews verbatim. However, the process of listening back to these interviews was uncomfortable. I cringed at my interview technique and chastised my past self for not asking certain follow-up questions during interviews, or for not showing as much empathy to participants as I felt was warranted on listening back. This clumsiness in technique, hopefully

forgivable for a researcher-in-training, was in itself another way that I had unconsciously 'sifted and sorted' my data. By asking certain questions, and not asking others; by empathising with some participants and alienating others I had already constructed some themes and suppressed other possibilities.

I entered my interview transcripts and ethnographic field notes into NVivo qualitative analysis software. Then I commenced a process of iterative thematic coding. I started with the etic themes that I had determined, based on key terms that I had intended to research, such as Clubhouse, work, and recovery. I also decided upon other codes based on concepts or terms that were frequently mentioned, or in written materials, that I came across during the course of fieldwork, which may be considered to be 'emic' themes. As noted by Agar (1980) the terms 'etic' and 'emic' are not unproblematic, they create a binary in which the researcher is 'outsider' and participants 'insider' within research. It has been long since established that this binary is unhelpful, and many feminist geographers have described the relationship between researcher and researched as one of 'betweenness' (England, 1994; Katz, 1994) constituted both through sameness and difference (Rose, G., 1997a). It is still useful to acknowledge the 'etic' and the 'emic' in a reflexive understanding of researcher positionality, but it must be acknowledged that my intersubjective relationship with participants and the space of The Club mean that the codes contained within each of these supposedly binary opposites overlap and are repeated. Not only has my ethnographic experience and conversations with members shaped my understanding, but my questions posed in interviews and in informal conversations will have also shaped participants' responses. Therefore, I followed Cook and Crang (2007:140) by adopting a "general drift" approach to coding with themes that were emic, etic, and frequently both.

After this initial open coding I enlisted a process of casual axial coding (Fielding, 2001). Rather than use NVivo to analyse the data, I created a coding report from NVivo and went through this document manually. Whilst perhaps not the most efficient method of coding (the report was more than one hundred pages long), it allowed me to really spend time with and read through the open coded data again, seeing where the repetition occurred, and noticing where I might have 'over coded' certain data, ascribing more meaning to some quotations than was perhaps warranted. Using software for axial coding highlights the strongest

relationships but can obscure overzealous interpretation. From the coding report I was able to identify the data that, from my perspective, best addresses the research objectives of this thesis.

4.4 Ethical Considerations

4.4.1 Formal Ethics Procedures

As mentioned in the introduction to this chapter, the methodological process can often be messy and appear at odds to the highly structured procedures and "organised frameworks" preferred by institutions and research councils who have a vested interest in research practice (Parr, 1998b:29). Nevertheless, these procedures and frameworks are vital to reduce the likelihood of harm to research participants, and to enable mitigation to be put in place for when research does not go to plan. In my research, I applied for and received approval to conduct my research from the College of Science and Engineering Research Ethics Committee at the University of Glasgow during the first year of my doctorate in 2017, and my research design observed the Economic and Social Research Council research ethics framework (ESRC, 2010). I am going to outline the formal ethical processes and procedures followed in this project, and the realities of attempting to conduct research ethically in practice.

In undertaking the University of Glasgow College of Science and Engineering research ethics review process, I attempted to construct a research design that would cause limited disruption to the work-ordered day and the routine of members. In completing this application, I drafted an information sheet for research participants and a participant consent form (previously mentioned and shown in appendices B and C) to demonstrate how I would achieve informed consent from my research participants undertaking interviews. I also explained the ways I had attempted to mitigate the risk of causing harm in the course of undertaking my ethnographic research. By conducting the research within The Club, I hoped that members would be comfortable within the environment, and that my presence would cause limited disruption. I indicated that if my presence was ever disruptive or distressing to any members, I would withdraw from the field for that session and avoid using any field notes collected from that session. In practice, this did not need to be exercised. I stated that participants would be

informed of the type of data being collected, the overall purpose of the study and the policies for data protection, anonymity and confidentiality. I also explained that if at any stage a participant chose to withdraw their contributions to the research, all data I had collected relating to this individual would be destroyed. In the event, no individuals chose to withdraw from the research. I further stated that all participants would be anonymised by pseudonyms that I had chosen, and that any personal data relating to them would be stored securely and separately from the research data.

In my application, I noted that research that involves qualitative methods asking for individuals' opinions always carries the risk of causing distress. I explained that I would attempt to mitigate this by thoroughly preparing for interviews and taking care to reflect the language of my participants and avoid terms that may perpetuate stigma in relation to mental ill-health. I confirmed that I would be available to be contacted by participants after interviews were conducted, both in person and by email. Finally, I also stated in my research ethics application that I would conduct short field visits at other Clubhouses, and that I would provide a similar information sheet to that used in The Club to explain my presence to members at these sites. I did not intend to conduct formal research interviews at these sites, nor include the data from these sites in the final thesis, as these visits were for my own contextual understanding only. My research ethics application was approved with no suggested amendments by the review committee, and the procedures laid out within it were beneficial in ensuring I could adopt a harm-minimising approach when I began conducting my fieldwork. However, these formal procedures alone do not guarantee that research is conducted ethically, and it is not possible to foresee all potential mitigations that may be required. Therefore, these ethical procedures required renegotiation throughout the data collection, analysis and thesis write-up stages. In addition to committing to review and improve the ethics of this research throughout the project, I attempted to adopt an ethical approach from the point I first conceived of this research, when I began writing my application for doctoral funding in 2015.

4.4.2 Ethics in Practice

My interest in the relationship between mental health and work had been piqued during my time as a volunteer at The Club earlier in 2015, and I had the Clubhouse in mind as a potential research site when I began drafting my research proposal. As I already had an established volunteer relationship with The Club, I arranged a meeting with the CEO to discuss the possibility of establishing a research relationship with the Clubhouse. I explained my research objectives and proposed research methods, and the CEO was open to my proposal. In this meeting he stated that to undertake my research at The Club, I would need to present my proposal to Clubhouse members, and they would make the final decision about my project. This was consistent with the Clubhouse model ethos of shared decision-making and full member participation (Clubhouse International, 2018). The CEO requested that I attend a 'house meeting' to present my research proposal, and if the membership approved my proposal by consensus decision I would be able to undertake my research within the Clubhouse. I prepared a short presentation and delivered it at a house meeting, clearly outlining my research objectives and my intended approach. The members approved my proposal by consensus, and I included The Club as an intended field site within my research proposal.

By presenting my research proposal to The Club membership, my approach to gaining consent for this research was intended to be overt and compliant with Clubhouse procedure. However, there are several issues to this approach that require consideration. Firstly, whilst house meetings are the forum at which decisions are made within the Clubhouse, only a small proportion of Clubhouse members attend these meetings. Therefore, whilst my project was approved through a formal Clubhouse process, it was only a small number of members who provided explicit consent to my proposal. Members who were not in attendance at this house meeting did not get the opportunity to provide their consent for my presence in The Club. Secondly, I cannot guarantee that all those in attendance at the house meeting fully comprehended and consented to my research, even if they voted in approval of my proposal. These meetings could be quite overwhelming, requiring those in attendance to process a significant amount of information in a short space of time, and sometimes it may have been easier for members to follow the consensus in a decision rather than raising opposition.

Finally, the 'messiness' of the fieldwork process (Rose, G., 1997a) means that research is often required to change and adapt from an initial research proposal or design, therefore the presentation I provided at the house meeting is not wholly representative of the research process I undertook in practice when I entered the field. I will examine the impact of adopting a flexible research design in greater detail in the next section of this chapter.

I was aware of these issues when entering the field, therefore I undertook several steps to attempt to ensure that my research was transparent and that I obtained and maintained informed consent from Clubhouse members as much as possible, and exercised caution in my fieldwork practice when I was not certain that gaining informed consent was possible. I produced a short information leaflet written in plain English that explained why I was attending the Clubhouse, the objectives of my research, my contact details and the contact details of my supervisors, and a photograph of myself. I made many copies of this leaflet and distributed them within The Club just prior to beginning my fieldwork, so that members would be aware of who I was and why I was in The Club. Upon entering the field, I introduced myself and my research at a morning meeting within The Club and attempted to do this every time I encountered a member for the first time. Throughout my fieldwork process I explained my research to anyone who asked why I was attending the Clubhouse. Despite this, I cannot be certain that I always had fully informed consent from all members of The Club throughout my fieldwork, therefore I undertook further measures to attempt to maintain an ethical approach within my ethnographic research. I did not take note of everything that I observed within the Clubhouse, particularly when I did not think that members were aware of my presence, or when the members involved were unaware of who I was. There are also some things I chose not to record in field notes when I felt that I would not be able to protect the identity of the individuals involved through anonymisation. I wrote my ethnographic field notes to serve as an aide-mémoire for my own understanding of the procedures and functions of the Clubhouse, therefore it was not essential to take note of everything that took place within The Club. Field diary excerpts within the empirical chapters in this thesis are used sparingly and not gratuitously; I have attempted to use extracts that help to elucidate a particular point of interest within the research. Furthermore, nobody is referred to by

their (real or anonymised) name within these ethnographic extracts, they are demonstrative vignettes intended to provide a 'lively' description of The Club, rather than tell the story of any specific individuals.

In maintaining this ethical approach, I made the further decision to focus my ethnographic research on the Clubhouse alone. Other ethnographic research undertaken with individuals with diagnoses of SEMHCs has taken a more involved approach, in which the ethnographer accompanies individuals in multiple settings including clinical and domestic spaces (Estroff, 1981; Knowles, 2000a; 2000b). As my research focused on experiences of work and the function of the Clubhouse, there was no need to observe or participate in the lives of members outwith the space of The Club. Furthermore, an element of my harm-minimisation approach relied on restricting my ethnography to within the Clubhouse, as this was a space that members were familiar with, within which they felt safe, and where there would always be other members and staff present. I did consider accompanying members on transitional employment placements, as these were a great example of members' experiences of work. As these placements were organised through the Clubhouse, and because members were accompanied by The Club staff at the start of a TEP, I considered that attending TEPs alongside members could be an extension of The Club ethnography. However, I chose to abstain from conducting ethnographic fieldwork on TEPs, instead trying to focus on member experiences of TEPs in my interviews instead. I was concerned that my presence at placements may be disruptive for members at a time when they may be particularly nervous; these placements were often very important to members and potentially a significant personal milestone in their lives. To get a 'flavour' of how a TEP may function, I attended The Community Café as a customer on several occasions, to see how the place operated, though I did not shadow any members on TEPs there, nor did I spend any time in the kitchen area watching them work. I would not take ethnographic field notes here either, usually visiting The Community Café to have a coffee and catch up on some reading. In taking this approach, I was able to minimise the harm and disruption that may have come to my participants as a consequence of my fieldwork, but still acquire the data necessary for my research.

For my research interviews, all participants were required to sign a consent form to take part in an interview. As I have noted in my earlier discussion of interviews, there were some members who I deemed I may not be able to guarantee informed consent for their participation. In approaching members to request an interview, I focused on individuals whom I had built up a rapport with through the course of my ethnographic fieldwork, as I believed that these individuals understood the reason for my presence in the Clubhouse and the nature of my research. Other potential interview participants were members suggested and sometimes introduced to me by The Club staff as being individuals with useful experiences who may value the objectives of my project. Two members that I approached asking to undertake an interview refused to participate, and after this point I also chose not to include them in my ethnographic field note-taking. Two other members approached me to undertake an interview. These were members that I had got to know during my time as a volunteer at The Club, therefore I already had an established relationship with them. I asked all members who had agreed to an interview to read the participant information sheet I had created before signing the consent form. I would also read out the key information on the information sheet and the questions on the consent form, to ensure that any members who may have had an undisclosed difficulty with reading understood the nature of their participation.

In the process of transcribing and analysing my data I worked further to ensure participant anonymity, removing the names of identifiable places or other individuals within my interview transcripts. In reviewing my field notes and coded interview transcripts for data to include within the final thesis, I tried to remove all identifying information, and when this could not be achieved, I made the decision not to include this quotation or information within the text. In the course of completing this thesis I have attempted to adopt an ethical approach to research that centres the voices of participants whilst minimising the disruption to their lives and reduce the chance of harm to participants or the field site. I have done this through enlisting both formal procedures and adopting a flexible approach to fieldwork practice. Negotiating ethics within research is an ongoing process that requires a constant re-evaluation of one's

research approach. As such, research ethics are inherently bound up in the concepts of researcher epistemology and positionality.

4.5 Epistemological Aspirations and Methodological Realities

Two decades ago, a special issue published in *Geographical Review* journal, co-edited by DeLyser and Starrs (2001:vi), provided candid accounts of geographical fieldwork to remedy the issue that "we spend comparatively little time learning or talking about doing fieldwork." This special issue helped to demonstrate not only the diversity of method and epistemological framing that could comprise geographical fieldwork, but also offered first-hand, evidential accounts of the emotional, physical, and practical 'messiness' of undertaking fieldwork already highlighted by feminist geographers (Katz, 1994; Rose, G., 1997a; see Hyndman, 2001; Parr, 2001 and DeLyser, 2001). Nearly two decades later another special issue has been produced, co-edited by McSweeney and WinklerPrins (2020), in an attempt to highlight what has endured in fieldwork and methodological writing practice, but also what has changed. Fieldwork has not got any less messy, yet our written accounts still do not do justice to the messiness:

> "accounts that describe the messiness and embarrassment of a botched field method continue to be stripped from research articles, ostensibly in the interest of word counts and space constraints. This leaves readers—especially students— with the impression that research results are derived exclusively from methodological triumph" (McSweeney and WinklerPrins, 2020:5).

Harrowell, Davies, and Disney (2018) have called for geographers to recognise, acknowledge, and think through failure in their research. They note that whilst we have begun to acknowledge the messiness, we are still underrepresenting it in the ways we write and speak about our research. I argue that one of the reasons for this underrepresentation is that it is very difficult to acknowledge this messiness through traditional forms of academic writing, and some geographers have made efforts to combat this through using different media of communication (see Jones and Evans, 2011). Frazier (2020) in her account in the *Geographical Review* special issue conveys her experiences of fieldwork failure through the use of a series of research vignettes. I am going to explicate my

epistemological position through narrating some of the messiness of my research process, all the while bearing in mind:

> "The storyteller must be accountable for narrative, as well as having confidence in authorship as ownership. When writing is offered as the personal expression of a moral centre, then this standard applies all the more so" (Lorimer, 2014:599).

I choose to own my research failures, as much as the successes, and hope that through this account the messiness remains and enriches the empirical material that will follow in the later chapters.

4.5.1 Doing Messy Research

In my initial research proposal and prior to undertaking my fieldwork, I proposed to establish a 'research group' within The Club, as one element of a multi-method qualitative research design. This method was intended to be a form of participatory action research (PAR), that has been favoured by some social geographers as a method that is more collaborative and democratic than traditional qualitative methods (Pain, 2004). This group would involve the voluntary participation of The Club members, and I would facilitate it. I would teach the members qualitative research skills in data collection and analysis, and we would work collaboratively to answer research questions determined by the group. The appeal of this method, for me, was its empowering potential, through offering the members of The Club skills to conduct research independently. In a self-serving manner, it was also a way to demonstrate 'innovative' research methods, to secure doctoral funding and to suggest the potential for future 'research impact' through collaborative methods that are now much lauded by social science funding bodies (ESRC, 2020). Moreover, this method seemed to be a means of responding to calls from both 'psychiatric survivors' and mad studies scholars to engage in more collaborative and service-user led research (O'Hagan, 2016). Often termed 'survivor research', this approach constitutes "the systematic investigation of issues of importance to survivors, from our [survivor] perspectives and based on our experiences" (Sweeney, 2016:37). It is placed in opposition to biomedical, clinical, positivistic research both methodologically in that it is qualitatively based and therefore centres subjectivity, and also ideologically, as survivor research often seeks to

produce a narrative outwith 'traditional' psychiatric discourse (Russo, 2012). This approach not only aligned with my own personal beliefs regarding the responsibility we have as researchers to make research accessible, empowering and emancipatory (Fuller and Askins, 2007) but also suited the Clubhouse ethos that does not centre psychiatric diagnosis (Jackson, 2001). Clubhouse International standard twenty states that all members should be given the opportunity to participate in any research taking place in the Clubhouse (Clubhouse International, 2018). However, whilst The Club is not a clinical or medical space, it is equally not an activist space, therefore I chose not to overtly frame the research group as 'survivor' research, as many members appeared comfortable with their psychiatric diagnoses and imposing any kind of survivor narrative upon them could have been damaging and may have appeared antagonistic or oppositional to The Club.

The research group was to take place in weekly sessions over ten weeks initially, with the intention that I would step back as facilitator after this time, and allow the group to carry itself, with my support as required. However, the realities of trying to establish this research group were quite different from my ambitions. Member attendance at already well-established groups could be patchy; trying to establish a new group with uncertain aims and no promise of members receiving a certification or qualification at the end of it was likely to be an overambitious undertaking. As previously mentioned, attendance at the Clubhouse and participation in the work-ordered day are entirely voluntary. Pain et al. (2012:2) explain that 'true' PAR is "driven by participants (a group of people who have a stake in the… issue being researched), rather than an outside sponsor, funder or academic." Similarly, survivor research demands the centring of psychiatric survivors as the initiators of research (Rose and Beresford, 2009). The proposal for the research group did not meet the standards for PAR and survivor research in this respect in that the proposal was driven and produced by myself and not members of The Club. This underpins the reasons for my inability to implement this research method in my project. As there was no member-led 'drive' to conduct research or establish a research group, I was unable to convince the work and learning unit member of staff who was in charge of the education groups within The Club that this group would be of any interest or benefit to members. While some members may have benefitted from learning

research skills, there was no way I could guarantee this, and for those who may have actively sought out research training, there were other means by which they could engage in this, through local college courses that The Club encouraged and assisted individual members in applying for.

4.5.2 The Importance of Fear

I was uncertain in my own ability to facilitate a group that would have any tangible benefits for members. I was very wary of undertaking anything that could potentially cause harm to my participants, with an awareness of the historic legacy of extractive research in geography and the 'epistemic violence' that can easily occur in fieldwork (Castree et al., 2008). While I had previous experience of working in The Club as a volunteer, and previous practise in qualitative methods research, I had never undertaken anything like this before and was acutely aware of being a researcher-in-training. The formal ethical structures that I have discussed earlier in the chapter reinforced my own understanding of the "landscape of power" (Rose, G., 1997a:313) that shaped my relationship with participants. I was acutely aware that I was being given permission to inhabit somebody else's space, and that it was "institutional privilege" in part that provided this permission (Rose, G., 1997a:308). My position of relative power over participants in this context not only made me very fearful of causing harm, but also pushed me to attempt to facilitate the smooth running of the Clubhouse, to offset the potential for disruption that my presence might cause. Laurier and Parr (2000) have stated the importance of recognising our emotional responses to our fieldwork, in order to orient ourselves ethically within the field. Recognising my fear of causing harm, I felt there was no way to implement a participatory research group without disrupting the work-ordered day, as there were already so many other activities taking place, it was impossible to find a regular, weekly two-hour time slot to establish the group. I decided that my time could be more usefully spent assisting with already established groups and courses within The Club.

An emancipatory epistemological approach advocates undertaking research to improve the quality of life of one's participants (Fuller and Askins, 2007). It is acknowledged that emancipatory research cannot hope to be emancipatory on its own but does so through the building of a "body of knowledge that challenges

exclusion" (Sweeney, 2009:31). I worried that my research would do nothing to improve the lives of my participants, even when my completed thesis was added to the 'body of knowledge'. In understanding that care ethics are 'endemic' to all social relations (Lawson, 2007), I cared about my participants and wanted to care *for* them in any way I could throughout the fieldwork process. Having come into doctoral study from previously working in a practical support role with individuals with diagnoses of SEMHCs, I struggled with the pragmatic impotence I felt in my new role as researcher. Whilst fear may have prevented the implementation of the research group, it was also useful in reducing my disruption of Clubhouse activities, as it held me back from 'busybody-ness' or attempting to 'fix' things. I contented myself with the 'emotional labours' of care that are common in the Clubhouse (Conradson, 2003a): being a listening ear, a person to chat to and a person to have 'patter' with. For some members I was able to undertake some practical tasks: telephoning the DWP on a member's behalf, filling out forms for members who struggled with literacy. Geographers studying health and disability in relation to social justice have argued that researchers "have a moral responsibility to contribute to the actual political struggles of disabled people against social injustice outside the academy" (Valentine, 2003:376). While these small acts of care towards my participants are not great acts of political activism, they are tangible gestures that had a positive impact on members' lives in that moment. These are the moments I am proudest of when reflecting on the wider fieldwork experience.

4.5.3 Giving Oneself Away

Each of us inhabits our 'researcher role' with a different set of complex intersectional subjectivities (Nagar, 1997). For the majority of people, some of these subjectivities are transparent to others, whilst some remain hidden unless we choose to reveal them. The configurations of which subjectivities are transparent and which are hidden are also different for every individual. Most people who spent a short amount of time interacting with me would easily be able to deduce that I am: white, mid-twenties (at time of fieldwork), middle class, English, able-bodied, cis-female. Other subjectivities, such as sexuality and religion, were hidden during fieldwork and were open to interpretation on the part of participants. Another hidden subjectivity that I chose not to reveal to The Club members is that I have a diagnosis of a mental health condition and

have accessed secondary mental health services. My anxieties to portray myself as a 'legitimate' researcher within The Club meant that I did not want to reveal this kind of information, not because of shame, but because it was information that I felt was very personal and therefore not relevant in a professional context. Furthermore, not only was I tentative in my researcher status, I was still very tentative in my role as a mental health service user, having only engaged with mental health services the year prior to commencing fieldwork. Whilst I was a 'service user', I was not member of The Club, and therefore I was aware that my service user status did not make me a 'peer' with members within the context of the Clubhouse. I did not want The Club members, staff, or the academic community to think I was trying to legitimise my research as 'survivor research' by terming myself service user. Survivor research demands there is a "shared [survivor] identity between researcher and researched" (Faulkner, 2004:4) and therefore by disclosing my service user status it might be interpreted that I was positioning myself as a potential participant that was driving the research. I was acutely aware that my intersubjectivity with The Club members only went so far; for the most part we had very different life experiences. I worried that any claims on my part to a service user status would be seen as an attempt to erase my class and financial privilege, which had aided me to undertake this research in the first place. Moreover, I do not share the identity of being a member of The Club, and therefore my service user status is not pertinent to the focus of my research.

Information concerning our personal identities, including health information, is private and I am not advocating for sharing this information in research encounters as common practice. However, in my own fieldwork process I believe I should have been more candid about my own mental health experiences, both for the welfare of my participants, and for my own wellbeing. Being open about my own mental distress at the time of fieldwork may have allowed me access to more support, and Clubhouse staff may have been more alert to signs that I was struggling in the field. I also spent a lot of time worrying about my lack of disclosure. I encountered members of The Club in the waiting room of the local community mental health team on several occasions, and I worried that my lack of disclosure to participants might lead them to think that I was there in a clinical staff capacity rather than as a patient. This worry, and the fear of being

'outed' as a service user rather than self-disclosing this fact dominated my fieldwork experience. I worried that my lack of disclosure from the start of the project would be interpreted as personal shame about my service user status by participants. The process of fieldwork had a detrimental impact on my mental health and reciprocally my poor mental health had a detrimental effect upon my fieldwork:

> "As we embrace thinking about and reflecting upon our own roles in fieldwork in more depth, there emerges a challenge of how to approach our fieldwork so that it does not consume us and incapacitate our confidence in conducting research projects" (Lucherini, 2017:430).

My fear and worry concerning the research group did 'consume me' and ultimately probably led to its failure. This failure then did have an impact on my confidence in undertaking the rest of my research. However, I also acknowledge the importance of that worry in the shaping of my epistemological understanding of the field. Despite my deteriorating mental health, I was still alert to the needs and wellbeing of my participants, and this was at the fore throughout the fieldwork process.

4.6 Introducing The Club

When writing about The Club throughout this thesis, I will mostly write in the past tense. This is because my field research pertains to a very specific timeframe in the history of The Club (between July 2017 and August 2018), or because I am offering historical context for the field research. I will make recommendations for The Club in the conclusion of this thesis, but these suggestions are based on and reflect only my short fieldwork period, and I do not want to suggest that the space or the operations therein are still as they were during my research period, as I have limited means or capacity to verify this.

In 1995, the current The Club Chief Executive Officer (CEO) visited a (now defunct) Clubhouse in Dartford, England. From this visit, he saw the Clubhouse model as a very "positive alternative to mainstream services" for mental health service users and in 1996 was appointed to a steering committee to establish a Clubhouse in Glasgow (Rosengard, Laing and Ridley, 2004:23). In 1996, with the aid of funding from a Scottish mental health charity, The Club tentatively

opened in a rented room in Glasgow city centre. In 1998, The Club was able to move to its current location. On moving into these premises, The Club were given the option of buying the building for a fixed price by 2001. With the aid of several charitable grants, most of the money was raised to purchase the premises. The rest of the money was provided by NHSGG&C Health Board and a small bank loan (The Club, 2002). Moving into an already constructed building means that the functions of the Clubhouse have to operate around the space of the building, rather than the space being purpose-built for the operation of the Clubhouse. The Club is split between two floors, and the functions of the house are split between the upstairs and downstairs. The Club have made significant alterations and improvements to the building over the years. Although the building was not designed as a workplace, it was converted into office space in 1949. Before the building was taken over by The Club in 1998, an architectural firm had occupied it. The Club replaced the stately boardroom with a kitchen and a removed the office partitions on the upstairs level. Since this time, many more improvements have taken place. Skylights were installed in the ceiling and a large projector screen was installed upstairs. A disabled access lift was installed in 2016, allowing members with limited mobility to reach the upstairs units.

The Club became an independent charity and limited company in 2001 (Companies House, 2001) and received Clubhouse accreditation from Clubhouse International in September 2003. After a first reaccreditation after one year, they maintained this accreditation with reassessments every three years until 2017, when their accreditation lapsed. They continued to be funded by a number of restricted and unrestricted voluntary grants throughout this time, though the bulk of their income (usually at least 80% of the voluntary unrestricted funds) was from a series of NHSGG&C tenders. Between 2012 and 2013 their annual income dropped by almost 20%, largely due to a significant reduction in the funding provided by NHSGG&C (The Club, 2012). This change in funding also came with the restriction that newly recruited members had to be accessing secondary mental health services (such as community mental health teams or forensic mental health services) at time of referral and have a diagnosis of a ‘long-lasting’ mental health condition. Another significant change occurred in 2015, when the only other Clubhouse in the Greater Glasgow and

Clyde catchment ceased operation (The Club, 2015b). The Club introduced an 'open door policy', allowing for any member of the other Clubhouse to join The Club without needing to go through a referral process. As a result, membership swelled. Since this time, the membership has continued to expand, albeit at a slower rate. At the time of my fieldwork, there was an average daily member attendance of 53, an average monthly member attendance of 178, and in that year 307 members engaged with the service (The Club, 2018). For comparison: in 2009, the average daily member attendance was 41 and 240 people engaged with the service (The Club, 2009).

During my fieldwork, The Club functioned with eight differently sized work units, split between the upstairs and downstairs of The Club. The upstairs units comprised: work and learning, that focused on getting members into employment or education courses; business and administration, that dealt with the administrative duties of The Club; finance, that handled the financial aspects including staff payroll; media, this involved managing The Club's online presence; and eBay and Amazon, this unit had the task of sorting through donated items and putting them for sale on eBay or Amazon Marketplace to raise funds. Downstairs units comprised: kitchen and café, that dealt with food preparation and service as well as cleaning these areas; membership, that managed member applications to The Club and associated inductions; and health and wellbeing, that focused upon improving members' physical and mental health. These units have different numbers of staff dedicated to their operation (The Club, 2018). The overall function of most of these units was to maintain the running of The Club: business and administration dealt with all the administrative and human resources tasks of The Club, finance managed the money, eBay and Amazon sold donated items to raise funds. The kitchen and café ran the internal catering of The Club, and membership dealt with referrals and induction of new members. In addition to this, the media group helped to promote the house to potential referrers and donors. The two units that were least involved in the 'functions of the house' were health and wellbeing, and work and learning. Health and wellbeing focused on the mental and physical wellbeing of members, by organising activities such as walking groups; they also maintained The Club allotment. Work and learning focused on improving the education and employment prospects of members. They organised skills courses

and Transitional Employment Placements for members. Members were not restricted in the number of units that they could participate in, however many members chose to dedicate most of their time to one or two units.

The Club had varying levels of success with its Transitional Employment Placement programme over the years. A much deeper examination of the TEP programme at The Club will be given in the final empirical chapter, however I will outline a few details here. In 2004, there were ten employment placements available: six were hosted by third sector mental health organisations, two were in NHS services, and two were 'commercial' placements (Rosengard, Laing and Ridley, 2004). The number of placements began to drop steadily after this point, falling to seven by 2009, and five by 2013 (The Club, 2009; 2013). This became problematic as the Clubhouse International accreditation process requires that the number of TEPs available should be at 20% of the average daily member attendance:

> "In order to provide sufficient employment opportunities for members, Clubhouse International Clubhouses should maintain a minimum of 50% of their average daily work-ordered day attendance (ADA-WOD) working on Standards-consistent jobs. At least 20% of the ADA-WOD should be working on Transitional Employment jobs" (Clubhouse International, 2012:1).

In 2004, ten TEPs were proportionate to 25% of average daily attendance. The 20% threshold was just about maintained until 2009 but increasing member attendance numbers and a lack of new placements, in conjunction with the termination of existing placements meant that the proportion of TEPs to active members continued to drop. The Club decided to find other ways of increasing the number of TEPs available by opening their own café as a social enterprise venture in conjunction with a local housing association, The Community Café. The Community Café will be thoroughly examined in the final empirical chapter, but the TEPs that were provided by this new venture meant that at the time of my fieldwork there were eight TEPs available at The Club. Though this did not quite meet the 20% threshold required by Clubhouse International, The Club were not seeking reaccreditation at this time.

I have already highlighted some of the significant changes that The Club implemented within the physical space of the Clubhouse, such as the installation

of skylights and a disabled access lift. I now want to provide a full explication of the layout of the space, referred to as 'the house' throughout this thesis, in order to allow for a greater understanding of the ways in which The Club functions, and the spatial issues faced in undertaking the work-ordered day. Figures 1 and 2 show floorplans depicting the layout of both levels of the house at the time of undertaking fieldwork. Adjacent to the main entrance is the area in which the membership unit was based. The kitchen and café unit clearly operated within the kitchen area and the café area where the round tables are shown in Figure 1. The health and wellbeing unit did not have a designated space, though the general administrative hub and meeting area downstairs was located where the long table is shown, beside the café space. Moving upstairs, no unit was assigned a specific space, although the main meeting area for the upstairs as a whole was located on the table that is beside the 'upstairs board'. The conference room at one end of the upstairs was used for meetings with external agencies and for member inductions. The '1:1 room' was used for private meetings and was often used by the work and learning unit for individual meetings with members. At the other end of the upstairs is an office space that was reserved for the CEO, though it was occasionally used for other purposes; the welfare rights advisor used it as a workspace and meeting room on the half a day each week that they visited. It is a stipulation of the Clubhouse standards that no space should be solely for either staff or members, so whilst this space was often used by the CEO, it was not exclusively their space. The other office at this end of the upstairs was being used for storage at the start of my fieldwork, though during the course of fieldwork, it was cleared and rented out as an office space to an external mental health organisation. The area marked 'the void' is an opening in the floor of the upstairs that allows one to look into the downstairs reception area. It was described as 'the void' by all The Club staff and members, and was seen as a nuisance, as it caused a lot of noise to carry from the reception area into the upstairs space. Although Figures 1 and 2 are a reasonable representation of the layout of The Club at the time of fieldwork, furniture moved frequently, and staff often tried new layouts to attempt to make the space amenable to particular activities, such as the skills course, house meetings, and the art group.

In delivering this brief introduction to the space and history of The Club, I am aware that the picture provided is one that appears very ‘flat’ and not full of the life, energy, and momentum that characterised my fieldwork experience. However, these technical details are vital to understanding the ‘liveliness’ of the Clubhouse, and through the thorough description and diagrams of the space, I hope that this will help to bring the space to life through enabling the reader to visualise the workings of the Clubhouse as they are explicated in the empirical chapters.

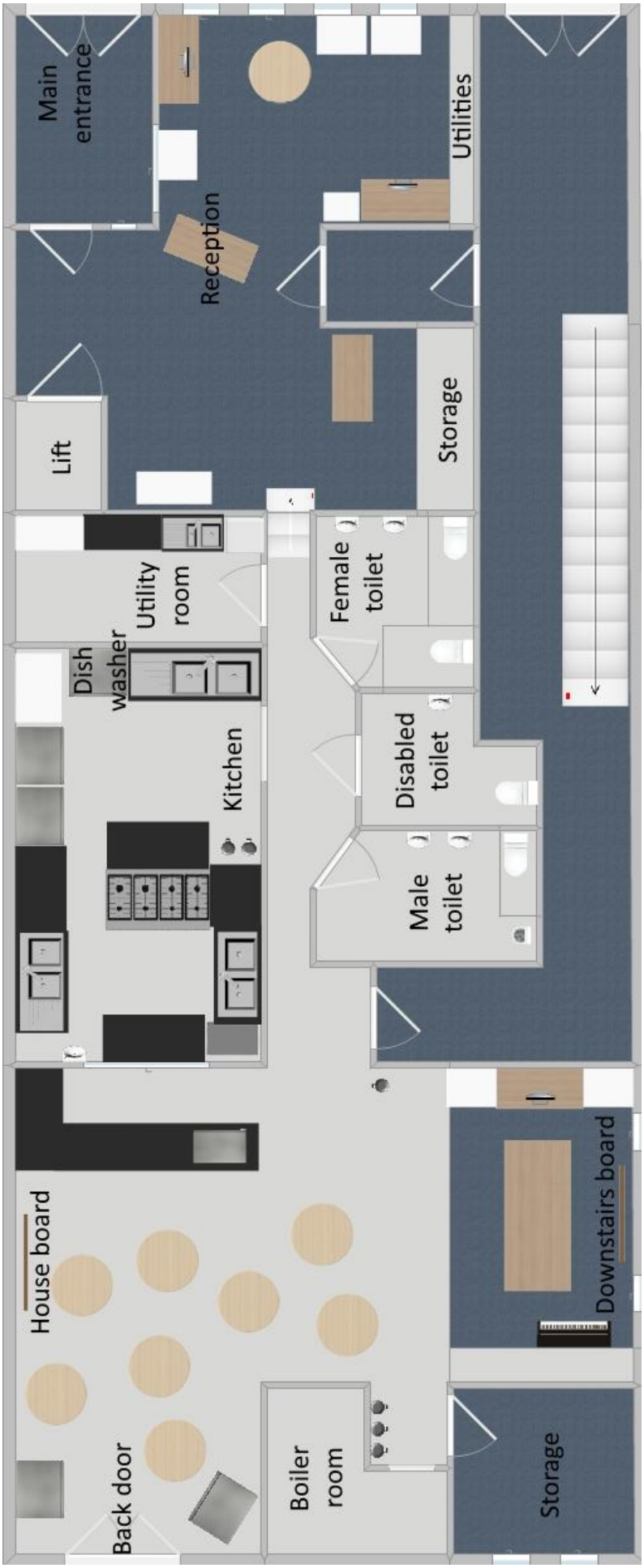
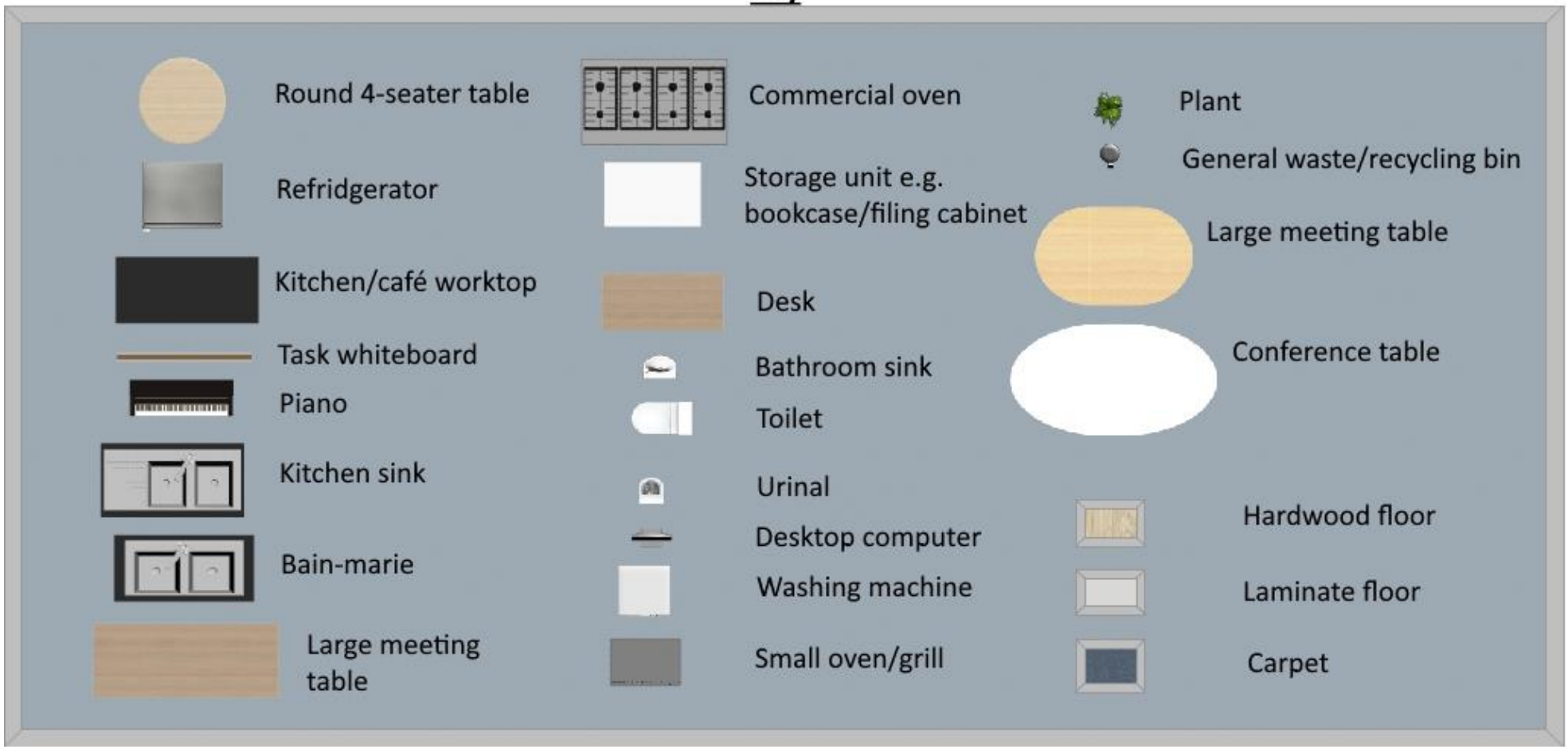


Figure 1: Floor plan of the downstairs of The Club. Created by the author.

Figure 2: Floor plan of the upstairs of The Club. Created by the author.

Key


Round 4-seater table
Refridgerator
Kitchen/café worktop
Task whiteboard
Piano
Kitchen sink
Bain-marie
Large meeting table
Commercial oven
Storage unit e.g. bookcase/filing cabinet
Desk
Bathroom sink
Toilet
Urinal
Desktop computer
Washing machine
Small oven/grill
Plant
General waste/recycling bin
Large meeting table
Conference table
Hardwood floor
Laminate floor
Carpet

4.7 Additional field sites

4.7.1 Introduction

I also undertook two short, intense micro-ethnographies at other Clubhouses in the UK. These were formative in my approach to data collection and analysis, as both visits took place during my fieldwork period at The Club and allowed for consideration of additional topics that required exploration before leaving the main field site. The differences between these sites and The Club shed light onto the idiosyncrasies of my main field site. Of these two additional field sites, the organisation in Kirkwall, Orkney, was not an accredited Clubhouse. However, parts of the organisation still operated under the principles of the Clubhouse model and given its particular 'island geographies', I decided to persevere with a field visit. The other site I visited was in Lambeth, London. This Clubhouse is the UK training base for the Clubhouse model, and now the only accredited Clubhouse in the UK. Whilst the short length of these micro-ethnographies mean that the data collected is not suitable for comparative case studies with The Club, they demonstrate that there are myriad configurations in which a Clubhouse can be constituted: as they inhabit very different sites, cover different employment landscapes, and serve different populations to The Club.

4.7.2 Orkney

This organisation is based in a small island community and at the time of fieldwork was the only mental health service on Orkney that was not a clinical NHS-led service. Its members are spread across the islands and therefore the practicalities of getting to the organisation on a daily basis are complex. Members are referred from a single community mental health team, but it is possible to self-refer as well, therefore members are not required to have a diagnosis of a mental health condition to attend. Members are almost exclusively white, and many are also not born Orcadians, and have made the decision to relocate to Orkney. There is less diversity of employment than in urban areas, but in general there are enough employment opportunities for those able to work, due to the small population. The organisation also has strong ties with other organisations in the community and is funded by the local authority. The trust is located on a main street in Kirkwall in a building that used to be a large

house and is split over five levels. There is a large garden at the back which is tended by members and staff (see Figure 3 below). As well as functioning as a Clubhouse, with a work-ordered day and TEPs, the organisation also operates a drop-in service, which is open on weekends as well as some evenings during the week.

Figure 3: Photograph of an area of the garden at the Orkney organisation. Photograph taken by author on 16th April 2018.

4.7.3 London

The Clubhouse is located in the London borough of Lambeth, in an area where there is a large black and minority ethnic population. As the UK training base for Clubhouse International, the Clubhouse often hosts visitors from other European Clubhouses, and runs a training programme alongside the tasks that comprise the work-ordered day. The Clubhouse has strong partnerships with other health organisations based in the local area, including the South London and Maudsley NHS Trust and Public Health England. The Clubhouse also encompasses an information hub which is open to the public, providing information about mental health services, but also welfare and housing support. There is an out of hours crisis service based in the Clubhouse as well, which is open to members and

other mental health service users, on a short-term basis. The Clubhouse is based in a single level building that was purpose-built to be a Clubhouse (see Figure 4 for a photograph of part of this purpose-built space). There is a small garden, which is maintained by members and staff, and used primarily to grow vegetables for the kitchen. The Clubhouse accepts self-referrals but potential members are required to have a primary diagnosis of a mental health condition, though this diagnosis does not need to be considered 'severe and enduring' and one does not need to be in touch with secondary mental health services. The age of eligibility for membership is younger than both The Club and the Orkney organisation, with individuals aged sixteen and older eligible to join. Consequently, this Clubhouse has a dedicated 'young adults' programme for members aged sixteen to thirty.

Figure 4: Photograph of the 'purpose-built' education, employment and information unit at the London Clubhouse. Photograph taken by author on 23rd July 2018.

4.7.4 The Realities of Micro-Ethnographies

It was my intention on both field visits to be an 'observant participant' as I had been in The Club. However, negotiating this was more complex as the short nature of my visits meant that I was treated as a visitor or a guest, therefore

these micro-ethnographies might be described as more conventional participant observation that comprises "description of and reflection upon embodied and emotional experiences, intersubjective and material exchanges, and social and nonhuman interactions" (Watson and Till, 2010:127). I spent the majority of my time talking with members and staff at both sites, asking about the operations of the Clubhouses, but also about what it is like to work and live in the area. At the London Clubhouse, I spoke with members about their TEP experiences, as the TEP programme was extensive and offered different employment placements to the opportunities available at The Club. At the Orkney organisation, I had many in-depth conversations with both members and staff. There was much opportunity to undertake these conversations on the move: with staff as we travelled in the Trust-owned minibus to collect members that lived some distance from the Clubhouse, and with members as I accompanied them to appointments in Kirkwall or on walks around the local area. These were a great opportunity to understand the specificities of 'islandness' in Orkney and what this means for individuals living with mental health difficulties (Vannini and Taggart, 2012). For those who had moved to Orkney from elsewhere this could mean a sense of tranquillity discovered in the rhythms of island life. It could also mean dealing with the realities of island mental health services: with only one hospital bed reserved for psychiatric patients on the islands, becoming unwell could mean being transported to Aberdeen for treatment. Outwith the hours of the work-ordered day I would spend time orienting myself in the local area of the Clubhouse, trying to explore local organisations and businesses, as well as familiarising myself with the public transport networks. The short nature of these visits allowed me to indulge in much deeper field note writing. In fact, it was essential to keep much more detailed field notes, as unlike at The Club, I could not return the following week to remind myself of what had taken place the previous week, or to continue half-finished conversations with staff and members. Whilst no data from these short-term ethnographies appear in my empirical chapters, they have influenced my understanding of what 'Clubhouse' means by the application of the model in different social, spatial and broader geographical contexts.

4.8 Conclusion

In this chapter I have detailed the methods I enlisted in undertaking my qualitative fieldwork. Whilst it is necessary to include precise detail and clarity in demonstrating one's attention to method and ethical procedures, I hope that I have also been able to convey at least some of the messiness, haphazardness, and 'making-do' of method that occurs in the process of doing fieldwork and in undertaking research more generally. My epistemological aims of conducting emancipatory research were tempered by my fear of causing harm to participants and by my engagement with ethical procedures and practices throughout the research process. This in turn ensured that I was able to conduct research with care for and about my participants, and with respect to the wider mechanisms of The Club. My visits to other field sites in London and on Orkney enabled an even deeper understanding of Clubhouse workings and offered a chance for me to reflect on my wider fieldwork process in The Club.

In engaging with in-depth ethnographic methods, I have aimed to provide a 'lively' description of The Club throughout the empirical chapters. Furthermore, it has enabled me to engage an approach that addresses the 'messiness' of the field itself, and the complex relations that Clubhouse members have with each other and the space. I hope to show through this research that deep ethnographic methods can be used to help us to 'get a feel' of a place, by helping to "fill the silences in talk" (Knowles, 2000a:17). This provides a better understanding of the workings of The Club, and the experiences and practices of working within the space of the Clubhouse, as an individual with a diagnosis of a SEMHC. I also hope to show how engaging with documentary data during an ethnography offers a more comprehensive spatial context for the research and provides 'organisational boundaries' to the otherwise potentially unbounded social and spatial relations which my research participants inhabit. However, I also do not wish to *ignore the talk,* and the use of semi-structured interview data helps to centre the voices of research participants, and their views about the meaning of work, recovery, and the role that The Club plays in their lives. Through this methodological combination I am able to bring to the geographies of mental health a detailed view of a space that both works within and resists neoliberal-ableist assumptions about work, employment and recovery for individuals with diagnoses of SEMHCs.

Through this methodological chapter I am asking researchers in the geographies of mental health to pay greater attention to work in 'psychiatric survivor research'. It is important to recognise that research within geographies of mental health often will not fulfil the requirements of survivor research, as the issue being researched needs to be identified by and the research initiated by 'psychiatric survivors' (Sweeney, 2016); however, we can still take influence from survivor research in the ways that we practice our research (Faulkner, 2004). Mental health geographers are in a good position to do this, as we are already attentive to the emotions and lived experiences of our participants; but there is still a dearth of collaborative and participatory research in this field, largely because of the obstacles that exist in attempting to conduct this research ethically.

In trying to consider the 'everyday geographies' (Hall, E. 2004) of individuals with diagnoses of SEMHCs, my ethnographic work highlights something that requires more attention in future geographies of mental health research, that is, the mundanity of everyday life. In attending to the sometimes different 'ways of being' that individuals with diagnoses of SEMHCs experience (Parr, 1999b), previous research has not always addressed the 'normality' of everyday life for many of these individuals. My research has attempted to attend to the broad range of experiences lived by individuals with diagnoses of SEMHCs, including the moments of everyday life that some may consider less 'compelling' as research data, in order to avoid 'sensationalising' the lives of already marginalised individuals. Furthermore, given my critical stance on the term mental health 'recovery', it has been important to show a fuller picture of the lives of individuals with diagnoses of SEMHCs through deep ethnographic work, and not just highlight 'illness experiences' explicitly. In doing this I do not aim to be reductive about any individual's distress, indeed distress is certainly represented within my empirical chapters; but I aim to demonstrate that individuals living with diagnoses of SEMHCs are much more than their 'illness identities'.

Through and with the voices of my participants, I am able to co-construct knowledge, in this chapter and most particularly in the following empirical chapters. Moreover, the fieldwork process and interactions with my participants have shaped me. This experience has not only increased my knowledge but

changed my ontological perspective on work, mental health, and the ethics of undertaking research in these subject areas:

> "we are made through our research as much as we make our own knowledge… [and] this process is complex, uncertain and incomplete" (Rose, G., 1997a:316).

I have been made, and more frequently un-made through this research. I found the process of fieldwork incredibly challenging at times, and it has required a mutability, a willingness to be un-made by the events that occurred, and to be re-made with a better, but no less partial understanding of my research. The journey of a research process, particularly one involving long, in-depth, sensitive ethnographic fieldwork cannot be adequately expressed in or confined to a methodological chapter. Its implications are inherently wound into every word of this thesis, the chapter structure, and crucially the empirical data I have chosen to highlight and the meanings I have derived from this data. I hope that the chapters that follow will do some justice to the voices of the individuals that gave me the privilege of listening to them.

5 Meaningful Work in the Space of the Clubhouse

5.1 Introduction

Funded primarily by NHSGG&C, we can describe The Club as a 'shadow state' service (Wolch, 1990) that is "influenced partially through grass-roots visions of community inclusion and support, and partially through state regulation" (Parr, 2000:228), whilst simultaneously acknowledging the complex relationship between third sector organisations and the state (DeVerteuil, Power and Trudeau, 2019). Though reliant on state funding, The Club had almost complete autonomy over the activity that took place within its space, 'the house', and was very explicitly "separate from any mental health centre or institutional setting" (Clubhouse International, 2018:2). In this chapter, I endeavour to explain how work in the Clubhouse is organised, then explicate the nature of the work tasks, members' experience undertaking these tasks, and whether or not the tasks are perceived as 'meaningful'. I then consider the disciplinary apparatuses that were enacted through the organisation of work, such as: the observation of member work through spatial organisation (Foucault, 1995) and the timetabling of work, meetings and breaktimes in the Clubhouse (Goffman, 1961). These disciplinary techniques are usually associated with enclosed institutional spaces (Philo and Parr, 2000), therefore The Club, as a space wherein all participation was voluntary and members could leave at any time, disrupted and altered the power of some of these techniques of discipline (Foucault, 1995). I examine how the framework of the work-ordered day is also used to foster relationships, social inclusion, and personal meaning for members within the Clubhouse. I hope to offer an "alternative and more nuanced account" that 'disrupts' the 'static geographies' of mental health recovery that are often presented in normalising discourses (Parr and Davidson, 2010:266).

Research in an Australian Clubhouse determined that "engagement in meaningful occupations is of central importance in mental health recovery" (Hancock, Honey and Bundy, 2015:508). Within the Clubhouse model, work is not framed explicitly as being either 'therapeutic' or 'productive', rather it is a tool to be used to facilitate mental health recovery through the work-ordered day (Beard, Propst and Malamud, 1982). Whilst acknowledging that 'recovery' is personal and unique to each individual, from a Clubhouse perspective,

'recovery' means living more autonomously within wider society and the individual gaining "some degree of control over their own lives" (Davidson and Roe, 2007:462). This perpetuates the ideas of 'normalisation' and 'responsibilisation' that I have criticised in my examination of the term recovery in my literature review (Rose, D., 2014). In the Clubhouse, it may not be the specific work tasks undertaken that are intended to contribute to mental health recovery, rather it is in undertaking these tasks that an impression of 'normality' is displayed to others and experienced for oneself (Rouse et al., 2017). The Club (2019) has stated that it broadly follows the 'CHIME' framework of recovery outlined by Leamy et al. (2011) and other Clubhouse research has categorised recovery as something that encompasses:

> "the presence of hope and meaning in life, developing a sense of identity apart from the illness, empowerment, being supported by others, and overcoming the effects of discrimination" (Conrad-Garrisi and Pernice-Duca, 2013:43).

'Recovery' within the Clubhouse model broadly follows the framework of 'personal' recovery whilst acknowledging that it is a subjective process, and a continually evolving concept (Pernice-Duca and Onaga, 2009). Much of the psychosocial rehabilitation literature considering the efficacy of Clubhouses has been conducted by researchers who also endorse the 'normalising' and 'responsibilising' discourses of personal mental health recovery (see Tanaka, Craig and Davidson, 2015; Tanaka and Davidson, 2015). However, as a space where all participation and attendance are voluntary, and lifetime membership of the Clubhouse is guaranteed and not contingent upon participation, the Clubhouse and those within it are able to resist the idea that the individual must take on all responsibility for their own recovery. Whilst members are guided towards 'autonomous choices' that encourage them to participate in the work-ordered day, they had the choice to opt out if they wished. In understanding that 'personal mental health recovery' reproduces problematic 'normalising' discourses, I must also acknowledge that it is a concept that some (but not all) members identified with, and that moving towards 'normality' may be preferable to extreme distress. Throughout this chapter I will engage with concepts that are considered conducive to personal mental health recovery within the 'CHIME' framework, such as: meaning-making, social connections, and identity formation (through feeling needed) (Leamy et al., 2011). I acknowledge

that these elements are things that are essential for living well in the world, without trying to pass a judgment on whether they are conducive to any kind of individual personal mental health 'recovery'. Therefore, in this chapter I will refer to 'recovery' to mean both the personal "situated knowledges and feelings" (Parr and Davidson, 2010:264) of individuals, and the broader discourse of recovery that The Club promoted, though I will try and delineate these by making reference to the 'CHIME' framework where relevant.

The focus of the Clubhouse is to foster a 'working *community*', a collective identity that prioritises maintaining and enhancing the Clubhouse (Jackson, 2001). Therefore, the work tasks of the work-ordered day are planned around this Clubhouse maintenance. The expectation is that individual members will derive meaning and fulfilment from their work tasks because they understand that they are contributing to a wider community (Mandiberg and Edwards, 2013). However, it cannot be guaranteed that all members will find tasks like this personally meaningful. Palacios-Ceña et al. (2016:110) explain that in order for an individual to find something meaningful, it must be engaging to them "to the extent that they improve either their emotional wellbeing, cognitive status, or their physical function." This suggests that not only are there multiple ways in which an individual might find meaning through work, but there are myriad ways in which they might experience this meaningfulness as well:

> "Meaningful activity is largely viewed as encompassing several dimensions of subjective experience, such as pleasure and enjoyment, purposeful behavior, and basic human needs fulfillment through choice, control, and belonging" (Hooker et al., 2020:821).

If we acknowledge that the experience of finding something meaningful is entirely subjective, then this experience is personal and unique to each individual (Leufstadius et al., 2008). This renders it impossible for a Clubhouse to plan work tasks that guarantee individual meaning-making. Therefore, it is more pragmatic for Clubhouse organisers to focus upon wider community building and fulfilling the individual need of belonging through work tasks, which may in turn help some members with their own individual meaning-making. It is important to be mindful of the history of work in relation to individuals who were deemed 'mad', as an apparatus of constraint (Foucault, 2006a) and a means of keeping the individual occupied (Laws, 2011). Meaning is "influenced

by the environment or social context" (Rosso, Dekas and Wrzeniewski, 2010:91), therefore in some contexts, 'occupation' can be a positive endeavour when individuals can choose to participate, and only participate if they find the occupation meaningful. Whilst work in the Clubhouse still does have the disciplinary potential to constrain individuals, each member's choice to participate means this potential is diminished.

Participating in the work-ordered day and helping other members may facilitate individual meaning-making because these are opportunities to interact with others and receive positive feedback about this interaction. Research conducted within Clubhouses has demonstrated how this may lead to an improvement in member wellbeing. Conrad-Garrisi and Pernice-Duca (2013) undertook qualitative research within ten Clubhouses across the US to determine how individual wellbeing might be improved by members feeling a 'sense of mattering':

> "individuals that experience a sense of mattering develop an important human connection that facilitates confidence and self-efficacy which assists in moving toward recovery. This human connection facilitates the development of identity and meaning and buffers against the negative effects of stigma associated with psychiatric illness" (Conrad-Garrisi and Pernice-Duca, 2013:43).

The authors explain that a sense of mattering has three main facets: a need to be known by others, a need to be considered 'important' in some way, finally the knowledge that others depend on us in mutual and reciprocal relationships. This 'sense of mattering' resonates very strongly with a concept of the Clubhouse model known as the 'need to be needed', that I have briefly considered in the examination of the Clubhouse model in the contextualisation chapter. I will provide a deeper explication of this concept later in the chapter, but broadly 'the need to be needed' mandates that the presence of members is required within the Clubhouse to undertake the work that maintains and enhances the community (Propst, 1992). Knowing that one is needed to undertake work tasks as part of the work-ordered day in the Clubhouse can help a member to feel that their presence and contribution is important, and also means that they are depended upon by others. This mutual dependency between members highlights the similarities between the need to be needed and a sense of mattering.

5.2 Spatial and Temporal Structure of The Club

5.2.1 Spatial Organisation of Work in The Club

The smooth functioning of the work-ordered day relies on both conceptual and material elements that need to be deployed, maintained, and reviewed on a regular basis. The most basic material element of the Clubhouse that requires organisation is the layout of the space within the building. The space houses the work that takes place during the work-ordered day and generates many of the work tasks that relate to the maintenance of the house. Environmental psychologists researching workplace design have emphasised that there is a direct connection between the material qualities of a space that a person works in and their feelings of job satisfaction (Vischer, 2005). As the undertaking of work is intended to facilitate 'mental health recovery' (Doyle, Lanoil, and Dudek, 2013) the notion of being 'satisfied' in the place one works is very important to the Clubhouse model. Feeling uncomfortable or dissatisfied in the workspace will detract from other possible positive outcomes of working, such as personal meaning-making, or feeling as though one is contributing to a community. Evidently environmental preferences are personal, and what constitutes an 'ideal' working environment depends on the task to be undertaken, but in general:

> "people's preferences are affected by, among other things… access to natural light, new furniture, and aspects of the acoustic environment, as well as some degree of participation in decision-making" (Vischer, 2008:99).

I have introduced the building layout and spatial aspects of The Club in my introduction to the field site within the methodology chapter. The Club had done much to improve the environment of the Clubhouse for members. Whilst the Clubhouse was under some spatial constraints due to the original design of the building in which they were based, prior to and during my fieldwork period there were constant aesthetic and design improvements being made. Skylights were installed on the upper floor to increase the amount of natural light, new furniture was purchased whenever the current furniture began to show significant signs of wear and tear, and there was ongoing discussion about how to improve the acoustic situation by reducing sound travelling through the 'void'

between the upper and lower floor. One suggestion that was being trialled whilst I conducted my fieldwork was the growing of a 'green barrier' of trailing plants across the void to dampen the sound that travelled between floors. The beginnings of this endeavour can be seen in Figure 5.

Figure 5: Photograph of 'the void' in The Club, from the upper floor. Photograph taken by author on 24th October 2017.

Members were always included in the ongoing discussions about improving the working environment within The Club. This participation in decision making meant that members were able to feel a greater sense of ownership over the space of The Club:

> "Environmental empowerment is directly linked to psychological comfort. People who are informed about workspace-related decisions, and who participate in decisions about their own space, are more likely to… have feelings of belonging and ownership" (Vischer, 2008:101).

This feeling of belonging and ownership is very significant in encouraging members' pride in the Clubhouse (Mandiberg and Edwards, 2013). The Club members had numerous ideas about further improvements to the space, but also understood the constraints that The Club was under:

> "we should have a room that's a sensory room. For those with mental health issues, or some sort of sensory issues, you could use the room to relax just for five minutes. We could use one of the rooms that's an office room… it could be turned into a sensory room. But we don't have funding for that and it's not part of the Clubhouse model" (Katie, member for one year).

Allowing members to be part of the decision-making process is a key element of the Clubhouse model (Valkeapää et al., 2019). It can help to build self-esteem for members (Tanaka, Davidson and Craig, 2018) and it also gives members a greater vested interest in the Clubhouse and therefore encourages their future participation in Clubhouse activities. Katie's comment exemplifies this: she wanted to create a sensory room to help members who may get overwhelmed in the busy and noisy spaces of the Clubhouse. Although she understood that the therapeutic nature of the space did not conform with the overall ethos of the work-ordered day, she could see the value of having such a space alongside the workspaces, that would improve members' 'psychological comfort' and therefore perhaps improve motivation for work participation. The Club staff were receptive to Katie's idea, but the sensory room did not come to fruition during my fieldwork, largely due to financial and spatial constraints.

Some spaces of The Club were more highly regulated than others. All tasks involving food preparation and cooking obviously needed to take place in the kitchen, as specific equipment was involved, and specific hygiene protocols had to be followed. The kitchen also contained more potentially hazardous equipment (see Figure 6), therefore a stricter level of regulation over the space and the people in the space was required. The organisation of space has the potential to discipline individuals, through the creation of rules or expected behavioural norms:

> "It is spaces that provide fixed positions and permit circulation; they carve out individual segments and establish operational links; they mark places and indicate values; they guarantee the obedience of individuals, but also a better economy of time and gesture" (Foucault, 1995:148).

Rules are necessary in the kitchen to keep everyone safe, but they require that individuals within that space conduct themselves in a particular 'normative' manner. The Club had a stringent setup for the cleaning of the kitchen. In

addition to the daily cleaning, there was a scheduled deep clean of the kitchen every month. This highlights the complexity of planning that is involved in the work-ordered day. In a space in which multiple activities will be taking place simultaneously, there is a requirement to be flexible and to be able to negotiate space with other units of the house. On the day of the deep cleaning of the kitchen, the usual lunch service would not take place. This meant the suspension of many work-ordered day tasks, and the implementation of several other different tasks related to the cleaning of the kitchen, and the possible preparation of a small amount of food for lunch (such as soup and sandwiches).

Figure 6: Photograph of the professional oven in The Club kitchen. Photograph taken by author on 24th October 2017.

It was not just the food preparation spaces that required cleaning, keeping the whole workplace clean was another important aspect of maintaining a pleasant and safe working environment. The Club was very successful at keeping the workspaces clean, this was achieved by making various aspects of cleaning into work tasks as part of the work-ordered day. The process of task allocation will be explored in the next section, but tasks such as sweeping, vacuuming and mopping would be listed as tasks that members could sign up for each day, and

members did ‘pitch in’ to help with the cleaning, sometimes after some gentle encouragement from Clubhouse staff:

> *When I walked past the kitchen on my way back upstairs, there were only two people cleaning up after the lunch service and they seemed a bit stretched, so I offered to help. A staff member said they were ok for now and told me to come back in ten minutes to check again. I did come back to check ten minutes later, and several members had already pitched in to help with the cleaning, so I wasn’t needed. I don’t know whether these members joined in without being asked, or if they were encouraged to participate, but pots were scrubbed, surfaces cleaned, floors mopped, the dishwasher filled and emptied, plates dried and put away, and the bins emptied. I went back upstairs. (Field diary extract, 1st November 2017).*

Spaces that did not need such stringent hygiene and cleaning protocols or specialist equipment as the kitchen were much more flexible in their layout and use, and therefore did not ‘guarantee the obedience’ of members in the same way as the kitchen (Foucault, 1995). In fact, most spaces in The Club needed to be multipurpose as there would be many different activities taking place in each space over the course of a week. For example, on a Friday afternoon, the downstairs meeting space would be given over to the art group; the same space was also used as an overflow for the café at lunchtimes when lunch service was particularly busy. This area had a partition wall that could be pulled across if necessary, but this was left open most of the time.

The spirit of the Clubhouse encourages group working and collaboration, and this can be further facilitated by having an ‘open-plan’ style setup (Becker and Sims, 2001). Having meetings in the ‘open’ spaces of The Club (see Figure 7 for an example) meant that members felt more able to join in, whereas the anxiety involved in knocking on a door and entering a meeting room may have discouraged some from getting involved. This setup also allowed for easy surveillance of most activities in the house. This was important from a safeguarding perspective, as it was the responsibility of all The Club staff to ensure that the space was a safe and welcoming environment for all inside it. However, the open plan layout also allowed for the possibility of surveillance of all work and member interaction within the Clubhouse, as another means of

‘guaranteeing obedience’. The prospect of surveillance of the individual is one of the most powerful disciplinary techniques of normalisation as it encourages individuals to ‘follow the rules’ at all times, as “it is the fact of being constantly seen, of being able always to be seen, that maintains the disciplined individual in his subjection” (Foucault, 1995:187). The Club setup did not allow for members to be covertly surveilled, and members were certainly not watched at all times, but the potential for constant surveillance existed. The knowledge of the possibility of constant surveillance may have prevented members from undertaking ‘harmful’ behaviour, but it did not necessarily discipline members into ‘productive subjection’ through work. Neither would it necessarily induce members to “make-work”, which is the act of looking occupied when one knows they are being observed (Goffman, 1959:68). As all work was voluntary, and members were not penalised for choosing not to participate, the notion of being surveilled would not necessarily be an incitement to undertake work tasks.

Figure 7: Photograph of one of the ‘open’ spaces of the upstairs of The Club, where meetings and activities took place. Photograph taken by author on 24th October 2017.

The open-plan setup, though vital for Clubhouse functioning, meant that sometimes parts of the Clubhouse could be noisy and busy, most notably the kitchen and café area during lunchtime. A delicate balance was required to have

open workspaces that were conducive to group work and conviviality, but also spaces available that allowed for privacy on occasion, that also helped to temper the disciplinary apparatus of surveillance by preventing total "omnivisibility" (Foucault, 2006b:48). There was opportunity for privacy, in the one-to-one space, and in other rooms that were not in use for other activities, such as the conference room and the CEO's office. Even in a community that promotes working together, sometimes there is a requirement for privacy or confidentiality, and the provision of spaces where it is possible to have a private conversation is important for the wellbeing of the people in the workspace (Margulis, 2003). While Katie's wish for a sensory room was not able to be fulfilled, there were still spaces of quiet that one could find to take a moment away from the hectic activity of the work-ordered day.

5.2.2 Task Allocation in the Work-Ordered Day

The method of allocation of work tasks at The Club reflected the spatial setting of those tasks: tasks that took place upstairs were allocated upstairs, and downstairs tasks were allocated downstairs. As explained in the methodology chapter, the work units that were based upstairs during my fieldwork were: work and learning, business and administration, finance, media, and eBay and Amazon. The work units based downstairs were: kitchen and café, membership, and health and wellbeing. Units had one or two members of staff dedicated to overseeing the work of the unit and were based on the floor that their unit was located in. Tasks were allocated centrally on each floor at task allocation meetings, and all available staff and members were expected to be at these meetings, as an opportunity for everyone to come together and understand which tasks needed to be completed that day. Tasks were allocated twice a day, first thing in the morning, and after the lunch break. There was a whiteboard upstairs and another downstairs where tasks were displayed. There were some tasks that needed to be completed daily, others weekly, and some monthly. These tasks were written on the board permanently or printed on a card and placed on the board when the task was to be completed. Other tasks that were one-off jobs were written on the board at each task allocation meeting. In the meetings, a member or staff member volunteered to stand at the board, read out each unit or work heading, and staff members announced any new tasks to be completed. All tasks were read out and individuals volunteered to undertake

them. The name of the volunteer was written next to the task, so everyone knew which jobs had been allocated.

An advantage of the whiteboard system of task-allocation was that it allowed members to arrive at any point during the work-ordered day and immediately know which tasks were still to be undertaken, so that they could volunteer themselves for these tasks:

> "I get on with things myself, because what happens is there's usually an itinerary where things are actually listed on a board so what would happen is people would take particular jobs from the board and actually do the tasks themselves" (Cameron, member for seven years).

The boards created a level of autonomy within the membership and allowed members to follow what was happening within each unit on that day. Organisational psychologists have identified the premise of 'job crafting', that jobs are not wholly defined by formal job descriptions or requirements but are shaped by workers in order to create work identity, or a meaning in one's work. These acts of crafting most frequently involve "changing cognitive, task, and/or relational boundaries to shape interactions and relationships with others at work" (Wrzesniewski and Dutton 2001:179). This term relates specifically to individuals in paid employment, however it also has some relevance within a Clubhouse setting. Job crafting is generally understood to be a positive action that enables workers to experience greater meaning in their work (Wrzesniewski et al., 2013). Allowing members to choose their own work tasks enabled them to create a work-ordered day that potentially offered a greater sense of meaning than just being assigned work tasks, and the opportunity to make these choices about work could be empowering. These 'empowering' work choices still require engagement with the 'right' choices that one can make within the 'normalising' method of personal mental health recovery (Rose, D., 2014), however as members also had the choice not to participate at all, the disciplinary potential of the work-ordered day is weakened (Foucault, 1995).

During my ethnographic fieldwork, the layout of the upstairs task allocation board changed several times; Figure 8 provides a close representation of how the upstairs board was laid out towards the end of my fieldwork visits. The

upstairs board listed tasks mostly by occupational category, such as tasks relating to finance or to social media. On the right-hand side of the board there was also important information such as which staff member was the designated fire warden for that day. The 'floater' tag referred to a member of staff who was based upstairs each day, whose job it was to generally facilitate the work-ordered day. The role of floater rotated between upstairs staff members. If a member came upstairs and was at a loss as to which tasks needed to be completed, they could approach the floater to ask for a task. Additionally, the floater was there to help members in undertaking tasks should they run into any issues. It has been recognised that an important accommodation for disabled workers is that they feel supported by others in the workplace (Buhariwala, Wilton and Evans, 2015). Supporting members to work was part of the staff role for all members of staff at The Club, but the 'floater' position allowed for a staff member to specifically focus upon this each day, and to signal to members that they were encouraged to ask for help if they needed it.

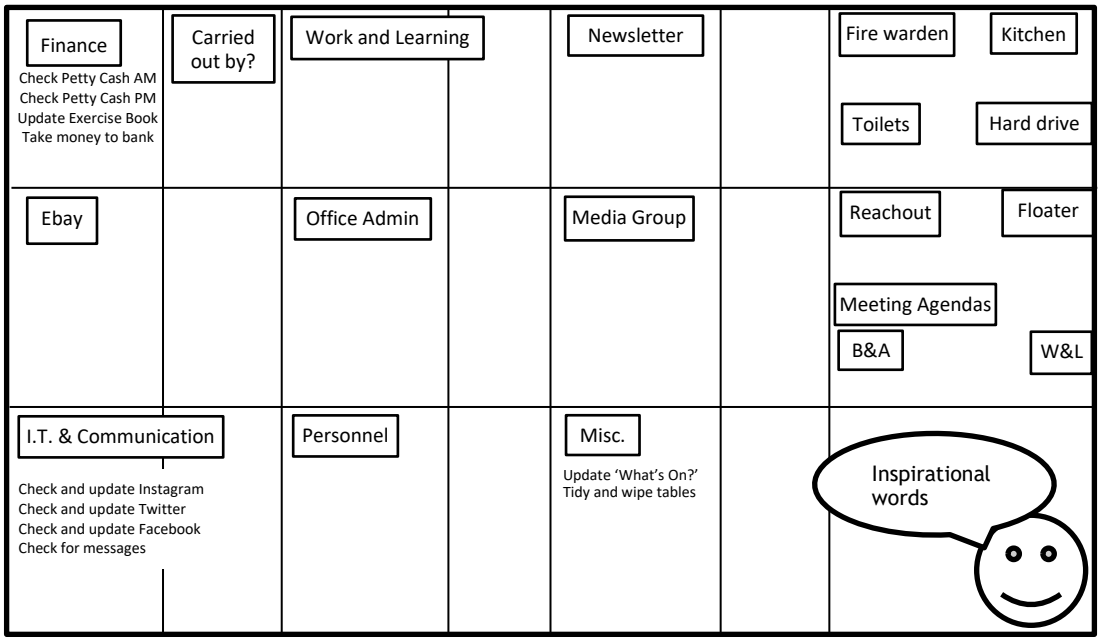


Figure 8: Visualisation of the upstairs task board in The Club.

The spatialities of the downstairs of The Club that we considered in the previous section of the chapter, particularly in relation to the kitchen and maintaining safety and hygiene, meant that the division of most work tasks downstairs were more clearly defined spatially. This was reflected in the way that tasks were listed on the task allocation board, as represented in Figure 9. The downstairs task board listed a number of tasks that were essential to the daily running of

The Club and without which the daily functions of the house would have ceased to operate. This was again related to the tasks of the kitchen, such as food preparation and cooking, but also those of the café, such as the cleaning and restocking of mugs and glasses, and ensuring there was enough milk in the fridge. Listing the tasks that needed to be undertaken daily, and in the morning or afternoon created some temporal structure and provided a 'better economy of time' within the work-ordered day (Foucault, 1995), however this timetabling was not rigid and sometimes tasks could 'slip'. It was the responsibility of the paid Clubhouse staff to ensure that all tasks were completed within the required timeframe (Clubhouse International, 2018). Within The Club, both staff and members expressed that there were improvements to be made in the way that the tasks of the work-ordered day were listed and presented on the whiteboards. On first approach, these whiteboards could seem quite intimidating and difficult to read, even before accounting for any issues one may have with literacy or learning difficulties.

DAILY TASKS FOR DATE

	KITCHEN	CAFE	RECEPTION	OTHER TASKS
MORNING	Cooking Short order prep Lunch tasks Local shopping Allergens Check traps	Clean tables Wrap cutlery Check drinks in fridge Check tea and coffee stock Check milk date	Reception Cover Reachout Cards Typing Stats REACHOUT	
AFTERNOON	Check fridge/ freezer temps Take bins out Take food out freezer for tmrw Check dates on fridge items	Clean tables Sweep floor Mop floor Restock mugs and glasses	Reception Cover Reachout Cards and Letters Hoover	

Figure 9: Visualisation of the downstairs task board in The Club.

There was negotiation around making the boards and the tasks on them more intuitive and accessible for all members:

> *At the accessibility meeting this morning we discussed ways of making the task boards more accessible for members. A member suggested using more images and pictorial aids for the boards, as many of the members struggle*

with English literacy. She offered to bring in some picture cards that she uses in her supported accommodation as a guide. We discussed how it is probably necessary to create some simple 'how to' guides for some of the tasks in the house, particularly those that involve using equipment such as a computer. We decided these tasks should be printed on paper, using a dyslexia friendly font, and demonstrative figures. We also considered using coloured paper to print these on but need to do more research on this. (Field diary extract 4th April 2018).

In a place of formal employment, we may consider pictorial aids to be a 'workplace accommodation' for a disabled worker. Employers are required to make 'reasonable adjustments' to workplaces to accommodate disabled workers, under the Equality Act (2010). As the work tasks within The Club for members were not paid employment, the same requirements to make workplace accommodations in the work-ordered day did not apply. The Club of course made much effort to be as inclusive as possible to all of its members, but as a charitable organisation it had limited financial resources, meaning that often staff and members were required to 'make do' with whatever resources were available. The discussion referred to in my field diary extract was quite typical of many discussions that took place during my fieldwork: both The Club staff and members were hugely committed to making the Clubhouse function better for everyone.

In Tanaka and Davidson's (2015:272) description of a 'typical Clubhouse', whiteboards are described "as if [they are] a symbol of the Clubhouse." The impact of using large whiteboards to list tasks meant that the tasks of the house were visible to everyone, so members knew what needed to be done, but more importantly tasks could be 'ticked off' after they were completed. Members 'saw' the impact of their work and appreciated that their presence in the house was valued, which could have contributed to members' 'sense of mattering' (Conrad-Garrisi and Pernice-Duca, 2013). Foucault (2006b:49) notes the significance of what he describes as "the game of writing in discipline." This is the way that individuals are disciplined through note-taking and record-keeping; their actions and behaviours are disciplined through the knowledge that there is a record of their movements being kept. The task whiteboards present an example of this: members may be more likely to undertake the work tasks they

have volunteered for because there is a written record of their name on the task whiteboard which will be 'checked up on' at the next task allocation meeting. However, this surveilling of work through writing is scrambled as a disciplinary technique in several ways both by the Clubhouse and by members. Firstly, as all work is voluntary, members face no punishment for not completing a work task, they will continue to receive support from The Club and will be treated no differently. Secondly, as meetings are attended voluntarily, members can choose not to attend a task allocation meeting, so they do not need to account for themselves if a task is not completed. Finally, the disciplinary power of these handwritten words is transient, as the names on the whiteboard can be easily wiped away.

5.2.3 Meetings and Breaktimes in The Club

In addition to the task allocation boards, the work-ordered day was structured temporally around various meetings and break times. The meetings were designed to allow the units to plan out longer term goals and translate these goals into tasks that could be completed as part of the work-ordered day. Everyone was welcome at all meetings, but attendance was not compulsory. I attended many of these meetings throughout my fieldwork, and they could vary substantially in length of time, number of members in attendance, number of agenda items to be discussed, and the feeling of progress being made or decisions taken on unit issues. Due to the sheer volume of activity taking place within the house; different members and staff would be in attendance at meetings each week, therefore sometimes content would need to be repeated from one meeting to next to ensure everyone in attendance was familiar with the topic of discussion. Despite this repetition, having a strong structure of meetings is essential to the facilitation of the work-ordered day:

> "the Clubhouse must have strong internal processes for members' involvement – meaningful, engaging work that is delivered through the units in a full and vibrant work-ordered day" (McLean and Keys, 2016:2).

The unit meetings, whilst perhaps not always appearing to substantially progress the work of the unit from week to week, were very important in ensuring transparency in the work of each unit and ensuring that there was opportunity

for all members to engage with the work. In addition to being the main forum for discussing unit work, the meetings were also expected to serve another function, to create community and enable relationships within the house to grow:

"Standard eighteen, under 'work-ordered day': The Clubhouse is organised into one or more work units, each of which has sufficient staff, members and meaningful work to sustain a full and engaging work-ordered day. Unit meetings are held to foster relationships as well as to organise and plan the work of the day" (Clubhouse International, 2018:2).

The creation and maintenance of relationships throughout the community of the Clubhouse will be explored in the next chapter; however it is imperative to consider the purpose of standard eighteen in the context of work structure. In The Club, work was used to engage members individually to facilitate personal meaning-making, but the working community could only function if member-member and member-staff relationships were built as well. In unit meetings, all those in attendance sat around a table, and discussions were held around each item on the agenda for that week. The meeting was chaired by one individual, there was a guidance sheet provided in the meeting areas to offer prompts to members about how to lead the meeting. Unit meetings allowed for these relationships to develop and additionally enabled members to become involved in the planning of the work and to feel like a colleague alongside staff members. Kinn et al. (2018) have identified the importance of enabling Clubhouse members to feel involved in work organisation in order to develop their 'professional identity'. In addition to meaning-making and forming social connections, establishing a 'positive sense of identity' is also one of the goals of the 'CHIME' framework of personal mental health recovery (Leamy et al., 2011). The focus upon forming a *professional* identity may indicate an emphasis on 'normalisation' in which individuals are encouraged towards paid employment in the future (Rose, D., 2014). However, if members were involved in all aspects of facilitating the work of the Clubhouse, they could have a greater understanding of the purpose and functions of the work-ordered day and therefore may have the opportunity to experience individual work tasks as genuinely personally meaningful, as they understood the importance of the contribution of each

individual task to maintaining and enhancing the Clubhouse (Hancock et al., 2013).

In addition to planning unit work, unit meetings provided temporal structure within the work-ordered day that other tasks could be structured around. The "detailed partitioning of time" through the rigid timetabling of activity is yet another disciplinary apparatus that was traditionally used to regulate the behaviour and actions of individuals in institutions (Foucault, 1995:150). In the asylum, "all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next" (Goffman, 1961:6). As a 'non-institutional space' The Club still utilised the timetabling of activity as a means of regulating the actions of individuals and use of space. Figure 10 is a photograph of a printed timetable showing the recurring weekly meetings and groups that took place in The Club, that demonstrates how the work-ordered day was highly structured around 'fixed' meetings and groups. These meetings provided a framework around which the 'doing' of the work took place, both as a means of planning the tasks, but also by offering specific time windows between meetings for these tasks to be undertaken. However, members were only subject to the disciplinary framework of the timetable if they chose to participate in the work-ordered day, and as Clubhouse attendance was voluntary, members were free to leave at any time.

The timetable shown in Figure 10 presents a rigid and 'static' impression of the work-ordered day. This is an inaccurate impression for several reasons. Firstly, the activities that appeared so 'fixed' in this timetable were not so. Some of the activities that were facilitated by external providers or required additional funding were time-limited. 'Love Later Life' or 'Lingo Flamingo' could not be sustained permanently with core Clubhouse funding or by Clubhouse staff alone. Secondly, the timings of 'core' meetings could change over time to coincide with times when more members were in the house or fit in better with staff schedules. For example: during my fieldwork period the time of the membership meeting moved from the morning to the afternoon in order to better suit the timetables of staff and members who frequently attended. Thirdly, this timetable shows none of the activities that members participated in that were outwith the building of The Club; but there were several activities that they were only able to take part in because of the support of The Club staff. This

included visits to the off-site allotment but also walking groups, social events, and attending other services, such as a local woodworking workshop. Finally, this image provides only a single snapshot which in no way captures "the vibrancy of the place" (Fiona, member for ten years) of The Club. While the work-ordered day provided structure for the work tasks, this did not make it immutable or inflexible. We have already examined the need for flexibility in the Clubhouse structure, such as on the days that the kitchen underwent a deep clean. In the remainder of this section, I hope to be able to bring some descriptive 'liveliness' to this understanding of temporal structure, which will elucidate the ways in which The Club both adopted and disrupted disciplinary techniques through the structure of work. I aim to demonstrate that The Club was "a site of embodied performance" of work (McDowell, 2009:11) and that the disciplinary power of this work was pervasive even during the times designated as time for 'rest'.

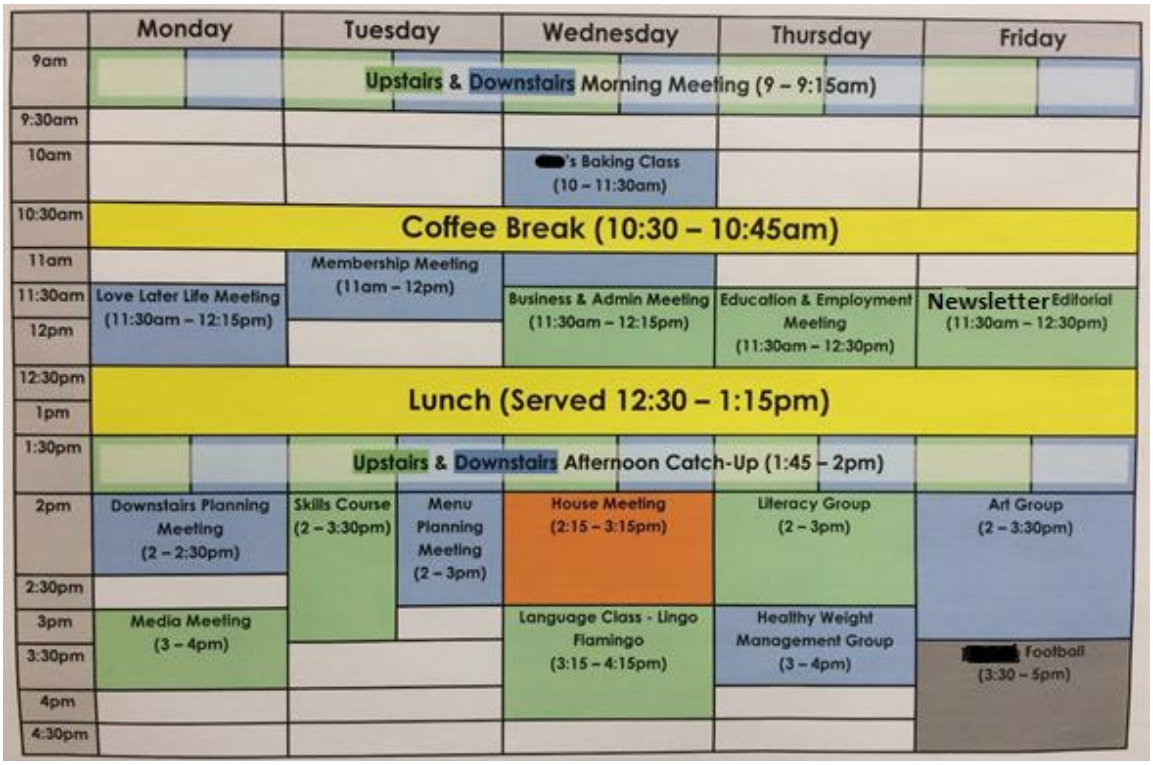


Figure 10: Photograph of a timetable of meetings and break times during the work-ordered day in The Club. Photograph taken by author on 10th October 2017.

In addition to meetings, the other type of regular 'event' that temporally structured the work-ordered day was the time that was taken as 'break' time from working. There are two break times shown in Figure 10, the fifteen minute morning 'Coffee Break' and the forty-five minute lunch break in the middle of the day. However, for many members in The Club, these times were their

busiest and most ‘productive’ in terms of work tasks. The ‘Coffee Break’ was the time when the whole of The Club got together for a meeting. Announcements were made, and the schedule for the day was discussed. At least two people were required to facilitate this meeting, this facilitation constituted a work task. Additionally, the meeting was held in the café, so the number of customers and amount of purchases increased significantly during this time, increasing the workload of the member who was working at the café counter. Another important matter that was discussed during the coffee break was which tasks needed to be undertaken at lunchtime, and who would take on these roles. The lunchtime service in The Club café (see Figure 11 for a photograph) operated with at-table service, therefore there were work roles for three order-takers and two servers. There were two people working behind the café counter, one on the till and one making drinks. There was also the role of maître d’, this person stood and fielded questions, requests, and complaints about food service between the café and the kitchen. There were usually four or five people working in the kitchen as well, serving various parts of the three-course meal, with another person making short orders of toasties, sandwiches and baked potatoes. In some respects, these lunchtime roles were very similar to service roles in a restaurant. Philip Crang (1994) in his own autoethnographic research as a restaurant waiter describes the work as ‘performance’, one that requires specific knowledges and practices, and the aptitude with which one undertakes this performance can invoke strong feelings of success or failure. Taking on the role of lunch-time order-taker at The Club required adopting a ‘role’ and putting on a kind of performance, that demanded ‘relational encounters’ with staff and other members (Goffman, 1959) that was not necessarily required in other work tasks in the house. For work to be totally disciplinary, it “imposes the best relation between a gesture and the overall position of the body, which is its condition of efficiency and speed” (Foucault, 1995:152), meaning that the whole body is engaged to carry out the work as efficiently as possible. However, the fact that The Club did not demand the “general bodily presentation of self that mark[s] out an appropriate performance” that is required to undertake many paid service work roles (McDowell, 2009:50) meant that this efficiency was not expected. Members were not required to dress in a certain way or follow a particular script. Furthermore, the opportunity for members to make mistakes in their work, and for there to be no ‘punishing’ consequences for this, and then

for members to be able to undertake this same work task again, with the possibility to learn, or make mistakes again, demonstrates The Club's power to unsettle some of the disciplinary aspects of work. This also enabled members that would otherwise not have the opportunity to 'try out' this kind of work to do so in a supportive environment. However, the demands of this task did exclude some members from participating, as it required the ability to communicate verbally, to have the capacity and energy to be mobile for thirty minutes, and the ability to read, write and do simple arithmetic. Therefore, whilst The Club was a more inclusive work environment than many 'mainstream' workplaces (Hall, E., 2004), not all tasks were necessarily inclusive.

Figure 11: Photograph of the café counter and some of the café seating in The Club. Photograph taken by author on 24th October 2017.

To provide a demonstrative example, the specific tasks required in the 'performance' of the role of lunchtime order-taker is described in Figure 12 below. The explanation of this work role is based upon my experience of undertaking it, having learnt how to fulfil the role from Clubhouse members. There was not a written guide to fulfilling the order-taking role whilst I was carrying out my fieldwork, rather members learnt by following the example of others, through peer teaching and support. This not only facilitated more

opportunities for members to interact with and learn from each other, the absence of a 'script' for this task also reduced the disciplinary capacity of the work, as the role of the 'performer' was not so strictly defined (Goffman, 1959). I often undertook this role during my fieldwork period at The Club, as it offered me the opportunity to learn the names of members and allow them to become familiar with my presence. I found the order-taking role physically and mentally demanding, as it required being on one's feet for some time and a significant amount of social engagement. For anyone undertaking a lunchtime work task, the embodied effort required could be significant:

> "when we're order-taking for lunch and for someone with severe mental health, sometimes it can be quite a big step to do order-taking or do different kinds of stuff like that. So it's quite a big role" (Katie, member for one year).

The activities of the work-ordered day in The Club were structured so that different members worked at different times. The result of this is that despite the principle of 'understaffing' the Clubhouse (Kinn et al., 2018), there was usually a member of staff available to offer support or a member around to offer peer support for other members undertaking work tasks. If the member did make a mistake or 'fail' at the task, there was always someone able to take over, and therefore some of the pressure in undertaking a 'big role' was relieved. This also means that while there were times framed as 'break-times', work was pervasive throughout the work-ordered day:

> "Discipline… arranges a positive economy; it poses the principle of a theoretically ever-growing use of time: exhaustion rather than use; it is a question of extracting, from time, ever more available moments and, from each moment, ever more useful forces" (Foucault, 1995:154).

Therefore, while the breaktimes appeared to provide some respite from the 'detailed partitioning of time' of structured activities in the Clubhouse, the disciplinary power of work persisted in these parts of the work-ordered day as well (Foucault, 2006b). In understanding how the disciplinary structures of the work-ordered day are enacted, we need to examine what exactly is considered to be 'work' within the context of the Clubhouse International standards. Through this we can glean a better understanding of how members viewed work

in The Club, and whether they found this work meaningful, and even if it could facilitate 'personal mental health recovery' for them.

To undertake the role of order-taker at lunchtime, you need to arrive in the café ten minutes before lunchtime service begins. This allows you the chance to see what is on the menu, find out who else is working the lunchtime service, collect a bundle of order forms and a pen, and be ready to start taking orders promptly at 12:30pm. You may negotiate with the other order-takers about which sections of the café each person will cover during the lunch service.

When lunch service begins, approach a table in the section you have agreed to cover. Ask one person at the table what they would like for lunch. Tell them what is on the menu if they ask, for example if they are unable to read what is written on the menu board. Write the customer's name at the top of the order form. Tick the appropriate boxes on the form, and double check that you have got their order correct. Ask the individual if they would like a drink. Tick the corresponding box, if they ask for tea or coffee remember to check whether they take milk and sugar. Add up the cost of the items, using the 'notes' section of the order form to do this if necessary. Write the cost of the meal in the 'Total Cost' section of the form. Inform the customer of the cost and wait for them to give you their money. Check that the money they give you covers the cost of the meal they have ordered. If they do not have the money to pay for the meal, they should have an I.O.U. issued that they can give you in lieu of payment. If the member does not have an I.O.U, ask them to go and get one from a member of staff.

Once you have the money or I.O.U. from a member, take the order form and the money over to the till, and wait until the worker at the till is free to process the order. Give the worker at the till the order form and the money and tell them the cost of the meal. If the order contains a drink, ask the worker that is making drinks to prepare the correct drink for you. Wait for the till worker to give you the correct change if necessary and collect the drink from the drink maker. Take the drink and change back to the customer. Approach the next person on this table and repeat this process.

When you think you have covered all the customers in your section, ask if there are any other orders still to be taken. When all orders have been taken, ask the other individuals working on the lunchtime service whether it is alright for you to sit down and eat your own lunch now. Be sure to inform the kitchen that you are going to sit down so that they can make sure you are served your meal.

Figure 12: Description of the tasks required in the lunchtime order-taker role at The Club, reconstructed from ethnographic notes.

5.3 Constituting Work in the Clubhouse

5.3.1 Defining Work through the Clubhouse Standards

The specific types of tasks undertaken as part of the work-ordered day in The Club were guided by the Clubhouse standards. As the Clubhouse actively worked to ensure that it was not a medicalised space, any task that appeared to focus on 'therapy' or 'cure' was not permitted, as is expressed in standard fifteen:

"Standard fifteen, under 'work-ordered day': The work-ordered day engages members and staff together, side-by-side, in the running of the Clubhouse. The Clubhouse focuses on strengths, talents and abilities; therefore, the work-ordered day must not include medication clinics, day treatment or therapy programs within the Clubhouse" (Clubhouse International, 2018:2).

The Club closely followed this standard and did not run any kind of programme that involved managing members' psychiatric medication or offered any kind of psychological therapy. However, this did not prevent some activities of the house from comprising therapeutic elements; what constitutes a 'therapeutic' activity is personal and individual, just as finding meaning and purpose is personal and individual. Previous research with members in the original Clubhouse, Fountain House in New York demonstrated that participating in work that feels 'purposeful' may be experienced as therapeutic (Chen and Oh, 2019). Furthermore, as work in the Clubhouse is intended to facilitate personal mental health recovery (Doyle, Lanoil and Dudek, 2013), in a sense all work in the Clubhouse may be considered 'therapeutic' (in the sense of healing an illness) to the extent that it is intended to have a rehabilitative purpose, to 'restore reason' in the individual (Foucault, 2006a). Additionally, there may be work tasks that have a therapeutic outcome, but that also serve another purpose. Filling the work-ordered day with both 'productive' and 'therapeutic' activities prevented the work in the Clubhouse from becoming undesirably 'work-dominated':

> "the Clubhouse ceases to be work-ordered, and becomes work dominated. Instead of not valuing work at all, which is the other extreme distortion in many Clubhouses around the country, these clubs make work and productivity the reason for the program. Work

> becomes a god that we serve instead of having work serve our needs" (Vorspan, 1992:52).

Within the Clubhouse model, work within the work-ordered day is a tool to be used to facilitate mental health recovery, therefore members' experience of undertaking the task is more important than the specific productive output of the task. Whilst the undertaking of work might be used to lead members towards 'normalisation' (Rose, D., 2014) the focus of the work-ordered day is that work will provide a sense of meaning to individuals rather than members becoming 'productive workers' (Rose, N., 1999b). Some therapeutic activities did take place within The Club (though not 'clinically' therapeutic activities such as medication management) and the boundaries of what constituted an acceptable proportion of therapeutic activity as part of the work-ordered day was negotiated during the course of my fieldwork:

> *At the upstairs morning catch-up meeting, there was a discussion between three staff members about whether the introduction of 'brain-training' games would mean there were too many activities within the house that were primarily focused on either social or therapeutic outcomes, rather than work or occupational outcomes. The other activities that might already be considered as not strictly work-based are the art group and the knitting group. In the end, the consensus seemed to be that brain-training was acceptable, as it did not have purely therapeutic outcomes, it also had learning objectives. As long as the balance is not tipped, as long as the majority of the activities in the house are work focused, then it seems that many activities are acceptable. (Field diary extract 9th January 2018).*

Groups such as the art group and knitting group were popular in the house, partly as they provided the opportunity to commune with other members and because they gave members the chance to create and produce something. Gavin, a longstanding member of The Club noticed that there had been a shift to include more activities that had creative outcomes, he saw this as a positive action:

> "I think things have changed recently and it has become more about creative things, not just the work-ordered day. There has been more about creativity. [I'd] not necessarily change the project but I'd

maybe like a few more things that are not work-oriented" (Gavin, member for twenty years).

The brain-training group, an activity that allowed members the chance to undertake cognitively challenging games and puzzles together, allowed for interaction that enabled the building of relationships and social networks within the house; forming social connections is recognised as an important aspect of 'recovery' in the 'CHIME' framework of personal recovery (Leamy et al., 2011; Pernice-Duca and Onaga, 2009). The work-ordered day was designed to facilitate relationship building, by encouraging group work. We have already examined how unit meetings were intended to foster these relationships, and in The Club this happened with varying success. However, including more activities that actively engendered group participation, even if the activity did not actively facilitate the work-ordered day could allow the work tasks to run more smoothly. Roth's (2017) research in a US Clubhouse noted that while members overall valued the work-ordered day and its purpose, some became slightly frustrated that the focus on undertaking work tasks could sometimes reduce the amount of peer interactions that were possible, as not all work tasks were group-oriented. Therefore, these activity groups in The Club did more than just provide a therapeutic activity, they enabled members to improve social skills and form working relationships. These stronger member-to-member relationships could assist the smooth running of the work-ordered day, arguably ensuring the maintenance and enhancement of the Clubhouse. As the previous field diary extract demonstrates, The Club staff worked hard to maintain the balance between valuing work and not allowing work to dominate, it was a constant process of negotiation.

Another defining feature of the work-ordered day within The Club was that the work that was undertaken within it was unpaid, as was laid out in the Clubhouse International standards:

"Standard sixteen, under 'work-ordered day': The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members

are not paid for any Clubhouse work, nor are there any artificial reward systems" (Clubhouse International, 2018:2).

There were several reasons for this, not least that it would be financially untenable to pay members for their attendance; and paying members for undertaking individual tasks would be very complex and could cause conflict within the membership. Furthermore, participation was voluntary, members were not required to undertake tasks. Finally, the principle driving the work-ordered day was that members would be motivated to participate through the notion of maintaining and enhancing the community; paying members for undertaking these tasks may push the motivation for work more towards individual personal profit rather than contributing to the Clubhouse. As mentioned in the methodology chapter, the Clubhouse also offered a small number of Transitional Employment Placements (TEPs) that enabled some members to gain some paid work experience. TEPs were time-limited job placements in partner organisations outwith the Clubhouse, paid at a 'competitive' wage. The specificities of TEPs and the issues involved with running them alongside the work-ordered day will be explored in the final empirical chapter; but it is significant to consider that The Club also had a programme that encouraged members to enter paid employment. This suggests the focus upon 'work' is indeed an effort to 'normalise' members within a capitalocentric society (Evans and Wilton, 2019), with the intention of guiding members towards paid employment in the future. However, the Clubhouse International standards explicitly state that the work of the work-ordered day is not 'employment training':

"Standard nineteen, under 'work-ordered day': All work in the Clubhouse is designed to help members regain self-worth, purpose and confidence, it is not intended to be job specific training" (Clubhouse International, 2018:2).

The 'CHIME' framework of personal mental health recovery anticipates that individuals will be able to 'recover' by finding meaning in life and feeling empowered (Leamy et al., 2011). The Clubhouse model upholds the idea that the work tasks of the Clubhouse can enable this recovery by ensuring that all work feels purposeful to members. Whilst it is problematic to suggest that a member should find meaning in a task that encourages 'normalisation' to the

labour-focused norms of society (Rose, D., 2014), members at The Club did state that they benefitted from taking part in the tasks of the work-ordered day, and that in spite of the lack of pay the work-ordered day offered a unique opportunity to connect with and learn from others with similar experiences (Coniglio, Hancock, and Ellis, 2012). The benefits of undertaking work tasks included: enjoyment of the tasks they were undertaking, learning new skills, or building self-esteem:

> "It helps me learn new skills. Sometimes, I generally base myself upstairs in the business and admin unit but I've been involved in counting the petty cash, I've been involved in putting stuff on eBay… I've been involved in the café" (Katie, member for one year).

> "I think one of the things that struck me, is how much pleasure I got from doing simple things, just simple things that were not taxing. Just putting stamps on envelopes or doing simple things that were not upsetting me or stressing me, but were still useful" (Gavin, member for twenty years).

Both Katie and Gavin appreciated that their experiences of mental ill-health had an impact on their ability to undertake work tasks, and therefore they saw the value of undertaking smaller tasks within the house and how this could help them to restore their confidence and stamina. They also understood the importance of these small tasks in contributing to the work-ordered day, and how each task offered the opportunity to work towards building the community, and this helped them find personal meaning in work (Pernice-Duca, Case and Conrad-Garrisi, 2012). Katie and Gavin's experiences also offer some insight into the types of tasks that a member might be encouraged to undertake within the course of the work-ordered day; alongside the tasks listed on the boards in Figure 8 and Figure 9 in the previous section.

In Figure 13 I temporally lay out a creative portrayal of a 'typical work-ordered day' that may be undertaken by a member at The Club. This was not the specific day of any one member, but was compiled from data from various member interviews, from The Club documentation concerning the work-ordered day, and from observing and participating in the work-ordered day myself. Through this theoretical 'typical' work-ordered day I have attempted to illustrate a variety of tasks and meetings that took place both upstairs and downstairs in The Club. This portrayal includes a lot of tasks, and many members would not necessarily

undertake all these tasks over the course of a single day. However, it demonstrates the capacity for members to be 'occupied' with tasks for the entirety of the work-ordered day if they chose. The "presence of structure" provided by the work-ordered day and the timetabling of meetings and breaktimes "promoted participation and links between people who might not otherwise get involved" (Prince et al., 2017:9). In addition to the work providing 'purpose' and an opportunity to regain 'self-worth', the structure offered through the work-ordered day enabled members to make 'social connections' which are also an important aspect of the 'CHIME' framework of mental health recovery. Therefore, it is apparent that the way that work is structured and defined through the Clubhouse model reinforces the 'normalising' discourse of personal mental health recovery (Rose, D., 2014). For some members, 'normalisation' was a desired outcome of their participation in the work-ordered day:

> "I think in a good phase, work makes me feel like I'm normal, like I'm part of society, that I'm useful, that I can contribute" (Gavin, member for twenty years).

In a capitalocentric society where one is constantly encouraged to be economically productive (Gibson-Graham, 2006), the desire to 'contribute' is unsurprising. Additionally, whilst a discourse of 'normalisation' is problematic in that it casts out those considered 'abnormal' (Foucault, 2004), the desire for social inclusion is common, and feeling 'normal' may be a way of experiencing this inclusion. Finally, as Katie and Gavin's testimony demonstrates, members did benefit from some of the outcomes that are associated with the work tasks of the work-ordered day, by learning new skills, and feeling 'useful', therefore members were able to make their own personal meaning out of this work, whether or not they considered work as significant to their 'mental health recovery'.

09:00 I arrive and sign in at Reception. I head straight upstairs to the morning catch-up meeting. The tasks that need to be worked on today are read out. I volunteer to check the general email account and update the social media pages.

09:30 I go downstairs to get a cup of coffee where I see a friend. We chat for ten minutes before I head back upstairs.

09:45 I find a computer, and successfully login to The Club email account and social media pages, after asking a member of staff to remind me of the password for the Twitter account. I check the Facebook page and Twitter account for any new followers or messages and I deal with enquiries to the email account, either by responding or forwarding them to the appropriate member of staff.

10:30 I head downstairs with everyone else, to the morning meeting. I am asked by a member of staff if I will lead the meeting with them, I agree. I read out the announcements and establish what meetings and groups are taking place in The Club today, whilst the member of staff writes them on the whiteboard. I remind everyone of the first aiders, fire wardens and health and safety officer for that day, and I then choose a member volunteer to read out today's Clubhouse standard.

10:50 I buy another cup of coffee. I am asked by another member to undertake a lunch task. I agree to take lunch orders.

11:00 I attend the membership meeting. I am asked whether I would like to take minutes in the meeting. I agree, but the effort and concentration involved in this task mean that I do not contribute suggestions in this meeting.

12:20 I head to the café to take up my role as order-taker for the lunch service. (See Figure 12 for an exemplification of this task).

13:10 Relieved from order-taking, I sit down and eat my lunch which has been reserved for me.

13:40 I go back upstairs for the afternoon upstairs catch-up. Going over the tasks on the board, I confirm that I have dealt with the emails and updated the social media pages. The task is 'ticked off' for the day. I do not volunteer for a task this afternoon.

14:00 I attend the skills course. We have been learning about podcasts for the past two weeks. This week we are scripting our own 'mock' podcast about living with a mental health diagnosis.

15:30 A staff member from downstairs telephones the upstairs units to ask if anyone is available to cover reception until closing. I offer, as I have forgotten to bring my knitting for the knitting group. It is a quiet shift at this time of day. There is one phone call, from a staff member from The Community Café. I forward the call to a downstairs staff member and spend most of my shift chatting to members who are on their way out, leaving The Club for the day. At 4.30pm, I follow suit, signing out at reception and leaving the Clubhouse.

Figure 13: A creative portrayal of a Tuesday in The Club, from the perspective of a member, reconstructed from ethnographic notes.

5.3.2 Finding a Routine and Being Occupied

In Foucault's (2006b:249) critique of the asylum, he contends that the institution obliged patients not to think about their illness but to "think about something else: read, work, go into the fields," that is to occupy the mind and body in order to distract from one's own 'madness'. However, in non-institutional spaces in which individuals are able to make the *choice* to participate in work or activities, and therefore choose to be 'distracted' (Tanaka, Craig and Davidson, 2015), the agency one has in making this choice can imbue the activity with greater meaning, and choosing to be occupied in order not to dwell on one's mental distress may be desirable:

> "I think work, voluntary work, paid work, it all helps, it can help towards your mental health and your recovery. Cos it gives you something to do. It gives you structure, routine, takes your mind off of other things" (Lee, member for six months).

> "At the end of the day, when I get home, it makes me feel… a good tired, knowing that I've been out and that I've been doing stuff all day. Keeping my mind occupied… knowing that I've helped and I've been able to help" (Catriona, member for eight years).

For these members, feeling 'usefully' occupied, being able to contribute something to a wider community, and not dwelling on their own difficulties, contributed to their wellbeing. This work left members with the experience of feeling 'a good tired' that remained after the work tasks had been completed. Thinking of the body as "a site of inscription" this residual tiredness is a visceral indicator for the member of their embodied engagement with work that day (Johnston, 2020:359), that 'inscribes' the member with a 'productive identity' as it demonstrates their capacity to be 'of use' in the Clubhouse. Within The Club, the 'presence of structure' of the work-ordered day provided a foundation upon which routine could be established, as the Clubhouse operated at the same times and on the same days every week (Prince et al., 2017):

"Standard Seventeen, under 'Work-ordered Day': The Clubhouse is open at least five days a week. The work-ordered day parallels typical working hours" (Clubhouse International, 2018:2).

However, whilst all the members I interviewed had heard of the work-ordered day, not all of them could explain its purpose or describe its function. A framework such as the work-ordered day, that structures both the individual's time and actions, as well as subjecting these actions to surveillance, only functions as a truly disciplinary power if the individual who participates within it understands and "assumes responsibility for the constraints of power" (Foucault, 1995:202). While this means that the disciplinary apparatus at The Club was incomplete, and that members were not constrained in this sense, it also raises the question of whether members understood that the work they were undertaking was supposed to be meaningful in contributing to the maintenance and enhancement of the Clubhouse. Further explanation of the work-ordered day and the Clubhouse ethos, and perhaps 'refresher courses' of these at regular intervals after member induction might have helped to ensure members could make informed choices about participating.

All members interviewed were aware that there were temporal elements configuring the work-ordered day, and several explained to me how this functioned to create structure within The Club:

> "It's providing structure, and it's meant to mirror kind of office hours, business hours. That's also to kind of reinforce the idea that we are here for a purpose and here to make this place run" (Fiona, member for ten years).

> "The work-ordered day aims to get people into the habit of, as if they were working in a real job. So they would come in at 9am and maybe leave at 2pm or 4pm. It's generally like, they do normal working hours, they don't really just stay for ten minutes" (Katie, member for one year).

Evans and Wilton (2016) have written about the 'meaningful routines' that can be created for individuals participating in supported employment in social enterprises. Philo, Parr and Burns (2005:784) found in their study of Training and Guidance units in the Highlands of Scotland that "being occupied in an organised and regularised fashion" was something that participants valued. Several members mentioned that coming to The Club had enabled them to establish routines, and some could easily recount their daily routines within The Club to me:

> "I normally come between 11am and 12pm, maybe have a cup of coffee… and then I'll have my lunch and I'll work in the kitchen for maybe two hours doing dishes, and sometimes I'll maybe do a worktop or two, I'll sweep and mop the floor, I've emptied bins before, we've done a big deep clean of the kitchen, I've helped out with that, I've checked fridge stock" (Fraser, member for three years).

> "I go in, I have a cup of tea, and then I might come upstairs to the business and admin and the work and learning people. Attend meetings, attend groups. Help with the typing and things. And sometimes just shredding paper and hoovering up. But other times I… can't be bothered with upstairs and I'll just help out in the kitchen. I like doing the dishes" (Lee, member for six months).

Participants identified that their daily routines within The Club were structured around particular tasks. Fraser and Lee both mentioned 'helping out' although neither of them specifically framed their routines around the wishes of others, suggesting they experienced significant autonomy in crafting their routines. They were aware of contributing to the Clubhouse community more broadly by taking part in smaller tasks that made up the work-ordered day, and this was enough to make them feel a sense of mattering (Conrad-Garrisi and Pernice-Duca, 2013). Their work involved attendance and participation, but they did not rely on the motivation of others to get involved. Interestingly, both participants stated that the first part of their routine in The Club was to purchase a hot drink. Testimonials from members from other Clubhouses have also noted the importance of 'sharing a coffee' in the social hub as a means of connecting with others in the space of the Clubhouse (Mitchell, 1995). Fraser and Lee did not mention specifically working with others in the work-ordered day to form social connections, but starting their days within The Club with a visit to the 'social hub' of the Clubhouse may indicate that the social networks within The Club were still important to their attendance (Pernice-Duca and Onaga, 2009), and indeed to any individual experiences of personal mental health recovery.

Unlike Fraser and Lee, other members did not provide such a coherent temporal narrative when asked to outline their daily routine within The Club. However, they still acknowledged the value of coming into The Club on a regular basis and participating in the work-ordered day to provide structure in their lives:

> "I can stay in the house and look at the four walls and then just start to fall asleep. At least if you've come here, you've done something" (Graham, member for two years).

> "I meet people, and on a social aspect, it gives me a structure to my day and also it gets me out of my bed in the morning and gives me something to do. Instead of sitting in the house just looking at the four walls" (Catriona, member for eight years).

> "It gives me a structured day, it gets me out of the house. My mum and dad are happy I'm coming here as well, they're really pleased" (Neil, member for seven years).

Having a "place to come" (Raeburn et al., 2013:376) motivated members to get out of their own homes where they may have been socially isolated, and to engage with and be motivated by others. Evans and Wilton's (2019) discussion of supported employment for individuals with diagnoses of SEMHCs notes the importance of 'getting out of the house' in regaining a sense of meaning in one's working life. Even without a complete understanding of the work-ordered day or participation in more structured work tasks, The Club members could benefit from spending time in a 'socially inclusive' space that gave structure to their day (Hall, E., 2004; Carolan et al., 2011).

The Club members continued to benefit from the routine and structure that Clubhouse attendance had afforded them even when they might be considered to have reached a level of 'normalisation' in their lives that was equated with 'personal mental health recovery' (Leamy et al., 2011; Rose, D., 2014). Attending The Club enabled these members to experience and practise how to implement structure in their lives and they were now able to apply this outwith the Clubhouse. Some members that had been attending the Clubhouse for a number of years had created routines that involved attendance at The Club, alongside other structured activities:

> "I've broken my life up into three different areas. One is exercise, the other one is actually helping people in the community and thirdly having a bit of rest time to myself and seeing my family" (Cameron, member for seven years).

> "I think for now, while I'm doing my two days [working] at [retail store] I've got three days a week I could come here. So I could do maybe five days a week and that's a good routine" (Fraser, member for three years).

Cameron considered his time at The Club as volunteer work where he could help his peers. He organised his two days at The Club around maintaining his own physical health and supporting his family. Fraser balanced his time at The Club with part-time supported employment in retail. The experiences of these members demonstrate the importance of 'being occupied' and having 'meaningful activity' to undertake, even when one is no longer living with extreme mental distress. Having the knowledge that one has lifetime membership, and therefore the Clubhouse is always a "place to return" (Raeburn et al., 2013:376) allowed members to pursue work or other opportunities outwith The Club, knowing that there was always the familiarity and the community of the Clubhouse to come back to. The notion of the Clubhouse as a 'place to return' gives members the opportunity to leave, try something else, and return to a place that will continue to support them and encourage them to try again.

5.4 Feeling Valued within the Clubhouse

5.4.1 Defining the 'Need to be Needed'

As we have already considered, the Clubhouse model encourages participation in the activities of the work-ordered day through the principle of the 'need to be needed' (Doyle, Lanoil, and Dudek, 2013). The need to be needed operates on the assumption that in addition to our basic needs for survival, we also have a yearning to feel as though our presence and skills are of use to other people (Rayle, 2006):

> "In a Clubhouse, each member is given the message that he or she is welcome, wanted, *needed and expected each day*. The message that each member's involvement is an important contribution to the community is a message that is communicated through the Clubhouse day" (Clubhouse International, 2019: no pagination; emphasis added).

The 'need to be needed' was coined by the former executive director of Fountain House, John Beard, and as such this principle is fundamental to the ethos of the Clubhouse. For members to understand that they have a 'need to be needed' and that this need could be fulfilled by attending a Clubhouse, certain conditions have to be constructed. First, there must be a task to be completed that requires a person's attendance and participation in the Clubhouse. This is

facilitated by creating the work tasks of the work-ordered day, which are usually the tasks that are essential to the everyday running of the Clubhouse. Second, the member needs to know that their presence is required in the Clubhouse to undertake the task. This is achieved by purposely 'understaffing' the Clubhouse, so that the work tasks of the work-ordered day can only be completed with the help of members:

"Standard nine, under relationships: Clubhouse staff are sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement" (Clubhouse International, 2018:1).

Next, members need to be encouraged to come to The Club to undertake these tasks. This can be achieved by creating a welcoming environment for members in the Clubhouse, and by staff asking members for help in undertaking tasks. Finally, when a member completes a task, they need to be told that their assistance is valued, and that their work is contributing to the maintenance and enhancement of the Clubhouse. At The Club, members were aware that their work was valued:

> "Work is recognised. People will say to each other 'thanks for doing that' or 'thanks for helping me with that'" (Fiona, member for ten years).

The hope is that this recognition of work will then fulfil the member's need to be needed and therefore contribute to their 'sense of mattering' (Conrad-Garrisi and Pernice-Duca, 2013). This means that the member is aware that their work is valued, and that others in the Clubhouse know who they are and depend upon them. If this experience is positive, the expectation is that the member will come back to the Clubhouse and participate again. The Clubhouse structures the work-ordered day to enable members to feel a sense of social inclusion, by making them feel needed within the Clubhouse. Successful implementation of this strategy increases the likelihood that members will return to the Clubhouse, undertake tasks, and interact with staff and other members. This can create social networks for members who otherwise might be quite isolated (Pernice-Duca and Onaga, 2009), which reflects Ed Hall's (2004) assertion that social inclusion for disabled individuals may be better facilitated by creating spaces that are inclusionary only for these disabled individuals. Therefore, the

Clubhouse may offer greater opportunities for members to form social connections than in 'wider society', fulfilling this aspect of the 'CHIME' framework of personal mental health recovery (Leamy et al., 2011).

The processes that facilitate the fulfilment of the 'need to be needed' were enacted at The Club: purposely understaffing the Clubhouse, encouraging members to come to the Clubhouse and undertake work, and making it clear to members that their contribution was valued. The phrase 'need to be needed' was not something that I noticed being discussed explicitly whilst I was undertaking my fieldwork, but it was evident that some members understood this concept and how The Club tried to fulfil this need:

> "It's structured so that there aren't enough staff members to make the place run. So right away you know that, as members, you're kind of needed. So that sets it out and then it's continually reinforced that we need as many hands as possible" (Fiona, member for ten years).

Fiona understood that members were encouraged to participate in all aspects of the work-ordered day. She also understood that each work task in the house was contributing to the broader goal of maintaining and enhancing the Clubhouse. She identified that this work was meaningful because it is needed within the Clubhouse (Tanaka and Davidson, 2015). She felt that contributing to the Clubhouse was a very worthwhile endeavour, as it was a space that could promote social inclusion or 'belonging', and maintaining this space for individuals with diagnoses of SEMHCs was very important:

> "It's to do with what I think is created in the Clubhouse environment. That belonging, that automatically makes [the work] feel valuable, feel important. It's like if we want this to continue to be the place that it is, then we're all part of that" (Fiona, member for ten years).

We have discussed the possibility that contributing to building the community of the Clubhouse could promote individual meaning-making when members understood that each individual task was important to keeping the Clubhouse operational (Hancock, Honey and Bundy, 2015). Additionally, to continue to have a space where one feels socially included, ongoing participation in the work-ordered day was required. This meant continued interaction, the opportunity to build relationships, and to learn and practise skills that help to build confidence:

> "I think the more you come in… the more you get to know people, the more opportunities are laid open to you. Certainly for companionship and friendship, the ability to learn new things, there's nowhere else" (Douglas, member for six years).

Douglas's experience of The Club is a prime example of the potential possibilities that participating in the work-ordered day can have for one's sense of mattering and the importance of the 'lifetime membership' that makes the Clubhouse a 'place to return' to (Raeburn et al., 2013). The first time Douglas was referred to The Club, he attended the Clubhouse once and did not engage with others and did not participate in a work task. He chose not to come back and his active membership lapsed. Sometime later, he was referred to The Club again and on his first visit he engaged in conversation with a member of staff. He was encouraged to undertake work tasks, and from doing this he would find he was interacting with more people, and he was presented with more opportunities to learn. This encouraged him to come back and participate more, and from doing this he became much more invested in ensuring The Club could continue to function.

Completing tasks as part of the work-ordered day bestowed members with individual responsibility for tasks that impacted the entire Clubhouse. Members could feel personal pride that they were being trusted with these kinds of responsibilities (Mandiberg and Edwards, 2013), which could help to promote individual self-esteem and feelings of empowerment, which is another key element of the 'CHIME' framework of personal mental health recovery, in addition to the social connections formed (Leamy et al., 2011). Research undertaken in Clubhouses has suggested that the ability to identify and pursue goals that one finds to be valuable can be empowering (Mowbray et al., 2004), the implication that the individual must self-motivate to identify and achieve these goals is a reflection of the problematic 'responsibilisation' discourse of personal mental health recovery (McWade, 2016). If someone was invested in continued participation at The Club, then it was likely that they would find value in contributing to its upkeep. However, sometimes bestowing the responsibility of the 'need to be needed' onto members would make them feel undue pressure to attend the Clubhouse, and to complete work to a certain standard:

> "[I] don't feel that I'm contributing sometimes, well I don't contribute sometimes to the group meetings, or learning computers, which I feel I'm somewhat behind in doing that. I just sometimes feel I'm not part of the, either socially or mentally up to doing anything useful within The Club" (Graham, member for two years).

Graham had feelings of insecurity and uncertainty about his contribution to The Club. He compared himself to other, younger members of the Clubhouse, considering himself 'slow' in comparison to them. Even in a 'protected' space for individuals with diagnoses of SEMHCs, Graham felt he had an embodied physical and mental difference to other members in terms of his work performance (Parr, 2008; McDowell, 2009). This demonstrates that even in 'inclusive' spaces, "social inclusion and exclusion are… 'entangled' within each other" (Hall, E., 2005:108). However, when he felt able, Graham did attend The Club regularly, attended meetings, asked for work tasks that he could undertake, and interacted with staff and members both in undertaking work and in a social capacity. Through his work and his presence, Graham was an asset to The Club, and it was clear that staff members valued his presence and enjoyed his company. I very much enjoyed chatting with Graham whenever our paths crossed in The Club, and he was one of the only members that actively approached me to participate in an interview for my research. The ethos of the Clubhouse attempted to help members feel a 'sense of mattering' but it could not of course guarantee it. However, Graham clearly still found some value in attending The Club, as he continued to attend and attempted to participate, whenever he felt able.

The extent to which an individual might have felt a 'need to be needed' in relation to their Clubhouse membership would of course vary from person to person. Some members were very committed to maintaining and enhancing the Clubhouse, others saw the Clubhouse primarily as a social space, and not as a place of work. Whilst participating in work tasks was strongly encouraged, it was of course voluntary. At times during my fieldwork I discovered tensions emerging over balancing the fulfilment of the common goals of the Clubhouse alongside the fluctuating work capacity or interest of individual members:

> "You get people saying 'oh yes I'll come in next Thursday and do this' and then 'oh I'm sorry I forgot all about it'" (Alasdair, member for twenty years).

Alasdair was a member who had a good understanding of the Clubhouse model and was committed to his work tasks in the Clubhouse. After reaching retirement age, he took a step down from many of his commitments, but in the past he had taken on a lot of Clubhouse responsibilities and found these taking up his time and mental energy outwith the hours of the work-ordered day:

> "I get very very anxious at times and I can't switch off at five o'clock and back on at 9 o'clock if I've got a problem with something within The Club, or anywhere, it's constantly with me. Even if it's Saturday, Sunday, it's with me all the time, because I just can't switch off" (Alasdair, member for twenty years).

Expecting members to take responsibility for tasks in order to fulfil their 'need to be needed' could make this work seem more meaningful, but this also presented the potential to 'let people down', which may have caused anxiety for some members. There were no 'punishing' consequences for members for non-attendance at the Clubhouse, but the 'responsibilisation' engendered by the 'need to be needed' could cause feelings of anxiety or guilt (McWade, 2016). To counter this, Clubhouse International (2018:2) make it clear that managing the Clubhouse is a *collective* responsibility and "responsibility for the operation of the Clubhouse lies… ultimately with the Clubhouse director." This was reinforced within The Club by encouraging group work and by supporting members to undertake a variety of different work tasks, so that absentee members were aware that there were other members who would be able to undertake those work tasks. As a 'working community', working together to complete the work of the work-ordered day was an inherent part of the ethos of the Clubhouse. The enactment of this philosophy of working 'side-by-side' (Tanaka, 2013) and the ways in which this helped to foster 'community' within The Club is the consideration of the next chapter.

5.5 Conclusion

In this chapter I have endeavoured to highlight the ways in which The Club attempted to create a space for 'meaningful work' for members within the Clubhouse in order to facilitate 'mental health recovery', principally through temporal and spatial structures. Through the use of ethnographic descriptive detail and field diary extracts in this chapter, I have provided an enlivened spatial account of The Club. This ethnographic detail has served as a backdrop to

the member quotations from semi-structured interviews included throughout, which offer an indication of the experiences of participating in the work of the 'working community' as an individual with a diagnosis of a SEMHC.

The Club made a great effort to be "separate from any mental health centre or institutional settings" (Clubhouse International, 2018:2), but in adopting a structure to facilitate the work-ordered day, it espoused some disciplinary techniques that were common in historic institutional settings (Philo and Parr, 2000). The open-plan layout of much of the workspace meant that observation of member work and behaviour was possible (Foucault, 1995), though the level of explicit staff observation over members was limited, other than for safeguarding purposes. The surveilling potential of the space meant that members may have 'self-governed' their behaviour, knowing that they could be seen by others. However, as a semi-private space for individuals with diagnoses of SEMHCs, members could behave and work in a manner that may not be considered 'normative' in a 'mainstream' employment context (McDowell, 2009). The task-allocation whiteboards had constraining potential, by making 'public' the allocation of work tasks to individual members. Whilst this "writing in discipline" (Foucault, 2006b:49) made it possible to hold members accountable over the completion of work tasks, the voluntary nature of work, and the 'wipeable' nature of the whiteboard meant the disciplinary potential of this was not fully enacted. The timetabling structure of meetings and break times served to temporally discipline members within The Club (Goffman, 1961). However, the ability of members to move between work units, or to opt-out of any work tasks or meetings taking place, and the unfixed nature of much of the work timetable meant that these disciplinary functions were also easy to avoid. Furthermore, members were able to choose only to follow certain aspects of this disciplinary structure, therefore, they could undertake anything that they found personally meaningful and avoid anything they did not find helpful to their personal mental health recovery.

As the work tasks of the work-ordered day were intended to "help members regain self-worth, purpose and confidence" (Clubhouse International, 2018:2), work 'productivity' was not the priority, though all work was intended to maintain and enhance the Clubhouse. Moreover, activities in The Club could not be explicitly 'therapeutic', as the Clubhouse International standards demanded

that the Clubhouse "must not include medication clinics, day treatment or therapy programs" (Clubhouse International, 2018:2). However, defining which activities were purely therapeutic was contentious, particularly in relation to the work being conducive to mental health recovery. The tasks that were seen as more 'therapeutic' were often those that could help to facilitate good social connections between members, which is significant in the 'CHIME' framework of mental health recovery (Leamy et al., 2011). Furthermore, creating strong relationships in The Club helped to facilitate the work of the work-ordered day, as members felt more comfortable working with each other, and could make the work feel more meaningful, as members would be contributing to maintaining a community within which they felt like a known and valued member. The approach of the 'need to be needed' in encouraging members to undertake 'meaningful' work did reinforce the 'responsibilisation' discourse of personal mental health recovery (Rose, N., 1999a; McWade, 2016), and undertaking structured work as part of the work-ordered day was intended to encourage 'normalcy' (Doyle, Lanoil and Dudek, 2013). However, for some members feeling 'normal' was what they desired in moving towards mental health recovery, that enabled them to feel a sense of social inclusion both in the Clubhouse and in wider society.

In contributing to the maintenance and enhancement of the work-ordered day, some members could find meaning in the work they undertook, even if these tasks were only small. The knowledge that one's presence was valued and needed also enabled this work to feel more significant and could contribute to members' sense of mattering (Conrad-Garrisi and Pernice-Duca, 2013). Members found that *choosing* to be occupied through contributing to the work-ordered day allowed them to focus on something other than being 'unwell' by working towards something that benefitted the lives of many others. In this sense the work did have a constraining power on them, however in the case where this reduces the individual's mental distress, this can also be 'facilitative' (Sharp et al., 2000). This could be made possible for even more members by ensuring that all members understand the values of and reasons for the work-ordered day. The Club helped members to structure their lives, both within and outwith the space of the Clubhouse. Members could create daily routines by undertaking tasks in the house and attending meetings and groups within The Club. The autonomy

that members had in choosing work tasks allowed members to structure their own daily routines, which could be empowering for individuals who may not have had the opportunity to do this during periods of mental ill-health. The Clubhouse remained a place of familiarity and a secure place to return for members who were further along in their personal mental health recovery (Staples and Stein, 2008). Members could continue to use the Clubhouse to structure their lives even as they moved on to other things, by maintaining visits to The Club as part of their routine, and knowing that they were able to return to more regular attendance if their mental health deteriorated. Members could contribute to each other's sense of mattering, through acknowledging each other's presence, working together and praising each other for their work, and through forming strong personal connections that persisted both within and outside the Clubhouse community.

6 Care and the Community of The Club

6.1 Introduction

This chapter examines how care and community were realised within the space of The Club, and the ways in which the relations of care and community run alongside each other and at times intersect. First, I will consider the notion of a specific Clubhouse identity, and how being a constituent of a global mental health movement shapes the community of The Club. I appraise how this Clubhouse identity is shaped both by the context of the Scottish mental health care and treatment landscape and by the doing-in-common of work. Following this, I consider member experiences of the doing-in-common of work tasks in the work-ordered day. To further understand the role of working 'side-by-side' and doing-in-common, I think about the social relationships within the Clubhouse. I endeavour to build a picture of the care relations that exist between staff and members, attending to the uneven power relations between these two groups. I then move to consider member-member relations, and the ways in which care relations do (and sometimes do not) occur between members. I contemplate how members' shared identity as mental health service users impacts their relationships and consider the significance of this in a specific incident that occurred during my fieldwork. Finally, I look at the collaborative process of decision-making in The Club, as an example of the doing-in-common of community, and the issues that can arise in trying to create a community that is safe and welcoming for all, alongside encouraging individual member autonomy.

Theorisations of 'community' within human geography are often entwined with discussions of identity formation, belonging, and social inclusion and exclusion (Rose, G., 1997b; Valentine, 2001; Welch and Panelli, 2007; Wiesel and Bigby, 2014). I am mobilising the term 'community' as it describes a phenomenon which is emplaced, such as in a neighbourhood or a community centre (Rogers, Castree and Kitchin, 2013), furthermore, Clubhouses are "place-based intervention[s]" (Jackson, 2001:40):

> "A sense of community is a goal, not articulated in this fashion by Clubhouse leaders, but one that is expressed with words such as, a place to belong, to be accepted, to contribute, to find meaningful tasks and so forth" (Herman et al. 2005:353).

Geographical examinations of community care have noted the mirroring of institution-like disciplinary logics within community spaces, through the emergence of 'shadow-state' services (Milligan, 2000; Milligan and Conradson, 2006), whilst acknowledging that these disciplinary logics are subject to resistance and subversion (Creese, 2006). Using the place-focused term 'community' allows for an examination of any institution-like practices, such as the disciplinary apparatuses considered in the previous chapter (Foucault, 1995; Goffman, 1961).

Clubhouses are described as 'working communities' within the Clubhouse model (Carolan et al., 2011). Doyle, Lanoil and Dudek (2013:np) explain that the 'working community' is "used to describe the nature of [the Clubhouse] and its methodology for the recovery and social inclusion of people suffering from mental illness." The synthesis of community through working together within the work-ordered day is an approach that is intended to foster personal recovery for the individual, and wider social inclusion for all in the group (Craig, 2013). As we examined in the previous chapter, these aims are intended to be achieved through allowing members to build confidence, find a sense of mattering and learn new skills (Conrad-Garrisi and Pernice-Duca, 2013). In this sense a Clubhouse is an 'intentional community', based on bringing a group of people together for a specific purpose:

> "Intentional communities were founded on the principle of consumer survivors providing mutual support to help each other reintegrate into the community following long-term hospitalization from a serious mental illness. Building an intentional community based on the value of recovery serves as the foundation of the… Clubhouse" (Pernice-Duca, Case and Conrad-Garrisi, 2012:132).

While the aim of an intentional community such as a Clubhouse is to help individuals to 'reintegrate' into society, the notion of community is by nature exclusionary, to group together individuals based on a certain characteristic: a belief, a shared experience, or an interest automatically excludes anyone who does not have this characteristic (Rose, G., 1997b). As the description of 'intentional community' above shows, the Clubhouse community is designed to include those with the shared experience of 'mental illness' and therefore excludes those who are not experiencing mental ill-health. We have previously explored that creating exclusive spaces for these groups to work can often

better facilitate social inclusion than spaces of 'mainstream' employment for individuals with disabilities (Hall, E., 2004; 2005; Wilton and Schuer, 2006) therefore, Clubhouse communities may be able to provide an inclusive environment for individuals who are more frequently marginalised in broader society (Glickman, 1992).

'Locally' emplaced communities are not invulnerable to the wider processes of neoliberalisation that occur at a society-wide scale (Bondi and Laurie, 2005). Sometimes these communities may engage willingly with neoliberal processes in order to meet their own local objectives and in the long-term effect change at a larger scale (McCarthy, 2005; Fyfe 2005). In understanding that communities are not 'sealed off' from society in an institutional fashion, and are imbricated in neoliberal processes at a variety of scales, we can consider community to be:

> "a dynamic, interconnected and power-laden process involving lively forms of co-relating and multi-scalar (dis)connections that are structural, discursive and performative" (Botterill, 2018:541).

Policy discourses frequently elide the terms 'community' and 'society' in reference to community care, however in this case I am considering The Club as the 'locus' of the community, whilst acknowledging that it is entangled with other 'forms' of community at larger and smaller scales. Hall and Wilton (2017:739) have acknowledged the importance of the "decentring of the subject" in disrupting the understanding of the disabled individual as an 'autonomous, political actor', rather the individual is bound up in complex relations of care and community. Furthermore, through understanding this community as relational, we can begin to unravel the power relations that exist both within a community, and through its connections to wider scale societal processes (Brenner and Theodore, 2002; Cloke and Conradson, 2018).

As an 'intentional community', the processes of the Clubhouse are designed to foster 'togetherness'. The act of undertaking a work task together or working towards a shared goal can create both physical and social spaces in which community may thrive (Carolan et al., 2011). Undertaking a task together requires individuals to share the same physical space, and the shared goal that they are working towards allows for shared 'conceptual' social space in which to discuss ideas and views:

> "Participants engaged in an activity can share in the ordered doing of practice even while holding widely diverging viewpoints, identities, and motivations" (Pratt, K., 2013:181).

If community is formed through undertaking tasks together, we may consider the formation of community to be practise-based, performative and always in process. Pratt (2013:180) describes these processes as "doing-in-common." In the case of the Clubhouse, 'doing-in-common' means undertaking work tasks together, but it also means being in the same space, negotiating this space with others, and sharing the goal of maintaining and enhancing the Clubhouse. Therefore, understanding the Clubhouse community not only as 'being-together-in-space' but 'doing-together-emplaced' we can see the community through the repetition of work practices, rather than just a convening of a group of people sharing a goal, or an experience. These work practices are a performative representation through which we can attempt to comprehend the affective atmospheres inherent to this relational community (Dewsbury, 2009).

As we will explore in examining the 'identity' of the Clubhouse, the imaginary of the Clubhouse created by Clubhouse International is not one of a space of 'care'. Whilst Herman et al. (2005:355) describe the Clubhouse as a "positive and caring community," in general the term 'care' is not used in literature relating to the Clubhouse model and does not appear in a single Clubhouse International standard. I would suggest that this lack of 'care' in Clubhouse literature is an intentional act to separate the Clubhouse from more traditional medical spaces of mental health care and treatment. However, I argue that the Clubhouse *is* a space in which care takes place, and that care is both inherent to and inextricably bound to the formation of community in the Clubhouse, and any attempt to construct an 'intentional community' cannot be done without undertaking care. In understanding the Clubhouse as a site that tries to resist some of the exclusionary mechanisms of wider societal processes, we might consider the Clubhouse to be a landscape of care (Pinfold 2000; Milligan and Wiles, 2010). Whilst the landscape of care is not spatially bounded, we can understand the Clubhouse as a 'node' in which these relations convene, and these relations move through, beyond and between the space and people of the Clubhouse. As a space in which people work together to form a community, we can witness a 'care ethics' in which "people operate in socially embedded relational contexts" (England, 2010:132) and are not wholly autonomous

neoliberal subjects. In focusing on the relations of care within the space, I attempt to offset the idea of the 'autonomous individual' who exists outwith any care relations (Popke, 2006) as a means of countering the 'responsibilising' and 'normalising' discourses of personal mental health recovery (Rose, D., 2014; McWade, 2016).

With the use of empirical evidence, in this chapter I will consider the ways in which The Club operated as a space of 'controlful care' (Philo and Parr, 2019), where members were both cared *about* and *for,* whilst simultaneously an element of control was exerted over individuals in order to create and maintain a 'community' that could be a restorative environment or 'enabling place' for all members (Duff, 2011). The affective capacity of an individual to both give and receive care could influence their experience of the Clubhouse as 'enabling', as the emotional intensities of caring *for* the Clubhouse could make this work more meaningful. In this chapter I draw on these concepts but hope to further pull out the 'doings' of both care and community, understanding them as inextricably linked relational processes. Through considering the ethical, affective, and practised aspects of care and the relational tensions between all of them, I hope to be able to present a nuanced and lively reading of The Club as a landscape of 'community care' (Puig de la Bellacasa, 2017).

6.2 Fostering Community within the Clubhouse

6.2.1 Creating a 'Clubhouse' Identity

In understanding the creation of the community of The Club, we need to consider its placement in the broader context of a global Clubhouse community. Whilst The Club had its very own distinct identity, this identity was constructed from a model that is designed to be replicated across the globe (Clubhouse International, 2020). The Clubhouse International standards are intended to be internationally applicable and are therefore generic and may not always be pertinent in the Scottish landscape of mental health treatment and care. An example of this is Clubhouse International standard twenty-nine, which relates to the responsibility of the Clubhouse to ensure the provision of adequate housing for its membership (Clubhouse International, 2018). Whilst The Club

staff took an interest in ensuring members were living in safe environments, they had no official capacity in arranging housing for the membership.

Striving to be a Clubhouse International accredited Clubhouse meant that The Club was already part of a global Clubhouse community (Moxley, 1993), one that might appear abstract and distant in relation to the everyday doing-in-common of The Club. Member awareness of the wider Clubhouse network varied significantly. Some longstanding members, and those who had been on Clubhouse training were aware of the broader Clubhouse movement, but other members did not have such knowledge. A study of US and Norwegian Clubhouses discovered that most members' knowledge of the Clubhouse model derived from being within and participating in the work of the Clubhouse (Kinn et al., 2018). This may suggest that knowledge of the broader history of the Clubhouse model is not pertinent to the day-to-day operation of the Clubhouse. At The Club, when asked about the Clubhouse model, most members would begin to talk about Transitional Employment Placements (which will be discussed in the next chapter), or they would provide information about the quantity or location of Clubhouses internationally:

> "I know that there's 325 Clubhouses in the world, if that's to do with the model? That's about all I know" (Catriona, member for eight years).

> "I believe that there are quite a number of Clubhouses around the world… there are several of them in numerous different countries, central Europe, America, Canada, etc. So there's quite a few of us. I don't know if there are many here in Scotland. Maybe one or two" (Rob, member for six years).

> "I just know it's an international Clubhouse thing. And there's standards that they need to adhere to, which is just the rules. How staff and members kind of operate together" (Lee, member for six months).

Lee linked the notion of Clubhouse International standards with the everyday functioning of The Club, understanding the way the standards shaped the organisational structure of the house and the social relations within it. The Club made efforts to connect the work of the house to the Clubhouse standards on a daily basis, to foster a geographical imagination of the international Clubhouse community within the space of The Club. At the end of the morning meeting, a

member was chosen to read a single Clubhouse standard out loud to the rest of the community. The standards were read in numerical order on a rolling basis, one standard each day, and after the standard had been read, everyone attending the meeting would applaud, and then continue the work tasks of the work-ordered day. While many members may not have connected the daily event of reading a standard to participating in a broader Clubhouse community, the standards themselves still had an influence on the organisational structure of The Club. Staff member Annabelle noted the importance of the Clubhouse standards on the formation of the community of The Club:

> "within the standards, there are things about where the Clubhouse needs to be, how accessible it is, because it's all about creating a community. It's weird, it's about creating an organic community in a non-organic fashion" (Annabelle, staff member for seven years).

The Clubhouse is intended to be "open to anyone with a history of mental illness" (Clubhouse International, 2018:1), however The Club's funding tender with NHSGG&C required it to direct its services to individuals with diagnoses of SEMHCs and who were also under the care of secondary NHS mental health services. This demonstrates another example of the difficulties of adhering to a global model within a local context, The Club had to negotiate its position within a broader landscape of mental health care and treatment that is provided by a range of private, public and third sector services. The reduction in state provision of health services and subsequent private sector intervention in third sector services that are hallmarks of roll-back and roll-out neoliberalism mean there is always a negotiation between the organisation's principles and the economic realities of being a 'shadow-state service' (Wolch, 1990; Bondi and Laurie, 2005). In creating a Clubhouse community identity, the intention is to move the focus of the Clubhouse away from the fact that all members have diagnoses of SEMHCs, hence the focus upon work (Craig, 2013). Increasing member understanding of the history of the Clubhouse model might make the work tasks of the work-ordered day more meaningful for members; as they could further understand the principles behind the work-ordered day and the model's former psychiatric patient-led origins (Doyle, Lanoil and Dudek, 2013).

Staff member Annabelle's use of the term 'organic community' suggests a community that is not manufactured by any external regulatory framework. This

apparent incongruity is engendered by the Clubhouse International standards, in attempting to adhere to a global framework, each Clubhouse is expected to manufacture its own distinct identity:

"Standard twelve, under space: The Clubhouse has its own identity, including its own name, mailing address and telephone number" (Clubhouse International, 2018:2).

This suggests that Clubhouse International, in producing its guidance for the creation of Clubhouses, recognises the need for the formation of 'local' community as well as the global community of the Clubhouse. Additionally, this standard dictates that the Clubhouse should be creating an identity distinct from other local mental health services. Although financially dependent on the NHS, The Club was both physically and administratively separate from state mental health treatment services, enabling it to forge its own identity. The name of 'The Club' gave no indication that the organisation was a facility for mental health service users, nor did this indicate that it was a space for work. Its slogan alluded to "mental health recovery" (The Club, 2015a:np) which offered some suggestion of the purpose of the organisation, though it did not make reference to the work undertaken within the house. This slogan demonstrated to both current and prospective members that it was a space where their personal 'social identity' as a mental health service user would not lead to them being 'discounted' (Goffman, 1963). The terminology adopted by the Clubhouse movement to describe its service and users are specifically chosen to encourage the fostering of community, and to infer a shared personal identity between individuals within the Clubhouse, whilst making no reference to mental health or psychiatric diagnoses (Glickman, 1992). Service users are called 'members' as to hold a membership is to belong to a certain group. The word 'Clubhouse' also infers membership, a Clubhouse is a building where members of a club meet. The notion of a club suggests a shared personal identity within its membership, a characteristic or interest that brings people together in a single space, a club-house.

The Clubhouse is intended to be a place that members are proud to actively attend (Anderson, S., 1998), in comparison to the relatively passive role of being a patient under a mental health treatment service. The creation of this

Clubhouse identity outwith medicalised mental health services enables members to adopt new roles beyond the 'good patient' role they may have been forced to adopt in the past (Goffman, 1961). In understanding the formation of community as processual and facilitated by doing-in-common, performing new roles as workers in a working community could enable the facilitation of 'personal recovery', in the sense that individuals are moved towards a 'normative identity' (Rose, D., 2018). This role as worker must be negotiated cautiously, particularly in relation to recovery, as it can reinforce the neoliberal-ableist concept of the 'recovered individual' as 'ideal neoliberal subject' (McWade, 2016; Runswick-Cole, Lawthom and Goodley, 2016) ready to return to economic productivity. As Butler (1988:528) points out, these roles that we are said to adopt are constructed outside of ourselves and are "constituted in social discourse." Therefore, the Clubhouse needs to create a discourse that allows individuals to take on new roles other than the passive patient role that they may have accepted in the past, and "focus on… personhood, rather than patienthood" (Jung and Kim, 2012:484) without automatically aligning this new 'personhood' with the goal of entering 'mainstream' employment (Wilton and Evans, 2016).

Another aspect that sets Clubhouses apart from clinical mental health spaces and helps them to establish a unique identity is the physical space of the Clubhouse. The Clubhouse must have its own material space, separate from any medical facility. In facilitating community by doing-in-common or working side-by-side, a physical location in which people are both able and willing to commune and work is essential. Additionally, the Clubhouse needs to be designed in a way that helps to facilitate the work:

"Standard thirteen, under space: The Clubhouse is located in its own physical space. It is separate from any mental health centre or institutional setting, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity" (Clubhouse International, 2018:2).

The building in which The Club is situated was not designed as a Clubhouse when it was constructed. However, it has been adapted by the organisation to make the space more conducive to the work tasks of the work-ordered day, through

the installation of task-specific equipment such as kitchen facilities, but also through the open-plan environment. In the previous chapter I considered how the open-plan layout enabled the work tasks of the work-ordered day to be surveilled by others (Foucault, 1995), this layout which makes work tasks visible may also encourage members to get involved in tasks. If individuals can see that other members may need help with a particular task, or they may see another member undertaking a task that they themselves want to learn, the open-plan environment allows a greater capacity for side-by-side working and teaching (Tanaka, 2013). Furthermore, in the previous chapter I considered the importance of having a pleasant environment in which to work (Vischer, 2005):

> "I think that if the environment is scruffy and run down that can make you depressed" (Gavin, member for twenty years).

Having a pleasant work environment can improve worker wellbeing and also increase enthusiasm to engage in work (Vischer, 2008). In the case of The Club, it was also important that the space felt different to clinical spaces, and there was no external indication that the building was a space for mental health service users. The space of the building, just like the terminology that is used to describe it can have a significant impact on experiencing a sense of community and producing a caring 'atmosphere'. What may be experienced as a caring place for one individual may not be experienced as such for another (Conradson, 2003a). However, the extent to which a space is 'cared for' does have an impact upon one's feelings of wellbeing, as Gavin notes above. Furthermore, spaces can be "definitely engineered" to foment particular "affective atmospheres" (Philo, 2017:22). Therefore, creating a space of care is more than just ensuring a space is not 'scruffy and run down', but organising a space in such a way to facilitate healing (Simonsen and Duff, 2020). In the Clubhouse this 'healing' is anticipated to take place through working side-by-side, therefore an environment that is conducive to group work may be considered 'healing'. This becomes complicated by the "folding of care and control" (McGeachan, 2019:206) where spaces in which individuals are meant to be cared for also become spaces where controlling mechanisms of power are exerted (Foucault, 1995; Philo, 2017). In enacting procedures with caring intention, for example through enforcing regulations intended to keep people safe within a space, this exerts control over the individuals within that space. In The Club, creating a space that was 'safe'

for everyone entailed staff sometimes exerting control over members in the Clubhouse. This will be explored in greater detail in the consideration of Clubhouse relationships later in the chapter.

6.2.2 Experiencing Community through Working Together

Community can be facilitated with the assistance of a perceived shared identity (Valentine, 2001), however the personal identity that Clubhouse members already share, that of being a 'mental health service user', is an aspect that the Clubhouse attempts to divert focus from. Therefore, the *work* of the Clubhouse is the aspect around which a shared or 'collective' identity is built, from which doings-in-common can be created:

> "the Clubhouse model may foster such a collective identity, as members have to build mutually supportive collaborative relationships to get through the tasks of the work ordered day and this mutual effort enhances the sense of belonging to and being an important player in the organisation. This sense of collective identity is further enhanced by the principle that the Clubhouse belongs to the members" (Craig, 2013:121).

The idea of being an 'important player' may be facilitated through the notion of 'the need to be needed' that was examined in the previous chapter (Rayle, 2006). Feeling needed by others also enables one to feel valued and as though one belongs. This belonging is then what facilitates a collective 'worker' identity of belonging to the Clubhouse as a valued member, a worker with skills to contribute:

> "Coming here makes me feel part of something" (Callum, member for nine months).

> "it is a community in and of itself. It's not about service users and staff it's about people having ownership over this thing they've created. And it's about focusing on making sure people are included" (Fiona, member for ten years).

> "I think the Clubhouse gives people a sense of belonging through their contribution to it - it's not just a contribution to the Clubhouse, or The Club, it's like when they contribute to each other as well" (Orla, staff member for six months).

Testimony from other Clubhouses has noted the importance of a feeling of 'ownership' of the Clubhouse in facilitating mental health recovery (Norwood, 1992; Chen, 2017). This sense of ownership is vital to fostering community as well: if one feels personally invested in a space, an organisation, and the people in it; one will continue to contribute to it and to the individuals within it, developing relationships and increasing one's experiences of 'social inclusion' (Hall, E., 2004).

Clubhouse research has identified that not only can building 'collaborative relationships' facilitate the work-ordered day, but reciprocally, the work-ordered day can foster these relationships (Mowbray et al., 2006). Clubhouse standard fifteen, discussed in the previous chapter, recommends that the work-ordered day "engages members and staff together, side-by-side" (Clubhouse International, 2018:2). Research has also identified three ways in which side-by-side working can facilitate peer support within the Clubhouse; task-sharing side-by-side, teaching (and learning) side-by-side, and leading side-by-side:

> "task-sharing side by side, where members collaboratively played a part to accomplish a shared WOD task; teaching side by side, where members who were more experienced in one task mentor peers who were new to the task; and leadership side by side, where members led a decision-making meeting in a manner that conveyed respect and appreciation for everybody's input and voluntary participation in the process" (Tanaka, 2013:145).

Within an organisation such as The Club, it is possible that you will have people from very different backgrounds, who share very little in common, other than the fact that they have a diagnosis of a severe and enduring mental health condition. Working side-by-side in the sense of task-sharing is a form of doing-in-common which helps to facilitate conversation and to create more common ground to enable relationships to develop:

> "Gives you something to talk about, you know, something in common" (Lee, member for six months).

> "I find it easier if you're working with people around a problem, or an activity, because I don't do small talk all that well. So it's good to be working on something then you get speaking to people and you find out things about them. And you've automatically got something in common" (Fiona, member for ten years).

These comments demonstrate that the work tasks themselves can begin to facilitate relationships, as doing-in-common through undertaking a work task together serves to provide 'something in common' for members to talk about (Pratt, K., 2013). In a working community, the work is the process, the 'doing', that helps create the 'common', the community. The specific work tasks of the doing will differ, and members will do tasks in-common with different members each day, enabling more doings-in-common to be created. The objective of completing work that maintains or enhances the Clubhouse community stays the same, and the process of undertaking tasks together helps create commonalities between different members and between staff and members, enabling the fostering of a shared 'worker' identity.

The process of undertaking work gave members a mutual experience to share, from which starting point they could begin to build more mutual experiences and share more of their personal opinions and experiences with each other, beyond their shared personal identity of a diagnosis of a SEMHC. The work of the work-ordered day also created shared experiences between members and staff, who may not have had the experience of being a 'mental patient':

> "when you're doing group work, you're talking about different things… When you're doing group work it's easier to make friends because you're getting to know somebody" (Callum, member for nine months).

> "I find that people can actually be more free, work freely together, and understand problems together a lot easier" (Cameron, member for seven years).

> "This sort of feeling of community. You're… working, mingling with like-minded individuals" (Russell, member for eight years).

Once members had overcome the initial obstacle of forming relationships through their doing-in-common, it became easier to build upon these relationships and grow social connections (Pernice-Duca and Onaga, 2009). The process of undertaking work allowed individuals to feel as though they were connecting with each other, and learning from each other:

> "I've learned from other members, and I've also learned from staff, and yourself, and also other members have learned from me. So we all bounce off each other" (Catriona, member for eight years).

Undertaking work together in the Clubhouse enabled a sharing of mutual experience, for shared enthusiasm to 'bounce off each other'. For members who may have been isolated and may not have worked for a long time, the experience of being in a busy environment and learning from others might have brought a renewed energy, and offered a very different experience to other mental health treatment spaces they had been in. This renewed energy, this 'bounce', was identified and described by Hamish as 'momentum':

> "You always feel a momentum. So you don't feel like you're wallowing in the stigma that you feel against you. You don't feel as though you're wallowing in the side effects of your medication. You don't feel as if you're wallowing in the symptoms of your illness. You come here, you might feel, I mean I feel anxious all the time basically, but there's a momentum with the anxiety. Even if I feel low, I can look at members getting involved in activities and that kinda makes the lowness have a momentum" (Hamish, member for eighteen months).

This momentum reciprocally drove the work of The Club, it enabled the practice of community, so that community as doing was always in process (Pratt, K., 2013). I suggest that this feeling of momentum is indicative of an affective atmosphere (Anderson, B., 2009), a collective energy that motivated members to contribute to the community and to continue to attend the Clubhouse. The affective capacity of this momentum is able to give shape to the specific and personal emotions of individuals, that may be experienced very differently by different people (Anderson, B., 2014). As Hamish explains, his feelings of 'lowness' or 'anxiety' are transformed into an experience of 'momentum' by his being within the space of the Clubhouse. The atmosphere of momentum would 'circulate' through the space of The Club and those within it. The energy that members put into the work of maintaining the Clubhouse, strengthened by the efforts of staff encouraging member participation (Chen and Oh, 2017) translated into a 'feeling' of momentum. Other members 'felt' this momentum facilitated through the doing-in-common of the work-ordered day and would join in with work tasks. This allowed for the momentum to gather within the space, and members would be encouraged to return the following day to 'feel' the momentum again. Duff (2016) explains the power of these atmospheres in individual experiences of personal mental health recovery:

> "these atmospheres are comprised in and of affects in their circulation as they move through bodies, acting on them by transforming what they are capable of doing or being. Such formulations suggest powerful new ways of accounting for how specific structures of feeling like hope, meaning or empowerment actually emerge for individuals in recovery, and how these affects mediate the capacities equal to this recovery" (Duff, 2016:65).

Whilst I have indicated the problematic nature of the term 'recovery' in the manner in which it produces an expectation of 'normalisation' and characterises 'symptoms' of mental illness as 'deficits' (Harper and Speed, 2012), I have also acknowledged that some facets of the 'CHIME' framework of recovery (Leamy et al., 2011) can have a positive impact on individuals, when the individual is able to define aspects such as meaningful activity and personal identity themselves. Duff (2016) suggests that we can use affective atmospheres to glean an *experiential* understanding of what meaning-making may *feel* like for an individual with a diagnosis of a SEMHC. Within The Club, the atmosphere of momentum experienced by some members may contribute to an accumulation of experiences that could facilitate mental health recovery on an individual, personal basis:

> "Rarely is recovery advanced by break-throughs or sudden moments of progress. More typically, recovery is pieced together from a series of otherwise remote, individually modest activities, practices, relations and experiences… What counts is the extent to which these practices and relations begin to ramify, to accumulate, to resonate together in the formation of an assemblage of health" (Duff, 2016:71).

The formation of community is a process of becoming that is facilitated by a doing-in-common that can be undertaken and repeated by different individuals day-to-day (Pratt, K., 2013) as long as these individuals are working towards the same community goal, in this case maintaining and enhancing the Clubhouse. Terming Hamish's experience of momentum as affective may appear to be further depersonalising the experiences of an individual. However, in understanding affective atmospheres as transpersonal (Thien, 2005), I am not negating the experiences of individuals, rather I am indicating each individual's capacity to affect the formation of community, and in turn the affective capacity of the community to influence an individual's emotions and even their potential experience of mental health recovery. I will explore a specific example of an individual's capacity to affect the community through their personal

emotional expression later in this chapter. In understanding the importance of individuals and the emotions and experiences they bring to the facilitation of community; we need to consider the relationships that have the potential to be formed within the space of the Clubhouse.

6.3 Forming Relationships and Being Together in the Clubhouse

6.3.1 Relationships between Staff and Members

Tanaka, Craig and Davidson (2015:134) discuss what constitutes a "Clubhouse 'atmosphere'" and determine that a unique element of the Clubhouse, as opposed to other mental health care and treatment spaces, is the relationship between members and staff. Clubhouses distinguish themselves from other mental health services partly through the convivial relationships that are formed between staff and members, constituting:

> "two-way interactions that share humanity as the common ground, notwithstanding mental health status, social roles, or the formal hierarchy inherent in any organizational structure" (Tanaka, Craig and Davidson, 2015:138-139).

This is likely to be very different to the experience of members as mental health service users in clinical mental health services, where they will have been patients under the 'care' of a medical practitioner. There are no 'patient' or 'doctor' roles in the Clubhouse, only workers. This can sometimes obscure the necessary organisational hierarchy that exists within the Clubhouse, and present all roles and relationships as equal:

> "I like the interaction with both the staff and the members. I get on well with the members and I like the interaction particularly with [the CEO], and with the other staff. I've always liked the fact that it's not all about us and them, it's not the boss at the top, and the others below. We're treated like equals. I can interact with [the CEO] and joke with him. I pretend to boss him around" (Gavin, member for twenty years).

> "I was very impressed with the two guys who showed me around. I couldn't work out if they were staff or not. They were just so knowledgeable about the place, but they come here for support themselves, I was very impressed" (Fraser, member for three years).

As stated in the previous chapter, the responsibility for the Clubhouse "lies with members and staff, and ultimately with the Clubhouse director" (Clubhouse International, 2018:2). As staff are paid employees and members are not, staff hold greater responsibility for the community of the Clubhouse. They also have a duty of care over all members, that is not a reciprocal duty of members to staff. Therefore, the relationships between staff and members cannot be equal, nor should they be. However, in any situation involving care relations, there is the chance that some of these relations may be exerted as controlling, as "care can do good, it can [also] oppress" (Puig de la Bellacasa, 2017:1). Even when the intention of the caring behaviour is benevolent, the way this behaviour may be enacted can exert control over those being cared for (Foucault, 1995). Within the Clubhouse philosophy, staff-member relationships and the work-ordered day are interdependent (Vorspan, 1999):

> "[staff] recognised that building a relationship was most essential in engaging members in participation. They observed that the relationship made a difference in eliciting assistance: members appeared more likely to offer help when asked by staff members with whom the members had a good relationship" (Chen and Oh, 2017:793).

Therefore, staff had to try and build relationships with members, whilst at the same time eliciting their assistance in work tasks. Clubhouse International standard three states that "there are no… rules intended to enforce participation of members" (Clubhouse International, 2018:1), however, the act of trying to engage members in work still constitutes an exertion of control.

The notion of members and staff working 'side-by-side' towards the common goal of maintaining and enhancing the Clubhouse (Mowbray et al., 2006) elides some of the "care-and-control logics" present within the work-ordered day (Philo, 2017:26), as it portrays the working relationship between staff and members as equal. However, the Clubhouse's attempts to flatten the hierarchy by sharing responsibilities for work and decision-making reveal that its intention is not to reproduce the power relations endemic to institutional mental health treatment spaces, rather it is an effort to hand over some of this control to members (Tanaka, 2013). This is an acknowledgement by the Clubhouse that power is exerted from the 'top-down' (Rose, G., 1997b); by flattening the hierarchy, the Clubhouse model aims to make the relations of power between

members and staff reciprocal, though not necessarily entirely equal. Members, as mental health service users, are understood to be part of a 'community' that has traditionally been marginalised and lacked personal autonomy and the 'power to act' within psychiatric institutions and wider society. As we have previously established in our consideration of the disciplinary potential of mental health spaces, participation in the Clubhouse is voluntary (Schonebaum, 2006), members can choose not to participate in these relations or responsibilities of working side-by-side. Members' choice in participation is a form of power that they hold over Clubhouse staff, staff can encourage but not coerce members to participate, and members can choose to leave at any time, whereas Clubhouse staff are contractually obliged to work in the Clubhouse to facilitate the work-ordered day. Therefore, any 'controlful care' that may be enacted by staff is limited by the very fact that members are able to choose when this control is exerted.

Within The Club each member was assigned a 'co-worker', who was a staff member who acted as a point of contact for that member, and whose responsibility it was to check-in with members about their wellbeing inside and outwith the Clubhouse (Chen, 2017). All Clubhouse staff were expected to be approachable so that members felt able to come to them with queries and problems. For issues relating to the house, most members would speak to the staff member who was most relevant to solving that issue, for example: if there was a problem with the lunch tasks, a member would speak to a staff member that often worked in the kitchen. If a member had intentions of seeking supported employment, they would speak to a member of staff in the work and learning unit, but they would probably also inform their co-worker. The role of a co-worker is to provide more general support for members, and help them deal with any other issues in their life outside of the Clubhouse, serving as a staff point of contact for the member in relation to other services such as health and welfare services:

> "The co-worker system is really good. It identifies one member with one member of staff, it's up to both the co-worker and the member to say 'it's time we had a chat, what's going on?' It's also very good because some members get on better with other staff members and situations change, people leave, circumstances change and there's no hard feelings if you change your co-worker" (Alasdair, member for twenty years).

As Alasdair explains, members are initially assigned a co-worker when they become a member of The Club, but once they have settled in and formed relationships, they are welcome to choose another member of staff that they may prefer to have as their co-worker (Kinn et al., 2018), as "members choose the way they utilise the Clubhouse, and the staff with whom they work" (Clubhouse International, 2018:1). Staff also valued these relationships they formed with members, particularly the ways in which they could specifically contribute to improving the lives of individual members:

> "just being able to hopefully contribute with someone to things getting better" (Owen, staff member for eighteen months).

> "I would say one of the most rewarding things for me is the sort of advocacy… it's not a main part of our job, but it comes from seeing someone so distraught… a gentleman I've been working with… to see him know that there is somebody that cares about him, that he does have a worth that's not based on somebody else's opinion of him" (Annabelle, staff member for seven years).

Relationships between a staff co-worker and member evidently cannot entail equal reciprocal care relations. A staff member may accompany a member to a welfare benefits appeal meeting with the Department for Work and Pensions, in return that member cannot support staff in a difficult event in the staff member's personal life, other than perhaps a small amount of social support within the space of the Clubhouse. A member can care *about* their co-worker, but the nature of Clubhouse staff-member relationships mean that members cannot care *for* staff. Caring *for* means taking an active role in the maintenance of the world and its relations, therefore if members are unable to put in the 'maintenance work' to care *for* staff outwith the Clubhouse, their relation is "closer to a moral intention" (Puig de la Bellacasa, 2017:5). Here we see the entanglement of care and community, for members, the limits of their caring relations with staff end at the physical bounds of the Clubhouse and the temporal bounds of the work-ordered day, their care is contingent on the formation and maintenance of the community. However, while The Club members could not actively care *for* staff outwith the Clubhouse, they certainly did care *about* them:

> "there's more and more being put on staff. Every house meeting it's creating new work for the staff… that can't continue, or your staff are

> going to burn out. So maybe a bit more consideration for staff" (Russell, member for eight years).

One means by which members were able to demonstrate their care within the context of the Clubhouse was to help reduce the work burden on staff by participating in the tasks of the work-ordered day, and by assuming collective responsibility for the Clubhouse (Lawson, 2007). In opposition to the discourse of personal mental health recovery, that demands individualised responsibility for one's subjectivity (McWade, 2016), a care ethic focuses upon the collective responsibility we have for maintaining our environment and each other (Tronto, 2001). Contributing to the doing-in-common of community, and therefore caring *for* the community was the means by which members could show that they cared *about* staff, even if they could not care *for* them individually (Bowlby, 2011). The other type of relationships that were important to the formation of community within The Club were the relationships between members.

6.3.2 Relationships between Members

Members spoke about the importance of member-member relationships in addition to staff-member relationships:

> "not necessarily just staff. Staff and members, but members and members. Because members can show other members what to do" (Gavin, member for twenty years).

> "I think the support in here from the staff is great, but it's also the support of your peers and those around you, who are possibly suffering just as badly as me" (Douglas, member for six years).

In recent years, peer support has been considered an important aspect of community mental health care and treatment, within the Clubhouse model and beyond (Repper and Carter, 2011; Biegel et al., 2012). Peer support is a means by which individuals with similar life experiences may offer practical and emotional help and guidance to each other. Clubhouse researchers have defined peer support as:

> "the notion of reciprocity in giving and receiving support based on the key principles of respect, responsibility and shared experience" (Coniglio, Hancock and Ellis, 2012:153).

In the Clubhouse, peer support is member-to-member and relates to members offering others support and guidance on the basis that both have experienced mental distress. Members were often willing to offer their support to other members, and reciprocally to accept support from other members, because there was a mutual understanding of the difficulties associated with experiences of mental ill-health. This was understood by 'older' and 'newer' members alike:

> "I've seen people coming in the way I used to be and so I've learnt to try and support them and look out for the warning signs and then I would maybe approach one of the members of staff and have a quiet word and then they'd go and see if the person was alright" (Douglas, member for six years).

> "because everybody's got similarities and can come to The Club, I can be part of somebody's recovery" (Callum, member for nine months).

Longer-standing members also gained from continued attendance: not only could they maintain the social connections that they had made from being a member of the Clubhouse, but helping other members provided a sense of achievement that aided their own wellbeing:

> "It's not always what I can get out of The Club, it's what I can help with The Club. I think that's more important than what I get out of it… I feel that, if I can help others, I'm actually helping myself" (Russell, member for eight years).

> "It's to give me a good motivation, and if I can make somebody else's day more… aye, to give them a better side to their day, to give another member that feeling, I feel that I've achieved something" (Alasdair, member for twenty years).

For these members, helping others to find their own place within The Club enabled them to continue to feel a sense of mattering within the context of the Clubhouse (Conrad-Garrisi and Pernice-Duca, 2013). Longer-standing members could experience a sense of mattering by feeling that other members depended upon them for peer support:

> "In a mental health context, peer support refers to a situation where people with experience of mental health problems are offering each other support based on their lived experience. Usually, the support that is exchanged between people might go in either direction or in different directions at different times, depending on their needs" (Faulkner et al., 2013:6).

Additionally, peer support could be reciprocal, it was not only that older members could offer their support to newer members, lifetime Clubhouse membership meant that if an 'older' member had a period of poor mental health, they could rely on the support of the Clubhouse to a greater extent again than they may have previously:

> "attending the Clubhouse may serve to provide a setting in which consumers begin to develop and appreciate the reciprocity of support and in turn utilize this support as well as provide it for others" (Biegel et al., 2012:257).

Peer supportive interactions require caring *about* and caring *for* other members, as to undertake peer support one must desire to help one's peers and additionally engage in supportive practices to enact this help. Although working side-by-side is a means of facilitating community, within the Clubhouse model, the work of the house is intended to facilitate individual personal mental health 'recovery'. Therefore, a member can engage with the work of the Clubhouse and care *for* the community in trying to fulfil their 'individual productive subjectivity', without actively caring *about* or *for* other members within the community. Whilst most members of The Club of course did care about others in the community, working side-by-side does not always "make it up to care" in the same way that peer supportive practices do (Puig de la Bellacasa, 2017:5). As members did not have the same overall responsibility to ensure the smooth facilitation of the work-ordered day as staff did, whilst a member participating in a work task could demonstrate that they cared *about* staff, it would not necessarily indicate that they cared *about* other members who shared an equal amount of responsibility for the Clubhouse. Some members who had been attending The Club for some time made an effort to guide and look out for younger and newer members:

> "I'm trying to keep an eye on the younger ones. I think that's the thing to do. Because if it wasn't for my peers in here, giving me advice and talking to me, as I learned from them, then others learn from me" (Douglas, member for six years).

This quotation from Douglas reveals the process of 'making it up to care'. He evidently cared *about* other members within The Club, as he tried to 'keep an eye' on members that he thought might be potentially more vulnerable than

himself. This caring *about* 'makes it up to' caring *for* in the maintenance work that he and others have undertaken, in talking to and listening to members, and learning from each other. He explains that this care is passed on, demonstrating that these care relations are not just reciprocal but reproductive (Tronto, 2001). In this sense care is an ongoing process, in that Douglas has learnt from members, then he has passed this knowledge onto other members, who will go on to pass it to others in the future. This passing on of care 'knowledge' within the space of the Clubhouse enables it to remain a caring community.

Although relationships between staff and members were constrained to 'work' relations and 'social' relations, the relationships between members could also be personal and romantic, and these would stretch beyond the spatial confines of the Clubhouse and the temporal confines of the work-ordered day. Many members participated in the social events that were organised by The Club every other Friday, but several members additionally enjoyed friendships with members within and outwith the Clubhouse:

> "Well from what I've seen myself as a member, I see that there are lots of the boys and girls in the group who see each other on a regular basis and have seemed to have formed pretty good lasting relationships and friendships" (Rob, member for six years).

> "I've made quite a lot of friends. I've got three or four very close friends. And then I've got people that I just say hi to and that. Then I've got a couple of people that I go out with outside of here, who I phone and text" (Catriona, member for eight years).

For Catriona, it was important that some of her relationships with members extended outside the space of the Clubhouse. Choosing to meet up with others outside of the intentional community demonstrated a level of social connection and care that was not necessarily mutually experienced between all members in the Clubhouse (Pernice-Duca and Onaga, 2009). In Catriona's case, the closeness of her relationships could be demonstrated by their strength outwith the community, as well as inside of it. In their research based in Fountain House in New York, Prince et al. (2017) considered the conditions required for individuals to achieve 'closeness' with each other, and found that members with similar diagnoses of SEMHCs, and frequent attendance at the Clubhouse were more likely to form 'close' relationships:

> "evening and weekend hours… could promote closeness by increasing time for interpersonal linkage, much as opportunity for closeness could evolve when staff brought absent people back to programs. Finally, we found that presence of flexible structure counteracted tendency to isolate. Rigid structures, that is, those that were not flexible, were repellent to some people" (Prince et al., 2017:10).

The programme of social events at the Clubhouse coupled with the autonomy that members had in structuring their own work-ordered day enabled opportunities for member relationships to form. Therefore, relationships between some members were able to extend beyond the doing-in-common of the work-ordered day and outwith the space of the working community.

Other members had very different experiences of relationships within The Club. There were a few members who did not feel as though they had made friends in their time within The Club, even though they had been members for several years. However, they explained that this did not stop them from being part of the community or participating in it, and that the space of the Clubhouse and the 'doings' within it assisted this:

> "I wouldn't say friends. Acquaintances but not friends… just being within the building and the overall aspects of The Club, it makes it easier to communicate, within and outwith The Club" (Alasdair, member for twenty years).

> "I talk to people but that doesn't mean to say that I'm actually a friend of theirs. But I try and be polite, because you can't like everybody. But as I say, it's more important that this sort of, well it's a bit like that thing that's going about the now, the hive. You know the sort of consciousness of a group" (Russell, member for eight years).

We might consider Russell's identification of this 'consciousness of a group' as indicative of an affective atmosphere. Though affects are in themselves 'pre-conscious', Ben Anderson (2009:77) describes affective atmospheres as ambiguously "between presence and absence, between subject and object/subject and between the definite and indefinite." Therefore, this 'group consciousness' may be an 'in-between' relational 'community feeling' that appeared to be shared by those who *consciously* chose to attend and participate in the work-ordered day at The Club, to contribute to the community. This may suggest that the Clubhouse fulfilled an unmet, unconscious need for many

members (Roth, 2017), who may not have had many previous experiences of social inclusion. Therefore, it is possible to experience the 'sense of community' (Herman et al., 2005) whilst not engaging with *active* caring relationships within it, through participating in the work-ordered day. Many members did care *for* each other, and the formation of community could be facilitated by this, but the production of community was not necessarily contingent on members caring for and about each other. As long as members respected each other, and focused on caring *for* the community more broadly, the community could still be facilitated. Therefore, whilst the relations of care and community are inherently entangled, these relations are complex, and they are not always mutually co-constitutive (Anderson, B., 2014).

6.3.3 Shared Experience of Mental Ill-Health

I have argued that the group work tasks at The Club created doings-in-common for members who otherwise might have shared little common ground, but some members also experienced a sense of community knowing that other members implicitly understood their experience of mental ill-health (Roth, 2017). Despite the aim of the Clubhouse to shift the focus from diagnoses and medical framings by attempting to create a shared identity through work (Craig, 2013), all members had experience of mental ill-health and for some members of The Club this was critical to their experience of community:

> "Really for me it was kind of a lifeline where I knew people were going through the same sort of thing as I was… I found by coming down here I was in amongst people who knew what I was going through and they tried their best to keep me sane, as it were" (Douglas, member for six years).

Clubhouse research in Fountain House in New York found that some members felt more able to come to the Clubhouse every day and take part in work tasks because there was no judgment of one's behaviour from other members if one was having a 'bad day' (Chen, 2017). Some members of The Club related to this experience, but this feeling was not universal. Some members did not see themselves as having much in common with other members, and while they may not judge other's behaviour, they did not necessarily implicitly understand it, even with shared experience of mental ill-health:

> "because of my illness, people with mental health problems frighten me a wee bit. I think I would find it more difficult helping them, but I would want to help them" (Fraser, member for three years).

Fraser acknowledged that his own mental ill-health meant that sometimes he was unable to relate to other individuals with diagnoses of SEMHCs. Prince et al. (2017) discovered that Clubhouse members who shared the same diagnosis of a SEMHC found it easier to relate to each other than members who did not share a diagnosis, but that spending time in the Clubhouse with a more diverse group of individuals enabled members to become more accepting of others with different diagnoses and more understanding of different behaviours. Being with and doing-in-common with individuals with different diagnoses could help to reduce the 'stigmatised identity' associated with mental ill-health that may have persisted even within the mental health 'community' (Goffman, 1963).

As a place that aimed to offer a space for mental health recovery, The Club tried to engender an 'atmosphere of recovery' (Duff, 2016). This is the reason that the collective identity of members within the Clubhouse is built around the doing-in-common of work, as it creates an atmosphere that is not focused upon the identity of being a mental health service user. This suggests that for 'personal recovery' to be a possibility, members need to be able to focus on other aspects of their lives than their illness, in order to build a personal identity beyond their experiences of mental distress (Leamy et al., 2011). This reinforces the 'normalising' discourse that for an individual to 'recover', they need to conform to certain societal norms (McWade, 2016). Of course, members will want to overcome any distress they may experience, but this does not mean they need to create a new 'identity'. However, even if the collective identity of the Clubhouse community is built around 'doing-in-common', the personal identity that members share of living with diagnoses of SEMHCs meant that members might be more understanding of 'abnormal' behaviours (Foucault, 2004). Furthermore, research in Clubhouses has determined that most members find the space of the Clubhouse safe and a space in which they can be themselves (Coniglio, Hancock and Ellis, 2012). Members of The Club expressed that the house had a friendly and welcoming atmosphere:

> "It's just the atmosphere, everybody's really friendly – everybody's been really nice" (Lee, member for six months).

> "It's just a place where there's a compassion and a willingness to help" (Douglas, member for six years).

This friendliness and compassion suggest that there was a convivial atmosphere in The Club that allowed people to 'be themselves'. However, there was still an assumption of member "conformity to certain expectations of behaviour" (Herman et al., 2005:353) and when a member's behaviour was deemed potentially harmful to individuals or the community, it was sometimes necessary for The Club staff to take action to discipline or remove the individual undertaking this behaviour:

> *Today a senior staff member asked a member to leave The Club and not come back for a wee while. This member had told another staff member to 'fuck off' and it is house policy in cases like this that a member is asked to leave the premises and given some time to calm down. I didn't see the incident but I spoke later to some members who had. They were empathetic, expressed pity towards the member, and described the member as 'not well', stating that this event was 'a shame'. (Field diary extract 1st November 2017).*

Other members' responses to this incident reflect Roth's (2017) finding that Clubhouses are caring environments. Members were generally accepting and non-judgmental of 'symptomatic' or 'abnormal' behaviour that may not be tolerated in other settings. However, there was an expectation from both staff and members that when someone is 'not well' in this way they should not be attending The Club. The Club recognised that a balance needed to be struck between attempting to be "open to vulnerable and marginalised people, some of whom may present with challenging behaviours" and at the same time ensuring the "safety and security of everyone in the Clubhouse" (The Club, 2015c:1). In the first instance when a member was behaving in a way that was considered unacceptable, they would be asked by a member of staff if they required any support. However, in a case where this behaviour was deemed 'inappropriate' and could not be immediately resolved the member could be asked to leave the Clubhouse, and they would only be able to return to the Clubhouse after a formal discussion with staff about the incident. Similar situations and staff

responses to such behaviour were examined in research in Fountain House in New York:

> "If the situation interfered with work or people felt threatened or uncomfortable, staff would intervene. [Staff] stressed the importance of creating a safe environment for members, so they used strategies to reduce the impact… speaking with the member in a separate space to process the personal matter, or taking a walk outside of Fountain House to help the member relax" (Chen, 2017:660).

When a member was behaving in a manner deemed inappropriate by The Club it was usually because they were acting on emotions that were not considered conducive to the formation of the community, such as anger. Whilst a person who had been temporarily suspended from the Clubhouse was not cast out of the community permanently, they were expected to suspend their doing-in-common with other members within the space of The Club. As explored in the literature review, Parr (2000) notes a similar exclusionary geography at a drop-in centre for individuals with diagnoses of SEMHCs, where individuals are sometimes prohibited from attending due to 'deviant' behaviour. In the incident recounted in my field diary extract, the member was vocally expressing an emotion (anger) that did not fit in with The Club's intentions of providing a welcoming atmosphere. This behaviour was explained by other members and by staff to have occurred because the member was 'unwell' and therefore not able to control their emotions or actions at that time. While angry and aggressive outbursts obviously could not be tolerated within the space of The Club, positioning dissenting behaviour purely as symptomatic is problematic, as this diminishes the member's personal agency to act in oppositional or defiant ways:

> "the unification of madness through its symptoms, even the most particular and regional symptoms, takes place at the level of an interplay between the voluntary and the involuntary. A person who is mad is someone in whom the demarcation, interplay, or hierarchy of the voluntary and involuntary is disturbed" (Foucault, 2004:157).

In this criticism of psychiatry, Foucault notes that the demonstration of a single abnormal behaviour causes the psychiatrist to identify the individual as 'mad' and cast them in the role of 'mental patient' (Goffman, 1961). In this role, all acts become 'involuntary' and they are all symptoms of madness. We have considered multiple intersubjective social roles that Clubhouse members may be

negotiating (such as patient, worker, peer, friend, colleague), and how these are "constituted in social discourse" (Butler, 1988:528). For many individuals, one of these roles might be an 'illness identity', that is distinctly personally linked to their own experiences of mental distress but may or may not be linked to behaviours that are considered not to be socially normative. The Club staff had to ensure the safety of all staff and members by reducing the likelihood of aggressive and harmful behaviour within the Clubhouse. Simultaneously, they had to refrain from constructing a social discourse that constituted all behaviour that was not conducive to the formation of community as 'illness behaviour'. This is further compounded by the complexities of staff-member relationships and the perceived 'flattened hierarchy' in the Clubhouse. While staff would be expected to have a duty of care over members, working side-by-side sits at odds with staff disciplining a member for their behaviour. This is when the notion of the 'illness identity' becomes useful, as staff are no longer disciplining members for their behaviour, rather they are caring for someone who is unwell. However, this not only reproduces the stigmatised identity of the mental patient (Goffman, 1963), it also prevents the tackling of potential conflict within the Clubhouse, as behaviour is dismissed as illness and not as 'legitimate' aggressive or defensive behaviour.

The capacity of the individual to affect the formation of community can be significant. Previous research in US Clubhouses by Roth (2017) identified the negative impact felt by members from the actions of one staff member described as a 'bad apple'. Members still recalled these incidents as significant even though they had occurred more than a decade before the research was undertaken, demonstrating that the actions of an individual could have a significant impact on shaping the formation of community for a considerable length of time. The incident recounted in my field diary extract was only a minor disruption, but it demonstrates the potential capacity for the emotions of a single individual to influence the emotions of other members and the momentum of the community in general. In this case the main feeling elicited from other members was sympathy or pity, and fortunately this incident did not appear to have a significant negative impact on the emotions of other members. However, it did disrupt the flow of the work-ordered day, and in doing so the affective momentum of the community (Anderson, B., 2009). Furthermore, as

affect is a "condition for subjectivity" (Anderson, B., 2017:2) the feeling of 'pity' demonstrated by other members for the member involved in the incident may be indicative of an affective atmosphere, through which members are attempting to distance themselves from the 'illness behaviour'. Affect causes "a represented [subject to] be apprehended and… take on a certain meaning" (Anderson, B., 2009:79), in this case the 'deviant' member has taken on the identity of the 'Other' and the atmosphere of pity may be formed by other members attempting to assert their 'normative subjectivity' (Anderson, B., 2010). The low level of disruption caused by this incident is a testament to the swift handling of it by The Club staff. Whilst taking the member out of the space of the Clubhouse limits that member's access to the care of the community for a short time, it also protects the rest of the community from further disruption, allowing for the continued facilitation of community through the doing-in-common of the work-ordered day.

In this consideration of the shared experience of mental ill-health, and where I have explained that sometimes members are expected to suspend their doing-in-common with the community, it is prudent to mention that other members who had not attended The Club for some time were very actively encouraged to come back to the community to resume their doing-in-common. Members who were in hospital for extended periods were sent 'get well soon' cards, so while they were not able to do-in-common they knew they were still cared *about*. Other members who had not visited The Club for some time were sent 'reach out' cards. Staff reaching out to socially isolated members is common Clubhouse practice (Prince et al., 2017). For members to know that they are being thought of and remembered even when they are not doing-in-common can contribute to their sense of mattering, as they know they are valued by others (Conrad-Garrisi and Pernice-Duca, 2013). The membership unit of The Club was responsible for working out who needed a card, producing the card, and encouraging as many staff and members as possible to sign it, before sending it by post to the member. These cards demonstrate that the care of the community was not bounded by the walls of the Clubhouse (Bowlby, 2012). However, it also indicated that while the care relations could extend outwith the Clubhouse, the care that The Club could offer beyond the bounds of its walls was limited. The cards would remind members that they were cared *about* by the community of

The Club, and if they wished to be cared *for*, they could resume their doing-in-common within the community at any time.

6.4 Making Decisions in the Clubhouse

6.4.1 Finding Consensus at the House Meeting

In an organisation with so many different members, and where participation from all is encouraged in the decision-making process, conflict between individuals may occur. We have considered the potential difficulties of conflict when behaviour is aggressive, and the way this might be framed as illness behaviour. However, members identified that conflict could sometimes arise within the Clubhouse, and that this was not necessarily always a bad thing:

> "there's going to be conflict, you know, these are the things that help push us on" (Russell, member for eight years).

The notion of 'pushing on' is reminiscent of Hamish's recognition of the momentum of the Clubhouse that is both facilitated by and experienced through the doing-in-common of the work-ordered day. Similarly, events that cause 'conflict' have an affective capacity to 'push us on' because they create a tension that needs to be resolved (Anderson, B., 2014). Kathryn Pratt (2013) explains how doing-in-common can create common ground between individuals who otherwise have very different viewpoints and experiences. Moreover, these different experiences and opinions can enrich the work that takes place, through the introduction of new ideas. Facilitating the doing-in-common of community might sometimes require conflict between individuals in order for progressive decisions to be made, as "democratic decision-making can be viewed as another aspect of side-by-side working" (Tanaka, 2013:139), and for a democratic decision to be made, members with differing viewpoints will need to negotiate with each other:

> "Participation that fosters a sense of community is likely to involve reciprocal interaction processes, or democratic/shared decision-making" (Tanaka, Craig and Davidson, 2018:283).

For this reason, member participation in the deliberation of decision-making is a fundamental element of the work-ordered day, as it is only through negotiation

and discussion that informed and meaningful decisions can be made, and a sense of community can be facilitated (Herman et al., 2005).

For individuals to find the work-ordered day meaningful they need to feel as though they have some stake in the decisions being taken (Norman, 2006). This is what we have previously discussed as having a feeling of ownership of the Clubhouse (Norwood, 1992). Involving members in the decision-making process offers potential for the disruption of the entangled 'care-and-control logics' (Philo, 2017) that exist in staff-member relationships; as members are given some control over how and when disciplinary power may be exerted over them. The process by which formal decisions were made in The Club was intended to be transparent and democratic, involving discussion and debate. This process could cause conflict and tensions that may be required for the momentum of progress, though of course any aggressive conflict was not condoned by The Club, and such behaviour could also disrupt the momentum. However, the procedures involved in ensuring it was a fair and democratic process meant decision-making could also progress quite slowly.

In the previous chapter we considered the significance of scheduled meetings within the Clubhouse in structuring and organising the work-ordered day, and the importance of these meetings in their capacity for relationship building between individuals (Pernice-Duca and Onaga, 2009). This exploration focused heavily upon the temporal structure that meetings afforded the work-ordered day, and the disciplinary power this timetabling could exert on controlling individuals within the social body (Foucault, 1995). Another meeting within The Club that we did not explore in the previous chapter is the house meeting. The house meeting took place weekly at The Club on a Wednesday afternoon at 2:15pm for approximately one hour. While this meeting served a disciplinary function by structuring the work-ordered day, it also had disruptive potential, as it was the meeting at which all the major decisions of the house were taken, and members were encouraged to bring forward suggestions for changes and to debate proposals that were presented. Any proposals or ideas that had been decided upon within unit meetings were added to the house meeting agenda and discussed before a decision was made. There was a communal whiteboard in the café where additional items could be added by anyone to the agenda for

discussion at the next meeting. At the house meeting, decisions were made using an adapted version of the Quaker tool of consensus, explained in Figure 14.

Consensus Decision-Making in The Club (The Club, 2017):

At the house meeting, the proposal is suggested and explained. There is an opportunity for anyone at the meeting to ask questions clarifying points of the proposal. There is then a test for consensus. Each member has a choice as to the response they offer to the proposal. The accepted responses are:

1. Agreement – agreeing with the proposal as it is.

2. Consent – allowing the proposal to go ahead as it is, even though one may not fully agree with it.

3. Stand aside – similar to consent in allowing the proposal to go ahead despite personal reservations. However, unlike consent, this vote does not count towards the passing of the proposal. This option may be used when a member feels they are perhaps not qualified to make a decision on this particular proposal for whatever reason.

4. Declare reservations – this choice states that the member will not allow for the proposal to go ahead as it is. This means that some reworking of the proposal is required before consensus can be reached.

5. Block – the member feels that the proposal is entirely wrong or inappropriate in design and will not offer consent to its passing.

Within The Club, consensus is reached when there is a quorate meeting, where all but two members of this quorum allow the proposal to pass.

Figure 14: the consensus decision-making process within The Club.

Consensus decision-making processes are used in many organisations and movements, the 'Occupy' movement of 2011-2012 is one high-profile example; these processes are recognised as offering more opportunities for collaboration and participation than simply voting proposals up or down (Urfalino, 2014). Consensus decision-making allows for 'conflict' to occur that is not damaging to the community; it allows for individuals to assert individual autonomy that would contribute to their own personal meaning-making within a framework that ensures the needs of the community more broadly are met (Tanaka and

Davidson, 2015). Moreover, the consensus process is significant in our consideration of care and control, as it allows for members to have much greater control of the procedures of the house. Members are able to veto proposals, furthermore the consensus process enables them to amend proposals until all members are happy to let them pass. Members are also able to make proposals, and therefore can propose changes to disciplinary procedures that may exert control over them. In order for a motion to be tested for consensus, a certain number of Clubhouse members were required for quorum to be achieved. Clubhouse staff could express approval or disapproval for a proposed motion but were not included in any test for consensus. Therefore, whilst individual autonomy in the decision-making process was important, doing-in-common was essential for decisions to be made. Achieving the threshold for a quorate meeting proved to be quite challenging during my fieldwork period.

The lack of quorum meant that it was sometimes difficult to make decisions within The Club. Some proposals were tabled for weeks and the decision-making process stagnated. During my fieldwork, whenever a house meeting *was* quorate, all these previously tabled proposals would be put to consensus in a single meeting, in order to speed up the process of decision-making. This could mean that proposals were rushed over: they will have been discussed in previous weeks but if it is the first time quorum has been met in some time, it is likely that some members at the quorum meeting will be hearing the proposals for the first time. To address this, The Club held a 'refresher' session to explain the consensus process, to make members aware of the importance of attending the house meeting:

> "Seventy-five percent of [the house meetings] in the last twelve months weren't quorate… the response was to remind people what consensus is" (Owen, staff member for eighteen months).

There was an assumption that members were not attending house meetings because they did not understand that their attendance was required in order for decisions to be made. Furthermore, as few members were attending the house meeting, those who did attend did not see or participate in the process of consensus, as there were rarely enough members at these meetings to facilitate the decision-making process. Therefore, some people who frequently attended the house meeting (myself included) were not aware of the consensus process.

As Owen notes in the quotation above, The Club's response to this was to run a training session to explain the process:

> *The house meeting was cancelled so we could all have consensus training. I had not been aware that decisions were made using a test for consensus, up until now I had thought decisions were made using a pass/fail vote whenever quorum was possible. The process for consensus is much more complex than this and I will have to give the paperwork provided in the training a more thorough examination to fully understand it. The training was delivered in a lecture style, with a PowerPoint presentation on the projector screen and the chairs all set up in rows. Even the staff member running the training mentioned that he felt as though he was giving a lecture. The upstairs had a very different atmosphere being set up like this, much more formal, much less Clubhouse. (Field diary extract, 18th October 2017).*

The consensus training was well attended, even by some members that were not often at the house meeting. One of the most notable features of this event was the 'lecture theatre' style delivery of the training, that at the time felt quite at odds to the everyday functioning of the work-ordered day. Due to the inertia of decision-making at The Club, a (non-consensus) decision was taken by staff to engage members in a style quite different from the 'teaching side-by-side' of the work-ordered day (Tanaka, 2013). In this case, to facilitate the further doing-in-common of decision-making, and to enable critical decisions about the running of the Clubhouse to be made, the collaborative process of working side-by-side had to be temporarily suspended and a small amount of controlful care was exerted. This demonstrates that there may be limits to the 'doing-in-common' method of facilitating community, and that sometimes other, notably hierarchical, mechanisms of power need to be enacted in order for the continued maintenance and enhancement of the community (Foucault, 1995).

A greater understanding of the consensus process may have encouraged some members to attend the house meeting. Nevertheless, member opinion regarding the house meeting was divided. One member actively sought out work tasks to do during this time to avoid attending. However, a few members attended almost every week and appeared to appreciate the opportunity for discussion:

> "I come here to… take part in meetings and stuff and put my point across" (Fraser, member for three years).

> "I make a risky comment at a meeting, within parameters, not offending anybody, or offending the function of the Clubhouse" (Hamish, member for eighteen months).

These members both considered attending the house meeting an important aspect of their work-ordered day. Furthermore, they considered that offering their own views was an important part of their contribution to the Clubhouse. Feeling that one's contributions are valued within the Clubhouse is an important aspect of the 'need to be needed' (Doyle, Lanoil and Dudek, 2013):

> "Individuals are attracted to a community where they feel influential and where through collective action of the community, the environment is changed to support community members… the Clubhouse is posited on the understanding that members have a direct influence on the Clubhouse environment" (Herman et al., 2005:353).

Hamish was a regular attendee and contributor at house meetings and understood that they were a space for discussion. However, he was still reluctant to make a comment that 'offended' the ethos of the Clubhouse. Hamish was a very respectful individual by nature, therefore opposing proposals may not have been something that he was comfortable with doing. Even so, this demonstrates that even within a system that is designed to encourage discussion and dissenting opinions, and within the safe space of the Clubhouse (Coniglio, Hancock and Ellis, 2012) where members understand if another member is 'having a bad day' (Chen, 2017), members still considered their contributing at a meeting 'risky'. For Hamish, taking this risk was part of what made his contribution meaningful, and gave purpose to his work-ordered day (Palacios-Ceña et al., 2016). However, for less confident members this risk might seem too great.

Norman (2006:189) identified that the Clubhouse environment could be "restricting for some and enhancing for other members," and that what more confident members might find empowering, shier members could find difficult. Staff recognised that the house meetings could be quite daunting for some members and tried to ensure that house meetings did not overrun the one-hour time slot that was allotted to them:

> "during the house meetings we tend to over-explain ourselves. I think, 'Keep it short, keep it sweet, keep it a little bit funny. Just make sure it's light.' People are just going to take in the information like that and everything else you say around it is just spaghetti" (Orla, staff member for six months).

A member attending a noisy and fast-paced meeting for the first time might be quite overwhelmed, particularly if it was a busy meeting with many issues being discussed. Furthermore, beyond attending the meeting, to contribute to the discussion would require speaking in front of a group of people and possibly going against another individual's opinion. The potential for unwanted conflict, and the stress of speaking in front of a group of people meant that some members did not feel able to voice their opinions at house meetings. For others, the potential conflict that might arise made the notion of raising ideas unappealing:

> "I mean you'll notice I don't say all these things at the house meeting because, maybe I'm wrong, but you know it's sort of a general sort of thing, you feel that you can't change these things" (Russell, member for eight years).

> "when I go to a meeting like that, where she's asking people 'oh what do you think?' and put me on the spot, I sort of turn round and I go a funny colour and I begin to think 'what am I doing here?'" (Graham, member for two years).

Members should have the possibility of participating in decision-making in a community of which they hold membership, however, some members did not want or feel able to take on this responsibility at that time. In Ed Hall's (2009) examination of the 'personalisation' of care for disabled individuals, he explains that while the aim is to allow individuals to choose the support that is best for them, there are many reasons why individuals may not be equipped to make the choice that best suits their needs, leaving them with inadequate care. The Clubhouse manages to disrupt institutional mechanisms to a certain extent by giving members greater autonomy over how they use the Clubhouse, but for some members having this choice does not enable them to be in the environment in which they feel most cared for. For some members, a space most conducive to mental health recovery may be a space in which they feel cared for, without feeling as though they must make decisions as to the nature of this care, responsibility to care for others, or responsibility over caring for the

community more broadly (Valkeapää et al., 2019). There may be some members for whom an even greater exertion of controlful care would be welcome and beneficial. However, the Clubhouse does not claim to be a space of 'care', it is a place for mental health recovery, and while some controlful care is enacted, this is not the aim of the organisation.

6.5 Conclusion

In this chapter I have attempted to discern the ways in which 'care' and 'community' are facilitated, enacted, and experienced within The Club. Through detailed examination of events that took place during my ethnographic fieldwork, I have been able to explore the Clubhouse as a 'working community' and provide a thorough geographical account of the relations of power within a space of 'community care'. Interview data has offered further elucidation of the experiences of participating in a 'working community' and members' attitudes to working side-by-side with other members and staff. The process of doing-in-common through undertaking the work tasks of the work-ordered day allowed members to forge a new social role outwith their illness identity (Goffman, 1961). This new role is a 'worker identity', which in addition to moving the individual away from their illness identity places them into a role that is more highly valued and socially accepted in wider society (Butler, 1988), enabling members to step away from their stigmatised selves (Goffman, 1963). Encouraging members to construct a new identity based around their value as a worker may be problematic, as they may only feel the benefit of this identity at times when they are able to work and slip back into their 'illness identity' at other times. The worker identity is also a reflection of a broader societal valorisation of work and the construction of 'neoliberal subjectivity', reproducing members as 'entrepreneurs of the self' (Foucault, 2008) that leads to the prioritisation of the individual over the community. The valorisation of paid work and the productive neoliberal subject in relation to The Club will be given thorough consideration in the next chapter, but it is important to note that these notions are pervasive within the work-ordered day, which is intended to function as a catalyst for building an intentional community. However, while doing-in-common does create an individual worker identity, these individuals are still working side-by-side in order to maintain and enhance the community. Therefore, members are creating their own new social role as a worker and

contributing to a community that provides a space for social inclusion for individuals who have been excluded elsewhere because of their stigmatised identity.

To enable members to feel incentivised to continually come to the Clubhouse to undertake work tasks as part of the doing-in-common of community, members needed to feel as though they were cared for and about. For some members, feeling that they were valued for their work contributions was sufficient to ensure their continued attendance. Participating in the doing-in-common of community was enough to provide them with a sense of mattering (Conrad-Garrisi and Pernice-Duca, 2013) particularly when the work they undertook felt meaningful (Norman, 2006), such as contributing their opinions in the decision-making process. For other members, the caring relationships that developed between themselves and other members and staff were a vitally important aspect of their Clubhouse experience that contributed to their feelings of social inclusion (Hall, E., 2004). For some members of The Club this entailed forming strong friendships with members that extended beyond the space of the Clubhouse (Bowlby, 2012), and these care relationships were no longer contingent upon the formation of the community of the Clubhouse. For others, their relationships were very much based upon being able to care about and for members within the space of the community, to encourage them to participate in the Clubhouse, and support them through "teaching side-by-side" (Tanaka, 2013:145). This care could be passed on within the space of the Clubhouse, which could help to further the community. Relationships between staff and members were bounded within the Clubhouse and constituted different caring relations to those between members. In spite of the Clubhouse ethos of working side-by-side (Tanaka and Davidson, 2015) staff-member relationships evidently could not be equal, and sometimes in order to provide a safe and caring environment for all, staff had to exert controlling mechanisms of power (Foucault, 1995). Within The Club, the disciplinary mechanisms exerted were used to ensure the safety of members (by preventing aggressive behaviour) or to further the building of community (by trying to jump-start the decision-making process). These "low-level mechanisms of control" are a kind of "controlful care" (Philo and Parr, 2019:245).

The emplaced nature of a Clubhouse community (Rogers, Castree and Kitchin, 2013) allowed for affective atmospheres to accumulate in the space as a result of the doing-in-common of the work-ordered day (Anderson, B., 2009). Within The Club, members identified a 'momentum' or 'pushing on' that had the affective capacity to transform the individual's emotions such as lowness or anxiety into something facilitative for their mental health recovery:

> "the rootedness of recovery in place insofar as specific places provide both the stage and the necessary social, affective and material resources for the everyday work of recovery" (Duff, 2016:66).

Furthermore, the emotional intensities involved in caring *for* the community in the doing-in-common of the work-ordered day provided the affective capacity for individuals to find the space of the Clubhouse 'healing' (Simonsen and Duff, 2020), as they experienced the work as meaningful. However, sometimes these affects through which individuals attempted to assert their own 'normative identity' could cause other members to be further marginalised due to their 'deviant' behaviour. The Clubhouse as a space for mental health recovery, alongside its firm commitment to avoid medicalised labels and the physical space it occupied outwith clinical mental health treatment spaces created a space of care for members to form social connections and try out a 'worker identity', in attempting to find their own personally meaningful form of mental health recovery.

7 Working Beyond the Clubhouse: Transitional Employment Placements

7.1 Introduction

In this chapter I examine the Clubhouse International standards in relation to Transitional Employment Placements. I characterise the ways that TEPs are distinctive from other forms of supported employment and explicate the ways that The Club adhered to and deviated from the Clubhouse expectations of a TEP programme. I also consider members' opinions of the TEP programme, and explore their experiences attempting to undertake TEPs. Through this I think about the ways that neoliberal-ableist values about work and employment pervade in members' experiences and decisions in relation to work. I evaluate how the Transitional Employment Placement programme within The Club both perpetuated and subverted the notion of striving for individual neoliberal subjectivity, understanding a productive neoliberal subject to be an individual who "seeks to make an enterprise of their own life, investing in their human capital in order to fuel the consumption that will produce their own satisfaction" (Houghton, 2019:623). I think about the significant positive outcomes of TEPs and explore how we can highlight these aspects, in moving beyond an understanding of personal mental health recovery that favours participation in the mainstream labour market (Evans and Wilton, 2016). I consider the ways that The Club 'works the space of neoliberalism' (Bondi and Laurie, 2005), in trying to do the best for its membership and the Clubhouse community, whilst still negotiating a neoliberal health and social care landscape in which individuals are expected to strive towards a certain ideal of personal mental health recovery (McWade, 2016).

The term 'supported employment' is used to describe multiple frameworks that enable individuals with disabilities to obtain and retain paid employment (Drake, Bond and Becker, 2012). Whilst undertaking supported employment encourages individuals to constitute their own 'productive neoliberal subjectivity', there are of course advantages to engaging in this kind of work. There is evidence to suggest that undertaking supported employment can improve individual self-esteem and hope for the future (Boyce et al., 2007); it can aid the formation of personal identity beyond diagnosis and pathology (Saunders and Nedelec, 2014);

it can help to create structure and routine in one's life (Torres-Stone et al., 2016); facilitate the creation of social connections and reduce isolation (Evans and Wilton, 2016); finally paid employment offers financial reward. However, for many individuals finding suitable, long-term supported employment may not be a reality and therefore their constitution as productive neoliberal subjects may be hindered (Hall and McGarrol, 2012). The "devalorization of the labor power of people with mental illness (and other disabled people) within the competitive job market" (Evans and Wilton, 2019:96) means that any supported employment opportunities that individuals might be able to undertake are more likely to involve precarious working conditions and low pay (Noack and Vosko, 2011). Individuals are both encouraged to strive for neoliberal subjectivity in their personal mental health recovery and prevented from achieving it by the ideals and mechanisms of neoliberalism itself.

Despite the "unapologetic mutation of late neoliberalism" (Peck and Theodore, 2019:249) in supported employment schemes and frameworks of personal mental health recovery, within any power relation there is opportunity to resist as "the process of subjective construction is a site for agency" (Wilton, 2004b:422). In constituting one's neoliberal subjectivity, one has the ability to subvert power in small ways, through undertaking actions that can maximise any 'positive' outcomes of becoming a neoliberal subject (such as increased self-esteem or financial reward) and resist the negative impact of neoliberal-ableist processes (Goodley and Runswick-Cole, 2014). The Club was an interstitial space, where members could inhabit identities between unwell and recovered, unproductive and productive, patient and worker. It is in these threshold spaces where these binaries can be disrupted, the notion of 'productivity' can be challenged, and there is an opportunity to focus on which aspects of working and paid employment may actually be positive for individual personal mental health recovery (Evans and Wilton, 2019). Principles of the Clubhouse model help to maintain this 'threshold' state: members are permitted to attend the Clubhouse for the whole of their lives, as guaranteed in the first Clubhouse standard. In addition to this, the Clubhouse model encourages participation within the Clubhouse by reminding members that their work is required to facilitate the work-ordered day (Conrad-Garrisi and Pernice-Duca, 2013). However, one of the other main objectives of the Clubhouse model is to provide: "opportunities to

obtain paid employment in the local labour market through a Clubhouse-created Transitional Employment program" (Clubhouse International, 2019:np). Members are encouraged to try out their neoliberal subjectivity and strive for personal mental health recovery, but at the same time are told that their presence is valued in the Clubhouse regardless of their 'success' in becoming a productive subject.

Within the Clubhouse model, Transitional Employment Placements (TEPs) are an alternative to a supported employment scheme. Torres-Stone et al. (2016) identify that TEPs can offer financial, psychological, and social benefits such as: increased financial stability and an individual sense of purpose. We can understand TEPs to be a specific form of supported employment scheme, and I will outline the specific characteristics of TEPs throughout this chapter. However, I will briefly highlight a few notable characteristics that differentiate TEPs from other forms of supported employment. Firstly, while various supported employment schemes last for different lengths of time, by definition TEPs are not long-term employment, they are time limited placements (Dorio et al., 2002). Secondly, the placements offered in TEPs do not technically qualify as 'competitive' employment, as these placements are 'protected placements' for Clubhouse members. Competitive employment in this context is used to describe 'mainstream' rather than 'sheltered' employment, that is jobs that anyone can apply for, paid at least at minimum wage (Wehman, Revell and Brooke, 2003). Whilst Transitional Employment Placements are located in 'mainstream' organisations, and are paid at the going rate, these placements are only available to Clubhouse members, meaning that members are only competing with other Clubhouse members when applying for placements. Finally, the level of staff support offered to members undertaking TEPs is much greater than it might be on other supported employment schemes. This will be explicated in greater detail in the chapter, but we can consider TEPs to be short-term, protected, highly-supported employment placements.

TEPs are intended to be an opportunity for members to gain experience in mainstream employment, but they are also a chance for members to explore their skills and strengths, and to determine what they find useful, meaningful, or enjoyable in different forms of work (Mueser et al., 2014). TEPs offer a period of self-exploration where one is supported and guided in a way that is not offered

in other supported employment schemes. In a study of Finnish Clubhouses, only 21% of seventy-six TEP participants identified further employment as a goal of undertaking transitional employment, whereas 39% wanted to gain a greater understanding of their own working capacity and strengths and almost as many (37%) stated earning money as a goal (Pirttimaa and Saloviita, 2009). Perhaps the most significant statistic from this study, only 5% of 105 members that had undertaken a TEP had subsequently moved into paid employment following the placement, whereas 40% resumed regular Clubhouse attendance. Advocates of Independent Placement and Support (IPS) have levelled criticism at the Clubhouse model for the lack of rigorous research demonstrating the efficacy of TEPs at helping members to find long-term competitive employment (Bond, 1998). Although the Clubhouse International standards demand that the Clubhouse endeavours to "assist members to secure, sustain, and better their employment" (Clubhouse International, 2018:3), the mainstream "labour market remains a precarious and exclusionary space for many disabled people" (Hall and McGarrol, 2012:1276).

During my fieldwork, there was no direct stream through which members could move into another form of supported employment following their TEP, though The Club were attempting to organise a partnership with the IPS scheme run by a national mental health charity that was rolled out to some CMHTs in the Greater Glasgow and Clyde health board, that I referred to in the contextualisation chapter. Only a small number of The Club members entered competitive employment after the completion of a TEP. In the 2016-2017 financial year, fourteen members (of 262 that engaged with The Club in that twelve-month period) were supported by The Club to remain in employment (outwith TEPs) (The Club, 2018). Some of these members had been in employment for some time, and not all of them had completed TEPs prior to finding their current employment. As the TEP programme was entirely managed and operated by Clubhouse staff, there could only be a limited number of placements and time spent on expanding this programme, as staff also had to facilitate the work-ordered day. However, in tendering for funding within a political landscape that encourages individuals with diagnoses of SEMHCs to enter paid employment (Stafford, 2015) The Club were also under some pressure to demonstrate that some members reached this goal.

7.2 Examining Transitional Employment Placements

In order to evaluate the ways that The Club both reinforces and subverts the notion of the 'productive neoliberal subject' as an essential element of personal recovery from mental ill health, we need to have a deeper understanding of how The Club represents 'paid employment' through its Transitional Employment Placement programme. TEPs are a highly specific form of supported employment, with precise criteria laid out in the Clubhouse International standards:

"Standard twenty-two, under employment: The Clubhouse offers its own Transitional Employment program, which provides as a right of membership opportunities for members to work on job placements in the labour market. As a defining characteristic of a Clubhouse Transitional Employment program, the Clubhouse guarantees coverage on all placements during member absences" (Clubhouse International, 2018:2).

The notion of 'guaranteed coverage' on all placements means that all TEP shifts will be covered by a member of Clubhouse staff in the case of a member being unable to cover their shift. The intended benefits of this are to encourage members to apply for a TEP who would otherwise be uncertain about putting themselves forward due to the possibility that they would take several absences throughout the course of the placement. Furthermore, all members undertaking TEPs are reassured that if they are too unwell to attend their placement, the work will still be completed. Finally, guaranteed coverage is also used as an incentive to get businesses and organisations to become TEP employment partners, as they do not need to worry about finding cover for shifts should a member become unwell. In 2015, The Club reported that it was able to cover 85% of absences on the TEP placements it offered over a three-month period (The Club, 2015d) suggesting that this guarantee of placement coverage can sometimes be difficult to maintain, though it is evidently an important aspect of the TEP programme that The Club found to be valuable for members and partners. The second half of Clubhouse standard twenty-two lists a set of criteria that TEP programmes must meet in order to qualify as a TEP programme under Clubhouse accreditation. These criteria are listed in Figure 15.

Basic criteria for Transitional Employment Placement programmes:

a. The desire to work is the single most important factor determining placement opportunity.

b. Placement opportunities will continue to be available regardless of the level of success in previous placements.

c. Members work at the employer's place of business.

d. Members are paid the prevailing wage rate, but at least minimum wage, directly by the employer.

e. Transitional Employment Placements are drawn from a wide variety of job opportunities.

f. Transitional Employment Placements are part-time and time-limited, generally 15 to 20 hours per week and from six to nine months in duration.

g. Selection and training of members on Transitional Employment is the responsibility of the Clubhouse, not the employer.

h. Clubhouse members and staff prepare reports on TE placements for all appropriate agencies dealing with members' benefits.

i. Transitional Employment Placements are managed by Clubhouse staff and members and not by TE specialists.

j. There are no TE placements within the Clubhouse. Transitional Employment Placements at an auspice agency must be off site from the Clubhouse and meet all of the above criteria.

Figure 15: Basic criteria for TEPs, as listed under Clubhouse standard twenty-two (Clubhouse International, 2018:3).

Whilst The Club discovered it was no longer accredited by Clubhouse International during my fieldwork period, their TEP programme was constructed through the Clubhouse model and had been reviewed in several previous accreditation processes. As the Clubhouse TEP programme is such a specific form of supported employment programme that has some quite distinctive elements, I will provide an explanation of how it operated within The Club using the criteria in Figure 15 as a rough guide. I consider the nature of the employment training and support that members were offered on TEPs and the challenges that staff faced in trying to offer adequate employment support to members whilst also facilitating the work-ordered day. I explicate the notion of the 'desire to work'

and ‘opportunity to fail’ as unique aspects of the TEP programme, that promoted neoliberal subjectivity in particular ways but also opened up prospects for members to question their own values around paid employment. I then examine the variety of placement opportunities that were available as TEPs within The Club, the views that members had about these opportunities, and how these views reflected societal neoliberal framings of work. I evaluate the notion of the ‘employer’ and the role that The Club played in this given that they managed the TEPs and the high level of support they offered during placements. I then examine TEP wage rates and the complexities of having TEPs operating alongside unpaid volunteer placements. After this I consider the length of each placement and the number of hours worked on a shift, and how the time-limited nature of placements is experienced by The Club members, particularly in relation to the opportunities for moving into further employment following a TEP.

7.2.1 Managing Transitional Employment Placements

The responsibility for the allocation of TEPs to participants, training of TEP participants, and management of the TEPs lies solely with the Clubhouse (Macias et al., 1999). All Clubhouse staff manage TEPs, as part of their ‘generalist’ role (Doyle, Lanoil and Dudek, 2013). When a new placement partnership is agreed with an external partner, Clubhouse staff will attend the TEP and undertake all the work tasks of the placement in order to be able to train members to undertake the TEP. Sometimes the staff TEP manager may undertake the TEP for multiple shifts, as a show of ‘good faith’ to the partner organisation and to demonstrate that there will be guaranteed coverage of the placement in the event of member absence from the TEP. From this experience, the member of staff is then able to create a ‘TEP booklet’ which is a written guide for the placement to provide information to members who are successful in attaining a placement. The booklet provides information about the location of the TEP, directions to the TEP on public transport from The Club, the rate of pay and the times and days of shifts, the contact details of the TEP manager in The Club as well as the point of contact at the partner organisation, and the procedure for members to inform the TEP manager if they will be absent from the placement. Additionally, the booklet offers a guide to all of the tasks that members will need to undertake on each shift, the equipment that is required for each task,

as well as any extra information about the tasks to be undertaken. Figures 16 and 17 are demonstrative examples reconstructed from a TEP booklet for a cleaning placement at a mental health organisation. This guide serves as a helpful reminder or 'task checklist' for members once they are comfortable with attending the TEP on their own.

When a member commences a TEP, the member and staff TEP manager travel together to the location of the placement on public transport from The Club. The TEP manager introduces the member to the placement contact at the employment partner. Then the TEP manager and member undertake the work tasks of the TEP together, the TEP manager showing the member how each task is done. The TEP manager will continue to accompany the member to the placement, offering as much support as the member needs. Usually after a couple of shifts the TEP manager steps back from undertaking the tasks, and acts as a reassuring presence for the member, and offers gentle reminders about how to undertake tasks. The TEP manager will continue to attend the placement with the member until the member states that they are comfortable attending the placement alone:

> "The TEP that I currently cover, I've had nearly six members in it since I took over. Sometimes I've only been there for three sessions and then they are ready to go, there are times when I've been there for three months before they're able to pick up the job themselves" (Annabelle, staff member for seven years).

It is hard to predict how long a staff member will need to actively supervise each member for, and it is unknown when a member may call in sick, so there is always uncertainty about how much availability each staff member will have in the Clubhouse to facilitate the work-ordered day. This is one of the major limiting factors in the number of TEPs that The Club can offer: there are only a small number of staff that work in the Clubhouse, and a certain number of staff are required within the Clubhouse to oversee and manage the work-ordered day. All Clubhouse staff are expected to supervise TEPs, and if a significant proportion of their time is taken up with managing and attending TEPs, they have little time left to facilitate the work tasks of the work-ordered day:

TASKS /DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1. DESKS/ OTHER TASKS	1. Clean all desks in big office and small offices. Use general purpose cleaner and white roll.	1. Clean the table in practice/board room. Use general purpose cleaner and white roll.	Week 1: Vacuum all fabric chairs. Week 2: Dust high surfaces and skirting boards. Week 3: Vacuum vents. Clean glass and blinds as required with glass cleaner and white roll Week 4: Damp wipe wooden chairs in practice/board room/office.	1. Clean all desks in big office and small offices. Use general purpose cleaner and white roll.	1. Clean the table in practice/board room. Use general purpose cleaner and white roll.
2. EMPTY BINS	2. Empty desk bins in all rooms and replace with white bags if required.	2. Empty desk bins in all rooms and replace with white bags if required.	2. Empty desk all bins if required and replace with white bags.	2. Empty desk bins in all rooms and replace with white bags if required.	2. Empty desk bins in all rooms and replace with new bags if required.
3.RECYCLING BINS/ CLEAN HANDLES	3. Empty recycling bins in the office and kitchen if required. Empty food bin.	3. Damp wipe door handles and doors. (Antibacterial cleaner) Empty food bin.	3. Empty recycling bins in the office and kitchen if required. Empty food bin.	3. Damp wipe door handles and doors. (Antibacterial cleaner) Empty food bin.	3. Empty recycling bins in the office and kitchen if required. Empty food bin.
4. HOOVER/ CLEAN CHAIRS	4. Hoover the main office rooms and/or space that requires it.	4. Hoover hall and practice room /board room.	4. Damp wipe wooden chairs in the kitchen every week.	4. Hoover the main office rooms and/or space that requires it.	4.Hoover hall and practice room /board room. 5. Damp wipe door handles and doors. (Antibacterial cleaner)
5. KITCHEN TABLES AND FLOOR	5. Damp wipe kitchen tables. Hoover and mop kitchen floor.	5. Damp wipe tables in kitchen. Hoover and mop kitchen floor.	5. Damp wipe tables in kitchen. Hoover and mop kitchen floor.	5. Damp wipe tables in kitchen. Hoover and mop kitchen floor.	6. Damp wipe tables in kitchen. Hoover and mop kitchen floor.
7. BIN BAGS	Remove full bin bags to the rear area.	Remove full bin bags to the rear area.	Remove full bin bags to the rear area.	Remove full bin bags to the rear area.	Remove full bin bags to the rear area.

Figure 16: A reconstruction of the schedule of the work tasks required to be undertaken on a daily basis during a cleaning TEP.

Tasks	Equipment	Notes
1. Damp wipe tables/hard surfaces with mild disinfectant/general purpose cleaner. **TWICE A WEEK** **Damp wipe doors/door handles with mild disinfectant.** **TWICE A WEEK**	General purpose cleaner/ Disinfectant spray J-cloth White paper roll	Use damp cloth and general purpose/ disinfectant spray to clean. Dry off with white paper roll.
2. Disinfectant mopping of dining area (wet mop and dry mop system). **EVERYDAY**	Wet mop and bucket Dry mop Wet floor signs	Two mop system may prevent slips on wet floors. Clean hot water decanted from kitchen boiler (using metal jug). Dirty water to be flushed in toilet.
3. Empty all waste bins and replace bin liners as required. **EVERYDAY**	Bin liners · Black for big bins · Small white bags for office bins.	Wipe bins clean if required.
4. Sort recycling. **THREE TIMES A WEEK**	Clear small bags for recycling bins Gloves	Remove obvious items from waste bins and replace in recycling.
5. Remove bins to bin area at rear of building. **EVERYDAY**		Bags to be placed in correct bin in back court area.
6. Vacuum daily debris from all floor areas (including hard floor in kitchen). **DIFFERENT AREA EACH DAY**	Vacuum cleaner	Vacuum carpets in offices, main admin area, store-room, kitchen and training room.
7. Damp wipe wooden chairs in kitchen/dining area only. **ONCE A WEEK**	Disinfectant spray Jay cloth White paper roll	Done on Wednesdays.

Figure 17: A reconstruction of a table from a TEP booklet explicating the cleaning tasks that need to be completed during the TEP and the equipment required to complete these tasks.

> "The management of the programme is likely to create stress for [staff] … in those situations where a member does not show up at the work site and [staff] would need to make immediate arrangements to go to the work site to solve the issue. Situations such as these highlight the occurrence of TE at the intersection of the Clubhouse community with its own values as a mini-world of its own and the site of TE as something that represents the world external to the Clubhouse community" (Valkeapää et al., 2019:20).

This quotation exemplifies the unusual position that TEPs hold in the Clubhouse, as a representation of 'the world external' to the interstitial space of the Clubhouse community. Staff members in their generalist role are required to urge members to participate in the work-ordered day, and at the same time encourage them to apply for TEPs and seek employment outwith the Clubhouse. Whilst TEPs are a very important element of the Clubhouse model, the number of members that are involved in the TEP programme on a daily basis is low in comparison to the number of members involved in the work-ordered day. As the Clubhouse was already 'intentionally understaffed' (Kinn et al., 2018) to enable members to feel a need to be needed (Conrad-Garrisi and Pernice-Duca, 2013) staff might sometimes find their presence was more urgently required in The Club, rather than at the TEP, which offers explanation for The Club's 85% coverage rate for TEP shift absences.

TEPs took up quite a large proportion of staff time, for a programme that only served a small proportion of Clubhouse members. The Club staff commented in interview that they greatly valued the TEP programme, but they did find it challenging balancing their time in The Club with managing TEPs:

> "I'm a great supporter of TEPs because I think they're an instance of supported employment that's really worthwhile… You work with somebody for at least the first couple of weeks. There was one TEP that I did that I supported someone for about six weeks actually, learning a cleaning job" (Owen, staff member for eighteen months).

> "TEPs are a wonderful, great thing. Just they're a challenge, I think, because you might cross the city. You might find in an hour that you need to leave what you're doing, cross the city to do, like, an hour and a half's work of painting an office and then come back" (Eugene, staff member for four years).

Some members also noticed the pressure that the TEP programme put on The Club staff. The notion of guaranteed coverage is designed to reduce the level of

anxiety members may experience in applying for a TEP as they know that their shift will always be covered. However, for Russell, guaranteed coverage discouraged him from applying for a TEP because he did not want to potentially burden The Club staff in the case of his absence:

> "I was going to put in for a TEP in the [local community centre], but then I thought… 'think how many times you're not here, and that's going to mean that member of staff is going to have to go and do your work.' I think it's good that they do that, but it's putting a burden on the staff" (Russell, member for eight years).

Russell thought that guaranteed coverage was an important aspect of TEPs, but in terms of his own employment ambitions, he decided it was better not to apply for a TEP. The possibility of having a member of staff who was not responsible for facilitating the work-ordered day, and whose job was wholly dedicated to the TEP programme, might encourage some members to apply for TEPs, though this would not comply with the expectation that all "Clubhouse staff have generalist roles" (Clubhouse International, 2018:2). Other members were not interested in undertaking TEPs, as they saw themselves as included in The Club community, and felt that this facilitated their mental health recovery:

> "The reason why I've never done a Transitional Employment opportunity from The Club is that I really enjoy being part of the group here and I could not cut myself in half and be in two places. So I do very much enjoy being here at The Club, involved in this" (Rob, member for six years).

The formation of a community that is welcoming and inclusive (Raeburn et al., 2013), and that also emphasises to its membership that they are needed within the Clubhouse (Doyle, Lanoil and Dudek, 2013), meant that not all members felt a desire to undertake TEPs, as they did not want to reduce the time that they spent in The Club. These members were able to pursue choices that enabled them to achieve a 'personal' recovery that was personally meaningful for them (Parr and Davidson, 2010) and not just those "regulated freedoms" (Rose, N., 1999a:22) that enable individuals to participate in their own self-governance in constituting neoliberal subjectivity (Bondi, 2005).

7.2.2 Members' 'Desire to Work'

At The Club, an interview process was undertaken to determine placement allocation. Approximately two months before a TEP position became available, The Club staff would inform members at the morning meeting that the position was open for members to put themselves forward for consideration. A sign-up sheet would be placed on the noticeboard for a few weeks and members could write their names on this to express their interest. All members who had expressed interest would then participate in a short interview with two members of Clubhouse staff, usually the member of staff who managed the TEP and a staff member from the work and learning unit. The TEP was then offered to the member who appeared most willing to work at that time, although participation in previous TEPs was considered, so that members who had not had the chance to undertake a TEP before were not overlooked in favour of candidates who had participated in previous TEPs. I did not sit in on any TEP recruitment interviews, as I acknowledged that this process could be difficult for members, and I did not want to contribute any more to their potential stress. However, the interview process was less challenging and intimidating than a job interview for competitive employment: the interview was conducted by staff who wanted the best outcome for all members, and members were also already familiar with their interviewers. Moreover, the interview did not focus on qualifications, CVs, or previous employment experiences, it concentrated purely on the member's desire to work. John Beard, the former executive director of Fountain House in New York and the individual credited with establishing the TEP programme, explicitly stated that the TEP allocation process would not involve interviews, as he believed this was one of the greatest barriers to employment for individuals with diagnoses of SEMHCs (Beard, 1978). More recently, research in US Clubhouses has identified that one of the advantages of TEPs over other supported employment programmes is that they do not involve any kind of interview process in order for a member to begin work (Dorio et al., 2002). Despite this, no members mentioned any objection to the interview process as a method of TEP allocation within The Club. Buhariwala, Wilton and Evans (2015) undertook research with social enterprises providing employment to individuals with diagnoses of SEMHCs. They found that enterprises that utilised interviews in the employment recruitment process tended to employ the individual that performed best at interview, meaning that the individuals already most

disadvantaged in mainstream employment would often miss out on these opportunities as well. The Club interview process, focusing on the 'desire to work', theoretically circumvented this issue, and enabled members who may not be considered 'productive subjects' to try out their neoliberal subjectivity.

The privileging of the 'desire to work' in the TEP allocation process reinforces the notion of neoliberal subject formation, as it indicates an assumption that individuals will want to undertake paid employment to find fulfilment and satisfaction in life (Foucault, 2008). The inference that individuals with diagnoses of SEMHCs will want to work demonstrates the pervasiveness of neoliberal governmentality within mental health care spaces:

> "This valorization of employment within recovery-based mental health care has itself found 'footholds' within neoliberalized governance contexts that emphasize individual responsibility" (Evans and Wilton, 2019:99).

As individuals strive for personal mental health recovery, they endeavour to find meaning in life and a sense of identity (Leamy et al., 2011). The neoliberal subject attempts to do this through engaging in 'productive labour' (Rose, N., 1999b). Whilst it is very important that members who participate in the TEP process actually desire to work, and do not feel compelled to participate because they believe they must take part in order to continue to receive support from the Clubhouse; the privileging of the 'desire to work' legitimises the idea that paid employment is a desirable goal and a necessary step to achieve mental health recovery. The promotion of a 'desire to work' becomes more problematic when considering that TEPs are time-limited placements, as this desire and one's neoliberal subjectivity can only be fulfilled temporarily.

Research considering the TEP allocation process at a Clubhouse in Finland has highlighted that there will always be other considerations than just the members' 'desire to work' when the decision for allocating TEPs is made by Clubhouse staff (Valkeapää et al., 2019). Whilst staff will attempt to privilege members' desire to work, they will also be thinking about the practicalities of the TEP, and which members might be best suited to the work that needs to be completed. Furthermore, staff need to consider the partner organisation that is hosting the TEP, and that a good relationship needs to be maintained with them

in order to keep the TEP operating. This means they may be encouraged to offer TEPs to members who attend the Clubhouse regularly as they may be considered more 'reliable'. The issue of reliability is countered somewhat by the fact that staff offer guaranteed coverage on TEPs when members are not able to work. However, this high level of staff support on TEPs, while advantageous to members, can mean that staff are out of the Clubhouse for significant periods. In allocating TEPs, Clubhouse staff may be thinking about how much time they will need to take out of their facilitation of the work-ordered day:

> "Although the Clubhouse model advances both collective and individual benefits, the benefits of the collective are considered the primary principle" (Valkeapää et al., 2019:18).

Staff may feel that their obligation to the Clubhouse community means that they should choose a member who is likely to require less support on the TEP. Evidently, members should not be offered the chance to undertake a TEP with the expectation that they will 'fail' in undertaking it, however allowing members the opportunity to fail is an important aspect of the TEP programme that enables members who are usually excluded from 'competitive' employment to participate.

We have already explored that some members chose not to participate in the TEP programme specifically because it would reduce the time they could spend in The Club, or they felt their undertaking of a TEP would put too much of a burden on staff. Staff member Eugene notes that in addition to this, many members did not have any prior work experience before becoming Clubhouse members, and had no particular inclination to work:

> "A lot of folks are coming from no work experience, or no desire for work necessarily, either" (Eugene, staff member for four years).

> "You can get some folks that they've come from, maybe, one to two – sometimes even three – generations of not working, certain areas. There are socioeconomic challenges from particular areas of Glasgow that are also real challenges with [getting people into employment]" (Eugene, staff member for four years).

For members who had spent much of their adult lives in psychiatric hospital, the notion of becoming a 'productive subject' by entering paid employment may

have always seemed so far out of reach that it was not something to even be striven for. Moreover, the proportion of workless households in Glasgow, that is households where no individual over the age of sixteen is in paid employment, has historically been one of the highest of all UK cities, and much higher than both the Scottish and UK averages (Glasgow Centre for Population Health, 2016). In 2019, almost a quarter (24.1%) of Glaswegian households were 'workless households' (ONS, 2019b). For individuals living in an area where most other people around them are also not in paid employment, they may not consider entering paid work a priority. However, just because a household is 'workless' does not mean that individuals within the household are not trying to get into paid work, and some members at The Club did consider it a personal goal to find competitive employment:

> "My long-term goal is to come off my benefits and basically full-time work would make me feel better within myself. I feel ok in myself now but in full-time work I'd have something to do every day. Basically being part of society and not being classed as taking money from society and not giving it back… It's not being tarred with a brush 'oh she's just this, she's just that. She can work but she's just being lazy.' I want to get a job so I can show people that, to prove to people that I want to do something" (Catriona, member for eight years).

Catriona's goal to undertake full-time competitive paid employment was partially guided by her desire to feel a greater level of social inclusion through 'being a part of society' but she was also concerned that others may be judging her employment status. She goes on to say that she desires to find paid employment to 'prove to people' that she *wants* to do something. Her desire to work is not fuelled by wanting to prove to others that she is capable of *being* a productive subject, rather it is to prove that she *desires* to be a productive subject. It is this that makes the privileging of the 'desire to work' in TEP allocation problematic, it demonstrates to members that in working towards personal mental health recovery, they not only need to work towards entering paid employment, but to fulfil their neoliberal subjectivity, they need to yearn to "make an enterprise of their own life" (Houghton, 2019:623), in the hope that it "produces his [*sic*] own satisfaction" (Foucault, 2008:226). The notion of the 'desire to work' reinforces the idea that members will want to participate in their own 'self-governance' (Bondi, 2005) in becoming an economically productive subject.

7.2.3 Conceptualising Failure in Transitional Employment Placements

If members are selected to undertake TEPs primarily on their desire to work rather than as a result of their previous work experience or qualifications, it therefore follows that members will be able to continue to apply for and successfully attain TEPs regardless of previous TEP 'success'. At The Club, Lee told me of his difficulties in undertaking a TEP in the past:

> "I kind of messed it up a wee bit. But it wasn't really my fault… I had to actually kind of stop my TEP. And it's just worked out not very well" (Lee, member for six months).

Despite the lack of completion of his first TEP, Lee did go on to be offered and commence a second TEP, demonstrating that The Club did offer subsequent opportunities to undertake TEPs even after an unsuccessful previous attempt. Research considering six years of TEP placements in a US Clubhouse has determined that 'messing it up' is an important aspect of undertaking TEPs for some individuals, and that these experiences can be useful for future adjustment to paid employment:

> "Repeated TE experiences, involving both successes and 'failures' are seen as necessary to eventual successful work adjustment for some members" (Henry et al., 2001:345).

Acknowledging that failures do occur and allowing members to have further attempts to undertake TEPs clearly separates the Clubhouse from 'mainstream' workplaces where failure is far less frequently tolerated. However, framing failure as a necessary phase of 'successful work adjustment' places these failures as an early step on a linear 'recovery journey' towards becoming an ideal neoliberal subject. Research considering the 'life stories' of individuals with diagnoses of SEMHCs explains that regardless of author intent or construction, these stories are frequently understood through a 'psychiatric gaze' as "producing 'resilience and recovery narratives' that work to build larger framings of [psychiatric survivors] as redeemable subjects" (Voronka, 2019:16). In this case the individual's diagnosis of a SEMHC is comparable to an individual's 'failures', the individual's 'illness' is only considered interesting or valuable as the start of a journey to 'success' or 'wellness'. In Western societies, as paid

employment remains unquestioned by policy-makers as the 'best' route to social inclusion for individuals with diagnoses of SEMHCs (Buhariwala, Wilton and Evans, 2015), achieving paid employment is seen as a marker of mental health recovery, and therefore 'recovery' becomes inherently entangled with the notion of becoming a 'productive neoliberal subject'. In a similar vein, geographers considering the neoliberalisation of the academy have also warned against the 'triumph-over-adversity' narrative of failure, where one uses their previous failures to demonstrate their own 'personal development':

> "We should guard against an impulse to speak about failures in ways which become instrumentally self-aggrandising, which perpetuate a sense that failure should lead to individualised success or personal development, or which exert a kind of pressure to triumph-over-adversity" (Horton, 2020:5).

These stories also tend to offer a 'smooth' narrative that represent failures as learning opportunities and moments for individual growth, when in many cases failure can be embarrassing, frustrating or just entirely mundane.

When asked in interview how the TEP programme could be improved, one staff member at The Club spoke about the importance of the type of language that staff used when discussing members' experiences with TEPs and paid employment:

> "It's about our language of just making sure people are trying stuff: 'You're not failing. You're not letting anyone down if you don't get this. We're just proud of people for going for it. If you go for it, you will get something. You'll get something. We'll find something.' So maybe just taking away some risk for people, while also helping them ease into responsibility" (Eugene, staff member for four years).

This indicates that staff make a significant effort to let members know that any setbacks they may face in applying for or undertaking TEPs are not 'failures'. However, Eugene also suggests that while these experiences are not treated as failures, the notion of 'success' is still something that has eluded members in these moments, as they will eventually 'get something', reinforcing the notion that every individual has the potential to become a 'productive subject' in spite of the 'devalorisation' of the productive potential of individuals with diagnoses of SEMHCs (Evans and Wilton, 2019). He reveals that TEPs are a method of encouraging members to 'ease into responsibility', which is reminiscent of the

"discourse of self-responsibility" that has pervaded in narratives of personal mental health recovery (McWade, 2016:73). Although 'personal recovery' theoretically promotes individual choice, what constitutes a 'recovered individual' is someone who sets personal goals that are conducive to becoming a 'productive' member of society (Rose, D., 2014). However, Eugene also mentions the notion of 'taking away some risk' in enabling members to try out different types of work. It is this removal of risk that enables The Club to offer employment placements that disrupt the constitution of neoliberal subjectivity in some small ways: members are able to access these placements without a (very) competitive application process, they have access to a high level of staff support throughout the TEP, and if the placement does not work out, there are no long-term negative consequences for their access to mental health support or their future potential to try for paid employment opportunities. Members appreciated not being treated as 'failures', but they also appreciated the high level of support offered in TEPs that reduced the possibility of 'failure':

> "if it doesn't work out, you're not treated like a failure. If you're ill and you can't make it, staff will cover it" (Gavin, member for twenty years).

While the aim of encouraging members to undertake TEPs may be an attempt to 'ease' them into taking on some responsibility, their receipt of support from The Club was not contingent upon 'succeeding' at taking on this responsibility or 'successfully' completing a TEP. The lifetime membership offered by The Club mitigated this drive towards 'personal responsibility' as members were always able to return to the Clubhouse, as they frequently did after the completion of a TEP. Furthermore, the repeated opportunities that members had to undertake TEPs provided a safe environment in which to 'try out' their neoliberal subjectivity, without fear of having support withdrawn or being cast as a 'failure' if these attempts did not work out as expected. When subject to neoliberal governmentality the individual is "responsible for her own successes and failures" therefore "the individual's well-being… becomes the sole responsibility of the neoliberal entrepreneurial subject" (Türken et al., 2016:34). The guaranteed coverage of placements removed some of the individual's responsibility to succeed, and the continued Clubhouse support meant the member was not wholly responsible for their wellbeing. This slight subversion of neoliberal self-governance by The Club allowed members to make

choices about what was meaningful to them in their personal mental health recovery, outwith the 'regulated freedoms' of the neoliberal discourse of 'individualised responsibility' (Pilmott-Wilson, 2017).

7.2.4 Diversity of Transitional Employment Placement Opportunities

As we have already explored, all aspects of TEP management, placement allocation and member training are managed by the Clubhouse, to reduce the required outlay of time and resources of the TEP partner. While this is intended as an incentive to encourage businesses to participate in the TEP programme, handing over responsibility of employee selection and training, and overall placement management to the Clubhouse may seem like quite a high-risk decision for some employers. As such a high level of trust is required by the organisation hosting the placement, TEPs are often established with organisations that already have a relationship with a staff member in the Clubhouse, and this is in fact a suggested method of recruitment of more TEP partners:

> "Responsibility for developing Transitional Employment Placements is often shared among staff… first contacts may be with friends or family members who have businesses or work in the community outside the Clubhouse" (Jackson, 2001:81).

There is an expectation that Clubhouse staff will already have established working relationships with external organisations and will use them to create more TEPs. Unsurprisingly, many of the organisations that The Club had working relationships with were third-sector organisations and NHS-funded services for individuals with diagnoses of SEMHCs. There were several advantages to forming TEP partnerships with these organisations. These groups were more likely to be empathetic towards individuals living with diagnoses of mental health conditions and understand what the challenges might be for an individual with a diagnosis of a SEMHC in trying to enter the workplace. Additionally, these organisations might share similar organisational goals as The Club, and they would not be focused upon turning a profit. As these organisations served similar populations, The Club frequently already had working relationships with them for other purposes and therefore had a contact person with whom to start a conversation about TEPs. A report researching Clubhouses published in 2004 reveals that the

TEPs available at The Club at this time were largely based in mental health services. However, many of these placements were no longer available at the time of my fieldwork:

> "Most [TEPs] were in voluntary mental health services (six) and two were with a hospital trust. Two others were commercial placements - a catering assistant post and a supermarket retail assistant" (Rosengard, Laing and Ridley, 2004:36).

During my fieldwork period, there were eight TEPs available. Other than The Community Café TEPs (that we will consider in the next section), and one based at a local community centre, all the other TEPs were based within NHS services or third-sector organisations with a mental health focus. Whilst turning profit was not the primary goal of any of these organisations, they would still have been subject to the impacts of the "neoliberal 'project' of retrenchment of government spending" and impacts of austerity that would have tightened budgets and reduced service provision (Power and Hall, 2018:305). Therefore, they may have been unable to sustain a placement in the longer term. Regarding any past or potential future 'commercial' TEPs, while many businesses make commitments to be charitable or 'give back' to their local community, their priority is to produce capital, and for them, there is little incentive to hire an individual on a temporary placement to undertake a job that they have no previous experience in, particularly as the wage rate expected by the Clubhouse might be higher than the business would usually pay for these services. In competitive employment, businesses will hire a candidate that appears most likely to be a 'productive subject' within the role they have applied for (Rose, N., 1999a), in hosting a TEP, they agree to hand over this decision to the Clubhouse.

Wilton and Schuer (2006) have identified that policy makers who devise supported employment programmes often make the assumption that there are plentiful fairly-paid, secure, and disability-accommodating jobs for individuals to undertake. In an "ever-more fragmented" labour market where many jobs either require extensive training or qualifications, or require less training but long working hours, there are fewer 'suitable' jobs than ever for disabled people (Hall and Wilton, 2015:222). During my fieldwork, the majority of TEPs available at The Club were cleaning placements:

> "We have a lot of cleaning TEPs, but we need more admin TEPs. We need some more diversity of job opportunities for people, but the more diverse you get, the harder it is for an employer. The more responsibility or the more that can go wrong, I think an employer thinks they aren't sure about taking a chance in employing someone" (Eugene, staff member for four years).

In addition to the fact that many TEP partners were mental health organisations, another reason for the lack of placement variety may relate to the limited responsibility or control that the partner organisation has over the placement. Whilst cleaning is an essential service and vital to any business or organisation, only a low level of pre-employment vetting is required as these workers do not interact with customers or have access to sensitive data in most workplaces. As Eugene alludes to, the greater variety of tasks that both members and TEP managers need to be trained in, the 'more that can go wrong'. Partner organisations may be reluctant to concede any more responsibility in employment placements because they are cautious that Clubhouse members will not be productive workers, however it is also likely that partners are concerned about offering responsibility to an individual that they have not hired or trained themselves. Introducing members and employment partners at an earlier stage in the process might offer reassurance to the employment partner and enable them to create roles with a greater level of responsibility, though the short-term nature of placements would make this logistically complex. We will explore the issues surrounding the time-limited nature of placements later in the chapter, however, as an average TEP lasts for only six months, there is limited scope for ongoing training or 'personal development' in the workplace. Furthermore, while third-sector organisations are not necessarily searching for 'productive subjects' to undertake roles in the same way as in a commercial business, they still need workers that can complete their job roles effectively, and in such short-length placements, it will be difficult to offer roles that entail a greater number of work responsibilities without allowing more time for on-the-job training.

Staff at The Club noted that the lack of variety of different types of Transitional Employment Placements meant that sometimes the amount of member interest in undertaking a TEP was limited:

> "we've maybe had five cleaning TEPs and it will be the same people doing them or applying for them, because other people aren't interested. And I get that, people want to have their own job, or something that interests them, maybe something that challenges them, something they've never done before" (Annabelle, staff member for seven years).

In the first empirical chapter I considered that meaningful activity, as well as being personal to every individual, is something that offers "pleasure and enjoyment, purposeful behavior, or basic human needs fulfillment" (Hooker et al., 2020:821). As Annabelle states, members wanted to spend their time doing things that interested them or challenged them, and for many members, a cleaning employment placement was not something that seemed pleasurable or purposeful to them:

> "I have made some enquiries in the past about them. Maybe if I'd put myself forward more and then kept on saying 'what about the TEP?' maybe they would have paid more attention thinking 'oh this chap's keen.' But I'm not that keen to be honest. Cleaning jobs, you know, don't sound all that attractive" (Graham, member for two years).

> "They offer a big range of courses and also these temporary employment placements, TEPs. But they're all cleaning … I think the health board should be mandated to help people back into employment, in proper jobs. Someone like me, who's been used to working in an office, they should be able to provide office work. It's not fair, the only jobs you're offered are cleaning jobs" (Eilidh, member for ten years).

Eilidh mentioned that she did not want to undertake a cleaning TEP because cleaning was a task that she already undertook in her own home, and she wanted to do something different in her work. However, her use of the phrase 'proper jobs' infers that she might have attributed different amounts of value to different types of work task, and that some tasks do not constitute 'proper jobs'. As considered in the literature review, feminist geographers have written extensively about how certain forms of care work are devalued (or indeed not recognised as work at all) because they are jobs traditionally undertaken by women, frequently in domestic settings (see Blunt and Dowling, 2006; Pratt, G., 2012; England, 2010). While the 'commodification of care' means that many of these jobs have now become part of the paid employment landscape (Cox, 2013a; McDowell, 2009) they are still often characterised as 'low-skilled' and of little value within a neoliberal-ableist framing:

> "As is clear in the language of neoliberalism, mutual dependence, self-sacrifice and care for others are unvalued notions" (McDowell, 2004:146).

Therefore forms of work that attend to 'care' whether in the form of cleaning, childcare, and health and social care, or other forms of caring *for* are undervalued and underpaid in a neoliberal economy, and it is still overwhelmingly women, working-class people and people of colour that fulfil these roles (Weeks, 2011; England and Lawson, 2005). Staff member Annabelle comments that the undervaluing of certain types of labour might prevent some members from wanting to undertake a cleaning TEP:

> "maybe the problem isn't work, but the hierarchy of work, and that entry level jobs are seen to be base, but in fact they're crucial jobs. They're the ones that actually - if you don't have a cleaner and your place is a mess, your staff aren't going to want to come in and work. So, actually, who is more important? I would say the people that are maintaining it" (Annabelle, staff member for seven years).

Annabelle identified that there may be a 'hierarchy of work', that was determined "via the setting of wage levels, and in relation to judgments about occupational status" (Weeks, 2011:9). When we are thinking about members' 'desire to work', and the potential outcomes of TEPs for members, it is important to consider the economic, social and cultural value that members may ascribe to different forms of work. They are less likely to find positive outcomes such as an increased sense of purpose, or a boost in self-esteem if they do not think the work holds any value, regardless of whether the work is 'essential'. Even members who enjoyed and valued the cleaning TEPs commented that they would like a greater variety of placement opportunities to undertake, to benefit from a larger range of employment experiences:

> "I'd be a cleaner again cos I enjoyed that and I could use that in my personal life at home. And I would love to do an admin TEP. But it's finding the TEPs that do admin, so most of the TEPs are cleaning" (Catriona, member for eight years).

> "I think employment placements here could actually be broadened a bit more" (Cameron, member for seven years).

Individuals are encouraged to take responsibility for their 'path' to mental health recovery (McWade, 2016), but this 'self-governance' is restricted to a

small number of choices, such as entering paid employment (Rose, D., 2014). At the same time, the individual is supposed to find meaning in these choices, even though the kind of work available is that which is societally undervalued and therefore less likely to be considered 'meaningful activity' (regardless of how essential the labour is). The Club attempted to increase the variety of placement opportunities in a number of ways, though they still encouraged members to engage with the cleaning TEPs. In addition to trying to find other external employment partners, The Club decided to create their own Transitional Employment Placements that did not require an external partner, through establishing The Community Café.

7.2.5 Defining the Employer in Transitional Employment Placements

The Community Café opened in December 2016, and was a joint venture undertaken by The Club in conjunction with a local housing association in Glasgow. The Community Café was based within a building containing several housing association offices and services, in an area that lacked local convenience shops and food vendors. The Community Café was open to the public for breakfast and lunch service, serving a variety of hot and cold meals. It also hosted catered-for events, often for The Club or the housing association. During my fieldwork, there were two permanent members of staff managing the day-to-day business at The Community Café, employed by The Club. There were also two Transitional Employment Placement positions available for members as kitchen porters. More recently, The Club has offered a part-time supported employment position to a member that had previously completed a TEP at The Community Café, but there were still two TEP positions available for other members to undertake (The Club, 2019). While The Community Café was a joint venture, The Club managed all of its business elements, therefore the TEPs were paid through The Club payroll. These TEPs were very popular among members, as they offered a different vocational experience to the other placements. However, these placements were contentious in relation to The Club's compliance to the Clubhouse model:

> "As far as the standards are concerned… the last accreditation we had in 2016 they said we shouldn't have the TEPs at The Community Café

> because they're getting paid from the Clubhouse" (Alasdair, member for twenty years).

Clubhouse International standard twenty-two states only that TEPs are paid by the placement 'employer', making no reference to who this employer is. The only stipulation regarding the separation of TEPs from the Clubhouse is that placements are not physically located on the site of the Clubhouse, which The Community Café TEPs were not. However, the previous standard, number twenty-one, more clearly states that the Clubhouse should not be providing paid employment to its membership:

"Standard twenty-one, under employment: The Clubhouse enables its members to return to paid work through Transitional Employment, Supported Employment and Independent Employment; therefore, the Clubhouse does not provide employment to members through in-house businesses, segregated Clubhouse enterprises or sheltered workshops" (Clubhouse International, 2018: 2).

This Clubhouse standard encourages members to seek their own employment, with the support of Clubhouse staff, and attempts to distance Clubhouse employment schemes from other forms of sheltered employment or social enterprise. The aim of the TEP programme is to prepare members for employment in mainstream workplaces (Anderson, S., 1998), suggesting an expectation that members will engage in the neoliberal 'self-governance' required to enable them to become 'productive subjects' in competitive employment after completing a TEP (Bondi, 2005). Defined by this standard, The Community Café might be understood to be a 'segregated Clubhouse enterprise', as some of its employment positions were protected solely for Clubhouse members. As it functioned more as a social enterprise, The Community Café might not have been considered a 'mainstream' workplace by Clubhouse standards.

Evans and Wilton (2016; 2019) have conducted research into social enterprises that provide work specifically for individuals with diagnoses of SEMHCs. The advantage of these spaces is that they can usually offer 'protected' work that is disability-accommodating, for example by offering flexibility in the hours

individuals work, whilst also providing jobs that allow individuals to interact with 'wider' society, either through working alongside 'non-disabled' individuals, or through undertaking 'customer-facing' roles enabling individuals to interact with the general public (Evans and Wilton, 2019). The Community Café offered both of these opportunities through its TEPs, members worked alongside the permanent café staff, and although the roles were kitchen porter roles, there was still an opportunity for customer interaction when moving between the café and the kitchen. This was a reason that The Community Café TEPs were so popular among The Club members:

> "people really want to go to The Community Café, but also there's a team environment there, while the other ones are just kind of solo" (Eugene, staff member for four years).

Research into supported employment in relation to the Clubhouse model has noted that individuals valued the experience of social participation in "larger society" (Torres-Stone et al., 2016:15). Therefore, whilst The Community Café TEPs did not involve an external partner, to members these placements offered greater social connections outwith the Clubhouse environment. This also relates to the nature of the placements, as Eugene notes, most of the other cleaning TEPs were lone-working placements. Nevertheless, some social connections could be made on these placements and The Club members undertaking cleaning TEPs noted the difference that friendly social contact could make to their experience of a TEP:

> "And while I was there the staff were very nice… if I had time I'd have a coffee and if they were on their break then I'd just have a wee five minute chat with them before I had to get home… And the next TEP I done was the [mental health advocacy charity]. I didn't really enjoy that one because it was a different environment and you couldn't really get the kind of 'hi how are you?' type thing like you did in [mental health care organisation]" (Catriona, member for eight years).

In addition to encouraging individuals to become productive subjects, participation in paid employment is suggested as a route to personal mental health recovery because it is expected that undertaking mainstream employment will enable individuals to experience a greater number of 'social connections', which is one of the core themes of the 'CHIME' framework (Leamy

et al., 2011). Catriona indicates how much she valued the friendly atmosphere on her first cleaning TEP, and how she noticed the absence of that atmosphere in her second placement, which led to her not enjoying the placement as much. The 'social' atmosphere of a TEP workplace can be very significant to the experience of the individual during their placement, but it may also influence their decision to pursue other employment in the future.

In the absence of an external placement partner in The Community Café TEPs, The Club acted as the member's employer during a placement. The Clubhouse model discourages this because it aims to get members into 'mainstream employment', furthermore the TEP programme is designed to demonstrate to members that they are valued outwith the space of the Clubhouse. Members are already expected to feel a 'sense of mattering' within the Clubhouse because they are frequently told that their presence is required to fulfil the work tasks of the work-ordered day (Conrad-Garrisi and Pernice-Duca, 2013). Members who undertook TEPs hosted by an external employer could experience their labour being valued, and knew that another organisation trusted them to undertake 'productive' work:

> "it's an opportunity for them to be part of that company, and I think that's what's important, that you're not employed… by The Club, you're employed by [TEP partners]. So, actually an outside party is invested in you, somebody that's not The Club has invested in you and wants to support you and make you feel part of the team" (Annabelle, staff member for seven years).

However, members explained that they valued that The Club trusted them enough to be a representative of the Clubhouse in an external organisation. Members wanted to succeed in TEPs, not only for their own sense of self-achievement, but to demonstrate to The Club how much they had managed to overcome their own mental distress, due to the support from the Clubhouse:

> "The Club has been really good for me and I like to reflect that in my work. And my work ethic is, get in and just do the job to the best of my ability, because The Club ultimately is my employer" (Douglas, member for six years).

Douglas' TEP was not at The Community Café, meaning that he was working for an external employment partner, yet he still considered The Club to be his

employer. Unsurprisingly, Douglas was more concerned with making a good impression to the Clubhouse that had offered him support for six years, rather than the organisation that was about to offer him employment for six months. As TEPs involved such a high level of input from the Clubhouse at every level of the placement, from recruitment, to training, to overall support, it is understandable that members considered The Club to be the employer, rather than the external employment partner. Furthermore, those members that were actively 'seeking to make an enterprise of themselves' (Foucault, 2008) would want to demonstrate their skills to the Clubhouse that could continue to support them beyond the end of the TEP, and possibly help them to undertake more TEPs, or help them move into supported employment.

7.2.6 **Valuing Paid Employment and Unpaid Work**

TEP opportunities organised by The Club have been paid in line with at least the national minimum wage for many years (Rosengard, Laing and Ridley, 2004). During my fieldwork period, members undertaking TEPs were paid at the 'real' living wage rate (for 2017) of £8.45 an hour, which is well above the contemporary 'national living wage' of £7.50 an hour (D'Arcy and Finch, 2016). For members living on Universal Credit or Employment and Support Allowance, the additional salary provided by working even a few hours a week on a TEP could be a significant income boost. This additional pay could enable members to fulfil their roles as neoliberal subjects through fuelling consumption that "produces his [*sic*] own satisfaction" (Foucault, 2008:226). In Evans and Wilton's (2016) examination of social enterprises as supportive workplaces they noted how individuals with diagnoses of SEMHCs might achieve a 'new sense of self' with the consumption provided by the money earned from working:

> "the extra money acquired through cleaning afforded [the individual] more choice in where she could eat and shop, as well as a new sense of self. On the other hand, the earned income did not challenge the broad material constraints facing people" (Evans and Wilton, 2016:86).

This 'new sense of self' is comparable to the constitution of a neoliberal subjectivity, as the individual has a greater choice in places to eat and shop, this can facilitate a new form of 'consumption'. While we need to challenge the 'broad material constraints' which cause many individuals with diagnoses of

SEMHCs to live in poverty, and I wish to question the suggestion that individuals need to strive for neoliberal subjectivity in their mental health recovery, it is also important to acknowledge that in living under a capitalocentric system, the opportunity for individuals to earn a small amount of extra income that could significantly improve their quality of life is very important. To simplify: we can acknowledge the advantages of engaging in 'productive labour' under the current capitalist system, that may allow individuals to buy a warm pair of socks or a hot meal; whilst simultaneously questioning why they need to 'sell' their labour to be able to access warm socks and hot meals in the first place (Goodley, 2016).

Entering mainstream employment has been extolled as the main marker for social inclusion for individuals with diagnoses of SEMHCs (Buhariwala, Wilton and Evans, 2015), which has led to the increased emphasis of entering paid employment as a marker of personal mental health recovery (Poole, 2011). The Club members spoke about the significance of earning a wage through TEPs, and how they considered this to be a 'milestone' in their personal mental health recovery:

> "It's great to be back into work, I never thought I would work again and the fact I'm getting paid for doing it, that's insane. For somebody who's as seriously ill as what I was to come through this" (Douglas, member for six years).

> "I think the first TEP that I did was only about 3 hours a week I think it was… that was the first time that I'd really got a payslip since before I went to uni. I never really got to a point of getting a payslip. So these things are milestones sometimes" (Gavin, member for twenty years).

Douglas explains that he would not have been able to undertake paid work when he was in significant mental distress, and therefore his capacity to make an "entrepreneur of himself" was a demonstration of his mental health recovery (Foucault, 2008:230). Gavin went on to explain that the first time he received a 'real' payslip he was forty years old, as any paid work he had undertaken up until this point was not 'formal' enough to involve a payslip. Douglas playfully expressed mock outrage that his first payslip from a TEP was an electronic payslip, and therefore he did not experience the satisfaction of receiving a physical piece of paper stating his renewed status as an earner. While Douglas'

comment was offhand and intended as humour, it highlights the significance of the 'status' afforded to paid work by individuals who have not been in paid employment for some time. Douglas may have attributed more symbolic value to the receipt of a payslip than the material value of the financial reward of undertaking the work. Most Clubhouse members evidently found value in 'work' beyond the concept of receiving financial reward for it, as they were willing to take part in the unpaid tasks of the work-ordered day. However, as the "prevailing cultural understanding of 'work' in modern capitalist societies is that it is an activity carried out for a wage" (Frayne, 2015:18), it is understandable that this moment of receiving a wage slip held significance for both Gavin and Douglas. A member who undertook The Community Café TEP mentioned receiving financial reward as a benefit of participating in the TEP scheme. As The Community Café has only been open since December 2016, there had only been a small number of TEPs undertaken there at the time of fieldwork. For this reason, this comment relating to The Community Café TEPs will not be attributed to a specific anonymised participant:

> "It gives me a sense of achievement, doing a paid job, it's good for my confidence, good to go to work and get out of the house."

Whilst getting paid is not the only benefit that this member garnered from their employment placement at The Community Café, this comment suggests that their sense of achievement and increased confidence they found in the role were directly related to being able to demonstrate to society their productivity as a neoliberal subject through the receipt of payment for their labour (Rose, N., 1999b).

During interviews, several members expressed the opinion that 'wider society' valued paid work more highly than any unpaid labour, regardless of the form of work undertaken. Fiona conveyed frustration that unpaid work is considered 'less valuable' than waged-work, and that by not undertaking paid work, one is not considered a productive subject. Catriona noted that volunteer work should be deemed equally as valuable as paid work:

> "This lack of value that's placed on something if it's not paid. That it doesn't really count, it's just something that you do to have something to do: 'oh that's nice dear.' And it's like no this actually

> does have an impact; I mean I'm not saying that it's life-saving but it's important. I'm doing it because I value doing it. And because hopefully it gives something to other people. But there is this 'right ok that's nice but when are you going to get a real job?' type thing" (Fiona, member for ten years).

> "I think volunteer jobs are as important as paid employment because you're still doing the same thing as the people who are getting paid but the difference is you're not getting paid for it. You're doing it off your own back" (Catriona, member for eight years).

Roulstone (2015:268) explains that the capitalocentric framing of work as waged labour is inadequate to account for the value of work undertaken by disabled people, and that unpaid voluntary work "contribute[s] in a way that, although difficult to monetise, is clearly adding value to the community, economy and wider workforce skillset." Some members, quite understandably, expected to be paid for any labour they chose to undertake:

> "I don't really like volunteering, I don't like not getting paid if I'm doing something. I think you deserve to get something back for it. Rather than just personal satisfaction. Cos you can get that anyway if you've got a job that you like" (Lee, member for six months).

Disabled individuals are just as likely to undertake voluntary work as non-disabled people (Williams et al., 2008), and much of this work directly or indirectly makes a substantial contribution to both the economy and society through "adding value to communities, stimulating economic activity, aiding environmental improvements and improving a social skill set" (Roulstone, 2015:268), but this work is not rewarded through financial recompense. We have already explored that certain forms of work are ascribed greater economic value regardless of how 'vital' the work is. The 'disabling division of labour' (Gleeson, 1999) that is generated from the normative notion that 'non-disabled' workers are 'productive' and 'disabled' workers are 'unproductive' (Evans and Wilton, 2019) means that notwithstanding willingness and ability to undertake work, access to paid employment for disabled people is highly uneven. This is significant when we consider that historically and at the time of my fieldwork, The Club operated voluntary *unpaid* work placements alongside TEPs:

> "my first job was a TEP and it was a voluntary one, at [independent café], and it was through [staff member], that I managed to get that. It

> was only one day a week for maybe four hours, washing a few dishes and maybe helping out in the kitchen" (Douglas, member for six years).

It is quite possible that The Club advertised this opportunity as an unpaid volunteer position and not a TEP, however Douglas obviously understood it to function as a TEP that was unpaid. During my fieldwork, in addition to the kitchen porter TEPs there were also volunteer positions at The Community Café:

> "the way that the volunteer programme works at The Community Café… people do the same work after they finish the TEP but for no pay" (Owen, staff member for eighteen months).

In a society that valorises paid employment, and already determines some labour to be more valuable than other labour (Weeks, 2011), asking a member to offer their labour for no financial reward while another member is getting paid for the same work, may undermine the unpaid individual's belief in the value of their own work. However, some members who may have had a lack of previous work experience, or negative work experiences in the past, may question their own potential to become a 'productive subject'. Staff member Eugene told me about a member who after successfully applying for a cleaning TEP experienced an extreme nervous reaction prior to each shift, and eventually this led to them having to leave this TEP:

> "We had to put someone else that interviewed for [the TEP] in it and then get [the nervous member] to volunteer somewhere – actually The Community Café, as a volunteer there. Now they're doing that TEP" (Eugene, staff member for four years).

As Eugene explains, this member then undertook a volunteering placement at The Community Café instead of the initial TEP, and after managing that with no difficulty undertook a TEP at The Community Café. I cannot say for certain why the member experienced such anxiety prior to undertaking the first TEP in comparison to the volunteering placement, but it is possible that undertaking an unpaid voluntary placement took away the pressure of needing to prove oneself productive *enough* to be paid. By the time the member undertook the TEP at The Community Café, they knew they could undertake the work of this placement productively, as they had undertaken the same tasks during the volunteer placement. Therefore, there is clearly an advantage to having

volunteer placements that enable members to ‘try out’ the work of TEPs before committing to undertaking a six-month placement.

7.2.7 Temporalities of Transitional Employment Placements

Under the Clubhouse International standards, Transitional Employment Placements are expected to employ members for fifteen to twenty hours a week for a period of six to nine months. During my fieldwork period, few of the placements at The Club took place for as many hours as this. Individuals in receipt of Employment and Support Allowance benefit (ESA) were only permitted to earn a limited wage in undertaking supported employment, though there was no cap on hours as there was for independent employment, usually known as ‘permitted work’ (DWP, 2019). In 2017 this wage limit was £120 (Kennedy, 2017), members being paid at the ‘real’ living wage of £8.45 at that time would have been able to work fourteen hours a week before having their earnings capped. Some members in The Club in the past had or at time of fieldwork still did receive ESA, and though some members were in receipt of Universal Credit instead, which has different rules relating to payment and hours worked, these earnings caps reduced the incentive to have many placements that lasted between fifteen and twenty hours a week. However, there were other reasons that placement hours were limited, related both to the types of placement work and the kinds of employment partners that The Club had formed TEP partnerships with. As many of the placements were cleaning positions within small offices, placements could only last for a limited time each day, as there were only a finite number of cleaning tasks to be completed. Furthermore, as we have explored, many of the external partners hosting TEPs were third sector organisations, that may not be able to commit the financial resources to host a TEP for more than a few hours a week. A ‘typical’ cleaning TEP would employ a member for between three and four-and-a-half hours a week, usually over two or three shifts, each shift lasting between one-and-a-half and two hours.

While these placements were highly valued by The Club, Clubhouse staff wanted to provide members with the opportunity to try other types of work and enable members to work for a greater number of hours per week. The Community Café TEPs offered placements of eight or sixteen hours that were split over two and four days respectively. These TEPs could cover a greater number of hours each

week as The Club did not need to negotiate these placements and their pay with a partner organisation. Furthermore, The Club did not need to reassure an external partner that TEP participants were 'productive subjects' (Rose, N., 1999b) therefore there were no issues involved in allowing members to undertake more working responsibility in their placements. Research in a US Clubhouse has identified that members who worked a greater number of hours in Transitional Employment Placements were more likely to go on to find competitive employment (Henry et al., 2001) though this was categorised by total number of hours worked on TEPs, not based on hours worked per week. In Gavin's case, working a greater number of hours per week in a TEP (not at The Community Café, but at a former TEP within an NHS service) gave him the confidence to think he might be able to undertake competitive employment again:

> "It's what made me think I can go back to work, once I could cope with twelve hours, I thought maybe I could cope with sixteen, in the right job. If I can do a job without it stressing me, I can actually do it for quite a long period" (Gavin, member for twenty years).

Therefore, there may be advantages to having TEPs that operated for longer hours, and for members receiving Universal Credit, who would not have their earnings capped (though could have their UC payments reduced), the potential extra income could be extremely valuable (Evans and Wilton, 2016). Although Gavin had re-entered competitive employment since undertaking the twelve-hour TEP some years ago, he was not working at time of interview, as his other positions had ended in redundancy, or were short-term employment contracts. Significantly, although Gavin had undertaken mainstream employment after his TEPs, he had not had to undertake the 'competitive' element of applying and interviewing for these jobs:

> "most of my jobs, I haven't had to apply and compete for them, they've been offered to me. Which bypasses the problem of me selling myself" (Gavin, member for twenty years).

Gavin had obtained most of his paid employment positions through a prominent member of The Club board of trustees who had connections in multiple businesses and organisations. Gavin was a very long-standing member who had joined The Club when its membership was very small, and therefore had known

the board member for many years. As The Club's membership had grown so much over two decades, opportunities like those offered to Gavin in the past were not possible for many other members. The 'protected' nature of placements in the TEP programme meant that members did not have the chance to practise applying for jobs as they would be required to do in seeking out competitive employment:

> "I don't think I would have found it easy to compete for jobs. Partly because of my lack of being able to sell myself. It's not that I didn't have the skills, but the confidence. I couldn't sell myself. And I wanted to be honest. I wanted them to know that I'd had mental health problems" (Gavin, member for twenty years).

Despite his success in previous work placements and jobs, Gavin still found it hard to embody his 'worker identity', not because he felt unable to undertake the work tasks, but because he felt under pressure to *perform* this 'productive worker identity' (McDowell, 2009). Whilst he was able to undertake the work, Gavin felt lacking in his "performative encounters" by not having the 'confidence' to perform the role of a productive worker in an interview situation (Crang, P., 1994:686). Therefore, even when an individual is the 'right kind' of 'docile body' to become a productive subject (Foucault, 1995), the disabling division of labour may prevent them feeling that they can perform this role (Gleeson, 1999). Even in The Club, where there was an interview process for TEP allocation, the process was very different to an interview for 'competitive employment', where the interview panel searches for the most qualified individual to take on the job role. Most of my other interview participants were not in paid work at time of interview, apart from those currently undertaking TEPs. The only participant interviewed that was in paid employment (other than a TEP) at time of interview was undertaking supported employment through an external agency to The Club, though they had never undertaken a TEP. The individual struggles of members in finding competitive work after completing a TEP may be demonstrative of the increasing inability for disabled people to access the 'mainstream' employment market (Hall and Wilton, 2015). Following the 2008 global financial crisis, the higher levels of unemployment and welfare cut-backs associated with this "further entrenchment of neoliberal rationalities and disciplines" (Peck, Theodore and Brenner, 2012:265) mean that an even greater number of people out of work are competing for increasingly precarious

employment opportunities. Many of these unemployed individuals without disabilities will be considered by employers to be more 'productive' subjects than individuals with diagnoses of SEMHCs and likely be favoured in competitive mainstream employment (Evans and Wilton, 2019).

Most TEPs in The Club were of six to nine months in duration. We have considered that some placements in third sector organisations could not be sustained because of a lack of financial resources due to the prolonged impacts of austerity across the health and social care sector (Power and Hall, 2018). However, another reason that many established and apparently successful TEPs ceased to continue is because the members on the placement were taken on as permanent employees:

> "After I started, The Club member of staff has helped me for two to three weeks. From there I was on my own. About six weeks into the job, I heard rumours about my work performance being excellent, and that there will be a stable job for me. Shortly after that I was offered full employment" (The Club, 2015e:np).

This example from The Club newsletter demonstrates how the time-limited nature of the TEP programme does not suit all organisations that choose to become TEP partners. This member undertook a TEP at the Glasgow branch of a large, international retailer. The TEP partner was so impressed with this member's performance that they chose to offer them permanent part-time employment and withdrew their placement from the TEP programme. This member has maintained their part-time position at the retailer for more than a decade, and this job remains an important aspect of their life and enables them to maintain good mental health, alongside their attendance at The Club. While not all members 'desire' to enter paid work, for those who do, finding stable, accommodating employment can evidently have significant positive impacts on the individual's life (Evans and Wilton, 2019). However, the employment partner's decision to withdraw from the TEP programme in this case has prevented other members from being able to experience these same benefits of either short-term or long-term employment. The member that undertook the TEP was able to become and remain a 'productive subject', other Clubhouse members did not have the opportunity to 'try out' their neoliberal subjectivity through this placement at all. Members that had undertaken other TEPs that had

not led to permanent employment lamented that the TEPs did not last for a longer period:

> "I love the TEP, and like others that have done, I'd like to keep it, but I can't. That's the worst thing about it" (Douglas, member for six years).

> "They were six months and I felt as if they could be longer. I wish they could have been longer but it just felt as if you just started it, you just got into it and then you finished" (Catriona, member for eight years).

In an organisation such as a Clubhouse, that offers members "equal access to every Clubhouse opportunity" (Clubhouse International, 2018:1), it seems problematic to offer a permanent placement to one member and not others. As mentioned earlier in this chapter, The Club created a supported employment position for one of its members who had completed a TEP at The Community Café. Another Café TEP position was created to prevent a reduction in the number of TEPs, however, the creation of this supported employment placement enabled one member to continue to 'make an enterprise of themselves' (Foucault, 2008), and benefit from the income this provides, whilst other members who have completed TEPs return to the Clubhouse to recommence their participation in the work-ordered day.

Despite the contentiousness of these permanent placements, Clubhouse International standard twenty-one does state that the Clubhouse should offer supported employment opportunities beyond its TEP programme, and there is evidence that some Clubhouses in the USA are able to do this with some success (McKay, Johnsen and Stein, 2005). If the goal of employment placements is to enable members to move into competitive employment, TEPs may be more effective in a Clubhouse that also offers other forms of supported employment, to allow a staged transition back into the workplace (Henry et al., 2001). During my fieldwork period, The Club staff were attempting to link up with the IPS service I referred to in the introduction to this chapter and in the contextualisation chapter, though there were some difficulties in this undertaking:

> "I think structurally there's a big issue in Glasgow, there's the IPS service now which does TEPs but on a much larger scale. Structurally

> the way that service is set up, 70% of your time is spent with employers to get more jobs, it's like an employment agency… I think it would be a good thing for The Club… [to] just by default put people in IPS. The difficulty with that is, in referral terms that actually wouldn't be possible, you have to be with the Community Mental Health Team. But that's a structural issue within the NHS" (Owen, staff member for eighteen months).

The structural issues to which Owen refers are caused by the fact that supported employment "provision is uneven in quality and location" meaning that some areas are able to offer greater provision than others (Hall and McGarrol, 2012:1280). The IPS service run by a national mental health charity and operated in conjunction with NHSGG&C CMHTs required individuals to be under the care of a CMHT. Since 2013, membership criteria for The Club have required that one be a patient under secondary mental health services. However, as Clubhouse membership is not time-limited, The Club members can remain as Clubhouse members even after they have been discharged from secondary services. In addition to this, the IPS service only operated within some of NHSGG&C's CMHTs, therefore not all The Club members would be guaranteed to have an IPS service within their mental health team. Moreover, even if all members that had completed TEPs were able to easily access this supported employment programme, the level of support provided by the IPS service once the individual is in employment is much more limited than in TEPs, with in-work support consisting of a single phone call from the 'IPS specialist' to the 'client' at the end of the first week in work, and phone calls every two to four weeks thereafter. As Owen states, the IPS scheme has similarities to an employment agency, in that the focus is upon matching individuals to jobs, rather than in-work support, therefore whilst it is supposed to function as a 'place and train' supported employment service, the training after placement appears limited (Ridley et al., 2005). The IPS scheme helps clients to search for and apply to jobs, a skill that The Club members will not have learnt in taking part in the TEP programme with its protected placements. Many members may not be able to move into the IPS service following a TEP, due to: ineligibility for the scheme, finding the gap in support-level between TEPs and IPS too great, or because they struggle with the job application process in which they may be required to confidently persuade an interview panel of their abilities (Wilton and Schuer, 2006). These members may find another employment scheme to participate in, they may choose to apply directly for independent 'competitive' employment,

they may attempt to undertake further TEPs, or they may find some unpaid voluntary work to get involved in. Alternatively, they may return to The Club on a more regular basis, to help maintain and enhance the Clubhouse through undertaking work tasks as part of the work-ordered day.

7.3 Conclusion

In this chapter I have engaged with interview data from members and staff to provide a picture of the experiences of Transitional Employment Placements for The Club members. Throughout, I have also critiqued the notion that the most effective way for individuals with diagnoses of SEMHCs to strive towards 'personal mental health recovery' is through engaging in mainstream paid employment. Paid employment has been designated "the primary marker of social… inclusion in Western neoliberal states" (Hall and Wilton, 2015:219) and social inclusion is also one of the key elements of the 'CHIME' framework of personal mental health recovery (Leamy et al., 2011). Therefore, 'employability' has become an increasingly important focus for 'shadow-state' mental health services that are competing for a reduced amount of funding due to the "neoliberal 'project' of retrenchment of government spending" in public services (Power and Hall, 2018:305). The Club applied for and successfully attained a National Lottery Community Fund five-year grant of £267,220 in 2016 under the heading of 'Employability and Entrepreneurship', that was intended to "deliver activities that will increase the confidence, skills and employability prospects for people with enduring health concerns" (National Lottery, 2016:np). This grant was used to hire two staff members in the work and learning unit to 'deliver' these various 'activities', including TEPs, alongside their facilitation of the work-ordered day. Whilst competitive employment is not explicitly mentioned here, the notion of 'employability prospects' implies a focus upon activities that may lead members towards mainstream employment. The Club's main source of income at time of fieldwork, a tendered contract from NHSGG&C, specified provision of a "range of meaningful day activity and employability opportunities" (Public Contracts Scotland, 2016:np) therefore even under this tender, there was a focus upon employability. Transitional Employment Placements were a means of fulfilling some of these employability expectations.

TEPs offered a unique form of supported employment that enabled individuals with diagnoses of SEMHCs who otherwise may not have had the opportunity to participate in paid employment to 'try out' their neoliberal subjectivity (Bondi, 2005). Members were able to learn new skills (Torres-Stone et al., 2016), test their work capacity (Pirttimaa and Saloviita, 2009), interact with new people including 'non-disabled' individuals (Buhariwala, Wilton and Evans, 2015), and earn some additional income (Evans and Wilton, 2016). TEPs held a unique position as a form of supported employment, as they offered 'protected' placements for Clubhouse members, that did not require a competitive application process in order to undertake them. Furthermore, there was a very high level of support on these placements, with one-to-one in-person support from a Clubhouse TEP manager available for as long as the member needed, and guaranteed coverage on the placement when the member was unable to attend. Finally, if members were unable to complete their placements for whatever reason, they were not prevented from seeking to undertake other TEPs in the future, as the primary criterion for allocating TEPs to members was based upon their 'desire to work' (Clubhouse International, 2018). This enabled some individuals who might not have been able to access any kind of paid employment in the past to explore their capacity to become 'productive subjects'. Most importantly, these placements were voluntary, and did not require members to participate in order to receive broader support from the Clubhouse. Therefore, whilst the TEP programme did focus upon 'employability', The Club more broadly attempted to encourage members to find meaning in the work they undertook, and to participate within the community of the Clubhouse. In encouraging both individual endeavour towards neoliberal subjectivity and fostering a sense of community, The Club 'worked the space' of neoliberalism (Bondi and Laurie, 2005) by engaging with notions of 'employability' without compromising its own position as a space that fosters care and a sense of community.

The Club, in attempting to offer both 'meaningful day activity and employability opportunities' disrupts some of the neoliberal-ableist discourse related to competitive employment in its position as an 'interstitial space' between a mental health treatment space and a mainstream workplace (Goodley, 2014; Evans and Wilton, 2019). The TEP programme at The Club was wholly managed

by Clubhouse staff, who spent time searching for new placements, engaging with potential TEP partners, training members for placements, and covering placements in case of member absence. At the same time, Clubhouse staff in their generalist role were expected to oversee and facilitate the work-ordered day. Therefore, the amount of time they were able to work on expanding the TEP programme was limited, so only a small number of members could participate in the programme at any one time. Additionally, The Club was 'intentionally understaffed' (Kinn et al., 2018) to ensure that members were aware that they were needed in the Clubhouse to undertake the work tasks of the work-ordered day (Doyle, Lanoil and Dudek, 2013). Therefore, not only were the number of TEP placements limited by the small number of staff in the Clubhouse, but members were actively encouraged to stay in the Clubhouse to participate in the work-ordered day. Finally, the notion of moving on to full-time competitive employment is antithetical to the notion of lifetime Clubhouse membership, so creating the Clubhouse as 'a place to return' (Raeburn et al., 2013) helped to alleviate the need for members to constantly strive to become productive subjects, as they had the knowledge that they could return to The Club at any time, even after entering mainstream employment.

Some members very much valued the experiences offered to them through TEPs, and some did wish to move into competitive employment, though members expressed differing views about the value of 'paid work'. However, the short-term nature of TEPs, and the lack of connection to a further supported employment scheme following the completion of a TEP meant that many individuals did not go on to enter mainstream employment after undertaking a TEP (Bond, 1998), even if they had a strong desire to work. The continued 'devalorisation' of the labour power of disabled individuals (Evans and Wilton, 2019), which has further widened the 'disabling division of labour' (Gleeson, 1999) means that many individuals with diagnoses of SEMHCs struggle to be considered 'productive subjects' within mainstream employment (Rose, N., 1999b). Whilst The Club members were able to experience the benefits of undertaking paid work during a TEP, this may not have been sustained in the longer term, and they therefore would be unable to 'make an enterprise of themselves' as ideal neoliberal subjects (Foucault, 2008). In attempting to reap the potential benefits of Transitional Employment Placements, whilst

simultaneously endeavouring to subvert the neoliberal-ableist discourse that encourages the individual to strive towards being a 'productive subject' in paid employment, I argue that we should consider TEPs as short-term stand-alone placements in a wider Clubhouse experience, where members can bring their new skills back to the work-ordered day. As "the process of subjective construction is a site for agency" (Wilton, 2004b:422), in 'trying out' their neoliberal subjectivity through undertaking TEPs, but without the pressure of needing to become a productive subject, members can glean a greater understanding of what they consider personally meaningful in work, in order to pursue their own personal mental health recovery.

8 Conclusion

8.1 Introduction

I am going to reflect on the broader contributions this research offers, before summarising the written chapters in turn, and indicating the ways that each chapter has addressed my research objectives. I will outline the core academic contributions this thesis offers to geographies of mental health research. I will then discuss some potential practical strategies that The Club could implement to ensure members continue to be well supported by the organisation and to make the works tasks of the house more personally meaningful for members. Following this, I will briefly contemplate the future of work and welfare in relation to individuals with diagnoses of SEMHCs in Scotland, consider some gaps in service provision that this research has identified, and suggest some broad recommendations for ongoing welfare and employability policy in Scotland. Before considering the academic contributions of this research, it is worth focusing on a few of the contributions that were made during the fieldwork process. As stated in my methodology chapter, the elements of this research that I am proudest of are the small 'emotional labours' of care that I was able to undertake as part of my ethnographic fieldwork (Conradson, 2003a). In assisting The Club members with navigating job application forms, and supporting them with difficult telephone conversations, I was able to contribute in a small way to making their lives easier in that moment. Furthermore, the research interviews provided the opportunity for members to spend an hour or more talking about their experiences in a non-judgmental, supportive environment, with an interested and attentive listener; which can be a rare experience for some individuals who have encountered marginalisation and social exclusion:

> "It's the first time I've actually had the chance to talk about it" (Catriona, member for eight years).

Some members were keen to share their experiences in the hope of helping other individuals with diagnoses of SEMHCs, and saw the interview as an exercise in 'anti-stigmatisation':

> "it's about what's happening here right now, having this discussion with you… it's fundamental that it's taken from here because this is

> like an anti-stigma, you know?" (Hamish, member for eighteen months).
>
> "I remember meeting you way back in that café down below. You know, it sounded quite interesting, if my experiences are of help to other people" (Graham, member for two years).
>
> "I just hope that whoever else hears this takes it in, because it's real and it's been a pleasure to talk about The Club… and the TEP" (Douglas, member for six years).

Therefore, whilst my fear of causing harm dominated my fieldwork process, it appears that some members valued and even enjoyed having the opportunity to speak about their experiences. Beyond the empirical value that these interviews evidently contributed to my research, I also felt very privileged in being able to have these conversations and extremely grateful that members chose to share their knowledge with me. In adopting an emancipatory epistemological approach, I hoped that this research would serve to improve the quality of life for my participants and others in similar situations (Fuller and Askins, 2007). In embracing a critical approach to 'personal mental health recovery', I hope I have been able to contribute to challenging exclusionary narratives of 'recovery' that frame individuals with diagnoses of SEMHCs as 'abnormal' others (Foucault, 2004). Furthermore, whilst the portrayal of the views of my participants has of course been shaped by the 'outsized positional baggage' that I bring to the research process (MacKian, 2010), I have taken care not to frame any of these voices as 'fetishized' "recovery or resilience narratives" (Voronka, 2019:16).

Biegel et al. (2012:258) have called for "ethnographic studies examining [the] interpersonal and support dynamics of the Clubhouse environment." There is a dearth of qualitative and particularly in-depth ethnographic research undertaken in Clubhouses, this thesis provides a new perspective on the Clubhouse model and the 'vibrant' space of a Clubhouse in its rich ethnographic description. Moreover, most studies of Clubhouses are undertaken by researchers within psychology, occupational therapy, and social work; therefore there is a lack of critical social science research concerning the Clubhouse model (although see Yakas, 2017). Much existing Clubhouse research endorses the framework of 'personal mental health recovery' that I have sought to challenge throughout this thesis, as such my research offers unique insight into the problematic

notions of ‘normalisation’ and ‘responsibilisation’ in relation to recovery within the space of the Clubhouse. Finally, this thesis adds to the body of research concerning work and employment within geographies of mental health (Philo, Parr and Burns, 2005; Laws, 2011; 2013; Buhariwala, Wilton and Evans, 2015; Evans and Wilton, 2016; 2019) and research considering geographies of social inclusion and exclusion of individuals with disabilities and mental health conditions in a Scottish context (Hall, E., 2004; 2005; Parr, 2008; Hall and Wilton, 2011). My thesis offers a distinctly spatial contribution in being added to this body of critical geographical research, as the Clubhouse is a “place-based intervention” approach (Jackson, 2001:40). In drawing upon some critical disability studies and mad studies research (Harper and Speed, 2012; Howell and Voronka, 2012; McWade, 2016; Voronka, 2019) and psychiatric survivor and ‘service user’ research (Sweeney, 2009; 2016; Rose, D. 2014; 2018) in my discussions, I have attempted to demonstrate how these fields can bring exciting methodological and critical theoretical insights to complement existing geographies of mental health research, which has sought to bring “more sharply into view the faces and voices of people with mental health problems” (Parr, 2008:11-12). The three most significant academic contributions I believe this thesis can offer to the geographies of mental health will be explored in greater detail in a later section of this chapter.

8.2 Addressing the Research Objectives

I will now provide a concluding overview of the chapters of this thesis, examining how each chapter addressed my research objectives. *Chapter 1* introduced the overall background to the research and situated it within previous research in the geographies of mental health. I presented the key academic concepts underpinning this research; explaining Foucault’s conceptualisations of disciplinary power in relation to spaces of mental health treatment (Foucault, 1995), his understanding of subjectivity as constituted by power (Foucault, 1978), and the concept of neoliberal governmentality and biopower in governing the subject (Foucault, 2008). I considered Nikolas Rose’s notion of the ‘productive subject’ (Rose, N., 1999a; 1999b) to introduce the ‘ideal neoliberal productive subject’ and explained how this notion was reinforced by neoliberal-ableist ideas of individualism, rationality, and autonomy

(Runswick-Cole, Lawthom and Goodley, 2016). I then introduced the four main research objectives of this research, which were:

- To explore a Clubhouse 'working community' as an alternative approach to 'welfare-to-work' and supported employment schemes
- To investigate the varied experiences of work and employment of individuals with diagnoses of SEMHCs
- To provide a 'lively and nuanced' geographical account of a space of 'community care'
- To critique established discourses of work and employment in relation to mental health recovery.

Chapter 2 considered a history of 'work' in relation to the treatment of 'madness' from the nineteenth century onwards in the UK, from moral treatment to occupational therapy and industrial therapy. This established an historical context from which discourses of work and employment in relation to mental ill-health could be questioned, as I demonstrated how work has traditionally been used to 'constrain' madness (Foucault, 1995; 2006a; 2006b). In the second section I examined therapeutic communities and the 'care-in-the-community' approach to mental health treatment to establish the ways that community has previously been understood in relation to mental ill-health in the UK. I then presented a theorisation of community as 'relational'; this provided part of the conceptual framing to present the Clubhouse as a space of 'community care' in later chapters. The next section explored the policies of welfare-to-work in the UK and approaches to supported employment, with a particular focus on Scotland. This setup the contextual background for presenting the Clubhouse as an alternative approach to already established supported employment schemes. The final part of this contextualisation chapter introduced the Clubhouse model, outlined some key characteristics of a 'working community' and provided vital contextual background about the Clubhouse.

Chapter 3 offered an interdisciplinary literature review on the terms 'recovery' and 'care'. I scrutinised the term 'recovery' and its usage within psychology and psychosocial rehabilitation literature and research, as a problematic term that pressures individuals with diagnoses of SEMHCs to take personal responsibility to

conform to certain societal norms, particularly in relation to participation in 'mainstream' employment (Rose, D., 2014; McWade, 2016). This formed the conceptual groundwork upon which I critiqued approaches to work and employment in the 'treatment' of mental ill-health within the empirical chapters. The next section of this chapter considered geographical conceptualisations of 'care' as a term that could be mobilised in resistance to the neoliberal-ableist discourses of mental health recovery. In advancing care as: ethical, affective, and practised I demonstrated it as a highly relational and mutable concept that provided the second part of the framing of the Clubhouse as a space of community care. I presented a relational understanding of care to use throughout the empirical chapters to show both the constraining and facilitative nature of care within The Club, to render the space differently than viewing it through the individualised lens of personal mental health recovery.

Chapter 4, the methodology chapter explored the well-established use of qualitative research methods within mental health and disability geographies research. I laid out the methods I used to undertake this research, delineating the ethnographic, documentary analysis, and interview techniques that have enabled me to write a 'lively and nuanced' account of the space of the Clubhouse. I then considered the process of data analysis and detailed the formal procedures and less formalised actions I undertook in order to practice research ethically. My methodology chapter also engaged with the 'messiness' of the fieldwork process (DeLyser and Starrs, 2001), paid attention to the importance of researcher emotions and positionality in undertaking 'sensitive' research (Laurier and Parr, 2000), and responded to the call for geographers "to 'write vulnerably' in their reflexive academic work, to normalize the productive place of failure within our neoliberal institutions" (Harrowell, Davies and Disney, 2018:236). In doing this I have been able to provide an account that adds to the small but growing collection of geographical literature that attempts to 'think through failure' (Frazier, 2020; Horton, 2020). I offered a preliminary historical and geographical introduction to my field site, The Club, and provided a brief overview of the two other field sites in London and Orkney at which I undertook micro-ethnographies, to set up the 'field' context for the empirical chapters.

Chapter 5 examined the organisation of work within The Club, in which I explored experiences of work for The Club members and provided a 'lively' description of The Club as a space for work. I demonstrated how institution-like mechanisms exerted disciplinary potential over members in their participation in the work-ordered day through the spatial and temporal organisation of work (Goffman, 1961; Foucault, 1995). However, in expounding the experiences of members of The Club, I determined that some of the 'constraining power' enacted through these mechanisms was welcomed and appreciated by the membership: members found the notion of routine and structure a useful tool in maintaining mental wellbeing. A deeper examination of the 'order-taker' role within the lunchtime service at The Club helped to demonstrate the "vibrancy of the place" (Fiona, member for ten years) and showed that whilst these work tasks still involved 'relational encounters', these were much less formal than in 'mainstream' workplaces (Goffman, 1959), allowing members who have been excluded from mainstream employment the opportunity to participate. Beyond spatially and temporally structuring the work of the house, the Clubhouse International standards also delineated the types of tasks that constituted 'meaningful work', for example, the work-ordered day should not include activities that are purely 'therapeutic'. In exploring the concept of the 'need to be needed', I determined that some members greatly benefited from feeling valued within the space of the Clubhouse, for others the expectation of their participation in the work-ordered day could cause worry or anxiety. Overall, I was able to examine the varied experiences of work for members through understanding the structures and procedures of the Clubhouse. These structures created a space that was conducive to productive, meaningful, and accessible work for members, if members were able and willing to engage with the structure of the work-ordered day and the concept of the need to be needed.

Chapter 6 further explored The Club as a 'working *community'* and a space of 'community care', as well as utilising 'care' as a means of critiquing problematic notions of 'mental health recovery'. The 'working community' was conceived as a space for "recovery and social inclusion" (Doyle, Lanoil and Dudek, 2013:np) but the promotion of 'individual autonomy' within the prevailing neoliberal discourse of personal mental health recovery is antithetical to the notion of social inclusion (McWade, 2016). I argued that by mobilising the term 'care', we

can more easily comprehend the inclusive aspects of The Club, that demonstrate how the 'working community' is an alternative approach to supported employment through its focus upon fostering a community. The Club encouraged working 'side-by-side' to help promote social inclusion and a collective 'worker' identity and was a space where some 'non-normative' behaviour was tolerated, though there were limits to the extent of both the practices of care and the space of community. I examined the care relations between members and detailed members' descriptions of their experiences of giving and receiving peer support within The Club. In exploring the care relations between staff and members, I determined that on some occasions practices of 'controlful care' were enacted (Philo and Parr, 2019), that shattered the perceived 'flattened hierarchy' between staff and members (Tanaka, 2013). Whilst this controlful care exerted a certain constraining power on the community, it did this to ensure that The Club remained as caring and inclusionary a space as possible for those within it, though for those engaging in 'deviant' behaviour this care could become temporarily inaccessible and the space of the community exclusionary. In understanding the Clubhouse as an "intentional community" (Pernice-Duca, Case and Conrad-Garrisi, 2012:132), I examined the way that the community was facilitated through the 'doing-in-common' of work (Pratt, K., 2013). This practice of work created a 'momentum' that I identified as having an affective capacity to motivate members to contribute to the 'doing-in-common' of community, and to encourage them to return. Rather than trying to "pin down" the affective atmospheres of The Club (Bondi and Davidson, 2011:595), I considered both care and community as entangled and (sometimes) co-constitutive relations. In conceptualising care and community in this way, I attempted to respond to recent appeals that "encourage further geographical work that engages with the relational plurality of voluntary sector geographies" (DeVerteuil, Power and Trudeau, 2019:932) and disability geographies (Hall and Wilton, 2017) in attempting to bring this space of community care 'to life'.

Chapter 7 explored members' experiences of employment, delineated how The Club is an alternative to other established supported employment schemes, demonstrated how The Club functions as an 'interstitial space' between spaces of mental health care and mainstream workplaces, and further critiqued narratives of mental health recovery that encourage individuals with diagnoses

of SEMHCs to enter 'mainstream' employment. Using the Clubhouse International standards as a rough framework, I evaluated the problematic facets of Transitional Employment Placements, whilst acknowledging and highlighting their positive aspects. TEPs offered an opportunity for members who have traditionally been excluded from spaces of mainstream employment to 'try out' their position as 'productive subjects'. This enabled them to test out their work capacity, learn new skills, and earn a wage, whilst receiving a high level of support from Clubhouse staff. At the same time, the Clubhouse International standards framing of TEPs as a 'first step' towards mainstream employment is unrealistic in a society where the "labor power of disabled people" has been systematically devalorised (Evans and Wilton, 2019:96). Furthermore, the TEP programme reinforced the narrative of striving to become a productive neoliberal subject by assuming that members will 'desire to work', in reality this was not always the case. This chapter explored the value that members ascribed to different types of employment, and within this "hierarchy of work" (Annabelle, staff member for seven years), the cleaning placements most frequently available in the TEP programme were not always highly valued. Members reported that they appreciated the experiences of social interaction in the TEPs they undertook, and The Community Café TEPs offered much greater opportunities for these kinds of interaction than the cleaning placements. The Community Café TEPs functioned more as a 'social enterprise' form of supported employment scheme, that allowed members to interact with non-disabled café staff and customers (Buhariwala, Wilton and Evans, 2015), enabling opportunities to form social connections outwith the 'mental health community' of The Club. With the aid of illustrative interview data from members and staff, I have been able to explore how the TEP programme of The Club functions as a positive alternative to welfare-to-work schemes, whilst offering a critical perspective of 'work' in relation to personal mental health 'recovery'.

8.3 Contributions to Geographical Research

8.3.1 'Interstitial Spaces' and 'In-Between Identities'

Chapter 2 illustrated the research that mental health and disability geographers have undertaken considering the project of 'care in the community' (Milligan, 2003, Conradson, 2003a, Parr 2008). The reduction of state funding and

responsibility for mental health care and treatment, and the relocation of this treatment 'in the community' (Milligan, 2000) over the past half century has led to the development of a 'shadow-state', a "para-state apparatus comprised of multiple voluntary sector organizations" (Wolch, 1990:xvi). This landscape is now further complicated by the "current context of austerity… accelerating existing trends in the neoliberal 'project' of retrenchment of government spending" (Power and Hall, 2018:305) which has led to a 'crisis' in health and social care funding. The result of this is that there is greater pressure on mental health care and treatment services to get 'service users' to 'move on', to be less reliant on formal care services and welfare benefits. At the same time, many third sector organisations do not necessarily share this ethos (Fyfe and Milligan, 2003) and instead may attempt to act as a 'mediator' of neoliberal policies (DeVerteuil, Power and Trudeau, 2019). As such, these spaces may engage with practices that attempt to help 'service users' be less dependent on services, by aiding them to enter 'mainstream' paid employment, but at the same time may try to protect their service users from the more brutal aspects of neoliberalised welfare-to-work policy, by assisting them with benefits appeals or work capability assessments.

Mental health geographers have shown interest in 'alternative' spaces of work for individuals with diagnoses of SEMHCs over the past two decades, though the amount of empirical research considering these spaces within this sub-discipline is still limited. Philo, Parr and Burns (2005:787) describe Training and Guidance Units in the Scottish Highlands as "in-between spaces" with both "economic and social" imperatives, that are free of "that time-work discipline so central to most other economic enterprises" (788). Evans and Wilton (2019:99) describe social enterprises in Canada that employ individuals with diagnoses of SEMHCs as "threshold" spaces between "real and therapeutic work." They explain that "not asking for more than workers can give" was central to the ethos of the social enterprises in their research, as these enterprises recognised the "different capacities for work that reflect varying degrees of… wellness" (Evans and Wilton, 2019:97). These studies demonstrate that these spaces simultaneously engage with the political rhetoric that 'work is good for your health and wellbeing', and also resist some of the mechanisms of neoliberal governmentality that demands the individual make "an entrepreneur of himself

[sic]" (Foucault, 2008:230) by trying to configure work in ways that do not require "economy of time and gesture" (Foucault, 1995:148). Therefore, these studies demonstrate the capacity of these third sector organisations and the staff and service users within them to 'work the space of neoliberalism' in their attempts to resist the sharper end of 'welfare-to-work' policy-making (Bondi and Laurie, 2005).

My research adds to these previous studies and demonstrates that The Club inhabits an 'interstitial space' between a 'space of mental health care' and a 'workplace'. Therefore, the members who attend The Club inhabit identities between 'workless' and 'employed', between 'patient' and 'worker'. In providing in-depth accounts of the 'working lives' of individuals within the space of The Club (the work undertaken within The Club in *Chapter 5*, and work outwith the house in *Chapter 7*), I have revealed how the space of The Club has shaped the way in which members engage with their identities, influencing their potential to become 'productive neoliberal subjects' in different ways at different times. At time of interview, Douglas described arriving at The Club in significant distress and not engaging with staff, members, or activities. From that point, he began to join in work within the work-ordered day, then undertaking a voluntary TEP, and eventually reaching the point where he was about to commence his first paid TEP. Douglas had moved from what could be considered an 'illness' identity to a 'worker' identity. Rob, on the other hand, had never undertaken a TEP, and did not intend to, as he was comfortable within The Club, finding meaning and social connections within that space, and did not feel the need to 'move on'. Rob was comfortable with his identity as a member of The Club, reliant on their support, but adopting a working role within the house. Gavin had undertaken a number of paid TEPs and part-time employment positions, alongside voluntary work, but all of his paid work opportunities had either been short-term contracts or ended in redundancy. Gavin did find value and meaning in 'feeling normal' through paid employment and inhabiting a 'worker identity', but the realities of trying to find and keep paid employment as a person with a diagnosis of a SEMHC meant that he was not always able to inhabit his 'productive subjectivity'. In these instances, The Club was there, to be a 'place to return' to (Raeburn et al., 2013), and to remind Gavin of his value outwith his productive capacity.

For these members, their 'worker' or 'patient' identities were tied-up in their relationship to The Club (as explored in *Chapter 6*), and the identity of 'Clubhouse member' carries with it both connotations of 'service user' and 'valued worker', as demonstrated through the concept of the 'need to be needed' (Conrad-Garrisi and Pernice-Duca, 2013). Therefore, the position of The Club as an 'interstitial space' promotes this 'in-betweenness' and has the capacity to "unsettle the boundaries between categories of sick-well, unproductive-productive, and normal-abnormal and make possible new economic and social identities" (Evans and Wilton, 2019:99). My research provides insights into the nature of these 'in-between' identities, it also highlights the significance of the space of The Club as a site of community care, in producing this 'in-betweenness'. Future mental health geographies research could look to investigate other 'interstitial spaces' of community care and think about how these 'in-between' identities between 'sick' and 'well' complicate the expectations of individual autonomy, rationality, and personal responsibility in relation to prevailing narratives of personal mental health 'recovery'.

8.3.2 Emancipatory Geographies of Mental Health

In *Chapter 1* I explained how mental health geographers have attempted to represent the experiences and voices of individuals with diagnoses of SEMHCs through researching the "experiential worlds" of these individuals (McGeachan, 2017:4). Research within the geographies of mental health engages with service user and psychiatric survivor perspectives within its empirical content, acknowledging that these individuals are the experts in their own experiences. This centring of 'mad' voices is very important, but I argue that we need to advance a more overtly political project, that stands alongside mad studies and critical disability studies in directly critiquing neoliberalism and the impact that neoliberal policy-making has had upon the lives of individuals with diagnoses of SEMHCs. Diana Rose (2018:738) advises that if academic disciplines wish to contribute to improving the lives of individuals with diagnoses of SEMHCs, we need to attend to "arguments about power, individualism and normality":

> "insofar as the wider academic community (outside the 'psy' disciplines) thinks about madness and distress it is from an ethical position of wanting to help, to ameliorate suffering and to do this not from a position of containment and control but… in order to

> ‘empower’… But if other academic disciplines are to do anything effective they must get rid of every last vestige of charitable but patronising approaches” (Rose, D., 2018:738).

I have attempted to attend to the issues of ‘power, individualism and normality’ throughout my thesis by utilising literature from mad studies, critical disability studies and psychiatric survivor research. By engaging with critical perspectives concerning mental health ‘recovery’ I have tried to demonstrate the ways in which this term has been taken out of its original psychiatric survivor context to instead represent an expectation that one will become a ‘productive subject’ (Rose, D., 2014). In engaging with literature from critical disability studies, I have attempted to show that the opportunities for individuals with diagnoses of SEMHCs to achieve their ‘productive subjectivity’ are hindered by the neoliberal-ableist values that demand that individuals be ‘rational’, ‘adaptable’ and ‘compliant’ (Runswick-Cole, 2014).

Geographers engaging in mental health research have identified that “a term like ‘recovery’ is complex and contentious” (Parr and Davidson, 2010:258). In engaging with scholars from mad studies and psychiatric survivor research, in Chapter 3 I explored this ‘contention’, examining how the term has been ‘co-opted’ by psychological and psychosocial rehabilitation literature to advance a form of recovery that requires the individual to follow a certain set of norms (Rose, D., 2018). I am critical of the ‘CHIME’ framework of personal mental health recovery, as I acknowledge that “central to recovery and resiliency frameworks… is that disability is understood as implicitly undesirable adversity, to be overcome through self-management” (Voronka, 2019:10). Without trivialising the very real experiences of distress that those with a diagnosis of a SEMHC may experience or suggesting that any aspects of this distress are ‘desirable’, I am trying to indicate that it should not be assumed that ‘normativity’ is desired by individuals with diagnoses of SEMHCs. Furthermore, this ‘adversity’ is not something that should be entirely the responsibility of the individual to overcome through ‘self-management’. I advance ‘recovery’ as a concept that is self-defined by the individual (including the potential that the term is rejected completely), and at the same time attempt to oppose the ‘recovery frameworks’ that “work to build larger framings of [psychiatric survivors] as redeemable subjects” (Voronka, 2019:16).

Critical disability studies scholars have created the term 'neoliberal-ableism' to describe the common set of values that define what a 'normative subject' *should* be within both neoliberalism and ableism. Ableism assumes that individuals will all look, behave and move in a certain (non-disabled) way. Under neoliberalism, it is assumed that individuals will strive to become autonomous and productive subjects. Therefore, under neoliberal-ableism "the ideal citizen is an adaptable citizen… an able individual… who is caught up in and complicit with the demands of late capitalism" (Runswick-Cole, Lawthom and Goodley, 2016:257). In utilising this term within the geographies of mental health, I hope to build on geographical work that has identified the "devalorization of the labor power of people with mental illness" (Evans and Wilton, 2019:96) by using 'neoliberal-ableism' as a concept that demonstrates the 'disabling division of labour' (Gleeson, 1999) being exacerbated by processes of neoliberalisation. In *Chapter 7* I demonstrated that these neoliberal values could be observed within the Clubhouse International standards framework for TEPs. In assuming that Clubhouse members have a 'desire to work', there is a neoliberal-ableist assumption that individuals will both want and be able to undertake work. As staff member Eugene comments, this 'desire' was not always present in members of The Club. Furthermore, the Clubhouse International standards framing of 'failure' as a necessary part of 'successful work adjustment' reinforces a 'triumph over adversity' narrative that places the responsibility for success onto the individual (Horton, 2020), without tackling wider systemic issues (such as the disabling division of labour) that may have made failure inevitable. For many disabled people, the 'failure' to enter mainstream employment is largely due to neoliberal-ableist assumptions about their capacity to be 'productive'. Therefore, to place 'failure' as a necessary part of work adjustment highlights the neoliberal-ableist assumption that all are capable of becoming productive subjects if they just 'work hard enough'. Future research within the geographies of mental health needs to further engage critically with neoliberalism in order to continue to build an emancipatory "body of knowledge that challenges exclusion" (Sweeney, 2009:31).

8.3.3 Care, Community, and Control

Beyond geographical work that examines the project of 'care in the community', mental health geographers have also taken an interest in the notion of care and

its relation to power, particularly within institutional spaces (Milligan, 2005; Philo, 2017; Philo and Parr, 2019; McGeachan, 2019; see Disney and Schliehe's (2019) special section in *Area* on 'troubling institutions at the nexus of care and control'). In my thesis I have attempted to pull some of these conceptualisations of care and control from institutional spaces and deploy them in the 'interstitial spaces' of community care. Whilst the relations of care and control within non-institutional spaces are not 'bounded' in the same way as in institutions (Bowlby, 2012), the material space of the Clubhouse is still a 'node' within the 'landscape of care' (Milligan and Wiles, 2010) in which caring relations and affective atmospheres may coalesce. In *Chapter 6,* I examined the way that some of these caring relations extend beyond the space of the Clubhouse within the relationships experienced between members. In paying attention to 'affective atmospheres' or the "intensities that are only imperfectly housed in the proper names we give to emotions (hope, fear)" (Anderson, B., 2009:77) that accumulate within these community spaces, I argue that we can better discern the caring relations that exist between individuals, and the way that a 'sense of community' is constituted. This is significant in a space such as The Club, where the perceived 'flattened' hierarchy presented in the Clubhouse model elides some of the power relations that exist between staff and members. This may also prove useful in studies of other spaces of community mental health care, where the relations between 'staff' and 'service-users' are often less formalised than the 'doctor-patient' relations familiar to institutional spaces of mental health care.

Through my in-depth ethnographic examination of The Club, I have attempted to demonstrate the potential for 'controlful care' within a community space of mental health care. The Club is a space in which attendance and participation are entirely voluntary, but there are still rules of conduct one is expected to 'conform' to, and behavioural 'norms' to follow. These rules and norms are a form of disciplinary control (Foucault, 1995), though these expectations are more relaxed than the norms of 'wider society'. As I explored in *Chapter 5*, members are not expected to undertake the same 'polished performances' of work tasks as would be expected in 'mainstream' workplaces (McDowell, 2009). We can see controlful care 'in action' when the rules of the Clubhouse are broken or the expected behavioural norms deviated from. The example in

Chapter 6 of the individual who is asked to leave The Club after an angry outburst is a demonstration of the exertion of controlful care. When an individual acts in a way that is 'deviant' (in this case by displaying aggressive behaviour), controlful care is exerted by Clubhouse staff which then takes away the agency of the 'deviant' individual to act. This agency is removed in two ways: firstly, by asking the individual to leave the premises, this removes their capacity to commit further disruptive acts within the space; secondly, in casting the individual as 'unwell', it frames them as the 'Other', one to be feared or pitied, rather than as an individual with the agency to subvert activity of the Clubhouse. In this incident, the 'expulsion' of the member from The Club created an affective atmosphere approximating 'pity' as other members attempted to distance themselves from the behaviour of the individual (Anderson, B., 2010), placing themselves as 'rational' subjects who acknowledge that the outburst is caused by 'illness behaviour'. Therefore, while the exertion of control is only enacted on a single member by a single staff member, by attempting to discern the 'affective atmospheres' we can see the influence this event has upon the entire membership of the Clubhouse. This is a reason that attempting to discern affective atmospheres can be valuable in research into spaces of community care, as it helps us to understand "the ways more collective emotional experiences contribute to the (re)creation of space and place" (Little, 2019:211). We are able to see that whilst this aggressive behaviour is not openly denounced, it is still cast as 'undesirable' by the membership of the Clubhouse and stigmatised as 'illness behaviour'.

In addition to disentangling the power relations that exist within spaces of community care, my research demonstrates how affective atmospheres may help geographers to determine how a 'sense of community' is (or is not) experienced within these spaces. The 'togetherness' of a community may be constituted by certain affective atmospheres; these atmospheres may reciprocally be constituted by the practices of togetherness. The practised doing-in-common of work (Pratt, K., 2013) in the formation of community within The Club was identified by Hamish as creating a 'momentum'. This momentum is a 'structure of feeling', that could give a positive shape to otherwise difficult individual feelings (such as lowness or anxiety) (Anderson, B., 2009). The sense of achievement created through undertaking work together, coupled with feeling

needed within the Clubhouse in order to undertake the work makes the individual feel cared *about*, as their labour is useful. In turn, their labour in participating side-by-side in the work-ordered day cares *for* the community of the Clubhouse. Russell describes this sense of community as a 'group consciousness', that members have a mutual experience of 'community' that feels positive (whether or not it is experienced as caring) and so they return to the Clubhouse in order to continue to 'maintain and enhance' the community (Propst, 1992). Whilst affective atmospheres can be difficult to grasp (Dewsbury, 2009), they can give us a 'sense' of relational constructs such as care and community by revealing how individuals and spaces interact, as my thesis has shown:

> "Affect decentres the individual… and instead prompts us to think about how different configurations of objects, technologies, and bodies come together to form different experiences of 'being with'" (Bissell, 2010:272).

Therefore, further research into the affective experiences of groups within spaces of 'community care' in mental health may prove fruitful in determining what it is about these spaces that can be 'healing' or 'restorative', and what is detrimental to mental wellbeing. Furthermore, affective atmospheres may help mental health geographers to consider the wider influence of individual acts of controlful care within a non-institutional community space where power may be less obviously exerted from the 'top-down', and it may help to further elucidate how 'community' is facilitated and experienced within these spaces.

8.4 Recommendations for The Club

The first research objective of this thesis has been to explore a 'working community' as an alternative to 'welfare-to-work' approaches. The Club does offer an alternative to these approaches as members are encouraged to engage in some employment activities, but receiving support is not contingent upon this, and their attendance is not linked to any form of 'conditionality' in relation to welfare payments (Dwyer, 2017). This allows for The Club to offer a distinct form of support that enables members to try out their 'productive subjectivity' within the context of a caring community. The Club is distinctly positioned as an 'interstitial space' on the threshold between spaces of mental health care and

treatment and ‘mainstream’ workplaces (Evans and Wilton, 2019). The Club is able to provide a unique form of highly-supported temporary employment, as part of a wider Clubhouse experience that includes: participation in the work-ordered day, volunteering opportunities, educational courses, and outdoors activities (such as walking groups and visits to the allotment). From my research, I have determined five recommendations that The Club could consider implementing, that would allow them to continue to offer their vital service, whilst potentially improving the support provided for members, and reducing workload burdens on staff. These recommendations are based upon my field research undertaken during 2017 and 2018, and therefore may not all be practical or appropriate actions in the context of the current COVID-19 pandemic. The impact of the pandemic will be briefly considered in the last section of this chapter. However, I believe all these recommendations may be useful in longer term strategic planning for The Club, in cementing its position as an alternative to welfare-to-work approaches.

The first recommendation is intended to make the work tasks of the Clubhouse more meaningful and purposeful for members, in order for them to feel a greater level of satisfaction in participating at The Club, and to encourage them to continue attending. In my interviews I discovered that some members did not have a full understanding of the purpose of the work-ordered day, that it is intended to create meaning for members as they contribute to the maintenance and enhancement of the community of the Clubhouse. Clubhouse staff were effective at reminding members that their contribution and presence was valued in The Club on an individual basis. However, I recommend that more formal reminders are delivered to all members regularly to reinforce that they are needed within the Clubhouse in order to help the community function. These reminders could be given at group meetings, such as at the ‘coffee break’ morning meeting. This could take the place of the reading of the Clubhouse standard at these meetings, a short statement reminding members of their purpose and value within the Clubhouse community could be read aloud once a week.

Secondly, I suggest that The Club place a greater focus on group activities, including some activities that would be considered more ‘therapeutic’ than ‘productive’. As I explored in *Chapter 5,* The Club has always had to maintain a

balance between productive and therapeutic tasks, as its adherence to the Clubhouse model means that the majority of activities in the house were required to be work-oriented. However, some of the most popular activities that The Club offered were both therapeutic and productive and included group activities such as the walking groups and the 'brain training' group. As The Club is no longer accredited by Clubhouse International, it has the flexibility to offer more of these activities and reduce the focus on undertaking purely 'productive' work tasks. A balance would still need to be struck to ensure that the tasks of the work-ordered day could still be completed. A solution to this would be to empower members to lead and facilitate some of the group activities or therapeutic tasks, reducing the amount of staff time taken up with facilitating these tasks. Facilitating these activities could also constitute a meaningful (and productive) work task for the members leading on these activities.

My remaining recommendations relate to the transitional employment placement programme within The Club, and the ways in which this could be improved for both Clubhouse members and staff. The Club has the potential to diverge from the Clubhouse International standard framing of TEPs that I explored in *Chapter 7* and it can implement changes to its TEP programme. I discovered through my interviews with The Club staff that TEPs are a huge time commitment for staff, therefore I propose a two-step approach that would reduce the TEP workload for staff. Firstly, the total number of placements could be reduced, as The Club no longer needs to reach a target number of placements that is between twenty and fifty percent of the average daily Clubhouse attendance (Clubhouse International, 2012). Instead, staff time could be used to focus on intensive and very high-quality support within the existing placements, to ensure that members are able to make the most of their TEP experience. Secondly, moving away from the Clubhouse model means that The Club staff no longer need to be 'generalist practitioners' who fulfil multiple roles within the Clubhouse. One or two members of staff could be hired to deal exclusively with the TEP programme. These staff members would still be based within The Club, and still attend wider house meetings so that members can get to know them, but the primary goal of these staff members could be to manage the TEP programme, freeing up time for other staff members who would no longer have to manage

employment placements in addition to their other responsibilities within The Club.

My fourth recommendation is for The Club to reconsider the way that TEPs are conceptualised and described within the space of The Club. Instead of framing TEPs as a first move towards 'mainstream' employment, offering them as a chance to 'try out' a temporary work placement may relieve some of the pressure for members to 'perform' in TEPs. Furthermore, altering the language used to describe the TEP programme could reduce anxiety that members may feel in applying for TEPs, in distancing the TEP programme from language that encourages members to "ease into responsibility" (Eugene, staff member for four years). This shift in philosophy does not mean that TEPs will not be the first 'step' of a member's 'journey' to mainstream employment, it just emphasises that it does not have to be a 'first step' if the member does not want it to be. This change in philosophy would be easier to implement in placements that The Club has complete control over, such as The Community Café placements.

I explored in *Chapter 7* that The Community Café TEPs may not have been wholly compliant with the Clubhouse standards for TEPs. Moving away from the Clubhouse model would allow The Club to expand its operations within The Community Café without the worry of ineligibility for Clubhouse reaccreditation. The Community Café hosted employment placements that were very popular with members, my recommendation is that The Club could offer a greater number of placements within The Community Café with highly tailored levels of support for different members. This could mean expanding from having kitchen porter placements, to also having placements for waiting staff, and even placements that focused on the financial, business, and administrative aspects of managing The Community Café. As The Club would not be required to convince external organisations of the capabilities of its members, members undertaking TEPs would have the opportunity to take on new responsibilities, and a greater variety of placements could be offered than the cleaning placements frequently offered by external organisations. In doing this, The Club could act as a 'mediator' that protected members from the sharper edge of neoliberal policy making in relation to work and welfare (DeVerteuil, Power and Trudeau, 2019) whilst continuing to offer opportunities for members to engage in work and employment activities if they chose. Although this may appear to

contradict with my earlier recommendation to reduce the size of the TEP programme, much of the time that occupies staff in the current TEP programme is related to finding and negotiating new placements with external organisations, maintaining these relationships with organisations, and travelling across Glasgow to attend placements. Creating new placements within The Community Café would reduce the amount of time that staff would need to spend communicating and negotiating with external partner organisations, and although The Community Café is not on the same site as The Club, travel between these two sites is already frequent and travelling to and from The Community Café could be easily integrated into existing The Club staff schedules.

8.5 Potential Policy Implications

Based upon this research, I also have four broader recommendations for the ongoing provision of employability programmes and mental health care and treatment within a Scottish context. There is potential to improve the lives of individuals with diagnoses of SEMHCs in Scotland as the Scotland Act (2016) and the Social Security (Scotland) Act (2018) have devolved the responsibility of the allocation of some welfare benefits to the Scottish Government, including disability benefits. Although Universal Credit is not among these devolved benefits, the Scottish Government have committed to "improving benefits for disabled people and people with ill health, and confirming that no assessments will be carried out by the private sector" (Scottish Government, 2020b:np). My thesis demonstrates the difficulties that individuals with diagnoses of SEMHCs face in trying to attain and retain paid employment, illustrating that the 'conditionality' of welfare payments for these individuals is detrimental to wellbeing (Dwyer, 2017). The requirement to engage in work-related activity such as job searches and applications can be extremely trying for these individuals, and they are less likely to attain paid employment than non-disabled individuals (Roulstone, 2015). Therefore, I recommend that the Scottish Government take this opportunity of the further devolvement of some aspects of welfare benefits to reduce as far as possible the impact of welfare assessments. In addition to committing to ensure that disability assessments are not carried out by the private sector, the Scottish Government should pledge to reducing the threshold of 'evidence' required for an individual to be deemed as 'unable'

to work. Furthermore, there needs to be a commitment to re-evaluate the way that benefits assessments are conducted to reduce the stress that these tests may cause disabled individuals.

Secondly, I am recommending two actions to increase the potential income a disabled individual is entitled to outside of conditional benefits such as Universal Credit. The first action is to expand the eligibility criteria for disability benefits to include a greater variety of health conditions and therefore a greater number of eligible individuals. As I explored in *Chapter 2,* the number of individuals who qualify as disabled 'enough' to receive unconditional welfare support has decreased significantly over the past three decades (Grover, 2015) and individuals with diagnoses of SEMHCs are no longer exempt from work capability assessments (Osborne, 2008). Expanding the eligibility criteria for disability benefits will enable a larger number of individuals to access unconditional welfare assistance. The second action I suggest is for the Scottish Government to commit to further studies to assess the viability of a universal basic income. The final report prepared by the Citizens' Basic Income Feasibility Study Steering Group in Scotland has recommended a full pilot study of basic income to evaluate the impact it would have on the Scottish population and economy (Basic Income Scotland, 2020). A pilot study could raise the income of some disabled individuals immediately and scope out the viability of a universal basic income for all in Scotland in the longer term. By ensuring that disabled individuals have enough money to satisfy their basic needs, and therefore do not have to worry about how they are going to pay their bills, they may have a greater amount of time and energy to explore their productive capacity, in paid employment or unpaid volunteer roles.

If these two recommendations are heeded, and disabled individuals have more time and energy to focus upon work, then we also need to ensure that there are plentiful disability-accommodating work roles for them to undertake (Wilton and Schuer, 2006). Therefore, my third recommendation relates to the provision of employability services for individuals with diagnoses of SEMHCs. In *Chapter 7*, I considered the difference between the levels of in-placement support provided to participants in the TEP programme compared to that provided in the IPS scheme available to patients under the care of some CMHTs in Greater Glasgow. I explored that the much lower level of in-role support for participants in the IPS

scheme in comparison to the intensive staff support for members undertaking TEPs meant that the IPS scheme was not necessarily a viable next step on the 'journey' to paid employment for some members who had undertaken TEPs. These two programmes are both funded by the same NHSGG&C procurement contract for 'employability services' for individuals with diagnoses of SEMHCs (Public Contracts Scotland, 2020). NHSGG&C could consider reorganising the way that this procurement contract is structured to ensure that gaps in provision are reduced. Specifically, an extra block of funding could be created to be shared between The Club and the IPS service. This funding could be allocated for the exclusive use of closing the gap in provision, by creating a direct pathway between TEPs and the IPS service.

Lastly, the Scottish Government has newly devolved responsibility for the delivery of employability services, so there is potential for implementing progressive change in this provision outwith NHS services. The recently launched service is called 'Fair Start Scotland', which is a voluntary employability programme that is tendered to different public, private and third sector organisations across different regions in Scotland (Employability in Scotland, 2020). This 'contracting out' of service delivery reproduces the neoliberal processes of 'rolling-back' state intervention and 'rolling-out' private sector investment in public services (Peck and Tickell, 2002). However, the hiring of external service providers allows for new types of service provision to be offered, particularly by third sector organisations that may be able to 'work the space of neoliberalism' in the services they offer (Bondi and Laurie, 2005). Working within this mixed economy of employment support, my final recommendation is that the Scottish Government reconsiders the way that contracts are tendered within this programme and grant multiple services that offer varied levels and different types of employment support to operate within each region. This would allow for different types of employment support for individuals with different needs. It would also create a service landscape that could provide individuals with diagnoses of SEMHCs multiple supported employment programmes with steadily reduced levels of support, to facilitate a 'journey' to mainstream employment for any individual who may desire it.

8.6 Moving Forward

In mid-March 2020, The Club temporarily closed its doors to its membership following health guidance from the Scottish Government (Scottish Government, 2020c). The day ceased to be work-ordered, and the membership were forced to stay at home. The COVID-19 pandemic has tested the limits of the *care and community* of The Club. They expanded their online presence, acquired technology for members without digital access, and stayed in contact with members over the phone. The Community Café, whilst not open to the public or able to offer TEPs, produced a large quantity of meals to be delivered to individuals in need in the community. As restrictions lifted, staff and members began socially distanced meetings outdoors and eventually The Club reopened its doors. However, members are now required to book to visit, and social distancing guidelines dictate that only a small number of members are able to attend the Clubhouse at any one time. As such, The Club operates in a very different way, and may continue to do so for some time. The Club has shown great ability to adapt during this period of crisis, hopefully they will continue to adapt to ensure they can offer the most supportive service to their members. Without attempting to speculate on the longer-term prospects of The Club, I want to briefly explain how the COVID-19 pandemic has highlighted the necessity to re-evaluate the use of paid employment in relation to the care and treatment of individuals with diagnoses of SEMHCs, and indicate the evidence that my research can bring to this examination.

In an "ever-more fragmented" labour market, it is a struggle for disabled individuals to attain paid employment (Hall and Wilton, 2015:222), in 2019 only 28.5% of individuals with diagnoses of SEMHCs were in paid work (ONS, 2019a). The devalorisation of the labour power of these individuals means that the jobs they find are often low-paid, precarious, and potentially unfulfilling (Wilton and Evans, 2019). The "further entrenchment of neoliberal rationalities and disciplines" (Peck, Theodore and Brenner, 2012:265) since the 2008 global financial crisis has further widened the disabling division of labour (Gleeson, 1999), making it even harder for disabled individuals to compete against non-disabled individuals searching for work. The COVID-19 pandemic has had a significant destructive impact upon the global economy, and the Organisation for Economic Co-operation and Development (OECD) predicted a potential UK-wide

unemployment rate of up to 14.8% by the end of 2020 (OECD, 2020). Furthermore, the hospitality and service sector, which is one in which many individuals with diagnoses of SEMHCs attain paid employment (Noack and Vosko, 2011) has been one of the most heavily impacted by closures as a result of the pandemic. More than ever before, we need to move beyond a conceptualisation of mental health 'recovery' that equates wellbeing with 'productive neoliberal subjectivity', as there is little evidence that undertaking paid employment can directly improve mental health and wellbeing, beyond earning money to fulfil basic needs in a 'capitalocentric' society (Gibson-Graham, 2006). As the '*Is work good for your health and wellbeing?*' report that I referred to in the introductory chapter states:

> "work is not harmful to the psychiatric condition or mental health of people with severe mental illness although, conversely, it has no direct beneficial impact on their mental condition either" (Waddell and Burton, 2006:21).

Therefore, we need to consider ways that individuals with diagnoses of SEMHCs can find purpose and meaning in life, and a sense of identity beyond striving for paid work and a 'worker identity'. My research demonstrates that organisations such as The Club have the potential to enable individuals to gain many of the benefits of paid employment, such as: a sense of routine, social connections, and the opportunity for meaningful activity; all within a supportive environment, without the pressure to 'perform' as a productive worker (McDowell, 2009). Although the work-ordered day has not been able to fully recommence for group activity, The Club has still been able to offer a supportive service that enables individuals to socially interact together outwith the Clubhouse and in protected online spaces. In moving towards a more 'mentally healthy' society for all, I argue that we must reduce the societal valorisation of paid employment and the encouragement of neoliberal autonomy (Weeks, 2011), and instead focus upon the improvement of public services, especially for those who are socially marginalised (Rose et al., 2020).

List of References

Agar, M. 1980. *The professional stranger: an informal introduction to ethnography*. New York: Academic Press.

Ahmed, S. 2003. Collective feelings, or the impressions left by others. *Theory, Culture and Society,* 21(2), 25-42.

Allen, P. and Guthman, J. 2006. From 'old-school' to 'farm-to-school': neoliberalisation from the ground up. *Agriculture and Human Values,* 23(4), 401-415.

Amin, A. 2009. Extraordinarily ordinary: working in the social economy. *Social Enterprise Journal,* 5(1), 30-49.

Anderson, B. 2009. Affective atmospheres. *Emotion, Space and Society,* 2(2), 77-81.

Anderson, B. 2014. *Encountering affect: capacities, apparatuses, conditions.* Farnham: Ashgate.

Anderson, B. 2017. Affect. In: D. Richardson, N. Castree, M. Goodchild, A. Kobayashi, W. Liu and R. Marstion eds. *The international encyclopedia of geography: people, the earth, environment and technology.* New Jersey: Wiley, pp.1-5.

Anderson, B. and Fenton, J. 2008. Spaces of hope. *Space and Culture,* 11(2), 76-80.

Anderson, J. 2011. *War, disability and rehabilitation in Britain: 'soul of a nation'.* Manchester: Manchester University Press.

Anderson, K. and Smith, S. 2001. Editorial: emotional geographies. *Transactions of the Institute of British Geographers*, 26(1), 7-10.

Anderson, S. 1998. *We are not alone: Fountain House and the development of Clubhouse culture*. New York: Fountain House Inc.

Andrews, G.J. 2004. (Re)thinking the dynamics between healthcare and place: therapeutic geographies in treatment and care practice. *Area,* 36(3), 307-318.

Andrews, G.J. and Evans, J., 2008. Understanding the reproduction of health care: towards geographies in health care work. *Progress in Human Geography* 32(6), 759–780.

Anthony, W. A. 1993. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.

Atkinson, S. 2011. Scales of care and responsibility: debating the surgically globalised body. *Social and Cultural Geography,* 12(6), 623-637.

Atkinson, S., Lawson, V. and Wiles, J., 2011. Care of the body: spaces of practice. *Social and Cultural Geography* 12(6), 563-572.

Barham, P. 2004. *Forgotten lunatics of the Great War*. New Haven: Yale University Press.

Barham, P. and Hayward, R. 1995. *Relocation madness: from the mental patient to the person*. London: Free Association Books.

Barnes, C. 1991. *Disabled people in Britain and discrimination*. London: Hurst Calgary.

Barnes, C. 2000. A working social model? Disability, work and disability politics in the 21st century. *Critical Social Policy*, 20(4), 441-57.

Barnes, C. and Mercer, G. 2005. Disability, work and welfare: challenging the social exclusion of disabled people. *Work, Employment and Society*, 19(3), 527-545.

Basic Income Scotland. 2020. Assessing the feasibility of Citizens' Basic Income pilots in Scotland: final report. [online] Available at: https://www.basicincome.scot/__data/assets/pdf_file/0024/175371/Draft-Final-CBI-Feasibility_Main-Report-June-2020.pdf

Batnitzky, A. and McDowell, L. 2011. Migration, nursing, institutional discrimination and emotional/affective labour: ethnicity and labour stratification in the UK National Health Service. *Social and Cultural Geography*, 12(2), 181-201.

Beard, J. 1978. *Beard unplugged.* Transcript of videotape. New York: Fountain House.

Beard, J. Schmidt, J. and Smith, M. 1963. The use of transitional employment in the rehabilitation of the psychiatric patient. *Journal of Nervous and Mental Disease,* 136(5), 507-514.

Beard, J., Goertzel, V. and Pearce, A. 1958. The effectiveness of activity group therapy with chronically regressed adult schizophrenics. *The International Journal of Group Psychotherapy*. 3(2), 124.

Beard, J., Malamud, T., and Rossman, E. 1978. Psychiatric rehabilitation and long-term rehospitalization rates: The findings of two research studies. *Schizophrenia Bulletin*, 4(4), 622–635.

Beard, J., Propst, R. and Malamud, T. 1982. The Fountain House model of psychiatric rehabilitation. *Psychosocial Rehabilitation Journal,* 5(1), 47-53.

Beatty, C. and Fothergill, S. 2018. Welfare reform in the United Kingdom 2020-16: expectations, outcomes and local impacts. *Social Policy and Administration*, 52(5), 950-968.

Becker, F.D. and Sims, W.R. 2001. *Offices that work: balancing communication, flexibility, and cost*. Ithaca: Cornell University.

Bennett, D. 1996. Work and occupation for the mentally ill. In: H. Freeman and G, Berrios, eds. *150 years of British psychiatry: Volume II the aftermath*. London: Athlone Press.

Bhurruth, M. 2015. Some impressions on taking the leadership of a therapeutic community. *Therapeutic Communities: The International Journal of Therapeutic Communities.* 36(4), 219-228.

Biegel, B. E., Pernice-Duca, F., Chang, C. and D'Angelo, L. 2012. Peer supports in an urban Clubhouse. *Community Mental Health Journal*, 48(2), 153-160.

Bing, R. 1981. Occupational therapy revisited: a paraphrastic journey. *American Journal of Occupational Therapy*, 35(8), 499-518.

Bissell, D. 2013. Habit displaced: the disruption of skilful performance. *Geographical Research,* 51(2), 120-129.

Blunt, A. and Dowling, R. 2006. *Home*. London: Routledge.

Board of Control. 1933. *Memorandum on occupation therapy for mental patients.* London: His Majesty's Stationery Office.

Boardman, J. 2005. New services for old- an overview of mental health policy. In: A. Bell and P. Lindley eds. *Beyond the water towers: the unfinished revolution in mental health services 1985-2005.* London: The Sainsbury Centre for Mental Health. Ch. 2.

Boardman, J. and Rinaldi, M. 2013. Difficulties in implementing supported employment for people with severe mental health problems. *The British Journal of Psychiatry,* 203(4), 247-249.

Bond, G. 1998. Principles of the individual placement and support model: empirical support. *Psychiatric Rehabilitation Journal*, 22(1), 11-23.

Bond, G., Drake, R., Becker, D. and Mueser, K. 1999. Effectiveness of psychiatric rehabilitation approaches for employment of people with severe mental illness. *Journal of Disability Policy Studies,* 10(1), 18-52.

Bondi, L. 2008. On the relational dynamics of caring: a psychotherapeutic approach to emotional and power dimensions of women's care work. *Gender, Place and Culture,* 15(3), 249-265.

Bondi, L. and Davidson, J. 2011. Lost in translation. *Transactions of the Institute of British Geographer*s, 36(4), 595-598.

Bondi, L. and Fewell, J. 2003. 'Unlocking the cage door': the spatiality of counselling. *Social and Cultural Geography,* 4(4), 527-547.

Bondi, L. and Laurie, N. 2005. Introduction. In: N. Laurie and L. Bondi. 2005 eds. *Working the spaces of neoliberalism*. Oxford: Blackwell. Ch.1.

Bosch, C., Sonnentag, S. and Pinck, A.S. 2018. What makes for a good break? A diary study on recovery experiences during lunch break. *Journal of Occupational and Organizational Psychology,* 91(1), 134-157.

Botterill, K. 2018. Rethinking 'community' relationally: Polish communities in Scotland before and after Brexit. *Transactions of the Institute of British Geographers,* 43(4), 540-554.

Bowlby, S. 2011. Friendship, co-presence and care: neglected spaces. *Social and Cultural Geography,* 12(6), 605-622.

Bowlby, S. 2012. Recognising the time-space dimensions of care: caringscapes and carescapes. *Environment and Planning A: Economy and Space,* 44(9), 2101-2118.

Bowlby, S., McKie, L., Gregory, S. and MacPherson, I., 2010. *Interdependency and care over the lifecourse*. London: Routledge.

Boyce, M., Secker, J., Johnson, R., Floyd, M., Grove, B., Schneider, J. and Slade, J. 2008. Mental health service users' experiences of returning to paid employment. *Disability and Society*, 23(1), 77-88.

Brenner, N. and Theodore, N. 2002. Cities and the geographies of "actually existing neoliberalism". *Antipode*, 34(3), 349-379.

Brown, M. 2003. Hospice and the paradoxical spaces of terminal care. *Environment and Planning A: Economy and Space,* 35(5), 833-851.

Buhariwala, P., Wilton, R. and Evans, J. 2015. Social enterprises as enabling workplaces for people with psychiatric disabilities. *Disability and Society,* 30(6), 865-879.

Burchardt, T. 1999. *The evolution of disability benefits in the UK: re-weighting the basket*. London: Centre for Analysis of Social Exclusion, London School of Economics.

Butcher, S. and Wilton, R. 2008. Stuck in transition? Exploring the spaces of employment training for youth with intellectual disability. *Geoforum,* 39(2), 1079-1092.

Butler, J. 1988. Performative acts and gender constitution: an essay in phenomenology and feminist theory. *Theatre Journal,* 40(4), 519-531.

Carolan, M., Onaga, E., Pernice-Duca, F. and Jimenez, T. 2011. A place to be: the role of Clubhouses in facilitating social support. *Psychiatric Rehabilitation Journal*, 35(2), 125-132.

Carr, C. and Gibson, C. 2015. Geographies of making: rethinking materials and skills for volatile futures. *Progress in Human Geography,* 40(3), 297-315.

Castree, N., Fuller, D. Kent, A., Kobayashi, A., Merrett, C., Pulido, L. and Barraclough, L. 2008. Forum: Geography, pedagogy and politics. *Progress in Human Geography,* 32(5), 680-718.

Centre for Mental Health. 2017. *IPS in the UK: improving employment support in mental health services*. London: Centre for Mental Health.

Chandola, T. and Zhang, N. 2018. Re-employment, job quality, health and allostatic load biomarkers: prospective evidence from the UK Household Longitudinal Study, *International Journal of Epidemiology,* 41(1), 47-57.

Chaney, S. 2016. Useful members of society or motiveless malingerers? Occupation and malingering in British asylum psychiatry, 1870-1914. In: W. Ernst, ed. *Work, psychiatry and society, c. 1750-2015*. Manchester: Manchester University Press. Ch. 13

Charland, L. 2007. Benevolent theory: moral treatment at the York Retreat. *History of Psychiatry,* 18(1), 61-80.

Chen, F-P. 2017. Building a working community: staff practices in a Clubhouse for people with severe mental illness. *Administration and Policy in Mental Health and Mental Health Services Research,* 44(5), 651-663.

Chen, F-P. and Oh, H. 2019. Staff views on member participation in a mental health Clubhouse. *Health and Social Care in the Community,* 27(3), 788-796.

Clark, D. 1965. The therapeutic community concept, practice and future. *British Journal of Psychiatry.* 11(1), 947-954.

Clarke, L. 2004. *The time of the therapeutic communities: people, places and events.* Gatehead: Athenaeum Press.

Cloke, P. and Conradson, D. 2018. Transnational organisations, affective atmospheres and new forms of being-in-common: Post-disaster recovery in Christchurch, New Zealand. *Transactions of the Institute of British Geographers,* 43(3), 360–376.

Cloke, P., Cook, I., Crang, P., Goodwin, M., Painter, J. and Philo, C. 2004. *Practicing Human Geography.* London: SAGE Publications.

Clubhouse International. 2012. *The faculty for Clubhouse development accreditation employment guidelines.* New York: Clubhouse International. [online]. Available at: http://www.clubhouse-intl.org/documents/clubhouse_employment_guidelines_07-29-16.pdf>

Clubhouse International. 2018. *International standards for Clubhouse programs.* [online]. Available at: https://clubhouse-intl.org/wp-content/uploads/2019/03/standards_2018_eng.pdf

Clubhouse International. 2019. *What Clubhouses Do.* [online]. Available at: https://clubhouse-intl.org/what-we-do/what-clubhouses-do/

Clubhouse International. 2020. *Research.* [online]. Available at: https://clubhouse-intl.org/what-we-do/research/

Cockburn, T. 2005. Children and the feminist ethic of care. *Childhood,* 12(1), 71-89.

Cohen, A. 2005. Primary care and mental health. In: A. Bell and P. Lindley, eds. *Beyond the water towers: the unfinished revolution in mental health services 1985-2005.* London: The Sainsbury Centre for Mental Health. Ch 7.

Companies House. 2001. *Certificate of incorporation of a private limited company: The Club.* Edinburgh: Companies House.

Coniglio, F.D., Hancock, N. and Ellis, L.A. 2012. Peer support within Clubhouse: a grounded theory study. *Community Mental Health Journal*, 48(2), 153-60.

Conrad-Garrisi, D. L. and Pernice-Duca, F. 2013. The relationship between sense of mattering, stigma, and recovery: An empirical study of clubhouse participants in the U.S. Midwest. *International Journal of Self-Help and Self-Care,* 7(1), 41-57.

Conradson, D. 2003a. Spaces of care in the city: the place of a community drop-in centre. *Social and Cultural Geography,* 4(4), 507-525.

Conradson, D. 2003b. Geographies of care: spaces, practices, experiences. *Social and Cultural Geography,* 4(4), 451–454.

Cook, I. and Crang, M. 2007. *Doing ethnographies*. London: SAGE Publications.

Cooper, D. 1967. *Psychiatry and anti-psychiatry*. London: Granada.

Cornish, C. 1997. Behind the crumbling walls: the reworking of a former asylum's geography. *Health and Place,* 3(2), 101-110.

Costa, L., Voronka, J., Landry, D., Reid, J., Mcfarlane, B., Reville, D., Church, K., 2012. "Recovering our Stories": A Small Act of Resistance. *Studies in Social Justice* 6(1), 85–101.

Council of Europe. 2013. *European Social Charter of 1961, 32nd national report on the implementation of the European Social Charter submitted by the government of United Kingdom*, [online]. Available at: https://rm.coe.int/090000168048574c

Cox, R. 2010. Some problems and possibilities of caring. *Ethics, Place and Environment,* 13(2), 113-130.

Cox, R. 2011. Competitive mothering and delegated care: class relationships in nanny and au pair employment. *Studies in the Maternal,* 3(2), 1-13.

Cox, R. 2013a. Gendered spaces of commoditised care, *Social and Cultural Geography,* 14(5), 491-499.

Cox, R. 2013b. House/work: home as a space of work and consumption. *Geography Compass,* 7(12), 821-831.

Craig, T. 2008. Recovery: Say what you mean and mean what you say. *Journal of Mental Health* 17(2), 125–128.

Craig, T. 2013. Expanding knowledge of peer-based mental health organisations: the experiences of Clubhouse. *International Journal of Self Help and Self Care,* 7(2), 119-130.

Crang, M. 2002. Qualitative methods: the new orthodoxy? *Progress in Human Geography*, 26(5), 647-655.

Crang, M. 2003. Qualitative methods: touchy, feely, look-see? *Progress in Human Geography*, 27(4), 494-504.

Crang, M. 2005. Qualitative methods: there is nothing outside the text? *Progress in Human Geography,* 29(2), 229-233.

Crang, P. 1994. It's showtime: on the workplace geographies of display in a restaurant in southeast England. *Environment and Planning D: Society and Space,* 12(6), 675-704.

Creese, G. 2006. Government restructuring and settlement agencies in Vancouver: bringing advocacy back in. In: D., Conradson and C., Milligan, eds. *Landscapes of voluntarism: new spaces of health, welfare and governance*. Bristol: The Policy Press. Ch. 11.

Crossley, N. 2006. *Contesting psychiatry. Social movements in mental health.* London: Routledge.

Crouch, R. and Alers. V. 2014. Introduction. In: R. Crouch and V. Alers, eds. *Occupational therapy in psychiatry and mental health*. Oxford: Wiley. pp. 1-2.

Curnock, E., Leyland, A. and Popham, F. 2016. The impact on health of employment and welfare transitions for those receiving out-of-work benefits in the UK. *Social Science and Medicine,* 162(1), 1-10.

Curtis, S. 2010. *Space, place and mental health*. London: Routledge.

Curtis, S., Gesler, W., Priebe, S. and Francis, S. 2009. New spaces of inpatient care for people with mental illness: a complex rebirth of the clinic? *Health and Place*, 15(4), 340-348.

D'Arcy, C. and Finch, D. 2016. *Calculating a living wage for London and the rest of the UK.* London: Resolution Foundation.

Datta, K., McIlwaine, C., Evans, Y., Herbert, J., May J. and Wills, J. 2010. A migrant ethic of care? negotiating care and caring among migrant workers in London's low-pay economy. *Feminist Review,* 94(1), 93-116.

Davidson, J., Bondi, L. and Smith, M. 2005. *Emotional geographies*. Farnham: Ashgate.

Davidson, L., O'Connell, M., Tondora, J., Lawless, M. and Evans, A. 2005. Recovery in serious mental illness: a new wine or just a new bottle? *Professional Psychology: Research and Practice,* 36(5), 480-487.

Davidson, L., O'Connell, M., Tondora, J., Styron, T., Kangas, K., 2006. The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services,* 57(5), 640-645.

Davies, G. and Dwyer, C. 2008. Qualitative methods II: minding the gap. *Progress in Human Geography*, 32(3), 399-406.

Davis, A. 2011. A revolution in maternity care? Women and the maternity services, Oxfordshire c. 1948-1974. *Social History of Medicine*, 24(2), 389-406.

Dean, K. and James, H. 1981. Social factors and admission not psychiatric hospitals: schizophrenia in Plymouth. *Transactions of the Institute of British Geographers,* 6(1), 39-52.

Dear M. 1977. Psychiatric patients and the inner city. *Annals of the Association of American Geographers,* 66(4), 588–594.

Dear, M. and Taylor, S. 1982. *Not on our street: community attitudes to mental health care*. London: Pion.

Dear, M. and Wolch, J. 1987. *Landscapes of despair: from deinstitutionalisation to homelessness*. Oxford: Polity Press.

Deegan, P. 1988. Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11–19.

Deegan, P. 1993. Recovering our sense of value after being labeled. *Journal of Psychosocial Nursing*, 31(4), 7–11.

Deegan, P. 1997. Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care,* 25(3), 11-24.

Deleuze, G. 1988. *Spinoza. Practical philosophy.* San Francisco, CA: City Lights Books.

DeLyser, D. 2001. "Do you really live here?" Thoughts on insider research. *Geographical Review,* 91(1-2), 441-453.

DeLyser, D. and Starrs, P. F. 2001. Doing fieldwork: editors' introduction. *Geographical Review,* 91(1-2), iv-viii.

DeLyser, D. and Sui, D. 2013. Crossing the qualitative-quantitative chasm III: enduing methods, open geography, participatory research and the fourth paradigm. *Progress in Human Geography*, 38(2), 294-307.

Department for Work and Pensions and Department of Health. 2016. *Improving lives: the work, health and disability green paper.* London: Her Majesty's Stationery Office.

Department for Work and Pensions, Department of Health and the Health and Safety Executive. 2005. *Health, work and well-being- caring for our future. A strategy for the health and well-being of working age people.* London: HM Government.

Department for Work and Pensions. 2007. *New Deal for Disabled People: third synthesis report – key finding from the evaluation. Research Report No. 430.* London: Her Majesty's Stationery Office.

Department for Work and Pensions. 2017. *Capability for work questionnaire*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/631921/esa-50-capability-for-work-questionnaire.pdf

Department for Work and Pensions. 2019. *Permitted work: factsheet*. Available at: https://www.gov.uk/government/publications/employment-and-support-allowance-permitted-work-form/permitted-work-factsheet

Department of Health. 1998. *Modernising mental health services: safe, sound and supportive*. London: Department of Health.

Department of Health. 2001. *The journey to recovery – the Government's vision for mental health care.* London: Department of Health.

DeVerteuil, G. and Evans, J. 2010. Landscapes of despair. In: T. Brown, S. McLafferty and G. Moon. 2010 eds. *A companion to medical and health geography*. Chichester: Wiley-Blackwell. Ch.16.

DeVerteuil, G., Power, A. and Trudeau, D. 2019. The relational geographies of the voluntary sector: dis-entangling the ballast of strangers. *Progress in Human Geography*, 44(5), 919-937.

Dewsbury, J.D. 2009. Performative, non-representation and affect-based research: seven injunctions. In: D. Delyser, S. Aitken, M. Crang, S. Herbert and

L. McDowell, eds. *The SAGE handbook of qualitative geography*. London: Sage, pp. 321–334.

Di Masso, J., Avi-Itzhak, T. and Obler, D. 2001. The Clubhouse model: an outcome study on attendance, work attainment and status, and hospitalisation recidivism. *Work,* 17(1), 23-30.

Digby, A. 1985. *Madness, morality and medicine: a study of the York Retreat 1796–1914.* Cambridge: Cambridge University Press.

Disabled Persons (Employment) Act 1944. (7 and 8 Geo. 6, c.10). London: His Majesty's Stationery Office.

Doerner, K. 1981. *Madmen and the bourgeoisie: a social history of insanity and psychiatry*. Oxford: Basil Blackwell.

Donald, M. 2018. When care is defined by science: exploring veterinary medicine through a more-than-human geography of empathy. *Area,* 51(3), 470-478.

Dorio J., Guitar, A. Solheim, L, Dvorkin, C. and Marine, S. 2002. Differences in job retention in a supported employment program: Chinook Clubhouse. *Psychiatric Rehabilitation Journal,* 25(3), 289-298.

Dougherty, S. 1994. The generalist role in Clubhouse organisations. *Psychosocial Rehabilitation Journal,* 18(1), 95-108.

Dowling, R., Lloyd, K. and Suchet-Pearson, S. 2016. Qualitative methods I: enriching the interview. *Progress in Human Geography*, 40(5), 679-686.

Dowling, R., Lloyd, K. and Suchet-Pearson, S. 2017. Qualitative methods II: 'more-than-human' methodologies and/in praxis. *Progress in Human Geography*, 41(6), 832-831.

Dowling, R., Lloyd, K. and Suchet-Pearson, S. 2018. Qualitative methods III: experimenting, picturing, sensing. *Progress in Human Geography*, 42(5), 779-788.

Doyle, A., Lanoil, J. and Dudek. K. 2013. *Fountain House: creating community in mental health practice*. New York: Columbia University Press.

Drake, R. and Bond, G. 2008. Supported employment: 1998 to 2008. *Psychiatric Rehabilitation Journal,* 31(4), 274-276.

Drake, R., Bond, G. and Becker, D. 2012. *Individual placement and support: an evidence-based approach to supported employment*. Oxford: Oxford University Press.

Driver, F. 1993. *Power and pauperism*. Cambridge: Cambridge University Press.

Dudley, C., McEnill, L. and Steadman, K., 2016. *Is welfare to work, working well? Improving employment rates for people with disabilities and long-term conditions*. London: The Work Foundation.

Duff, C. 2011. Networks, resources and agencies: on the character and production of enabling places. *Health and Place*, 17(1), 149–156.

Duff, C. 2012. Exploring the role of 'enabling places' in promoting recovery from mental illness: A qualitative test of a relational model. *Health and Place*, 18(6), 1388-1395.

Duff, C. 2016. Atmospheres of recovery: assemblages of health. *Environment and Planning A: Economy and Space,* 48(1), 58-74.

Dwyer, C. and Davies, G. 2009. Qualitative methods III: animating archives, artful interventions and online environments. *Progress in Human Geography*, 34(1), 88-97.

Dwyer, P. 2004. Creeping conditionality in the UK: from welfare rights to conditional entitlements. *Canadian Journal of Sociology*, 29(2), 264-288.

Dwyer, P. 2017. Rewriting the contract? Conditionality, welfare reform and the rights and responsibilities of disabled people. In D. Horsfall and J. Hudson, eds. *Social policy in an era of competition: from global to local perspectives*. Bristol: Policy Press. pp.135–148.

Dwyer, P., Scullion, L., Jones, K., McNeill, J. and Stewart, A. 2020. Work, welfare and wellbeing: the impacts of welfare conditionality on people with mental health impairments in the UK. *Social Policy and Administration,* 54(2), 311-326.

Dyck, I. 1999. Body troubles: women, the workplace, and negotiation of a disabled identity. In: R. Butler and H. Parr, eds. *Mind and body spaces: geographies of illness, impairment and disability.* London: Routledge. Ch.6.

Economic and Social Research Council. 2010. *Framework for research ethics* [online] <http://www.esrc.ac.uk/about-esrc/information/research-ethics.aspx>

Economic and Social Research Council. 2020. *Guidance for collaboration.* [online] Available at: https://esrc.ukri.org/collaboration/guidance-for-collaboration/

Edginton, B. 1997. Moral architecture: the influence of the York Retreat on asylum design. *Health and Place*, 3(2), 91-99.

Edwards, C. 2010. Evaluating workfare: disability, policy and the role of geography. In: V. Chouinard, E. Hall and R. Wilton, eds. *Towards enabling geographies. 'Disabled' bodies and minds in society and space*. Farnham, Surrey: Ashgate. Ch.9.

Employability in Scotland. 2020. *Contract award details* [online]. Available at: http://www.employabilityinscotland.com/find-support/about-fair-start-scotland/-contract-award-details/

England, K. 2010. Home, work and the shifting geographies of care. *Ethics, Place and Environment,* 13(2), 131-150.

England, K. and Henry, C. 2013. Care work, migration and citizenship: international nurses in the UK. *Social and Cultural Geography*, 14(5), 558-574.

England, K. and Lawson, V. 2005. Feminist analyses of work: rethinking the boundaries, gendering and spatiality of work. In: L. Nelson and J. Seager, eds. *A companion to feminist geography.* London: Blackwell. Ch. 6.

Equality Act. 2010. (c.1) [online]. Available at: https://www.legislation.gov.uk/ukpga/2010/15/contents/enacted

Ernst, W. 2016. Introduction: therapy and empowerment, coercion and punishment. Historical and contemporary perspectives on work, psychiatry and society. In: W. Ernst, eds. *Work, Psychiatry and Society, c. 1750-2015*. Manchester: Manchester University Press, pp. 1-32.

Estroff, S. 1981. *Making it crazy: an ethnography of psychiatric clients in an American community*. Berkeley: University of California Press.

Evans, J. and Wilton, R. 2016. "I'm a better person when I'm working": supportive workplaces, mental illness, and recovery. In: M. Giesbrecht and V. Crooks, 2016, eds. *Place, health, and diversity: learning from the Canadian experience*. London: Routledge. Ch 5.

Evans, J. and Wilton, R. 2019. Well enough to work? Social enterprise employment and the geographies of mental health recovery. *Annals of the American Association of Geographers*, 109(1), 87-103.

Eyles, J. 1988. Mental health services, the restructuring of care, and the fiscal crisis of the state: The United Kingdom case study. In: C. Smith and J. Giggs eds. *Location and stigma: contemporary perspectives on mental health and mental health care*. London, Unwin Hyman. Chap 3.

Faulkner, A. 2004. *The ethics of survivor research: guidelines for the ethical conduct of research carried out by mental health service users and survivors*. Bristol: Policy Press.

Faulkner, A., Sadd, J., Hughes, A., Thompson, S., Nettle, M., Wallcraft, W., Collar, J., de la Haye, S. and McKinley, S. 2013. *Mental health peer support in England: piecing together the jigsaw*. [pdf] London: Mind. Available at: https://www.mind.org.uk/media/5910954/piecing-together-the-jigsaw-full-version.pdf

Fielding, N. 2001. Ethnography. In: N. Gilbert and P. Stoneman, eds. *Researching Social Life*. London: SAGE Publications. Ch.17.

Fisher, S., Beard, J. and Goertzel, V. 1960. Rehabilitation of the mental hospital patient: the Fountain House programme. *International Journal of Social Psychiatry,* 5(4), 295-298.

Flannery, M. and Glickman, M. 1996. *Fountain House: Portraits of Lives Reclaimed for Mental Illness*. Center City, Minnesota: Hazelden.

Flore, J., Kokanovic, R., Callard, F., Broom, A. and Duff, C. 2019. Unravelling subjectivity, embodied experiences and (taking) psychotropic medication. *Social Science and Medicine,* 230(1), 66-73.

Foucault, M. 1983. The subject and power. In: H. Dreyfus and P. Rabinow, eds. *Beyond Structuralism and Hermeneutics*. Chicago: University of Chicago Press.

Foucault, M. 1986. *The care of the self. The history of sexuality: volume 3*. Translated by R. Hurley. New York: Random House.

Foucault, M. 1995. *Discipline and punish: the birth of the prison*. Translated by Alan Sheridan. New York: Random House.

Foucault, M. 2004. *Abnormal. Lectures at the Collège de France*, 1974-1975. Translated by G. Burchell. London: Verso.

Foucault, M. 2006a. *History of madness.* Translated by Jonathan Murphy and Jean Khalfa. London: Routledge.

Foucault, M. 2006b. *Psychiatric power: Lectures at the Collège de France 1973-1974.* Translated by G Burchell. Basingstoke: Palgrave Macmillan.

Foucault, M. 2008. *The birth of biopolitics. Lectures at the Collège de France, 1978-79.* Translated by G. Burchell. Basingstoke: Palgrave Macmillan.

Fountain House. 1956. *Fountain House bulletin* [document]. New York: Fountain House.

Francis, R., Barnes, H., Lucy, D., Savage, J. and Oakley, J. 2008. *Helping people who are out of work because of ill-health return to work.* Brighton: Institute for Employment Studies.

Frayne, D. 2015. *The refusal of work: rethinking post-work theory and practice.* London: Zed Books.

Frayne, D. 2019. *The work cure: critical essays on work and wellness.* London: PCCS Books.

Frazier, E. 2020. When fieldwork 'fails': participatory visual methods and fieldwork encounters with resettled refugees. *Geographical Review,* 110(1-2), 133-144.

Freebody, J. 2016. The role of work in late eighteenth- and early nineteenth-century treatises on moral treatment in France, Tuscany and Britain In: W. Ernst, eds. *Work, Psychiatry and Society, c. 1750-2015.* Manchester: Manchester University Press. pp. 31-54.

Freud, D. 2007. *Reducing dependency, increasing opportunity: options for the future of welfare to work. An independent report to the Department for Work and Pensions.* Leeds: Corporate Document Services.

Friedli, L. 2006. Public mental health and mental health promotion. In: C. Jackson and K. Hill eds. *Mental health today: a handbook.* Brighton: Pavilion.

Fuller, D. and Askins, *K.* 2007. The discomforting rise of ' public geographies': a 'public' conversation. *Antipode*, 39(4), 579-601.

Fussinger, C. 2011. Therapeutic community, psychiatry's reformers and antipsychiatrists: reconsidering changes in the field of psychiatry after World War II. *History of Psychiatry,* 22(2), 146-163.

Fyfe, N. 2005. Making space for 'neo-communitarianism'? The third sector, state and civil society in the UK. In: N. Laurie and L. Bondi, eds. *Working the spaces of neoliberalism.* Oxford: Blackwell. Ch.7.

Fyfe, N. and Milligan, C. 2003. Out of the shadows: exploring contemporary geographies of voluntarism. *Progress in Human Geography,* 27(4), 397–413.

Gale, E. and Grove, B. 2005. The social context for mental health. In: A. Bell and P. Lindley, eds. *Beyond the water towers: the unfinished revolution in*

mental health services 1985-2005. London: The Sainsbury Centre for Mental Health. Ch. 9.

Gibson-Graham, J.K. 2006. A *postcapitalist politics*. London: University of Minnesota Press.

Giddens, A. 1998. *The Third Way: the renewal of social democracy*. Cambridge: Polity.

Giddens, A. 2000. *The Third Way and its critics*. Cambridge: Polity Press.

Giggs, J. 1973. The distribution of schizophrenics in Nottingham. *Transaction of the Institute of British Geographers,* 59(1), 55-76.

Giggs, J. 1986. Schizophrenia and affective psychosis in Nottingham. *Social Science and Medicine,* 23(10), 945-961.

Gillies, V., 2005. Raising the 'meritocracy': parenting and the individualisation of social class. *Sociology,* 39(5), 835-853.

Gilligan, C. 1982. *In a different voice: psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Ginn, F. 2014. Sticky lives: slugs, detachment, and more-than-human ethics in the garden. *Transactions of the Institute of British Geographers,* 39(4), 532-544.

Glasgow Centre for Population Health. 2016. *Workless household in UK cities*. [online] Available at: https://www.understandingglasgow.com/indicators/economic_participation/workless_households/trends/uk_cities

Gleeson, B. 1999. *Geographies of disability*. London: Routledge.

Gleeson, B. and Kearns, R., 2001. Remoralising Landscapes of Care. *Environment and Planning D: Society and Space* 19(1), 61–80.

Glickman, M. 1992. "What if nobody wants to make lunch?" Bottom line responsibility in the Clubhouse. *Psychosocial Rehabilitation Journal,* 16(2), 55-59.

Goertzel, V., Beard, J., and Pilnick, S. 1960. Fountain House Foundation: case study of an ex-patient's club. *Journal of Social Issues,* 16(2), 54-61.

Goffman, E. 1959. *The presentation of self in everyday life*. New York: Doubleday.

Goffman, E. 1961. *Asylums: essays on the social situation of mental patients and other inmates*. Harmondsworth, Middlesex: Penguin.

Goffman, E. 1963. *Stigma: notes on the management of spoiled identity*. New York: Simon and Schuster.

Goodley, D. 2014. *Dis/ability studies: theorising disablism and ableism*. London: Routledge.

Goodley, D. 2016. *Disability studies: an interdisciplinary introduction*. London: Sage Publications.

Google Scholar. 2020. *Articles citing 'Recovery from mental illness: the guiding vision of the mental health service system in the 1990s'*. https://scholar.google.com/scholar?cites=5982155399796555293&as_sdt=2005&sciodt=0,5&hl=en

Gorman, J., McKay, C., Yates, B. and Fisher, W. 2018. Keeping Clubhouses open: a roadmap for sustainability. *Administration and Policy in Mental Health,* 45(1), 81-90.

Gorz, A. 1989. *Critique of economic reason.* London: Verso.

Graham, H. 1983. Caring: a labour of love. In: J. Finch and D. Groves, eds. A labour of love: women, work and caring. London: Routledge. pp. 13-30.

Green, M. and Lawson, V., 2011. Displacing care. *Social and Cultural Geography,* 12(6), 639-654.

Greenhough, B. 2010. Thoughts on 'geographies of care' prompted by reading Annemarie Mol's 'The logic of care: health and the problem of patient choice.' *Area,* 42(1), 135-139.

Griffith, G. and Jones, K. 2020. When does geography matter most? Age-specific geographical effects in the patterning of, and relationship between mental wellbeing and mental illness. Health and Place, 64. DOI: 10.1016/j.healthplace.2020.102401

Gronfein, W. 1985. Psychotropic drugs and the origins of deinstitutionalization. *Social Problems*, 32(5), 437-454.

Grover, C. 2007. The Freud report on the future of welfare-to-work: some critical reflections. *Critical Social Policy,* 27(4), 534-545.

Grover, C. 2015. Employment and support allowance, the 'summer budget', and less eligible disabled people. *Disability and Society*, 30(10), 1573-1576.

Gulland, L. 2017. Working while incapable to work? Changing concepts of permitted work in the UK disability benefits system. *Critical Disability Studies*, 37(4), DOI: 10.18061/dsq.v37i4.6088

Gumber, S. and Stein, C. 2018. Beyond these walls: can psychosocial Clubhouses promote the social integration of adults with serious mental illness in the community. *Psychiatric Rehabilitation Journal,* 41(1), 29-38.

Hall, E. 2004. Social geographies of learning disability: narratives of inclusion and exclusion. *Area,* 36(3), 298-306.

Hall, E. 2005. The entangled geographies of social exclusion/inclusion for people with learning disabilities. *Health and Place,* 11(2), 107-115.

Hall, E. 2009. Being in control: personal budgets and the new landscape of care for people with learning disabilities, *Mental Health Review Journal,* 14(2), 44-53.

Hall, E. 2010. Spaces of social inclusion and belonging for people with intellectual disabilities. *Journal of Intellectual Disability Research,* 54(1), 48-57.

Hall, E. and McGarrol, S. 2012. Bridging the gap between employment and social care for people with learning disabilities: local area co-ordination and in-between spaces of social inclusion. *Geoforum,* 43(6), 1276-1286.

Hall, E. and Wilton, R. 2011. Alternative spaces of 'work' and inclusion for disabled people. *Disability and Society,* 26(7), 867-880.

Hall, E. and Wilton, R. 2015. Thinking differently about 'work' and social inclusion for disabled people. In: C. Grover and L. Piggott eds. *Disabled people, work and welfare: is employment really the answer?* Bristol: Policy Press. Ch. 12.

Hall, E. and Wilton, R. 2017. Towards a relational geography of disability. *Progress in Human Geography*, 41(6), 727-744.

Hall, J. 2016. From work and occupation to occupational therapy: the policies of professionalization in English mental hospitals from 1919 to 1959. In: W. Ernst, ed. *Work, psychiatry and society, c. 1750-2015.* Manchester: Manchester University Press. Ch. 15.

Hancock, N., Bundy, A., Honey, A., Helich, S. and Tamsett, S. 2013. Measuring the later stages of the recovery journey: Insights gained from clubhouse members. *Community Mental Health Journal,* 49(3), 323–330.

Hancock, N., Honey, A. and Bundy, A. 2013. Sources of meaning derived from occupational engagement for people recovering from mental illness. *British Journal of Occupational Therapy,* 78(8), 506-515.

Hänninen, E. 2012. *Choice for recovery: Community-based rehabilitation and the Clubhouse model as means to mental health reforms*. Helsinki, Finland: National Institute for Health and Welfare.

Harper, D. and Speed, E., 2012. Uncovering recovery: the resistible rise of recovery and resilience. *Studies in Social Justice,* 6(1), 9–26.

Harrington, V. 2009. Innovation in a backwater: The Harpurhey Resettlement Team and the mental health services of North Manchester, 1982-1987. *Health and Place,* 15(3), 819-826.

Harrowell, E., Davies, T. and Disney T. 2018. Making space for failure in geographic research. *Professional Geographer,* 70(2), 230-238.

Hay, I. 2020. Qualitative data. In: D. Richardson, N. Castree, M. Goodchild, A. Kobayashi, W. Liu and R. Marstion eds. *The international encyclopedia of geography: people, the earth, environment and technology*. New Jersey: Wiley, pp.1-10.

Heap, D. 2015. Disabled people, welfare reform and the balance of rights and responsibilities. In: C. Grover and L. Piggott, eds. *Disabled people, work and welfare: is employment really the answer?* Bristol: Policy Press. Ch. 5.

Henderson, D., 1925. Occupational therapy: series of papers presented at a meeting of the Scottish division held at the Glasgow Royal Mental Hospital on Friday, May 2, 1924. *Journal of Mental Science,* 71(1), 59–80.

Henry, A., Barreira, P., Banks, S., Brown, J. And McKay, C. 2001. A retrospective study of Clubhouse-based transitional employment. *Psychiatric Rehabilitation Journal,* 24(4), 344-354.

Herbert, S. 2000. For ethnography. *Progress in Human Geography,* 24(4), 550-568.

Herbert, S. 2005. The trapdoor of community. *Annals of the American Association of Geographers,* 95(4), 850-865.

Hills, D., Child, C., Blackburn, V. and Youll, P., 2001. *Evaluation of the New Deal for Disabled People innovative schemes pilot, DSS Research Report 143*. Leeds: CDS.

Hitchings, R. and Latham, A. 2020a. Qualitative methods I: On current conventions in interview research. *Progress in Human Geography*, 44(2), 389-398.

Hitchings, R. and Latham, A. 2020b. Qualitative methods II: on the presentation of 'geographical ethnography'. *Progress in Human Geography*, 44(5), 972-980.

Hochschild, A. 1983. The managed heart: *the commercialization of feeling*. Berkeley: University of California Press.

Hocking, C. 2008. The way we were: Romantic assumptions of pioneering occupational therapists in the United Kingdom. *The British Journal of Occupational Therapy*, 71(4), 146–154.

Hooker, S., Masters., K., Vagnini, K. and Rush, C. 2020. Engaging in meaningful activities is associated with meaning salience and psychological well-being. *The Journal of Positive Psychology,* 15(6), 821-831.

Horton, J. 2020. Failure, failure, failure, failure, failure, failure: six types of failure within the neoliberal academy. *Emotion, Space and Society,* 35, 1-6.

Houghton, E. 2019. Becoming a neoliberal subject. *Ephemera: theory and politics in organisation,* 19(3), 615-626.

Howell, A. and Voronka, J., 2012. Introduction: the politics of resilience and recovery in mental health care. *Studies in Social Justice,* 6(1), 1-7.

Hyde, M. 1996. Fifty years of failure: employment services for disabled people in the UK. *Work, Employment and Society*, 10(4), 683-700.

Hyde, M. 1998. Sheltered and supported employment in the 1990s: the experiences of disabled workers in the UK. *Disability and Society*, 13(2), 199-215.

Hyde, M. 2000. From welfare to work? Social policy for disabled people of working age in the United Kingdom in the 1990s. *Disability and Society,* 15(2), 372-341.

Hyndman, J. 2001. The field as here and now, not there and then. *Geographical Review,* 91(1-2), 262-272.

Imlah, N. 2003. *Work is therapy: The history of the Birmingham Industrial Therapy Association 1963-2003*. Studley: Brewin Books.

Independent. 2017. *Scotland bans private firms from carrying out benefits assessments.* [online]. Available at: http://www.independent.co.uk/news/uk/politics/scotland-benefit-assessment-ban-private-companies-social-security-agency-department-work-pensions-a7706896.html

Jackson, R. 2001. The Clubhouse model: empowering applications of theory to generalist practice. Belmont, CA: Wadsworth.

Jacob, S., Munro, Taylor, B. and Griffiths, D. 2017. Mental health recovery: a review of the peer-reviewed published literature. *Collegian,* 24(1), 53-61.

Jarl, B. 1992. Living with the standards in a growing Clubhouse. *Psychosocial Rehabilitation Journal,* 16(2), 31-34.

Johnston, L. 2020. Body. In: A. Kobayashi, M. Boyle, N. Castree, F. Collins, J. Crampton, S. de Leeuw, E. Ho, I. Luginaah and B. Maharaj, eds. *International encyclopedia of human geography, 2nd edition.* Amsterdam: Elsevier. pp.359-363.

Johnston, L. and Longhurst, R. 2012. Embodied geographies of food, belonging and hope in multicultural Hamilton, Aotearoa New Zealand. *Geoforum,* 43(2), 325-331.

Jones, J. 2000. Mental health care reforms across Britain and Italy since 1950: a cross-national comparative study. *Health and Place,* 6(3), 171-187.

Jones, J. 2001. The geography of mental health. *Epidemiologia e Psichiatria Sociale,* 10(4), 219-224.

Jones, K. 1972. *A history of the mental health services*. London: Routledge.

Jones, K.1993. *Asylums and after. a revised history of the mental health services: from the early 18th century to the 1990s*. London: Athlone.

Jones, M. 1952. *Social psychiatry*. London: Routledge.

Jones, M. 1968. *Beyond the therapeutic community: social learning and social psychiatry*. New Haven, CT: Yale University Press.

Jones, P. and Evans, J. 2011. Creativity and project management: a comic. *ACME,* 10(3), 585-632.

Joseph, A. and Kearns, R. 1996. Deinstitutionalization meets restructuring: the closure of a psychiatric hospital in New Zealand. *Health and Place,* 2(3), 179-189.

Jung, S.H. and Kim, H.J. 2012. Perceived stigma and quality and life of individuals diagnosed with schizophrenia and receiving psychiatric rehabilitation services: a comparison between the Clubhouse model and a rehabilitation skills training model in South Korea. *Psychiatric Rehabilitation Journal,* 35(6), 460-465.

Karlsson, M. 2013. Introduction to mental health Clubhouses: how the Fountain House Clubhouse became an international model. *International Journal of Self-Help and Self-Care,* 7(1), 7-18.

Katz, C. 1994. Playing the field, questions of fieldwork in geography. *Professional Geographer,* 46(1), 67-72.

Kearns, R. 1990. Satisfaction with community life among chronically mentally disabled persons in Auckland. *Community Mental Health in New Zealand,* 5(1), 47–63.

Kearns, R. and Joseph, A. 2000 Contracting opportunities: interpreting post-asylum geographies of mental health care in Auckland, New Zealand, *Health and Place,* 6(3), 159-170.

Kennard, D. 1983. *An introduction to therapeutic communities.* London: Routledge.

Kennard, D. 2012. The therapeutic community impulse: what makes it grow? *Therapeutic Communities: The International Journal of Therapeutic Communities,* 33(2/3), 110-116.

Kennedy, S. 2017. *Permitted Work Rules.* House of Commons Library Briefing Paper no. 7909. London: House of Commons Library. [online] Available at: https://researchbriefings.files.parliament.uk/documents/CBP-7909/CBP-7909.pdf

Kinn, L., Langeland, E., Tanaka, K. and Davidson, L. 2018. "We are actually colleagues": Clubhouse staffs' experiences of working side-by-side with members. *Journal of Psychosocial Rehabilitation in Mental Health,* 5(1), 63-72.

Knowles, C. 2000a. *Bedlam on the streets.* London: Routledge.

Knowles, C. 2000b. Burger King, Dunkin Donuts and community mental health care. *Health and Place,* 6(3), 213–224.

Kofman, E. and Raghuram, P. 2006. Gender and global labour migrations: incorporating skilled workers. *Antipode,* 38(2), 282-303.

Kramer, M. 2016. Sanctuary in a residential treatment center: creating a therapeutic community of hope countering violence *Therapeutic Communities: The International Journal of Therapeutic Communities,* 37(2), 69-83.

Labour Party. 1997. *New Labour because Britain deserves better* [manifesto]. Labour Party.

Laing, R.D. 1960. *The divided self: an existential study in sanity and madness.* Harmondsworth: Penguin.

Laurier, E. and Parr, H. 2000. Emotions and interviewing in disability and health research. *Ethics, Place and Environment,* 3(1), 98-102.

Laws, G. and Dear, M. 1988. Coping in the community: a review of factors influencing the lives of deinstitutionalised ex-psychiatric patients. In: C. Smith and J. Giggs, eds. *Location and stigma: contemporary perspectives on mental health and mental health care.* London: Unwin Hyman. Chap 5.

Laws, J. 2011. Crackpots and basket-cases: a history of therapeutic work and occupation. *History of the Human Sciences,* 24(2), 65-81.

Laws, J. 2013. ‘Recovery work’ and ‘magic’ among long-term mental health service-users. *The Sociological Review,* 61(2), 344-362.

Laws, J. 2016. Magic at the margins: towards a magical realist human geography. *Cultural Geographies,* 24(1), 3-19.

Lawson, V. 2007. Geographies of care and responsibility. *Annals of the American Association of Geographers,* 97(1), 1-11.

Lawson, V. 2009. Instead of radical geography, how about caring geography? *Antipode,* 41(1), 210-213.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. 2011. Conceptual framework for personal recovery in mental health: systemic review and narrative synthesis. *The British Journal of Psychiatry,* 199(6), 445-452.

Lees, J., Haigh, R., Lombardo, A. and Rawlings, B. 2016. Transient therapeutic communities: the living-learning experience trainings. *Therapeutic Communities: The International Journal of Therapeutic Communities,* 37(2), 57-68.

Lemke, T. 2001. “The birth of bio-politics”: Michel Foucault’s lecture at the College de France on neoliberal governmentality. *Economy and Society*, 30(2), 190-207.

Leufstadius, C., Erlandsson, L., Björkman, T. and Eklund, M. 2008. Meaningfulness in daily occupations among individuals with persistent mental illness. Journal of Occupational Science, 15(1), 27-35.

Lewis, J., Corden, A., Dillon, L., Hill, K., Kellard, K., Sainsbury, R. and Thornton, P. 2005. *New Deal for Disabled People: an in-depth study of job broker service delivery*. Leeds: Corporate Document Services.

Little, J. 2019. Editorial: emotional geographies and Transactions. *Transactions of the Institute of British Geographers*, 44(2), 210-213.

Long, V. 2013. Rethinking post-war mental health care: industrial therapy and the chronic mental patient in Britain. *Social History of Medicine,* 26(4), 738-758.

Long, V. 2016. Work is therapy? The function of employment in British psychiatric care after 1959. In: W. Ernst, ed. *Work, psychiatry and society, c. 1750-2015.* Manchester: Manchester University Press. Ch. 16.

Longhurst, R. 2013. Using Skype to mother. *Environment and Planning D: Society and Space,* 31(4), 664-679.

Lorimer H. 2005. Cultural Geography: the busyness of being ‘more-than-representational’. *Progress in Human Geography*, 29(1), 83-94.

Lorimer, H. 2008. Cultural geography: non-representational conditions and concerns. *Progress in Human Geography*, 32(4), 551-559.

Lorimer, H. 2010. Caught in the nick of time: archives and fieldwork. In: D. DeLyser, S. Herbert, S. Aitken, M. Crang, and L. McDowell, eds. *The SAGE handbook of qualitative geography.* London: SAGE Publications Ltd. Ch.14.

Lorimer, H. 2014. Homeland. *Cultural Geographies,* 21(4), 583-604.

Lowe, J., DeVerteuil, G. and Moon, G. 2014. Mental health geographies. In: W. Cockerham. R. Dingwall and S. Quah, eds. *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*. Oxford: Blackwell, pp.1-5.

Lucherini, M. 2017. Diabetes and an inescapable (auto)ethnography. *Area,* 49(4), 429-435.

Lunacy (Scotland) Act 1857. (20 and 21 Vict., c.71). London: Her Majesty's Stationery Office.

Lunacy Act 1845. (8 and 9 Vict., c.100). London: Her Majesty's Stationery Office.

Macias, C., Jackson, R., Schroeder, C. and Wang, Q. 1999. What is a Clubhouse? Report on the ICCD 1996 survey of USA Clubhouses. *Community Mental Health Journal,* 35(2), 181-190.

Macias, C., Propst, R., Rodican, C., and Boyd, J. 2001. Strategic planning for ICCD Clubhouse implementation: development of the Clubhouse Research and Evaluation Screening Survey (CRESS)." *Mental Health Services Research*, 3(3), 155-167.

MacKian, S. 2010. The art of geographic interpretation. In: D. DeLyser, S. Herbert, S. Aitken, M. Crang, and L. McDowell, eds. *The SAGE handbook of qualitative geography.* London: SAGE Publications Ltd. Ch.20.

MacLean, C. 1997. The Clubhouse model in the UK: a personal overview. *Mental Health Review Journal*, 2(2), 25-29.

Mandiberg, J. and Edwards, M. 2013. Collective identity formation in the mental health Clubhouse community. *International Journal of Self-Help and Self-Care*. 7(1), 19-39.

Mansfield, C. and Gregory, D. 2019. *Capitalism in crisis. Transforming our economy for people and planet*. London: Social Enterprise UK.

Margulis, S. T. 2003. On the status and contribution of Westin's and Altman's theories of privacy. *Journal of Social Issues,* 59(2), 411-429.

Marshall, J. 1982. *Madness: an indictment of the mental health care system in Ontario.* Toronto: Ontario Public Services Employees Union.

Martin, D. 1968. *Adventure in psychiatry: social problems in a mental hospital*. London: Faber and Faber.

Marx, K. 1849. *Wage-labour and capital*. Chicago, Illinois: Wildside Press.

Massey, D. 2004. Geographies of responsibility. *Geografiska Annaler* 86(1), 5-18.

McCaig, M., McNay, L., Marland, G., Bradstreet, S., Campbell, J., 2014. Establishing a recovery college in a Scottish university. *Mental Health and Social Inclusion,* 18, 92-97.

McCarthy, J. 2005. Devolution in the woods: community forestry as hybrid neoliberalism. *Environment and Planning A: Economy and Space,* 37(6), 995-1014.

McCormack, D. 2013. *Refrains for moving bodies: experience and experiment in affective spaces*. Durham and London: Duke University Press.

McDowell, L. 2004. Work, workfare, work/life balance and an ethic of care. *Progress in Human Geography,* 28(2), 145-163.

McDowell, L. 2009. *Working bodies: interactive service employment and workplace identities*. Oxford: Wiley-Blackwell.

McDowell, L. 2010. Interviewing: fear and liking in the field. In: D. DeLyser, S. Herbert, S. Aitken, M. Crang, and L. McDowell, eds. *The SAGE handbook of qualitative geography*. London: SAGE Publications Ltd. Ch.9.

McDowell, L., Ray, K., Perrons, D., Fagan, C. and Ward, K. 2005. Women's paid work and moral economies of care. *Social and Cultural Geography,* 6(2), 219-35.

McGeachan, C. 2017. Mental Health Geographies. In: D. Richardson, N. Castree, M. Goodchild, A. Kobayashi, W. Liu and R. Marstion eds. *The international encyclopedia of geography: people, the earth, environment and technology*. New Jersey: Wiley. pp.1-5.

McGeachan, C. 2019. 'A prison within a prison'? Examining the enfolding the spatialities of care and control in the Barlinnie Special Unit. *Area*, 51(2), 200-207.

McKay, C., Yates, B. and Johnsen, M. 2007. Costs of Clubhouses: an international perspective. *Administration and Policy in Mental Health and Mental Health Services Research,* 34(1), 62-72.

Mckie, L., Bowlby, S. and Gregory, S. 2001. Gender, caring and employment in Britain. *Journal of Social Policy,* 30(2), 233-258.

McLean, A. and Keys, S. 2016. *A strong, full, varied, and vibrant employment and education program*. [pdf] Brisbane: Stepping Stones Clubhouse. Available at: http://www.clubhouse-intl.org/documents/employment_australia_conf_2016.pdf

McSweeney, K. and WinklerPrins, A. 2020. Introduction to the special issue: fieldwork in the 21st century. *Geographical Review,* 110(1-2), 1-7.

McWade, B. 2016. Recovery-as-policy as a form of neoliberal state making. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice,* 5(1), 62–81.

Mental Health (Care and Treatment) (Scotland) Act 2003. (asp.13). [online] Available at: https://www.legislation.gov.uk/asp/2003/13/contents/enacted

Mental Health (Scotland) Act 1984. (c.36). [online] Available at: https://www.legislation.gov.uk/ukpga/1984/36/contents/enacted

Mental Health Act 1959. (7 and 8 Eliz. 2, c.72). London: Her Majesty's Stationery Office.

Mental Health Act 1983. (c.20). [online] Available at: https://www.legislation.gov.uk/ukpga/1983/20/contents/enacted

Mental Health Act 2007. (c.12). [online] Available at: https://www.legislation.gov.uk/ukpga/2007/12/contents/enacted

Mental Health Resistance Network. 2017. *Mental Health Resistance Network: home*. [online] Available at: <http://mentalhealthresistance.org/> [Accessed: 4th March 2017].

Mental Treatment Act 1930. (20 and 21 Geo. 5, c.23). London: His Majesty's Stationery Office.

Milligan, C. 1998. Pathways of dependency: the impact of health and welfare restructuring the voluntary experience. *Social Science and Medicine*, 46(6), 743-754.

Milligan, C. 1999. Without these walls: a geography of mental ill-health in a rural environment. In: R. Butler and H. Parr, eds. *Mind and body spaces: geographies of illness, impairment and disability*. London: Routledge. pp. 221-239.

Milligan, C. 2000. "Bearing the burden": towards a restructured geography of caring. *Area,* 32(1), 49–58.

Milligan, C. 2003. Location or dis-location: from community to long-term care - the caring experience. *Social and Cultural Geography*, 4(4), 455-470.

Milligan, C. 2005. From home to 'home': situating emotions within the caregiving experience. *Environment and Planning A: Economy and Space,* 37(12), 2105-2120.

Milligan, C. and Conradson, D. 2006. Contemporary landscape of welfare: the 'voluntary turn?' In: D. Conradson and C. Milligan, eds. *Landscapes of voluntarism: new spaces of health, welfare and governance*. Bristol: The Policy Press. Ch. 1.

Milligan, C. and Fyfe, N. 2006. Renewal or relocation? Social welfare, voluntarism and the city. In: D. Conradson and C. Milligan, eds. *Landscapes of voluntarism: new spaces of health, welfare and governance*. Bristol: The Policy Press. Ch. 3.

Milligan, C. and Wiles, J. 2010. Landscapes of care. *Progress in Human Geography,* 34, 736-754.

Mills, J. and Harrison, T. 2007. John Rickman, Wilfred Ruprecht Bion and the origins of the therapeutic community. *History of Psychology,* 10(1), 22-43.

Mitchell, J. 1995. Engaging members in clubhouse activities: Choices, options, coffee, and relationships, 1–3. [online] Available at: http://www. iccd.org/19mitch.htm

Modini, M., Tan, L., Brinchman, B., Wang, M-J., Killackey, E., Glozier, N., Mykletun, A. and Harvey, S. 2016. Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. *The British Journal of Psychiatry*, 209(1), 14-22.

Moon, G. 1988. "Is there one round here?" - investigating reaction to small-scale mental health hostel provision in Portsmouth, England. In: C. Smith and J. Giggs eds. *Location and stigma: contemporary perspectives on mental health and mental health care*. London, Unwin Hyman. Ch. 10.

Moon, G., Kearns, R. and Joseph, A. 2015. *The afterlives of the psychiatric asylum. Recycling of concepts, sites and memories*. Farnham, Surrey: Ashgate.

Moore, R. 2012. *Towards the sociology of truth*. London: Continuum.

Morrison, H. 2017. Henderson and Meyer in correspondence: a transatlantic history of dynamic psychiatry, 1908-29. *History of Psychiatry,* 28(1), 72-86.

Morrow, M. and Weisser, J., 2012. Towards a social justice framework of mental health recovery. *Studies in Social Justice,* 6(1), 27–43.

Morrow, M., 2013. Recovery: progressive paradigm or neoliberal smokescreen? In: B.A. LeFrançois, R. Menzies, G.Reaume eds. *Mad matters: a critical reader in Canadian mad studies.* Toronto: Canadian Scholars' Press. pp. 323-333.

Mowbray, C.T., Lewandowski, L., Holter, M. and Bybee, D. 2006. The Clubhouse as an empowering setting. *Health and Social Work*. 31(3), 167-179.

Mueser, K., Bond, G., Esscock, S., Clark, R., Carpenter-Song, E., Drake, R. and Wolfe, R. 2014. The effects of supported employment in Latino consumers with severe mental illness. *Psychiatric Rehabilitation Journal,* 37(2), 113-122.

Murphy, E. 2006. Workhouse care of the insane, 1845-90. In: P. Dale and J, Melling eds. *Mental illness and learning disability since 1850.* London: Routledge.

Murray, S.J. 2007. Care and the self: biotechnology, reproduction and the good life. *Philosophy, Ethics and Humanities in Medicine,* 2(6), 1-15.

Nagar, R. 1997. Communal places and the politics of multiple identities: the case of Tanzanian Asians. *Ecumene,* 4(1), 3-26.

National Association for Mental Health. 1959. *The place of work in the treatment of mental disorder: proceedings of a conference*. London: Frank Juckes Ltd.

National Audit Office. 2014. *The Work Programme* [online] Available at: https://www.nao.org.uk/wp-content/uploads/2014/07/The-work-programme.pdf

National Health Service and Community Care Act 1990. (c.19). [online] Available at: https://www.legislation.gov.uk/ukpga/1990/19/contents/enacted

National Institute for Mental Health. 2017. *Important events in NIMH history* [online]. Available at: https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh

National Lottery. 2019. *Employment and entrepreneurship.* Available at: https://www.tnlcommunityfund.org.uk/funding/grants/0031033910

Nelson, G., Lord J. and Ochoka, J. 2001. *Shifting the paradigm in community mental health. Towards empowerment and community.* Toronto: University of Toronto Press Incorporated.

Noack, A. and Vosko. L. 2011. *Precarious jobs in Ontario: Dimensions of labour market insecurity by workers' social location*. Toronto: Law Commission of Ontario.

Noiseux, S. and Ricard, N. 2008. Recovery as perceived by people with schizophrenia, family members and health professionals: a grounded theory. *International Journal of Nursing Studies,* 45(8), 1148-1162.

Nord, C. and Högström, E. 2017. *Caring architecture: institutions and relational practices.* Newcastle-Upon-Tyne: Cambridge Scholars Publishing.

O'Hagan, M. 2016. Responses to a legacy of harm. In: J. Russo, and A. Sweeney, eds. *Searching for a rose garden: challenging psychiatry, fostering mad studies.* London: PCCS Books. Ch. 1.

Oades, L., Slade, M., and Amering, M., 2008. Recovery: an international perspective. *Faculty of Health and Behavioural Sciences - Papers (Archive)* 128–137. DOI:10.1017/S1121189X00002827

Office for National Statistics. 2019a. *Disability and Employment, UK: 2019.* [online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/bulletins/disabilityandemploymentuk/2019

Office for National Statistics. 2019b. *Labour Market Profile for Glasgow City.* [online] Available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157420/report.aspx?town=glasgow#workless

Ogborn, M. 2010. Finding Historical Sources. In: N. Clifford, and G. Valentine, eds. *Key Methods in Geography*. London: SAGE Publications Ltd. Ch.7.

Olsson, G. and Gren, M. 2017. Between caring and architecture. In C. Nord and E. Hogstrom, eds. *Caring architectures: institutions and relational practices*. Newcastle-Upon-Tyne: Cambridge Scholars Publishing. pp 1-6.

Onyett, S. 2005. Mental health teams- hitting the targets, missing the point? In: A. Bell and P. Lindley, eds. *Beyond the water towers: the unfinished revolution in mental health services 1985-2005*. London: The Sainsbury Centre for Mental Health. Ch. 8.

Organisation for Economic Co-operation and Development. 2020. OECD Employment Outlook 2020. Worker security and the COVID-19 crisis [online]. Available at: https://read.oecd-ilibrary.org/view/?ref=134_134947-lyixdpsqh2&title=Employment-Outlook-UnitedKingdom-EN

Osborne, S. 2008. The work capability assessment. *Child Poverty Action Group Welfare Rights Bulletin*, 204. London: CPAG.

Pain, R. 2004. Social geography: participatory research. *Progress in Human Geography,* 28(5), 652-663.

Pain, R., Whitman, G., Milledge, D. and Lune Rivers Trust. 2012. *Participatory action research toolkit: an introduction to using PAR as an approach to learning, research and action*. Durham: Durham University.

Palacios-Ceña, D., Gómez-Calero, C., Cachón-Pérez, J.M., Velarde-García J.F., Martínez-Piedrola, R. and Pérez-De-Heredia, M. 2016. Is the experience of meaningful activity understood in nursing homes? A qualitative study. *Geriatric Nursing*. 37(2), 110-115.

Parr, H. 1998a. Mental health, ethnography, and the body. *Area,* 30(1), 28-37.

Parr, H. 1998b. The politics of methodology in 'post-medical geography': mental health research and the interview. *Health and Place,* 4(4), 341-353.

Parr, H. 1999. Delusional geographies: the experiential worlds of people during madness/illness. *Environment and Planning D: Society and Space,* 17(6), 673-690.

Parr, H. 2000. Interpreting the hidden social geographies of mental health: ethnographies of inclusion and exclusion in semi-institutional places. *Health and Place,* 6(3), 225–237.

Parr, H. 2001. Feeling, reading and making bodies in space. *Geographical Review,* 91(1-2), 158-167.

Parr, H. 2002. New body geographies: the embodied spaces of health and medical information on the internet. *Environment and Planning D: Society and Space,* 20(1), 73-95.

Parr, H. 2003. Medical geography: care and caring. *Progress in Human Geography,* 27(2), 212–221.

Parr, H. 2006. Mental health, the arts and belongings. *Transaction of the Institute of British Geographers,* 31(2), 150-166.

Parr, H. 2007. Mental health, nature work and social inclusion. *Environment and Planning D: Society and Space,* 25(3), 537-561.

Parr, H. 2008. *Mental health and social space: towards inclusionary geographies?* London: Wiley-Blackwell.

Parr, H. and Davidson, J. 2010. Mental and emotional health. In: T. Brown, S. McLafferty and G. Moon, eds. *A companion to health and medical geography.* Malden, Massachusetts: Wiley-Blackwell.

Parr, H. and Philo, C., 2003. Rural mental health and social geographies of caring. *Social and Cultural Geography*, 4(4), 471–488.

Parr, H. and Stevenson, O. 2014. 'No news today': talk of witnessing with families of missing people. Cultural Geographies, 22(2), 297-315.

Parr, H., Philo, C. and Burns, N. 2004. Social geographies of rural mental health: experiencing inclusions and exclusions. *Transactions of the Institute of British Geographer*s, 29(4), 401-419.

Parr, H., Philo, C. and Burns, N. 2005. 'Not a display of emotions': emotional geographies in the Scottish Highlands. In: J. Davidson, L. Bondi and M. Smith eds. *Emotional geographies*. Farnham: Ashgate. Ch. 7.

Paterson, C. 2007. 75th anniversary of the founding of the Scottish Association of Occupational Therapists. *British Journal of Occupational Therapy,* 70(12), 537-540.

Paterson, C. 2010. *Opportunities not prescriptions: the development of occupational therapy in Scotland 1900-1960.* Aberdeen: Aberdeen History of Medicine Publications.

Peck, J. 2001. *Workfare states*. New York: Guilford.

Peck, J. and Theodore, N. 2001. Exporting workfare/importing welfare-to-work: exploring the politics of Third Way policy transfer. *Political Geography,* 20(4), 427-460.

Peck, J. and Theodore, N. 2010. Recombinant workfare across the Americas: transnationalising 'fast' social policy. *Geoforum,* 41(2), 195-208.

Peck, J. and Theodore, N. 2019. Still neoliberalism? *South Atlantic Quarterly,* 118(2), 245-265.

Peck, J. and Tickell, A. 2002. Neoliberalizing space. *Antipode*, 34(3), 380-404.

Peck, J., Theodore, N. and Brenner, N. 2012. Neoliberal resurgent? Market rule after the great recession. *South Atlantic Quarterly,* 111(2), 265-288.

Pentland, D. and Pentland, B. 2015. Sir David K Henderson and the origins of British occupational therapy. *Scottish Medical Journal,* 60(4), 249-251.

Pernice-Duca, F. 2010. Staff and member perceptions of the Clubhouse environment. *Administration and Policy in Mental Health and Mental Health Service Research,* 37(4), 345-356.

Pernice-Duca, F. and Onaga, E. 2009. Examining the contribution of social network support to the recovery process among Clubhouse members. *American Journal of Psychiatric Rehabilitation,* 12(1), 1-30.

Pernice-Duca, F., Case. W. and Conrad-Garrisi, D. 2012. The role of intentional communities to support recovery from mental illness. In: L. LAbate, ed. *Mental illnesses: evaluation, treatment and implications*. London: IntechOpen. Ch. 9.

Petersen, A. 2011. Research with individuals labelled 'Other': reflections on the research process. *Disability and Society,* 26(3), 293-305.

Philo, C. 1987a. "Fit localities for an asylum": the historical geography of England's nineteenth-century "mad-business" as viewed through the pages of the Asylum Journal. *Journal of Historical Geography*, 13(4), 398–415.

Philo, C. 1987b. 'Not at our seaside': community opposition to a nineteenth century branch asylum. *Area,* 19(4), 297-302.

Philo, C. 1989. Enough to drive one mad: the organisation of space in 19th century lunatic mental hospitals. In: J. Wolch and M. Dear, eds. *The power of geography: how territory shapes social life*. London: Unwin Hyman. Ch. 12.

Philo, C. 1997. Across the water: reviewing geographical studies of mental hospitals and other mental health facilities. *Health and Place,* 3(1), 73-89.

Philo, C. 2004. *A geographical history of institutional provision for the insane from medieval times to the 1860s in England and Wales: 'The space reserved for insanity'*. Lampeter, Wales: Edwin Mellen Press.

Philo, C. 2005. The geography of mental health: an established field? *Current Opinion in Psychiatry,* 18(5), 585-591.

Philo, C. 2007. Review Essay. Psychiatric power: lectures at the Collège de France. *Foucault Studies,* 4(1), 149-163.

Philo, C. 2012. Troubled proximities: asylums and cemeteries in nineteenth-century England. *History of Psychiatry*, 23(1), 91-103.

Philo, C. 2013. 'A great space of murmurings': madness, romance and geography. *Progress in Human Geography,* 37(2), 167-194.

Philo, C. 2017. Covertly entangled lines. In: C. Nord and E. Hogstrom eds. *Caring architecture: institutions and relational practices.* Cambridge: Cambridge Scholars Publishing. pp. 19-32.

Philo, C. and Parr, H. 2000. Institutional geographies: Introductory remarks. *Geoforum*, 31(4), 513–521.

Philo, C. and Parr, H. 2019. Staying with the trouble of institutions. *Area*, 51(2), 241-248.

Philo, C. Parr, H. and Burns, N. 2005. "An oasis for us": 'in-between' spaces of training for people with mental health problems in the Scottish Highlands. *Geoforum,* 36(6), 778-791.

Philo, C., Parr, H. and Burns, N. 2003. Rural madness: a geographical reading and critique of the rural mental health literature. *Journal of Rural Studies,* 19(3), 259-281.

Piat, M., Sabetti, J., Couture, A., Sylvestre, J., Provencher, H., Botshcner, J. and Stayner, D. 2009. What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychiatric Rehabilitation Journal,* 32(2), 199-207.

Piddock, S. 2007. *A space* of their o*wn: the archaeology of nineteenth century lunatic asylums in Britain, South Australia and Tasmania*. New York: Springer.

Piggott, L. and Grover, C. 2009. Retrenching incapacity benefit: employment support allowance and paid work. *Social Policy and Society*, 8(2), 159-170.

Pilgrim, D. 2008. 'Recovery' and current mental health policy. *Chronic Illness* 4, 295-304.

Pilmott-Wilson, H. 2017. Individualising the future: the emotional geographies of neoliberal governance in young people's aspirations. *Area,* 49(3), 288-295.

Pinfold, V. 2000. 'Building up safe havens…all around the world': users' experiences of living in the community with mental health problems. *Health and Place*, 6(3), 201-212.

Pirttimaa, R. and Saloviita, F. 2009. Transitional employment and its effects in Finland. *Psychiatric Rehabilitation Journal*, 32(3), 231-134.

Pollard, T. and Tjoa, P. 2020. T*his isn't working: reimagining employment support for people facing complex disadvantage*. London: New Local.

Poole, J. 2011. *Behind the rhetoric: mental health recovery in Ontario*. Toronto: Fernwood.

Popke, J. 2006. Geography and ethics: everyday mediations through care and consumption. *Progress in Human Geography,* 30(4), 504-512.

Porter, R. 1996. *A social history of madness: stories of the insane*. London: Phoenix.

Power, A. and Hall. E. 2018. Placing care in times of austerity. *Social and Cultural Geography*, 19(3), 303-313.

Pratt, G. 2012. *Families Apart. Migrant mothers and the conflicts of labor and love*. Minneapolis: Minnesota Press.

Pratt, K. 2013. Rethinking community: conservation, practice and emotion. *Emotion, Space and Society,* 5(3), 177-185.

Prince, J., Ansbrow, J., Bennedict, A., DiConstanzo, O. M. and Schonebaum, A. 2017. Making connections: severe mental illness and closeness with other people. *Social Work in Mental Health,* 15(1), 1-13.

Prior, L., Jones, K. and Manley, D. 2020. Ageing and cohort trajectories in mental ill-health: An exploration using multilevel models. *PLoS ONE* 15(7). DOI: 10.1371/journal.pone.0235594

Propper, C., Jones, K., Bolster, A., Burgess, S., Johnston, R., and Sarker, R. 2005. Local Neighbourhood and Mental Health: Evidence from the UK. *Social Science and Medicine,* 61(10), 2065–2083.

Propst, R. 1992. Standards for Clubhouse programs: Why and how they were developed. *Psychosocial Rehabilitation Journal*, 16(2), 25-30.

Propst, R. 1997. Stages in realizing the international diffusion of a single way of working: the Clubhouse model. *New Directions for Mental Health Services*, 74, 53-66.

Public Contracts Scotland. 2016. *Contract Award Notice*.

Public Contracts Scotland. 2020. *Contract Award Notice*.

Puig de la Bellacasa, M. 2017. *Matters of care: speculative ethics in more than human worlds*. Minneapolis: University of Minnesota Press.

Raeburn, T., Halcomb, E., Walter, G. and Cleary, M. 2013. An overview of the clubhouse model of psychiatric rehabilitation. *Australasian Psychiatry,* 21(4), 376-378.

Rapoport, R. 1960. *Community as doctor: new perspectives on a therapeutic community*. London: Tavistock.

Rayle, A. 2006. Mattering to others: implications for the counselling relationship. *Journal of Counselling and Development*, 84(4), 483-487.

Recovery in the Bin. 2016. *About* [online]. Available at: https://recoveryinthebin.org/

Reed, K. 2005. Hall and the work cure. *Occupational Therapy in Health Care*, 19(3), 33–50.

Reinarz, J. and Schwarz, L. 2013. Introduction. In: J. Reinarz and L. Schwarz, eds. *Medicine and the workhouse*. Rochester: University of Rochester Press. pp. 1-18.

Repper, J. and Carter, T. 2011. A review of the literature on peer support in mental health services. *Journal of Mental Health,* 20(4), 392-411.

Repper, J. and Perkins, R., 2003. *Social inclusion and recovery*. London: Ballière Tindall.

Richardson, L. 2016. Feminist geographies of digital work. *Progress in Human Geography,* 42(2), 244-263.

Ridley, J., Hunter, S. and Infusion Cooperative. 2005. *"Go for it!" Supporting people with learning disabilities and/or autistic spectrum disorders in employment*. Edinburgh: Scottish Executive Social Research.

Rinaldi, M., Miller, L. and Perkins, R. 2010. Implementing the individual placement and support (IPS) approach for people with mental health conditions in England. *International Review of Psychiatry*. 22(2), 163-172.

Robbins, S. 1954. Social rehabilitation at Fountain House. *Journal of Rehabilitation,* 20(3), 8-10.

Roger, A., Castree, N. and Kitchin, R. 2013. A dictionary of human geography. Oxford: Oxford University Press.

Rose, D. 2014. The mainstreaming of recovery. *Journal of Mental Health,* 23(5), 217-218.

Rose, D. 2018. A hidden activism and its changing contemporary forms: mental health service users/survivors mobilising. *Journal of Social and Political Psychology,* 6(2), 728-744.

Rose, D. and Beresford, P. 2009. Introduction. In: A. Sweeney, P. Beresford, A. Faulkner, M. Nettle and D. Rose, eds. *This is survivor research*. London: PCCS Books, Ch.1.

Rose, G. 1997a. Situating knowledges: positionality, reflexivities and other tactics. *Progress in Human Geography,* 21(3), 305-320.

Rose, G. 1997b. Spatialities of 'community', power and change: the imagined geographies of community arts projects. *Cultural* Studies, 11(1), 1-16.

Rose, G. 2016. *Visual methodologies: an introduction to researching with visual materials*. 4th edition. London: Sage.

Rose, N. 1999a. *Powers of Freedom.* Cambridge: Cambridge University Press.

Rose, N. 1999b. *Governing the soul: the shaping of the private self*. London: Free Association Books.

Rose, N., Manning, N., Bentall, R., Bui, L., Burgess, R., Carr, S., Cornish, F., Devakumar, D., Dowd, J., Ecks, S., Faulkner, A., Keene, A., Kirkbride, J., Knapp, M., Lovell, A., Martin, P., Moncrieff, J., Parr, H., Pickersgill, M., Richardson, R. and Sheard, S. 2020. The social underpinnings of mental distress

in the time of COVID-19 – time for urgent action. *Wellcome Open Research,* 5, 166.

Rosengard, A., Laing, I., and Ridley, J. 2004. *A review of Clubhouses in Scotland*. Glasgow: Ann Rosengard Associates.

Roth, G. 2017. Perspectives from within the Clubhouse: a qualitative investigation into a peer-to-peer vocational support program for adults with serious mental illness. *Journal of Psychosocial Rehabilitation in Mental Health,* 4(1), 5-17.

Roulstone, A. 2000. Disability, dependency and the New Deal for Disabled People. *Disability and Society*, 15(3), 427-443.

Roulstone, A. 2015. Disability, work and welfare. In: C. Grover and L. Piggott, eds. *Disabled people, work and welfare: is employment really the answer?* Bristol: Policy Press. Ch 14.

Rouse, J., Mutschler, C., McShane, K. and Habal-Brosek, C. 2017. Qualitative participatory evaluation of a psychosocial rehabilitation program for individuals with severe mental illness. *International Journal of Mental Health,* 46(2), 1-18.

Runswick-Cole, K. 2014. 'Us' and 'them': the limits and possibilities of a 'politics of neurodiversity' in neoliberal times. *Disability and Society,* 29(7), 1117-1129.

Runswick-Cole, K. and Goodley, D. 2015. Disability, austerity and cruel optimism in Big Society: resistance and 'The Disability Commons', *Canadian Journal of Disability Studies*, 4(2), 162-186.

Runswick-Cole, K., Lawthom, R. and Goodley, D. 2016 The trouble with 'hard working families'. *Community, Work and Family,* 19(2), 257-260.

Russo, J. 2012. Survivor-controlled research: a new foundation for thinking about psychiatry and mental health. *Forum: Qualitative Social Research,* 13(1), Art 8.

Sage, D. 2018. Unemployment, wellbeing, and the power of the work ethic: implications for social policy. *Critical Social Policy,* 39(2), 205-228.

Saloviita, T. 2000. Supported employment as a paradigm shift and a cause of legitimation crisis. *Disability and Society*, 15(1), 87-98.

Saunders, S. and Nedelec, B. 2014. What work means to people with work disability. *Journal of Occupational Rehabilitation,* 24(1), 100-110.

Scholz, F. and Ingold, J. 2020. Activating the 'ideal jobseeker': experiences of individuals with mental health conditions on the UK Work Programme. H*uman Relations,* 1-24. DOI: 10.1177/0018726720934848

Schonebaum, A. and Boyd, J. 2012. Work-ordered day as a catalyst of competitive employment success. *Psychiatric Rehabilitation Journal,* 35(5), 391-395.

Scotland Act 2016. (c.11) [online] Available at: https://www.legislation.gov.uk/ukpga/2016/11/contents/enacted

Scottish Government. 2010. *A working life for all disabled people. The supported employment framework for Scotland*. Edinburgh: Scottish Government.

Scottish Government. 2020a *Employment support* [online]. Available at: https://www.gov.scot/policies/employment-support/

Scottish Government. 2020b. *Social security* [online]. Available at: https://www.gov.scot/policies/social-security/

Scottish Government. 2020c. *Coronavirus (COVID-19): First Minister's speech 17 March 2020* [online]. Available at: https://www.gov.scot/publications/fm-covid-19/

Scottish Recovery Network. 2015. *What is recovery?* [online] Available at: https://www.scottishrecovery.net/what-is-recovery/

Scull, A. 1979. Moral treatment reconsidered: some sociological comments on an episode in the history of British psychiatry. *Psychological Medicine,* 9(3), 421-428.

Sennett, M. 2001. *Work-ordered day: how can three simple words have so much meaning?* [online]. Available at: http://clubhouse-europe.org/wp-content/uploads/2015/10/Work-Ordered-Day-How-Can-Three-Simple-Words-English.pdf

Sharp, J., Routledge, P., Philo, C. and Paddison, R. 2000. *Entanglements of power: geographies of domination/resistance*. London: Routledge.

Simonsen, T. and Duff, C. 2020. Healing architecture and psychiatric practice: (re)ordering work and space in an in-patient ward in Denmark. *Sociology of Health and Illness*, 42(2), 379-392.

Singer, B. 2002. *The Clubhouse: its structure, philosophy and values* [document]. Paper presented at the IAPSRS Conference in Toronto, June 2002.

Slade, M., 2009. Personal recovery and mental illness: a guide for mental health professionals. Cambridge: Cambridge University Press.

Smith, C. 1975. Being mentally ill in the asylum or the ghetto. *Antipode,* 7(1), 53-59.

Social Exclusion Unit. 2004. *Mental Health and Social Exclusion*. London: Office of the Deputy Prime Minister.

Social Security (Scotland) Act 2018. (asp.9) [online] Available at: https://www.legislation.gov.uk/asp/2018/9/contents/enacted

Staeheli, L. and Brown, M. 2003. Where has welfare gone? Introductory remarks on the geographies of care and welfare. *Environment and Planning A: Economy and Space,* 35(5), 771-777.

Stafford, B. 2005. New Deal for Disabled People: what's new about the New Deal? In: A. Roulstone and C. Barnes, eds. *Working futures? Disabled people, policy and social inclusion*. Bristol: Policy Press. pp. 45-58.

Stafford, B. 2015. Why are the policies and organisations seeking to help disabled people access work failing? In: C. Grover and L. Piggott, eds. *Disabled people, work and welfare: is employment really the answer?* Bristol: Policy Press. Ch. 4.

Staples, L. and Stein, R. 2008. The Clubhouse model: mental health consumer-provider partnerships for recovery. In: S. Chambré and M. Goldner, eds. *Patients, consumers and civil society*. Bingley, UK: Emerald Group Publishing, pp. 177-196.

Studdert, D. and Walkerdine, V. 2016. *Rethinking community research inter-relationality, communal being and commonality*. London: Palgrave Macmillan.

Sunley, P., Martin, R. and Navitel, C. 2006. *Putting workfare in place: locating labour markets and the New Deal*. Oxford: Blackwell.

Sweeney, A. 2009. So what is survivor research? In: A. Sweeney, P. Beresford, A. Faulkner, M. Nettle, and D. Rose, eds. *This is survivor research*. London: PCCS Books, Ch.3.

Sweeney, A. 2016. Why mad studies needs survivor research and why survivor research needs mad studies. *Intersectionalities,* 5(3), 36-61.

Tanaka, K. and Davidson, L. 2015. Meanings associated with the core component of Clubhouse life: the work-ordered day. *Psychiatric Quarterly,* 86(2), 269-283.

Tanaka, K., Craig, T. and Davidson, L. 2015. Clubhouse community support for life: staff-member relationships and recovery, *Journal of Psychosocial Rehabilitation in Mental Health,* 2(2), 131-141.

Tanaka, K., Davidson, L. and Craig, T. 2018. Sense of community Clubhouse belonging and empowerment. *International Journal of Social Psychiatry,* 64(3), 267-285.

Taylor, S. M. 1988. Community reactions to deinstitutionalization. In: C. Smith and J. Giggs, eds. *Location and stigma: contemporary perspectives on mental health and mental health care*. London: Unwin Hyman. Ch. 11.

The Club. 2002. *Financial statements for the year ended 31st March 2002*. Glasgow: The Club.

The Club. 2009. *Report and annual statements for the year ended 31st March 2009*. Glasgow: The Club.

The Club. 2012. *Report and annual statements for the year ended 31st March 2012*. Glasgow: The Club.

The Club. 2013. *Report and annual statements for the year ended 31st March 2013*. Glasgow: The Club.

The Club. 2015a. *The Club Homepage* [online].

The Club. 2015b. *Report and annual statements for the year ended 31st March 2015*. Glasgow: The Club.

The Club. 2015c. *Member conduct policy and procedure*. [Policy document] Glasgow: The Club.

The Club. 2015d. *Annual Report*. Glasgow: The Club.

The Club. 2015e. *Newsletter. Summer 2015*. Glasgow: The Club.

The Club. 2017. *Consensus decision making at The Club*. [PowerPoint presentation] Glasgow: The Club.

The Club. 2018. *Report and annual statements for the year ended 31st March 2018*. Glasgow: The Club.

The Club. 2019. *The Club report and financial statements for the year ended 31st March 2019*. Glasgow: The Club.

The Employment and Support Allowance Regulations 2008. (No.794). [online] Available at: https://www.legislation.gov.uk/uksi/2008/794/contents/made

Thien, D. 2005. Affect or beyond feeling? A consideration of affect and emotion in geography. *Area*, 37(4), 450-454.

Thrift, N. 2000. Entanglements of power: shadows? In: J. Sharp, P. Routledge, C. Philo, and R. Paddison, eds. *Entanglements of power: geographies of domination/resistance*. London: Routledge. Ch.13.

Timms, D. 1965. The spatial distribution of social deviants in Luton, England. *Australian and New Zealand Journal of Sociology*, 1, 38-52.

Tolia-Kelly, D. 2006. Affect: an ethnocentric encounter? Exploring the 'universalist' imperative of emotional/affectual geographies. *Area*, 38(2), 213-217.

Torres-Stone, R., Sabella, K., Lidz, C., McKay, C. and Smith, L. 2016. The meaning of work for young adults diagnosed with serious mental health conditions. *Psychiatric Rehabilitation Journal*, 41(4), 290-298.

Tronto, J. 1993. *Moral boundaries: a political argument for an ethic of care*. London: Routledge.

Tronto, J. 2001. Who cares? Public and private caring and the rethinking of citizenship. In: N.J. Hirschmann and U. Liebert, eds. *Women and welfare: theory and practice in the United States and Europe*. New Brunswick, NJ: Rutgers University Press. Ch.4.

Tronto, J. and Fisher, B. 1990. Toward a feminist theory of caring. In: E. Abel, and M. Nelson, eds. *Circles of care*. Albany, NY: SUNY Press. pp. 36-54.

Tuke, S. 1813. *Description of the Retreat: an institution near York, for insane persons of the Society of Friends*. York: Alexander.

Türken, S., Nafstad, H., Blakar, R. and Roen, K. 2016. Making sense of neoliberal subjectivity: a discourse analysis of media language on self-development. *Globalizations*, 13(1), 32-46.

Urfalino, P. 2014. The rule of non-opposition: opening up decision-making by consensus. *The Journal of Political Philosophy*, 22(3), 320-341.

Valenstein, E. 1986. *Great and desperate cures: the rise and decline of psychosurgery and other radical treatments for mental illness.* New York: Basic Books.

Valentine, G. 2001. *Social geographies: society and space*. Harlow: Prentice Hall.

Valentine, G. 2003. Geography and ethics: in pursuit of social justice – ethics and emotions in geographies of health and disability research. *Progress in Human Geography,* 27(3), 375-380.

Valkeapää, T., Tanaka, K., Lindholm, C., Weiste, E. and Stevanovic, M. 2019. Interaction, ideology, and practice in mental health rehabilitation. *Journal of Psychosocial Rehabilitation in Mental Health,* 6(1), 9-23.

Van Stolk, C., Hofman, J., Hafner, M. and Janta, B. (2014). *Psychological wellbeing and work: improving service provision and outcomes.* Cambridge: RAND Europe.

Vannini, P. 2015 Enlivening ethnography through the Irrealis mood: in search of a more- than-representational Style' in P. Vannini, eds. *Non-representational methodologies*. London: Routledge. Ch.7.

Vannini, P. and Taggart, J. 2012. Doing islandness: a non-representational approach to an island's sense of place. *Cultural Geographies,* 20(2), 225-242.

Vischer, J. 2005. *Space meets status: designing workplace performance*. Oxford: Taylor and Francis.

Vischer, J. 2008. Towards an environmental psychology of workspace: how people are affected by environments for work. *Architectural Science Review,* 52(1), 97-108.

Voronka, J. 2019. Storytelling beyond the psychiatric gaze: resisting resilience and recovery narratives. *Canadian Journal of Disability Studies,* 8(4), 8-30.

Vorspan, R. 1992. Why work works. *Psychosocial Rehabilitation Journal,* 16(2), 49-54.

Waddell, G. and Burton, K. 2006. *Is work good for your health and well-being?* Norwich: The Stationery Office.

Watson, A. and Till, K. E. 2010. Ethnography and participant observation. In: D. DeLyser, S. Herbert, S. Aitken, M. Crang, and L. McDowell, eds. *The SAGE handbook of qualitative geography.* London: SAGE Publications Ltd. Ch.7.

Webb, B. 2001. *The voluntary nature of the Clubhouse* [document]. Paper presented at the Eleventh International Clubhouse Seminar, Tennessee.

Weeks, K. 2011. *The problem with work: feminism, Marxism, antiwork politics and postwork imaginaries*. London: Duke University Press.

Wehman, P., Revell, G. and Brooke, V. 2003. Competitive employment: has it become the 'first choice' yet? *Journal of Disability Policy Studies,* 14(3), 163-173.

Welch, R. and Panelli, R. 2007. Questioning community as a collective antidote to fear: Jean-Luc Nancy's 'singularity' and 'being singular plural'. *Area,* 39(3) 349-356.

Welfare Reform and Pensions Act 1999. (c.30) [online] Available at: https://www.legislation.gov.uk/ukpga/1999/30/contents/enacted

Weston, J. 2002. Supported employment and people with complex needs: a review of research literature and ongoing research. *Journal of Social Work*, 2(1), 83-104.

Whiteley, S. 1979. Progress and reflection. In: R. Hinshelwood and N. Manning, eds. *Therapeutic communities: reflections and progress.* London: Routledge.

Whiteley, S. 2004. The evolution of the therapeutic community. *Psychiatric Quarterly,* 75(3), 233-248.

Wiesel, I. 2009. Community and the geography of people with intellectual disability. *Social and Cultural Geography*, 10(5), 599-613.

Wiesel, I. and Bigby, C. 2014. Being recognised and becoming known: encounters between people with and without intellectual disability in the public realm. *Environment and Planning A: Economy and Space*, 46(8), 1754-1769.

Wilkinson, R. 1996. *Unhealthy societies. The afflictions of inequality.* London: Routledge.

Williams, B., Copestake, B., Eversley, J. and Stafford, B. 2008. *Experiences and expectations of disabled people*. London: Office for Disability Issues.

Williams, J. and Keating, F. 2005. Social inequalities and mental health- an integrative approach. In: A. Bell and P. Lindley, eds. *Beyond the water towers: the unfinished revolution in mental health services 1985-2005.* London: The Sainsbury Centre for Mental Health. Chap 10.

Wilmer, H. 1981. Defining and understanding the therapeutic community. *Hospital and Community Psychiatry,* 32(2), 95-99.

Wilson, S. 2012. Therapeutic communities in mental hospitals. *Therapeutic Communities: The International Journal of Therapeutic Communities,* 33(1), 50-70.

Wilton, R. 2003. Poverty and mental health: a qualitative study of residential care facility tenants. *Community Mental Health Journal,* 39(2), 139-156.

Wilton, R. 2004a. Putting policy into practice? Poverty and people with serious mental illness. *Social Science and Medicine,* 58(1), 25-39.

Wilton, R. 2004b. From flexibility to accommodation? Disabled people and the reinvention of paid work. *Transactions of the Institute of British Geographers,* 29(4), 420-432.

Wilton, R. and Evans, J. 2016. Social enterprises as spaces of encounter for mental health consumers. *Area,* 48(2), 236-243.

Wilton, R. and Schuer, S. 2006. Towards socio-spatial inclusion? Disabled people, neoliberalism and the contemporary labour market. *Area,* 38(2), 186-195.

Wolch, J. 1990. *The shadow state: government and voluntary sector in transition*. New York: The Foundation Centre.

Wolch, J. and Philo, C. 2000. From distributions of deviance to definitions of difference: past and future mental health geographies. *Health and Place*. 6(3), 137-157.

Wolpert, E. and Wolpert, J. 1974. From asylum to ghetto. *Antipode*, 6(1), 63–76.

Woods-Waters, A. 2012. Welfare reform and the Single Work Programme: a local perspective. *Local Economy,* 27(5-6), 475-479.

Wright, S., Fletcher, D.R. and Stewart, A. 2020. Punitive benefit sanctions, welfare conditionality and the social abuse of unemployed people in Britain: transforming claimants into offenders. *Social Policy and Administration,* 54(2), 278-294

Wrzesniewski, A. and Dutton, J. 2001. Crafting a job: revisioning employees as active crafters of their work. *Academy of Management Review,* 26(2), 179-201.

Wrzesniewski, A., LoBuglio, N., Dutton, J. E. and Berg, J. M. 2013. Job crafting and cultivating positive meaning and identity in work. In: A. B. Bakker ed. *Advances in positive organizational psychology: Vol. 1. Advances in positive organizational psychology*. Bingley, United Kingdom: Emerald Group Publishing, pp. 281-302.

Wykes, T. and Callard, F. 2010. Diagnosis, diagnosis, diagnosis: towards DSM-5. *Journal of Mental Health,* 19(4), 301-304.

Yakas, L. 2017. 'Work is love made visible': purpose and community in Clubhouses. *Disability Studies Quarterly*, 37(4). DOI: 10.18061/dsq.v37i4.6096

Appendices

Appendix A: Field note framework for ethnographic notetaking

DATE:
Work-ordered day

Morning catch up: Upstairs? Downstairs?
Comments:

Morning meeting
Comments:

Other meetings: Young people? B&A? W&L? Membership?
Comments:

Afternoon catch up: Upstairs? Downstairs?
Comments:

House meeting
Comments:

Education/learning activity

Well-being/ill-being

Relationships/community/belonging

Work that was witnessed/resisted

Mental work

Physical work/body work

Workspaces

Other comments:

Appendix B: Participant information sheet

School of Geographical and Earth Sciences, College of Science and Engineering, University of Glasgow.

INFORMATION SHEET

Working in the Clubhouse: experiences of work and employment. Research project.

Why have I received this information sheet?

My name is Eleanor Martin and I am a PhD researcher from the School of Geographical and Earth Science at the University of Glasgow. For my PhD project I am doing research about views and attitudes towards work and employment. I am distributing this information to let you know what the research is about and how you can get involved if you would like to.

What is the purpose of the research?

In my research, I aim to get a better understanding of people's experiences of working/not working and employment/unemployment to learn more about how the Clubhouse helps you and how it could help you further. I also want to learn more about the day-to-day running of the Clubhouse and the reasons that you choose to come here.

What will taking part in the research involve?

You are invited to take part in an informal and friendly interview, and this would last for about one hour (or less if you prefer) and would take place in a quiet room in The Club during its opening hours. I will ask you questions but you can answer as many or as few as you like. With your permission, I will take a sound recording of our interview so that I can listen back to it later so that I make sure I have a record of all the things you tell me. If you do not want to be recorded, I will make some hand-written notes instead. The themes that the interview will focus on are:

The organisation of the working day

Work and pace

Coming to the Clubhouse

Making connections in the Clubhouse

Working in the Clubhouse

The Clubhouse as a working community

Feelings about work

Transitional Employment Placements (TEPs)

Looking for work in the 21st century

Who is organising and funding the research?
My research is funded by the College of Science and Engineering at the University of Glasgow.

Can I take part in the research?
If you are either a member or staff at the Clubhouse then I would very much appreciate your participation in this research. It does not matter how often you attend, I want to hear from you. Your participation is *completely voluntary* but your involvement would be greatly appreciated.

You can withdraw from the research at any time.

What happens to the results of the research?
After I have collected all the data, I will analyse it to inform my PhD thesis. I will use direct quotations from the conversations that we have but your own name *will not* be included in this work. A different name will be chosen for you (or you can choose a name yourself). There are lots of members at The Club so it is unlikely that people will be able to identify you in the research. I will make sure I do not use quotations that may reveal anyone's identity.

Only I and my research supervisors will have access to the data I collect. All copies of the data, including any minimal personal details will be destroyed once the research project is complete. The research is compliant with the University of Glasgow's Data Protection policy and your anonymity and confidentiality is assured.

How do I take part?
You can contact me on the email address provided below. If you are a member and would like to take part, you can inform your co-worker and they will let me know that you are interested. Remember that your participation is entirely voluntary and you are free to withdraw from the research at any time.

Thank you very much for taking the time to read this information sheet.

Researcher contact details:

Eleanor Martin
Email:

If you have any concerns about the project, please contact the research supervisors and school ethics officer:

Professor Hester Parr (primary supervisor and ethics officer).
Email: Hester.Parr@glasgow.ac.uk
Dr Cheryl McGeachan (co-supervisor).
Email: Cheryl.McGeachan@glasgow.ac.uk

Appendix C: Participant interview consent form

RESEARCH PROJECT CONSENT FORM
This form must be completed by the research participant and signed in the presence of the researcher.

Tick appropriate box

Have you read and understood the information sheet?	Yes ☐	No ☐
Have you had the opportunity to discuss the research with the researcher and ask all questions you may have?	Yes ☐	No ☐
Do you understand that your participation in this research is completely voluntary?	Yes ☐	No ☐
Do you understand that you may withdraw from this research at any time?	Yes ☐	No ☐
Do you understand that, unless you request, all information provided may be used in the research?	Yes ☐	No ☐
Do you agree for the research to be audio recorded?	Yes ☐	No ☐
Do you understand that all information will be stored securely and destroyed once the research is complete?	Yes ☐	No ☐

Signature: **Date:**

…… ……..
Print Name:

……..

Appendix D: Interview schedule for member interviews

Interview schedule: The Club
(Pilot period Nov-Dec 2017)

I am conducting this interview as part of the research that I am doing for my PhD. You are taking part in this interview because you have read and understood the information sheet and read, understood and signed the consent form. *You understand that, with your permission, I am going to audio record this conversation*. Are there any questions you wish to ask me before we commence the interview?

Background information
How long have you been a member at The Club?
How did you hear about The Club?
What was your understanding of what The Club before you came here?
Were you in employment previously and was that relevant for your placement at The Club?
What did/do you know about the Clubhouse model?

Using The Club
How often do you come in to The Club?
What do you do most days when you are in The Club?
What are your usual working hours?
What are the most important things about coming to The Club for you?
How do you benefit from your attendance?

Working at The Club (personal reflections)
What does the word 'work' mean to you?
What does the 'work-ordered day' mean to you?
Is it difficult or easy to adopt the 'work-ordered day' at The Club?
Do you come to The Club to 'come to work'?
What is a 'good work day' at The Club?
What are your working responsibilities at The Club?
How does it feel to be in charge of work? And the work of others?
What happens if you feel you can't work at The Club on a particular day?
Do you feel like a 'Club worker' or do you think 'worker' is the wrong term for what happens here?
Do people around you check how well you are working? How?
Does work have to be fast or effective at The Club?
Is 'good work' discussed and how would that happen?
How do members know they have done 'good work'?
Can you think of any examples where the standard of work or the pace of work has been questioned?
Do you have to re-do work tasks to improve the work?
Is your work or your team's work reviewed? Would that help?
Has the experience of working at The Club made you feel a sense of self? Place? belonging?
Has the experience of work impacted your health and mental health?

How work is organised at The Club (organisational reflections)
Do you think working can help mental health recovery?
Do you think working helps your own mental health recovery?
Do The Club organise work in the best way to achieve this?
What does mental health recovery mean for you?
Have you ever undertaken a Transitional Employment Placement at The Club? If so, how was it? If not, why not?
Would you do *(another)* TEP?
How could TEPs be improved at The Club?
Are you interested in getting back into education? If so, why? Do you think education is important when looking for work?
If The Club didn't have a Work and Learning unit, what do you think would be different here?

Working outside The Club/moving on
Do you feel that The Club offers you a way to 'practise work' in ways that will help you get a job outside The Club?
How does The Club experience make you feel about getting back into employment?
Have you worked in the past? What did you do?
How did that work compare to work at The Club?
Do you think jobs and the job market have changed since you last had a job/since when you first began work?
Do you feel pressure from friends, family or mental health professionals to get a job?
How long will you stay at The Club?

Overall reflection on The Club
Is The Club a good place to make friends?
Do the activities in The Club make it easier to make good relationships?
What is it about working with someone else that helps a relationship grow?
If you could change one thing at The Club, what would it be?
Do you have more thoughts about work, The Club or recovery? Is there anything else you would like to say?

Thank you very much for taking this time out of your day to speak to me, I really appreciate it. Your thoughts are very valuable and will really help me in my research. If you decide later that you would prefer that I don't use this interview in my research, that's fine you can let me know.

Appendix E: Interview schedule for staff interviews

Staff interview schedule

I am conducting this interview as part of the research that I am doing for my PhD. You are taking part in this interview because you have read and understood the information sheet and read, understood and signed the consent form. *You understand that, with your permission, I am going to audio record this conversation.* Are there any questions you would like to ask before we commence the interview?

How long have you been a member of staff at The Club?
Were you aware of The Club before you applied for your position here? (i.e. through a student placement, or word of mouth).
What was your understanding of The Club before you came here for the first time?
Summarise what The Club does in two sentences.
Can you tell me what you know about the Clubhouse model?

What are your usual working days/hours?
What is your position here?
What are your core responsibilities in your role at The Club?
Have you worked in mental health before your position here?
Have you worked in 'employability' before your position here?

What differentiates The Club from other mental health projects in Glasgow/Scotland?
Have you visited any other Clubhouses? How do they differ from The Club?
What does the term 'mental health recovery' mean for you?
In what ways does The Club foster a feeling of community?

What does the term 'work' mean for you?
Can you explain the 'work-ordered day'?
What does a 'good work day' at The Club look like?
How can staff encourage 'good work' to take place?
What is the pace of work like at The Club? Fast? Slow? Does it vary? How?
Do you think there should be greater discussion of what work means within the House?

Do you (or have you ever) supervised a TEP? Tell me about that.
How could TEPs be improved in general?
What would be different about The Club if it didn't have a 'work and learning' unit?
The work-ordered day is highly structured around various meetings. How do you feel about that?
Can you tell me about consensus? Is it an effective decision making tool?

What do you value most about your job?
What is the most rewarding thing about being a co-worker?
What new programmes would you implement here, given unlimited time and resources?
If you could change one thing at The Club, what would it be?

Do you have any more thoughts about work, The Club, or recovery? Is there anything else you would like to say?

Thank you for taking the time out of your day to speak to me, I really appreciate it. Your thoughts are very valuable and will be a great help in my research. If you decide later that you prefer that I don't use our conversation in my research, that is no problem, just let me know.