

The Clubhouse: Addressing Work-Related Behavioral Challenges  
Through a Supportive Social Community <sup>1</sup>

Harvey E. Jacobs, PhD

Private Practice

Philadelphia, Pennsylvania

Jacobs, H.E. “The Clubhouse: Addressing work-related behavioral challenges through a supportive social community.” Journal of Head Trauma Rehabilitation, *12*:(5), 14-27, 1997.

Running Head: Social Supports and Behavior

1. Contact: Harvey Jacobs, 9221 Forest Hill Avenue, Richmond, VA 23235  
(804) 814-0609, e-mail:[hejacobs@comcast.net](mailto:hejacobs@comcast.net)

## The Clubhouse: Addressing Work-Related Behavioral Challenges Through a Supportive Social Community

Employment remains an often cited but elusive goal for the majority of people who experience severe disability following brain injury. Two decades of outcome studies consistently report that only 20% to 30% of all people with severe disability following brain injury subsequently enter and sustain employment<sup>1-5</sup>. Yet, despite such poor odds it should come as no surprise that employment remains an important goal.

First, wages remain a primary means of covering the costs of living in the community. Second, compensated employment is the predominant daily activity pattern for most adults in our society. Third, work offers important opportunities for socialization, access to recreation and other avocational venues that may not otherwise be available. Research has also documented that the incidence of physical and mental illness, asocial behavior, marital problems and other distressful life events increases following job loss, even among "non-disabled" populations, but are typically rectified through the reversal of vocational mis-fortune<sup>6,7</sup>.

Whereas physical, cognitive and behavioral disabilities are often cited as the primary reasons why many people do not attempt employment after brain injury<sup>8,9</sup>, interpersonal skill deficits and behavior dysfunction are the primary reasons identified for people subsequently losing employment<sup>10-12</sup>. Frequent reasons for dismissal include unacceptable social interaction, poor social awareness, loss of motivation, inflexibility to changing work demands, anxiety, decreased frustration management, anger, boredom and isolation. Unfortunately, these descriptors do not fully identify the actual causes of job loss. Behavior is not its own entity but a product of the interaction between a person and their environment. It can have many causes, especially in the work place, with noted "behavior problems" produced by many different factors.

Because half of all traumatic brain injuries occur at age 22 or younger, many people have little work experience prior to the time of injury. For many younger people, job placement following brain injury may be their first exposure to work. Here the challenge is not one of vocational re-habilitation, but of initial vocational training and job experience (i.e., vocational habilitation). Without proper training **and** sufficient experience to integrate skills into daily repertoires, many people are unable to effectively address the pre-vocational, vocational and social challenges that inhabit the workplace. It is therefore not surprising when people decompensate on the job. They are simply doing the best they can with available, but incomplete abilities.

There is no doubt that persisting brain injury sequelae also contribute to poor job performance. Impairment related deficiencies of attention and concentration, problem solving, frustration management, adaptability to changes in response sets and work situations, stamina and other problems can all challenge work placement and job maintenance<sup>9,13</sup>. Many people are especially susceptible to changes in work demands after vocational rehabilitation services have been "successfully" terminated. Few work sites are stagnant, especially in today's economy as businesses continually adapt to ever increasing social and market place changes. The position that an individual was successfully placed and trained in six months ago is unlikely to resemble the workplace they face today or tomorrow. As businesses change, supports established during job coaching may no longer be relevant to the work environment. However, the worker is now on their own and may be unable to successfully manage this challenge.

Inadequate community and psycho-social supports may also impair job performance. Deficient housing and transportation may make it difficult to get sufficient rest or arrive to work on

time. Instability at home, with family or friends, or in the community can easily unbalance a delicate social homeostasis previously negotiated by a job coach or treatment team. Arguments can easily spill onto the job and persisting problems at home can distract even the most dedicated worker. Those within a person's supportive network, including family members, may not understand job responsibilities and schedule competing demands or minimize the accomplishment of staying employed. Employment efforts may even be sabotaged by people close to the worker who may be concerned that return to work will upset other needs and benefits, such as disability payments and medical assistance. Most entry level jobs do not provide such benefits or adequate salaries to cover these expenses

In rare cases, severe behavioral decompensation may occur at work, but people with such presentations are usually screened out of job placement efforts early in the evaluation process. Instead, it is generally the subtle and insidious problems that build over time which often challenge job tenure.

The dynamics of the vocational rehabilitation service delivery system can also contribute to "behavioral disruption." Employment opportunities are much more influenced by the market place than the Vocational Rehabilitation Act. People applying for vocational rehabilitation assistance may have to wait too long to receive adequate services, something that is excruciatingly difficult without income or financial reserves. Many people simply give up or attempt their own solutions with varying results. Different people also have different service needs. Some may require a comprehensive continuum of assessment, skills training, job creation and supported employment. Other people may find their own jobs but require opportunistic support at critical times, and not according to scheduled therapist availability.

Finally, determination of successful placement after 60 days of independent work, the famous "26 closure," has been repeatedly demonstrated as inadequate for many people who experience disability following brain injury. People may require long-term, intermittent support at critical vocational and life junctures. Follow-along services attempt to address this issue, but can be exceedingly expensive when delivered under a traditional treatment model<sup>14</sup>. Employment maintenance support groups have variable success. Most people drop out after a few sessions due to lack of interest and are unlikely to return at the first signs of job trouble when problems may be more easily remediated. Once employed, many people do not want to return to the hospital or treatment center where they may have to more acutely face their disability or return to past roles as patients. It's hard to come back to a group, hat in hand, when your principal relationship to other people is based on failure.

When we holistically view these factors it is possible to recognize a wide range of variables and relationships that contribute to incomplete vocational outcomes due to "behavior problems."

- Impairment from brain injury clearly produces a wide range of disabilities that can directly affect job performance or the ability to even attempt employment.
- Disability and handicap following brain injury changes interpersonal roles, values and relationships. This often makes the individual attempting work more vulnerable to the influence of others who may not understand or support the person's goals, or the means to achieve these goals.
- Up to half of all people who experience severe disability following brain injury have limited job experience. Technical skill training alone is frequently insufficient for work stability. Many people also need pre-vocational and social skills training with sufficient time to integrate these skills (via experience) into their daily repertoires.

- Vocational services must be responsive to the demands of the job, realities of the employment market place, and provided when needed and not when convenient to schedule.
- Many people will need long-term, intermittent monitoring and support. The challenge is how to make such services palatable and affordable.

Present day vocational rehabilitation services are effective for a number of individuals. But, there is no singular model for everybody. Different people may respond better to different service delivery models. One such approach is the Clubhouse, a program that originated 50 years ago by and for people who experience disability due to psychiatric impairment<sup>15-17</sup>. In the past ten years this model has also been successfully adapted to meet daily living and vocational challenges for a number of people who experience disability following brain injury<sup>18-22</sup>. Approximately 10 such programs now operate in the United States. Clubhouse design and operations also appear to programmatically address some of the classic social and interpersonal "behavioral problems" and service delivery challenges reported when people who experience disability following brain injury attempt employment.

### The Clubhouse Model

Throughout this article the words Clubhouse and Clubhouses are used interchangeably to represent a specific service delivery model.

### Membership

A Clubhouse is a consumer-directed, community-based day program that is operated by and for its members who experience disability following brain injury. There are no patients or clients in a Clubhouse, only members of all ages (range 17 - 70) who take responsibility for the program's overall goals and daily direction. In this manner people begin to re-assume positive identities and responsibility for their goals and destiny.

"Person first" philosophy is a matter of daily Clubhouse operation. Although most people may enter the program by virtue of neurologic impairment, each person is recognized according to their own interests, goals and abilities. Thus, there are no "brain injured people" in a Clubhouse, but there are people with numerous abilities, goals and interests who also happen to have experienced brain injury. Limited staff assist members as needed, but they are also part of the milieu and must adhere to the same program rules as all other members.

Each member is regarded expert in expressing their needs and long-term goals. On a regular basis each member meets with a staff member of their choice to review past progress, establish new goals, identify Clubhouse and community resources to meet goals, and the means to evaluate progress. Goals are rarely disputed. Instead, members are encouraged to break down large or magnanimous goals into smaller steps that can have immediate benefit. Thus, the member who wants to become a truck driver will be supported in this long term goal and encouraged to first learn how to use local transportation without getting lost. This is not only important for truck driving, but also necessary to be able to get to appointments and other community commitments on time. In this manner the dignity of the larger goal is maintained while working on a smaller component that has relevance to a variety of larger options.

The emphasis on member direction purposely affects staff behavior. Because there are insufficient staff to operate an entire Clubhouse, staff have no choice but to work with and rely on members. By established standards<sup>21</sup> no program operations can occur without member

involvement. As a result, staff roles are facilitative rather than directive and follow members' leads. Staff are also deployed opportunistically according to member preferences, goals, and activities. Thus, the coach on a new job is likely to be the staff who works most closely with the member at the Clubhouse. The two already have a good working relationship and are familiar with each other's abilities. Similarly, staff and members work together according to need rather than a schedule. A member with few needs may use little staff time and get most of their support from other members and the program's social milieu, while another member in crisis may receive intensive assistance. "As needed" usage allows "zone vs. person-to-person" deployment of staff, which provides greater flexibility and more efficient use of available resources.

Finally, Clubhouse membership is forever. Members may transition in and out of daily participation for many different reasons. These may include employment, school, personal interests, other competing activities, changes in family and extended support network structure, and so on. Members who are absent on days they customarily attend are contacted by other members to assure they are okay (not why they failed to come in). Identified problems are referred to the proper resources for assistance. Similarly, members who leave a Clubhouse day program are contacted at least monthly to learn of their status. A member may re-appear at the Clubhouse at any time and re-enter its activities on that same day. Re-entry is rarely difficult since people know one another and daily program routines. Returning members never crowd out currently active members as there is always more work than can be accomplished within the program.

### Daily Organization

Between 15 and 60 members may participate in a Clubhouse on a daily basis, according to its size and location. As with any organization tremendous work is required to keep the program operating. Clubhouse tasks are organized into work units to aid the efficiency and accountability of operations. Thus, the Clerical / Communications Unit manages Clubhouse telephones, correspondence, public relations, fund raising, newsletter publishing, tours and training of visitors, orientation of prospective new members and other associated tasks. The Kitchen Unit plans menus, shops for supplies, and prepares meals, beverages and snacks that are available at a nominal cost. The Maintenance Unit keeps the Clubhouse clean, repaired and performs minor construction. A Research Unit maintains data on attendance and other data required for reports, reimbursement, grants and formal publications. Other Clubhouse activities are similarly organized to facilitate overall operations.

No member is assigned to any unit or required to do any work. Members select any unit they wish to participate in according to personal interests and can change units at any time. Some members select a unit based on a vocational goal and the skills that they can learn. Others select a unit based on personal interest or to survey different jobs in order to find their work aptitude and interests. Still other members may select a unit because of people they know, or according to other personally relevant criteria. Members rarely move capriciously across units and most changes are made following careful deliberation.

All work in a Clubhouse is functionally related to member goals and program operations. Aggregate member goals set the focus and direction of the overall program and daily program activities concomitantly help members achieve their goals. There is simply no "make work" designed to keep members busy.

Members place a greater value and responsibility to their work since it has direct programmatic implications. Aggregately, the success or failure of a Clubhouse may depend on how

well people work together. However, this long-term outcome is beyond most people's awareness. Instead, the daily events direct the focus and molding of individual member skills. Thus, members purchasing meals from the kitchen clearly make their pleasure or concern known to the cooks. The telephone receptionist may receive a thank you for a message he or she took for another member that resulted in a new apartment. A member who fails to show up for a meeting with another member will probably hear about it from the other member and how it prevented their job from getting done. Somebody who passes off shoddy work will probably get it returned by the recipient. Alternatively, someone who helps another member with a difficult task will frequently receive their sincere appreciation.

This type of feedback is very concrete, generally well articulated and immediate. Most people are willing to listen because of the supportive Clubhouse environment. The context of the feedback is also clear since it is provided in the setting where the work or behavior occurred. These are all critical features for any effective behavior change program.

### Program Costs

By virtue of its community basis, member direction and organizational structure, Clubhouses can provide their full-day services for a direct cost between \$30.00 and \$60.00 per member per day, depending on location and organizational affiliation. This makes long term programmatic support financially viable for many potential members.

### Skill Development

Within a Clubhouse people focus on practical goals that relate to daily life. Few members "learn the computer," but many people learn how to keep daily logs, manage expenses, write letters, etc., using a computer. This helps provide a direct and immediate benefit to skill mastery.

Second, large - global skills are broken down into daily steps consistent within program activities.

Third, the rich context of events in a Clubhouse provides broad support and numerous cues to support learning.

Fourth, members learn experientially, through daily activities with numerous opportunities for feedback and repetition. Training is also adapted to the manner in which each member actually learns, rather than how they are "supposed" to learn.

Fifth, members look to one another as well as staff for training and assistance. There is usually someone close by when help is needed.

Sixth, the long term focus of a Clubhouse supports gradual assimilation of skills, allowing people to learn at their own pace.

Seventh, people learn skills and the situations in which the skills are customarily used. For example, it is one thing to learn how to operate office equipment in a classroom and another to learn how to use the equipment in an operating work environment where other people are also using the machines, equipment failures occur, and deadlines loom.

Finally, a Clubhouse environment is not capable of helping all members develop requisite skills. However, through Clubhouse experience it is possible to more precisely identify a person's training needs and refer them to more appropriate services through schools, therapies, apprenticeships and other venues.

The daily Clubhouse milieu may also support practical and continuous assessment of each member's strengths and challenges. Different indices can be combined to assess different activity

patterns. Thus, daily attendance, productivity within work units, initiation, time on task and social interaction can help determine if a member may be capable of attempting employment. Information on a member's interpersonal relationships, task demands, and activity levels within a Clubhouse may help to determine when he or she is able to work with others and when behavioral decompensation is likely to occur.

#### Social Supports to Behavioral and Vocational Ability

These subtle distinctions are essential to the orientation, operation and success of each Clubhouse<sup>21</sup>. They also help to minimize some of the iatrogenic contributions to social and interpersonal behavior dysfunction. First, because people are recognized for ability over disability, individual roles and relationships are based on contribution rather than dependency. People treat each other with respect and there is tolerance among Clubhouse members. When problems do occur members are likely to be more understanding of the situation and help the member in crisis. At the same time this person is expected to accept ownership of the issue and responsibility for its resolution. Life continues within the Clubhouse and the individual in crisis is recognized as a valued member of the program who is dealing with a problem, rather than a problem member who comes to the Clubhouse.

Anthony was a valued member of the Clerical / Communication Unit, but had a low frustration tolerance and would sometimes throw things at walls. One day he threw a broken stapler at the wall and stormed out. When he returned, another member had pasted a picture of a stapler encircled by the universal "NOT" symbol on the unit door with the following inscription: "Every three minutes across the United States an office stapler is verbally or physically abused. Stop the madness!" Anthony broke out laughing when he saw the sign and never threw a stapler, or anything else again.

COMMENT: Members were able to address Anthony's challenge with a unique perspective, based on their ongoing social relationships.

Second, each member is responsible for deciding when and how they participate and entrance criteria are minimal, basically the ability to be involved in a community-based program. As a result, the approximately 80% of applicants who choose to join the program sustain a high level of motivation.

Because of personal choice, there is no "controlling party" to rebel against because someone is forced to do something against their choice. At the same time, the social milieu of the program encourages productive participation. Members come to understand their unique opportunity to marshal Clubhouse resources for their personal goals. We find that most people are working as hard as they can to regain control of their lives. Since each member establishes and monitors their own goals, there is a higher level of personal accountability and the opportunity to come to grips with some of the more difficult issues of adapting to life with disability.

Fourteen years ago 25 year old Lisa was involved in an automobile crash and remained in a coma for 45 days. After extensive cognitive retraining, she first attempted to return to her job as an employee trainer and then as a clerical assistant with no success. Lisa was devastated. She loved her job and much of her self-image was invested in her work. She remained at home for the next eight years wondering what she could do.

Two years ago Lisa entered a Clubhouse still intent on returning to work. Unable to accept work she felt was beneath her, she became very selective of the jobs that she would consider. Even at the Clubhouse, though polite to other members, she would only associate with the staff. Gradually, and with subtle coaxing from the staff, Lisa started teaching other members how to use computers.

Lisa was able to face some of her own challenges while working with other members. She got frustrated when other members forgot, but realized that her memory wasn't all that great, either. Finally, still wanting to return to work and armed with a new understanding of herself, Lisa took an entry level job in a bank. With support from her newly found co-workers, Lisa has now been working at the bank for nearly two years.

COMMENT: Lisa was never ready to hear from others about her limitations, but when given the opportunity to explore her own abilities from a perspective of competence (teaching other members how to use a computer) she was able to more dispassionately understand her attributes and limitations. In addition, she found that she was much more to people than just a good worker.

Third, a Clubhouse is a program of long-term support and recognizes that learning and making changes take time. The program purports no "cures" for brain injury or the ability to reverse long term sequelae in a 30 to 60 day period. This reduces unrealistic expectations, frustration and anxiety while allowing people to progress within their own pace, abilities and resources. Inability to achieve a goal is not viewed as a failure or the loss of the **only** opportunity one may have to make a change, but as important information to try another way.

Paul had a significant verbal memory deficit and carried a log book to record daily events. Unfortunately, he frequently forgot where he put the book, which in turn would disrupt his daily routine. One day he announced that he was going to use a computer to keep his log. He explained that a computer was too big to move, so he couldn't carry it around and lose it.

Due to his memory deficit it took Paul two weeks just to remember which Clubhouse computer he was using. Over the course of the next six months he pieced together enough knowledge of WordPerfect 5.1 to keep his log. With mass repetition and someone, often another member, around to answer his immediate question, he learned enough to meet his goal. In fact, he also bought a computer for use at home.

COMMENT: By all practical and professional indices we probably would never have suggested that Paul even attempt learning how to use a computer program, especially one with such a verbally intensive interface. It is still not clear how Paul learned to use the program, but he was able to within his own schema of memory and learning.

Fourth, Clubhouses are "of and by the community." Programs are located in community settings away from hospitals and other rehabilitation programs. As a result, people assume roles within the community rather than the patient or client roles of a treatment program. Clubhouses rely on community resources for daily operation; everything from shopping, to work, to education. Activities and resources that are locally available are not duplicated in a Clubhouse. Thus, each member becomes involved in settings where they are likely to continue to use acquired skills. This

helps to reduce problems of confusion, frustration, amotivation, incomplete generalization and poor skill maintenance that may occur when people attempt to learn new skills in settings that are unfamiliar or inconsistent with their own lives.

### Return to Compensated Employment

Members are not paid for work performed in a Clubhouse. Those with requisite job skills are supported in their efforts to seek paid positions in the community. This prevents a Clubhouse from assuming characteristics of sheltered work and further supports the development of normative opportunities. Most employed members maintain some form of continued program involvement and may still rely on Clubhouse operations for social contact or support with other aspects of daily living.

Recently published data <sup>22</sup>, reported that 35% of the members in the MossRehab Clubhouse in Philadelphia, Pennsylvania and 17% of the members in the Dayle McIntosh Clubhouse in Anaheim, California had participated in compensated work experience through their respective Clubhouse programs. Members for both Clubhouses principally consisted of individuals who had been previously determined as not able to sustain employment, or who had been unsuccessful in past job placement attempts. Thus, they represented the 75% of all people with severe disability following brain injury who generally fail to attain employment <sup>1-5</sup>. In this respect, Clubhouse programming may provide an additional venue to help to increase the overall percentage of people who experience disability following brain injury who were able to return to work.. Still, a significant number of people who experience severe disability following brain injury remain unemployed, but productively involved in a daily community venue of a Clubhouse.

Members develop vocational goals by virtue of their within program experiences, personal skill development and strong social supports for productive activity. "Budding vocational abilities" may also be more quickly discovered by staff by virtue of their nearly daily contact with members, than by members who have limited insight or vocational experience. These abilities may then be more quickly developed by virtue of the staffing strategies available in a Clubhouse.

Some members rely on "traditional" supported employment services. Job coaching may either be provided by a designated job coach or the Clubhouse staff that the member is most comfortable working with. Follow-along services are automatically provided once job coaching has ended by virtue of the continuing contact provided to all Clubhouse members. In addition, staff can be immediately deployed to the work site in the event of problems.

Other members are able to find their own jobs or begin employment without staff assistance. When possible, some level of job performance monitoring is established with the member. More intensive assistance such as job coaching, employer contact and support for other daily living situations that may affect work remains available to all members when ever it is necessary.

Transitional employment (TE), a staple of Clubhouses operated by and for people who experience disability due to psychiatric impairment <sup>23</sup>, is a relatively new concept in vocational rehabilitation for people who experience disability following brain injury <sup>22,24</sup>. Under TE a Clubhouse contracts for paying jobs with local community employers. Members enter the positions for time limited periods and receive job coaching from Clubhouse staff. After a three to six month period, the employed member transitions out of the job and a new member enters. The exiting member may enter another TE position, attempt permanent employment, seek education or training opportunities, or return to daily Clubhouse activity.

Although this approach appears counter-intuitive to the traditional "place and train" model of supported employment<sup>25-27</sup>, many people who experience disability following brain injury appear to benefit from this model. Because employment is time-limited, people are willing to try jobs that they would avoid if being placed for long term employment. This encourages people to sample new opportunities. Second, the amount of job coaching required for TE positions is significantly less than supported employment positions. This may be due to positions being less complex and the fact that many peripheral issues that are critical to job success are addressed by other Clubhouse systems. The daily opportunities for observation and training of skills in Clubhouse help to address some of the pre-vocational and social skills training issues that might otherwise have to be taught on the job.

Members do gain experience and retain basic skills acquired on TE assignments that can be applied to other positions. By virtue of the type of positions that comprise most TE placements, those members who are transitioning out of a TE position and remain interested in continuing similar employment are frequently hired by the employer in an equivalent position. The TE position itself, however, remains with the Clubhouse for the vocational benefit of other members.

### Case Examples

The following cases demonstrate some of the different ways that program operations can help to support individual member's vocational involvement. Some of the techniques used are similar to "traditional" rehabilitation programming. The alternative service delivery model of a Clubhouse does not preclude its use of available and effective strategies.

#### Case of Donald: Gradual Work Return and Awareness

Donald was a 25 year old male who was seven months post viral encephalitis and recently discharged from outpatient treatment when he entered the Clubhouse. He reportedly became verbally aggressive and physically agitated in the apartment he shared with his mother, sister and two teen age nieces and was on a variety of psychotropic medications.

At first Donald slept most of the time, so his psychiatrist agreed to wean him off all but his anti-seizure medications. As dosages decreased Donald became more active and joined the Kitchen Unit because of his work history as a cook. Over the next two and a half months Donald assumed responsibility for management of the Clubhouse kitchen, teaching members and staff efficient operations and new recipes.

Donald then approached his former employer and was offered a dish washing job. The employer understood that Donald had to stop work by 9:00 PM since lack of sleep was a precursor to seizures, but scheduled him until 2:00 am the first night. When Donald asked to be relieved because he was not feeling well, he was told him not to come back to work if he left. Donald returned to the Clubhouse the next day where he was congratulated for his decision to protect his health over his job. He was offered support to approach the employer to re-instate his job, but he declined.

Over the next six months Donald continued his participation at the Clubhouse while exploring a number of vocational and educational opportunities through the Clubhouse and state vocational rehabilitation services. Ultimately, following a lead from a friend, he landed his own job as a chef that he sustained over eighteen months until the restaurant closed. Donald then went on to work in a retail clothing store.

COMMENT: There is good evidence that Donald's initial "behavior problem" was iatrogenic in nature, having to live in a crowded apartment with little chance for other social contact or productive activity. No behavioral problems were noted in the Clubhouse environment where he could set his own activity levels. With the cessation of medication Donald became one of the program's more industrious members.

Donald was subsequently able to resume his career as a cook but only after facing the undesirable dilemma of health vs. work place demands. Termination of the work site did not mean termination of program services and support opportunities for Donald. Over subsequent months, Donald integrated Clubhouse resources with other resources to investigate his future opportunities and ultimately land a new job.

#### Case of Beatrice: Benefits of Transitional Employment Experiences

Beatrice was a promising writer in high school until her hypoxic injury. She entered the Clubhouse approximately three years later with no vocational or educational activity pattern. However, she remained interested in continuing her writing and possibly going to college.

Beatrice first worked in the Clerical / Communications Unit and continued her writing with little success. Her follow through on activities was minimal and she was generally unsuccessful in her attempts to complete writing or clerical projects without substantial assistance. Her attendance and punctuality were also sporadic. However, she was unwilling to consider other alternatives. Despite these problems, she was able to successfully accomplish other goals of independent money management, learning to use a word processor, home maintenance skills and greater participation in community activities during this same time.

Finally, twenty-two months after entering the Clubhouse, Beatrice decided to switch to the Kitchen / Maintenance Unit and sample other types of jobs. Much to her surprise she liked the work. Her attendance and punctuality also dramatically improved. When a janitorial transitional employment position opened a month later, Beatrice assumed the challenge.

With job coaching, Beatrice quickly learned the technical skills of the job but had trouble getting to work on time. On some occasions her mother did not drive her to work on time. On other occasions her father used the bathroom before her in the morning and took too much time, making her late. Contact with the family finally revealed their fears that Beatrice would lose her medical assistance benefits if she were successful at work. She had a chronic medical condition that required expensive treatment and was not covered by insurance. Once the family was assured that these benefits were not in jeopardy Beatrice began arriving to work on time.

Six months later, as her transitional employment placement was ending, the firm offered Beatrice a permanent position which she gladly accepted. She continues working and has used some of her wages to buy a computer, which she uses to practice her writing.

COMMENT: The Clubhouse provided Beatrice a safe, non-judgmental and supportive environment to explore her writing skills. As a result, she was able to come to a successful resolution of her desire to be a writer but concomitant lack of ability.

Subsequent supports helped her find a new vocational area and manage out-of-work challenges that could have sabotaged her employment. Although Beatrice spent a considerable amount of time at the Clubhouse before attempting employment, she was able to achieve other important goals during this period. In addition the low cost of program operations allowed us to provide the support over such an extended period.

#### Case of Marsha: Shaping Interpersonal Skills

Marsha is a 40 year old female who sustained a severe traumatic brain injury when she was eight years old. She continues to live with her parents and was referred to the Clubhouse after an unsuccessful attempt at inventory training by another program. Unfortunately, Marsha could not learn enough of the position to make her skills marketable. The referring program also noted deficient hygiene, grooming and dressing, and socially obtrusive interaction. Marsha would indiscriminately interrupt others and begin a conversation. She was verbose, egocentric and a poor listener.

In order to address her hygiene and grooming goals Marsha agreed that she should only enter the Clubhouse when she was cleanly groomed and dressed. She only had to go home once to change her clothing.

Marsha's initial social interactions at the Clubhouse were obtrusive and egocentric. However, members would naturally tell her to wait, or ignore her whenever she interrupted. Gradually, Marsha learned to identify when people were open to conversation. She similarly found that people would only pay attention when she was succinct, listened to what others had to say and took interest in what other people were doing. Although always her own "personality," Marsha gradually became accepted into the Clubhouse social milieu.

Marsha's time on task and attention to detail at the Clubhouse was poor. After sampling many activities she settled into the Clerical / Communication unit where she served as a telephone receptionist and helped produce the Clubhouse newsletter. She also began a job search but was never called for interviews. Given her lack of job finding success and general skills in the program, it appeared that daily Clubhouse participation would remain Marsha's primary activity pattern.

Four months into her participation Marsha landed a telephone solicitation job which lasted two days. Marsha returned to the Clubhouse and one month later independently landed a job as a supermarket clerk. This time, she accepted Clubhouse job coaching support and was working independently within a month. Despite her gregarious behavior at the Clubhouse, Marsha was all business when on the job.

Marsha's position lasted two months when she and 12 other employees were laid off at the end of the holiday season. She again returned to the Clubhouse and landed a full-time job in a warehouse one week later. Marsha initially declined Clubhouse job assistance until five months later when she wanted to quit because she learned that another employee was earning more than she was. She wanted to get even with her boss by quitting and landing a better paying job. She was ultimately convinced that it was easier to find a new job while working than when unemployed. Marsha continued the job for another year until leaving due to a worker's compensation claim. She subsequently began a transitional employment position at a local restaurant with hopes of landing a full time job at the end of the TE assignment.

COMMENT: The daily response of members and staff to Marsha's grooming and social skills quickly resolved many of these issues when she first entered the Clubhouse. Other members gave her direct feedback, with support that is not generally available in other treatment settings. Although Marsha has not been able to sustain long-term employment at any one location, she is now more successful in her employment efforts than before her Clubhouse membership. The Clubhouse has been able to provide opportunistic assistance to Marsha as required in these positions and Marsha has learned to use the Clubhouse as a base of operations between jobs.

### Discussion

It is not unusual to first focus on the individual in situations of behavior dysfunction and too frequently assume that full ownership for the "disorder" rests with that person. Behavior, however, is a product of complex interactions between a person and the prevailing environment. Changes in any of the accompanying variables can produce changes in the production of behavior. There are presently few options available to directly resolve most long term neurological impairments following brain injury, so we frequently look to environmental changes for alternative venues.

Work sites offer a special challenge to environmental modification since these settings are ultimately designed for the benefit of the business. The onus for change therefore frequently rests with the perspective employee who is expected to adapt to prevailing business culture. Under current service delivery models, techniques involving skills training and supportive / prosthetic strategies such as job coaching can become very expensive and exceed the salary benefits that the new worker accrues. This often limits the accessibility or duration of such services to the detriment of long term job outcome. It can also result in the perverse situation of requiring the client to adapt to the treatment system criteria in order to be considered successful rather than the treatment system adapting to the "real world" needs of the client.

Other service delivery models may more flexibly address some of the continuing employment needs of some people who experience disability following brain injury. This includes but is not limited to Clubhouse programming. Some Clubhouse services are similar to those provided by other return to work programs, while other services differ and may be able to address persisting issues through different mechanisms of support and levels of cost. Again, no one program or service delivery system is capable of meeting all needs of all people all of the time.

It is also important to recognize that the goal of stable long-term employment at a single location may be just as illusive for some people who experience disability following brain injury as for some people in the general population. Business and social values are in the midst of change which in turn affects the manner in which all people work and sustain employment. Different people may have different models of work and the challenge may be to help people adapt to a strategy that optimizes personal abilities and opportunities. This may require substantial change in overall vocational rehabilitation service delivery systems and outcome philosophies.

As a first step it may be time to acknowledge that for many people the concept of the truly successful "26 closure" may be just as incongruous as that notion that "neurorehabilitation" actually rehabilitates neurons. A broad spectrum of services and supports are needed to support employment and we must learn how to provide such services within available resources. It is also obvious that some people may not be capable of returning to compensated work and other means to support productive activity.

Behavior is not mysterious, but too often we phenomalize it. Too often judgment about a specific behavior ends up as judgment of the individual from which the behavior emanates. When our efforts begin to narrow onto behavioral abnormality we often lose sight of the overall abilities and qualities of the individual and how to support their overall competence. This can result in iatrogenic programming where services are directed toward suppression of a specific aspect of behavior rather than promotion of overall personal ability. A person treated this way soon begins to respond in this manner and a self-fulfilling prophecy can quickly become fulfilled. There is no mystery why the "behaviorally disordered, brain damaged client" is unable to work.

"Person first" philosophy is an excellent way to prevent this cycle from beginning. There is no doubt that all of us need corrective feedback and direction from time to time, but the role of social recognition for our accomplishments is also very clear. Services that recognize this balance in their basic operation may be more successful managing "behavior problems" because they create fewer opportunities for their occurrence. Successful "behavioral programming" begins with personal recognition and strong alliances of ability.

### References

1. Brooks N, McKinaly W, Symington C, Beattie A, Campsie I. Return to work within the first seven years of head injury. Brain Injury. 1987; 1:5-19.
2. Jacobs HE. The Los Angeles head injury survey: Procedures and initial findings. Arch Phys Med Rehab, 1988;69:425-431.
3. Jellinek HM, Harvey R. Vocational/educational services in a medical rehabilitation facility: Outcomes in spinal cord and brain injured patients. Arch Phys Med Rehab, 1982;63:87-88.
4. Kaplan SP. Social support, emotional distress, and vocational outcomes among persons with brain injuries. Rehab Couns Bul, 1990;34(1):16-23.
5. Thomsen IV. Late outcome of very severe blunt head trauma: A 10 - 15 year second follow-up. J Neurol Neurosurg Psychiat, 1984;47:260-268.
6. Catalano R, Dooley D, Jackson R. Economic predictors of admissions to mental health facilities in non-metropolitan areas. J Health Soc Beh, 1981;22:284-297.
7. Dooley D, Catalano R. Economic change as a cause of behavioral disorder. Psych Bul, 1980;87:450-468.
8. Kay T. Selection and outcome criteria for community-based employment: Perspectives, methodological problems and options. In Thomas DF, Menz, FD, McAlees DC, eds. Community-Based Employment Following Traumatic Brain Injury. Menomonie, WI: Research and Training Center, University of Wisconsin-Stout, 1993.
9. Thomas DF, Menz FE. Functional assessment of vocational skills and behaviors of persons with brain trauma injuries. J Voc Rehab, 1996;7:243-256, 1996.
10. Kaplan SP. Five-year tracking of psychosocial changes in people with severe traumatic brain injury. Rehab Couns Bul, 1993;36(3):151-159.
11. Millis SR, Rosenthal M, Lourie IF. (1994). Predicting community integration after traumatic brain injury with neuropsychological measures. Int J Neurosci 1994;79(34):165-167.
12. Ulicny GR. Behavior management of persons with head injuries in community-based vocational settings: New challenges for professionals. In Thomas DF, Menz, FD, McAlees DC, eds. Community-Based Employment Following Traumatic Brain Injury. Menomonie, WI: Research and Training Center, University of Wisconsin-Stout, 1993.
13. Corthell DW (ed.). Employment Outcomes for Persons With Acquired Brain Injury. Menomonie, WI: Research and Training Center, University of Wisconsin-Stout, 1993.
14. Nagele DA, Jenkins BR, Steiner SL. Keeping persons with head injury working: New strategies to assure supported employment retention. Final Grant Report, Philadelphia: MossRehab Hospital: 1993.
15. Anderson SB. Mental Illness and Normal Life: Fountain House and the Development of Clubhouse Culture. New York: Author; 1994.
16. Beard JH, Malamud TJ, Rossman E. Psychiatric rehabilitation and long-term rehospitalization rates: The findings of two research studies. Schiz Bul, 1978;4, 622-635.
17. Beard JH, Propst Rn, Malamud TJ. The Fountain House model of psychiatric rehabilitation. Psych Rehab J, 1982;1, 47-53.
18. DeMello C, Jacobs HE. The Clubhouse Model, Part I: Origins and Basic Philosophy. TBI Challenge! National Head Injury Foundation, 1994;2(3).
19. Jacobs HE, DeMello C. The Clubhouse Model Part II: Applications Following Brain Injury. TBI Challenge! National Head Injury Foundation, 1994;2(4).

20. Jacobs HE, DeMello C. The Clubhouse Model Part III: Designing a Clubhouse. TBI Challenge! National Head Injury Foundation, 1995:3(1).
21. Jacobs HE, DeMello C. The Clubhouse Model Part IV: Clubhouse Standards. TBI Challenge! National Head Injury Foundation, 1995:3(2).
22. Jacobs HE, DeMello C. The Clubhouse model and employment following brain injury. J Voc Rehab, 1996;7: 169-179.
23. Bilby, R. Transitional employment: Pointers, problems, politics, and practices. In R. Vorspan (Ed..) Clubhouse Papers: Selected Papers from the Seventh International Seminar of the Clubhouse Model. New York: International Center for Clubhouse Development; 1993.
24. Haffey WJ, Abrams D. Employment outcomes for participants in a brain injury work re-entry program: Preliminary finding. J Head Trauma Rehab, 1991;6 (3), 24-34.
25. Wehman P, Kreutzer J, Stonnington HH, Wood W, Sherron P, Diambra J, Fry R, Groah, C. Supported employment for persons with traumatic brain injury: A preliminary report. J Head Trauma Rehab, 1988;3:82-94.
26. Wehman P, Kreutzer J, Wood W, Stonnington H, Diambra J, Morton MV. Helping traumatically brain injured patients return to work with supported employment: Three case studies. Arch Phys Med Rehab, 1989;70:109-112.
27. Wehman P, Kreutzer JS, West MD, Sherron PD, Zasler ND, Groah CH, Stonnington HH, Burns CT, Sale PR. Return to work for persons with traumatic brain injury: A supportive employment approach. Arch Phys Med Rehab. 1990;71:1047-52.