An Active Treatment Alternative: A Clubhouse Model

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Although employment is an often cited goal for persons with head injury, only 20% to 30% of persons with severe disability after head injury subsequently enter and sustain employment (Kaplan, 1990; Thomsen, 1984, 1992). Existing services are becoming more costly and less available as a result of increasing limitations in public spending. For example, the Brain Injury Association reports that 95% of all persons with head injury do not receive the services they need to establish personal sufficiency. An alternative service delivery model that is addressing this challenge is the Clubhouse, a peer-directed, community-based model that provides long-term**,** community-based support for people with severe disabilities.

History of the Clubhouse Model

The Clubhouse model was begun by a group of patients at a psychiatric hospital who realized that one of the reasons for their frequent rehospitalizations was because they had no place to live, work, and affiliate after they were discharged (DeMello & Jacobs, 1994). Back in an unsupported community, these patients decompensated. Deciding to remain together as a community, the group called themselves "We Are Not Alone" (WANA), a name that was later changed to Fountain House when a hospital staff member donated a house to the group that had a fountain in the backyard. WANA began as an evening support group, meeting in various locations in New York City. Participation was open to anyone and focused on helping members in the daily challenges of community life. Although WANA functioned in its early years without staff, members realized the need for additional support to meet the challenges of the membership. The members hired John Bears, a social worker, who assisted the members in the direction of the program.

Beard had developed a therapy in the back ward of a large, custodial institution of chronically ill patients before the advent of psychotropic medication, based on the premise that therapy should consist of developing relationships responsive to expression of health instead of symptoms of illness (Anderson, 1997). Hence, Beard began working on algebra problems with a patient who muttered about persecution but indicated an interest in algebra. Bcars convinced several employers to hire patients at part-time jobs, with Beard himself training the patients, working with them some of the time, and taking responsibility for meeting performance standards. Beard found that as involvement in these activities continued, symptoms of illness diminished and behaviors expressing health and normalcy were augmented.

Beard was persuaded to move from Michigan to the New York area to become the executive director one month after the opening of the Fountain House. He opened the building during the daytime, and invited members in to help him clean, paint, and fix up the various rooms in the clubhouse building. He involved other members by engaging their assistance in helping a secretary, who had previously worked by herself, with various clerical operations. With a number of people now spending the whole day at Fountain House, Beard hired a staff worker who began engaging members in preparing and serving lunch for those at the club. Other work activities that grew naturally out of the needs of the club were soon started.

A design was soon established by which members joined with staff to help accomplish the work generated by the needs of their clubhouse. Through participation, members helped themselves by helping the clubhouse. The cooperation ensuing from working together and the appreciation expressed by those who benefited from that work, built relationships where members experienced themselves as valued contributors. By experiencing themselves as wanted, needed, and appreciated, the environment at Fountain House enabled members to help themselves by gaining a transformed self image.

The Clubhouse Model

Because it is a place for people to congregate and be accepted for who they are, the model became known as the Clubhouse. Membership is lifetime and people may enter and leave (and reenter) the Clubhouse at their discretion. Members are responsible for overall program operations, including answering phones, maintenance of the building, preparing meals, and program planning. Staff assist members, but responsibilities and job duties are the obligation of Clubhouse members. Moreover, staff members are purposely limited in number to assure that the Clubhouse cannot operate without member involvement hence, the work of the Clubhouse is the work of its members.

Clubhouse activities are organized into a work-ordered day. Tasks are divided into work units that logically represent program operations and activities, such as food service, maintenance, and clerical. Unlike similar program that merely simulate work, these tasks are critical to the operation of the program. Members choose work according to their personal goals and interests. In this process. members gain new work skills and interact with people. Although member work at the Clubhouse is

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not financially compensated, members are encouraged to become involved in the community and outside compensated employment. Although transitional employment provides the primary model for job development, members may also pursue time-limited community jobs, as well as supported work or competitive community employment.

In the 50 years since the Clubhouse model began, there are more than 300 Clubhouses in a dozen countries serving persons with psychiatric disability (Jacobs & DeMello, 1994). Since 1987, there have been six Clubhouse designed for persons with head injury. Clubhouses that extensively modified the model have not been successful; this has also been the case of Clubhouses that have combined persons with psychiatric disability with persons with head injury. Preliminary outcome data for the surviving Clubhouses for persons with head injury suggest that between 20% to 40% of its members have been able to return to work, 50% to 60% live in independent community settings, and up to 85% are independent in daily community activities (Jacobs & DeMello, 1994).

Philosophical Beliefs, and Policies of the Clubhouse Model

The Clubhouse model was one of the earliest to oppose the cultural tendency to make a total identification between his or her person and the disability (Anderson, 1997). Persons participating in the Clubhouse are called members, as opposed to patient or client. The Clubhouse model, according to Beard, Rudyard, and Thomas (1982), provides four profoundly important messages to every individual who chooses to become involved in its programs:

1. Since the Clubhouse is a club, it belongs to those who participate in it and who make it come alive. Memberships, as opposed to patient status or client status, is regarded as a far more enabling designation, creating a sense of the participant's belonging to a vital and significant society to which one can make in important contribution and work together with fellow members in the possibility of ultimately securing entry-level employment.
2. The Clubhouse is structured such that all members realize that their presence is expected on a daily basis. Staff and members of the house greet each member in the morning.
3. Creating a climate in which each member feels wanted by the program is the third intentional element in the Clubhouse model. This climate is a stark contrast to the atmosphere created in more traditional day programs where persons participate not because they are wanted by the program but because they are in need of the services provided to them by the program. All program elements are constructed to ensure that each member realizes that he or she is a contributor to the program. Each program is intentionally set up so that it will not work without the cooperation of the members. The members working side by side with staff share every function of the program. Staff never ask members to do any jobs that the staff would not do themselves.
4. Because the program is designed to make each member feel wanted and needed as contributor, the Clubhouse can prepare the member for the real world of work.

Guidelines have also been formalized through the International Center for Clubhouse Dissemination (1993):

Membership

1. Membership is voluntary and without limits.
2. The Clubhouse has control over its acceptance of new members. Membership is generally open to all people who have experienced brain injury unless that person poses a significant and current threat to the general safety of the Clubhouse community.
3. Members choose the way they utilize the Clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.
4. All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.
5. Members, at their choice, are involved in the writing of all records reflecting their participation in the Clubhouse. All such records are to be signed by both member and staff.
6. Members, have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a threat to the community.

Relationships

7. All Clubhouse meetings are open to both members and staff. There are no formal member-only meetings or formal staff-only meetings where program decisions and member issues are discussed.
8. Clubhouse staff are sufficient to engage the membership, yet small enough in number to make carrying out their responsibilities impossible without member involvement.

9. Clubhouse staff have generalist roles. All program staff share employment, housing, evening and weekend, and unit responsibilities. Clubhouse staff do not divide their time between Clubhouse and other major work responsibilities.
10. Responsibility for the operation of the Clubhouse lies with the members and staff and ultimately with the Clubhouse director. Central to their responsibility is the engagement of members and staff in all aspects of Clubhouse operations.

Space

11. The Clubhouse has its own identity including its own name, mailing address, and telephone number.
12. The Clubhouse is located in its own physical space. It is separate from the mental health center or institutional settings, 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.
13. All Clubhouse space is member and staff accessible. There are no staff-only or member-only spaces.

Work-Ordered Day

14. The work-ordered day engaged 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 is inconsistent with medication clinics, day treatment or therapy programs within the Clubhouse.
15. 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.
16. The Clubhouse is open at least five days a week. The work-ordered day parallels normal working hours.
17. All work in the Clubhouse is designed to help members regain self-worth, purpose and confidence; it is not intended to be a job-specific training.
18. Members have the opportunity to participate in all the work of the Clubhouse, including administration, research, intake and orientation, reach out, hiring, training and evaluation of staff, public relations, advocacy and evaluation of Clubhouse effectiveness.

Employment

19. The Clubhouse enables its members to return to paid work through Transitional Employment and Independent Employment; therefore, the Clubhouse does not provide employment enterprises or sheltered workshops.

Transitional Employment

20. The Clubhouse offers its own transitional emp1oyment program, which provides as a right of membership opportunities for members to work on job placements in business and industry. The Transitional Employment program meets the following basic criteria:
    a. The desire to work is the single most important factor determining placement opportunities.
    b. Placement opportunities will continue to be available regardless of success or failure 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 20 hours per week and six 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 Transitional Employment for all appropriate agencies dealing with members' benefits.
    i. Transitional Employment placements are managed by Clubhouse staff and members and not be specialists.
    j. There are no Transitional Employment placements within the Clubhouse itself or its auspice agency.

Independent Employment

21. The Clubhouse assists and supports members to secure, sustain and upgrade independent employment.
22. Members working full time continue to have available all Clubhouse supports and opportunities including advocacy for entitlement, and assistance with housing, clinical, legal, financial and personal issues as well as participation in the evening and weekend programs.

Functions of the House

23. The Clubhouse is located in an area where access to local transportation can be assured, both in terms of getting to and from the program and accessing Transitional Employment Opportunities. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.
24. Community support services are provided by members and staff of the clubhouse. Community support activities are centered in the work unit structure of the Clubhouse and include helping with entitlements, housing, and advocacy, as wall as assistance in finding quality medical, psychological, pharmacological and substance abuse services in the community.
25. The Clubhouse is committed to securing a range of choices of safe, decent and affordable housing for all members. The Clubhouse has access to housing opportunities that meet these criteria, or if unavailable, the Clubhouse develops it's own housing program. In Clubhouse training:
    a. Members and staff manage the program together,
    b. Members who live there do so by choice;
    c. Members choose the location of their housing and their roommates;
    d. Policies and procedures are developed in a manner

congruent with the rest of the Clubhouse culture.

e. Members and staff actively reach out to help members keep their housing, especially during periods of decompensation.

26. The Clubhouse provides members education, which focuses upon basic tools such as literacy and computer skills as well as more advanced educational opportunities. As a significant dimension of the work-ordered day members serve as major resources for tutoring and teaching the member education programs.
27. The Clubhouse assists members to take advantage of the adult education system in the community in support of their vocational and personal aspirations.
28. The Clubhouse has a method and takes responsibility for objectively evaluating its own effectiveness.
29. The Clubhouse director, staff members, and other appropriate persons participate in a three-week training program in the Clubhouse model at a certified training base. Consultations by the International Center for Clubhouse Development are provided to all programs seeking to implement the model.
30. The Clubhouse has recreational and social program during evening and weekends. Holidays are celebrated on the actual day they are observed.
31. The Clubhouse provides an effective reach out system to members who are not attending, becoming isolated in the community or rehospitalized**.**

Funding, Governance and Administration

32. The Clubhouse has an Independent Board of Directors, or if it is affiliated with a sponsoring agency, has separate Advisory Board comprised of individuals. Uniquely positioned to provide fiscal, legal, legislative, consumer and community support and advocacy for the Clubhouse.
33. The Clubhouse develops and maintains its own budget, approved by the board or advisory board prior to the beginning of the fiscal year and monitored routinely during the fiscal year.
34. Staff salaries are competitive with comparable positions in the mental health field.
35. The Clubhouse has the support of appropriate public authors and has required licenses or certifications. The Clubhouse seeks and maintains effective relationship with family, consumer and professional organizations.
36. The Clubhouse holds open forum and has procedures which enable members and staff to actively participate in decision-making regarding governance, policy-making, and the future direction and development of the Clubhouse.

Management of the Clubhouse

Nothing is more striking about a well-run Clubhouse than the blending of staff members and club members in the fulfillment of daily work tasks. Members become better and more competent in their tasks because the staff working along side them need their help and talents and seek them out on a regular basis. The attitude is in sharp contrast to traditional training and treatment programs that seek to empower club members through a separatist mentality that leads to the alienation of both members and staff (Glickman, 1989). Rather than asking questions as how members can be motivated, staff in Clubhouses ask what they as staff can do to make a more attractive clubhouse. Staff seek ways to make the clubhouse more inviting and more welcoming to members. Staff also seek new opportunities to help members find a niche in the clubhouse world and to develop a supplicated range of transitional employment jobs. Finally, staff take risks and delegate responsibilities for those who might otherwise be overlooked (Glickman, 1989).

In helping members to take on more responsibility, the staff take on even more responsibility themselves. The responsibility lies with the staff because they have to be in the clubhouse every day to assure the continuity which enables a sophisticated opportunity center to run smoothly. Staff members create a context in which club members are provided with the right and with the opportunity to give and take according to how much they are able and where they can be best served. In turn, staff offer their talents and skills in a way that is hopefully most satisfying to them as well.

At first, the staff are at the center of the clubhouse, because the members need someone to say, "You can do it and I'll do it with you" (Glickman, 1989). From the director on down, there must come a sense of urgency that more and more will be done in the clubhouse. There is no more motivating force for staff than knowing that without the help of the members they cannot accomplish the work for which they are responsible. When the director expresses enough urgency for more opportunities, the staff will have to move faster and struggle harder to find the member talent to get the work of the clubhouse done.

Finally, there is a delicate balance between the duties of staff and members. The operation of the clubhouse is ideally a partnership between members and staff where members can co-manage any aspect of the club's operation but can always depend upon staff to pick up the slack. Staff must also relinquish, delegate, and share status with members. Finally, the bottom line responsibility of the staff is to create a clubhouse where staff are fully immersed in the clubhouse culture with the members.

Conclusion

The Clubhouse model is a cultural development which has evolved over fifty years. Its evolution has been driven by the unfolding implications of a single conviction - that disability is not the whole of a person and that persons with disability retain normal, healthy needs, capabilities, and aspirations (Anderson, 1997). The Clubhouse model has fought against the prevailing cultural notion that persons with disability are unfit for normal involvement in society. The Clubhouse model stands for communities designed to promote recovery from disability by reversing this separation and bringing people together with processes of normal life.

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