The Relationship Between the Level of Personal Empowerment and Quality of Life Among Psychosocial Clubhouse Members and Consumer-Operated Drop-In Center Participants

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Statement of the Research Problem

The history of the treatment of people with serious mental illness is rich and complex. Only through deinstitutionalization in the last 20 to 30 years have mental health consumers, who were long-term residents of state psychiatric hospitals, been given the opportunity to be a part of community life again. Deinstitutionalization is a recent policy movement. Factors influencing this movement included: a) the funding of programs like Medicaid, b) the philosophy and promise of community mental health, c) the introduction of psychotropic medications, d) case law precedents in the legal arena, and e) the psychiatric survivor's movement (Gerhart, 1990). Today, the result is the emergence of a consumer role in planning, providing, and evaluating mental health services (Dixon, Kraus, & Lehman, 1994) and a move towards community-based care. In addition to community-based services, such as case management, psychosocial clubhouses, and community support programs, a variety of consumer-operated services have emerged, such as consumer case managers and consumer-operated drop-in centers.

The clubhouse model has emerged as a popular community-based service for people with serious mental illness, while consumer-operated drop-in centers have emerged as a popular consumer-centered service. Both provide important alternatives/adjunct services to the traditional mental health system. A psychosocial clubhouse is a place where people with mental illness can go for acceptance and learn new vocational and socialization skills. Work is the central tenet of this model (Vorspan, 1992). Clubhouses are comprised of learning or training units, such as the kitchen unit, the transitional employment unit and the clerical unit. In each unit, members and staff work in a partnership towards some agreed upon goal. The philosophical basis of the clubhouse model is based on empowerment. The overall function of the clubhouse model is to improve members' quality of daily life by providing daytime support and meaningful prevocational activities. Clubhouse members can participate in paid employment through Transitional Employment Programs (Mastbloom, 1992).

Drop-in centers are places, usually governed by consumers, where people can find friends and a sense of belonging (Chamberlin & Rogers, 1990). The self-help group, Justice In Mental Health Organization, defined a drop-in center as "a place which provides a critical social support function for high-risk hospital users with both organized and

informal recreational and social activities where individuals and center staff assist each other in solving their social, recreational, housing, transportation, and vocational problems" (Mowbray & Tan, 1992, p. 19). Hence, the overall goal of drop-in centers is to improve one's quality of life in these areas. The philosophical basis of drop-in centers are rooted in empowerment and usually follow a self-help approach where relationships are on equal ground (Meek, 1994), sharing power across rather than having the "helper" and "helpee" roles (Zinman, 1986).

Currently, there is a limited literature examining the relationship between personal empowerment and quality of life concepts, though additional definitions of empowerment are emerging (Chamberlin, 1997). Limited information also exists on the relationship between empowerment and quality of life among clubhouse and drop-in center participants. The number of studies investigating the effects of psychosocial clubhouses and consumer-operated drop-in centers is low compared to the overall proliferation of these programs in the mental health system. The social work profession has an opportunity to make a significant contribution to the knowledge base in each area above as social workers hold varied positions in the mental health arena.

Research Background Questions/Hypotheses

This study investigated the relationship between the level of personal empowerment and quality of life among 151 participants at three psychosocial clubhouses and three consumer-operated drop-in centers. The main purpose of this study was to explore the empirical relationship between empowerment and quality of life. A secondary purpose was to compare these two concepts among two groups of people with serious mental illness participating in two important but different community-based service options for people with mental illness: psychosocial clubhouses and consumer-operated drop-in centers.

The following research hypotheses were based on implications from the current literature and the experiences of the researcher which suggest that, currently, information assessing the relationship between the level of personal empowerment and the quality of life among clubhouse members and drop-in center participants was lacking in the literature. This study fulfilled this identified gap in the literature. The overarching research question is: What was the relationship between the level of personal empowerment and quality of life among psychosocial clubhouse members and consumer-operated drop-in center participants? This study tested the following three hypotheses:

There would be a positive correlation between the level of personal empowerment and quality of life across both groups of participants.

Consumer-operated drop-in center participants would report significantly higher levels of empowerment compared to psychosocial clubhouse members.

Consumer-operated drop-in center participants would report significantly higher levels of quality of life compared to psychosocial clubhouse members. Further refinement of the empowerment concept and predictors of personal empowerment were also explored.

Research Methodology

Design. This study employed a cross-sectional, correlational design using structured face-to-face interviews to investigate the relationship between empowerment and quality of life among 151 clubhouse and drop-in center participants. The exploratory and descriptive nature of this design was warranted based on the limited knowledge level of the relationship between personal empowerment and quality of life, as well as the differences among these and other characteristics among clubhouse members and drop-in center participants.

Sample. An availability sampling technique was employed to recruit 151 consumers (25 per site) for participation in this study. The author completed all 151 interviews. The limitations of availability sampling are well-known. These will be discussed in the full text of the paper, as well as efforts to overcome sampling bias.

Data Collection. Interviews were completed over a three-month period. The interview took about 30-45 minutes to complete and covered demographic and background information, level of personal empowerment, and subjective and objective quality of life domains.

Measures. Personal empowerment was operationalized using Segal and colleagues' (Segal, Silverman & Temkin, 1995) 10-item Personal Empowerment Scale (PES). Quality of life was operationalized using Lehman's Quality of Life-Brief Interview (QOL-B) (Lehman, Kernan, & Postrado, 1995). The QOL-B assesses the subjective and objective quality of life circumstances of persons with serious mental illness in eight life domains: a) living situation, b) daily activities and functioning, c) family relations, d) social relations, e) finances, f) work and school, g) legal and safety issues, and h) health. The PES and QOL-B have good reported psychometric properties.

Statistical Methodology

The data analysis plan utilized a three-stage approach. First, univariate statistics were used to provide the researcher with a description of pertinent demographic characteristics of the participants and determined the overall values on the PES and the subjective and objective QOL-B subscales.

Second, bivariate analysis, specifically, Pearson product moment correlation coefficients were applied to determine the relationship between the level of personal

empowerment and quality of life across both groups of participants (hypothesis 1). In addition, a one-way analysis of variance (ANOVA) and multiple analysis of variance (MANOVA) were applied to the PES and the objective and subjective QOL-B scales to determine if a difference existed between the clubhouse and drop-in center groups (hypothesis 2 and 3, respectively). Partial correlations and multiple analysis of covariance (MANCOVA) were also used to test the three study hypotheses for the effects of gender and use of psychotropic medication.

Finally, a three-stage multiple regression analysis to explore the contribution of demographic and background variables, and subjective and objective quality of life dimensions as predictors of personal empowerment was conducted. The Constant Comparative Method (Maykut & Morehouse, 1994) was employed in the analysis of the responses to the open-ended question on empowerment.

Results

The first study hypothesis predicted a positive relationship between empowerment and quality of life. As predicted, there was a low positive relationship between these two concepts for 13 of the 15 quality of life domains. The highest correlations were between empowerment and satisfaction with social relations and the amount of social contact. Study hypotheses also predicted drop-in center participants would report higher levels of empowerment and quality of life. As predicted, drop-in center participants reported slightly higher levels of personal empowerment. Mixed results were obtained for quality of life. Clubhouse members reported higher levels of general life satisfaction, more family contact, less victimization, and fewer arrests. Drop-in center participants reported more leisure activities, had twice as much monthly spending money, and better financial adequacy.

An open-ended question on empowerment was analyzed using the Constant Comparative Method (Maykut & Morehouse, 1994) and further refinement of the meaning of empowerment to consumers was offered. Five predictors of personal empowerment were found: a) being a nonminority, b) living in one's own private room, house, or apartment, c) high levels of social contact, d) high satisfaction with one's health, and e) high satisfaction with one's living situation.

Utility for Social Work Practice*

Note: Implications for mental health policy formulation, knowledge building and research, and program evaluation are offered in the full-text paper.

Historically, social work is a value-based profession focusing on advocacy for vulnerable populations of people to not only empower such groups as the mentally ill and the poor, but to also assist them in obtaining a better quality of life. Empirical evidence

and refinement of concepts, such as empowerment and quality of life, are important to the growth of theoretical practice models of the social work profession for two reasons. First, empowerment-based models, such as the strengths perspective (Saleebey 1996), are increasingly being used in direct practice with people with mental illness; such models need ongoing empirical evidence of their effectiveness. This evidence can also assist in the refinement of empowerment and quality of life concepts in empowerment-based models, so that the definitions continually develop with the empirical evidence.

Second, this study was an initial exploration of the relationship between empowerment and quality of life in psychosocial clubhouses and consumer-operated drop-in centers, two mental health settings in which social workers are employed or affiliated. Social workers comprise the largest professional group who work in the psychosocial clubhouse setting (Mastbloom, 1992). As such, social workers in clubhouse settings need to be knowledgeable about this relationship and interventions, which enhance clients' personal empowerment and quality of life because such knowledge can build member esteem and mastery. Many drop-in centers have affiliations with social work practitioners, social work policy makers and social work researchers. Social workers affiliated with drop-in centers would benefit with knowledge of personal empowerment and quality of life because it enhances their understanding of the drop-in center model and how it assists clients in obtaining resources, connections, and insight.

Third, the results of this study call for social workers to be able to clearly articulate their definition of empowerment and quality of life concepts, which are representative of social work practice principles and mental health service concepts. Well-defined nominal definitions of both terms are warranted because clinical practitioners are increasingly evaluating their practice, and social work administrators are evaluating human service programs. A critical examination of program evaluation material in social work curricula is needed. While most masters level social work programs may include program and practice evaluation in research courses, individual classes on these topics alone seem to be limited. Evaluation of programs and practice is necessary for social workers to add to the knowledge base on empowerment and quality of life, but more important, to direct financial resources towards programs and practice techniques which have successful outcomes for clients.

Fourth, with 92% of clubhouse members and 52% of drop-in center participants reporting use of psychotropic medication, social workers need to be cognizant of the affect medications may have on measuring empowerment and quality of life variables. Knowledge of such medications and their side effects and function is essential because of the number of new medications approved each year for mental illness. Social workers also need education about cost and compliance issues associated with medications.

Fifth, gender, ethnicity, and use of psychotropic medications may potentially explain the group differences on empowerment and quality of life domains. For this

reason, these variables should be considered when social workers design programs and practice techniques fostering increased levels of personal empowerment and quality of life in clients. A firm understanding of gender and ethnic differences with respect to mental health program development and design and social work practice techniques will arm the social worker with knowledge needed to create specialized programs and techniques to address these individual needs.

Sixth, social workers can play an important role in developing impact evaluations of clubhouse and drop-in center programs because they are employed in a variety of direct practice settings serving people with serious mental illness. Studies, which show the effectiveness of the clubhouse and drop-in center models are needed as policy makers and program planners begin to provide funds, based on outcome services research. Social workers should actively involve consumers in the research and program evaluation process.

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