LIVING IN THE COMMUNITY WITH SERIOUS MENTAL ILLNESS: COMMUNITY INTEGRATION EXPERIENCES OF CLUBHOUSE MEMBERS

Shinakee Gumber

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Committee:

Catherine H. Stein, Ph.D., Advisor

Susan Huss, Ph.D.
Graduate Faculty Representative

Kenneth Shemberg, Ph.D.

Jennifer Gillespie, Ph.D.
ABSTRACT

Catherine H. Stein, Advisor

Essential components of community integration of people coping with serious mental illness entails development of social relationships with the larger community of individuals who are not identified as coping with serious mental illness. However, previous research on community integration has not made an attempt to understand how people coping with serious mental illness are differentially integrated with peer/consumer/client community versus their integration experiences with the larger non-client/consumer community.

The present study used the context of psychosocial clubhouses to understand how program level, individual level and family level variables are differentially associated with perceived community integration within clubhouses versus outside with clubhouse with the larger non-client/consumer community. Data were collected from 92 adults coping with serious mental illness who were also members of psychosocial clubhouses in New York State. Findings of the present study indicate that members report greater degree of integration within the clubhouse as compared to social integration outside the clubhouse with members of the larger non-consumer/client community. Further, program level factors such as perceptions of the clubhouse environment as having a practical orientation were associated with reports of greater integration within the clubhouse but not outside the clubhouse. Conversely, level of employment, specifically independent level of employment, and feelings of self-worth were associated with greater integration outside the clubhouse but not within the clubhouse.

Results also suggested that perceived family support was associated with integration within the clubhouse and outside the clubhouse with members of the larger non-consumer/client community. The findings are discussed with respect to their implications for community practice and directions for future research.
ACKNOWLEDGEMENTS

The completion of this project represents the culmination of a long and glorious journey. This journey entailed relationships with new people, culture, knowledge and ways of thinking. It also entailed the support and love of my beloved friends and family. With all of my heart, I would like to thank both my old and new companions.

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As I walked with my family, I learned the true meaning of faith; I learned that I am loved and supported eternally and immeasurably, and I learned that they can carry me long and far.

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CHAPTER I. INTRODUCTION

In the United States, the community integration of people coping with serious mental illness has been an important goal of mental health policies and programs (Linhorst, 2006). Conventionally, serious mental illness has been defined with respect to a diagnosis of psychotic disorders, major depressive disorders, and bipolar disorders (Baillargeon, Hoge, & Penn, 2010). Community integration involves helping people coping with mental illness to live successfully with others in the community along with optimizing their abilities to carry out activities of daily living in the community (i.e. physical integration), to engage in social interaction with non-disabled members of the community (i.e. social integration) and feel a sense of belonging in their communities (i.e. psychological integration; Wong & Solomon, 2002). Although achieving community integration is a primary aim of many community based mental health services, there is insufficient research evidence to show the degree to which mental health services have been able to accomplish this important goal.

Research has indicated that modest physical community integration of people coping with serious mental illness has been achieved (Aubry & Myner, 1996). The decreasing population in mental health institutions and reduction in the length of hospitalization provide further testimony that people with serious mental illness are, for the most part living in the community (Lemarie & Mallik, 2005). However, research is sparse on how various services and programs impact social and psychological integration outcomes of people coping with serious mental illness. Further, only specific types of programs such as supported housing programs and assertive community treatment programs have been researched to evaluate how they impact community integration of their clients. Other programs such as psycho-social rehabilitation clubhouses and employment although subject to empirical research, have not been specifically examined to see how they promote community integration for people coping with serious mental illness. Lastly, community integration entails integration of
people coping with serious mental illness with the larger community of individuals who are not identified as coping with a mental illness (Taylor, Racino, Knoll & Lutfiyya, 1987). However, previous research has not considered this important distinction in its’ evaluation of various programs’ impact on community integration.

The present study addresses these gaps in literature by studying community integration for individuals coping with serious mental illness who are members of psycho-social rehabilitation clubhouses. Further, a distinction is made in understanding members’ experiences of integration within the clubhouse milieu with other members, i.e. internal community integration versus their experiences of community integration within the larger non-member/client community, i.e. external community integration. Psycho-social rehabilitation clubhouses serve people coping with serious mental illness to provide socialization opportunities, sense of community and vocational assistance (Beard, Propst, & Malamud, 1982). The psychosocial rehabilitation clubhouse was selected for the present study for a number of reasons. First, the clubhouse programs attempt to overcome barriers that prevent its members from fully participating in the community (McKay, Johnsen & Stein, 2005). However, very little research has examined community integration with respect to clubhouse members. Second, employment is a major focus of the clubhouse model and is articulated as a “right” of clubhouse membership (Cook & Razzano, 1995). Employment programs outside the context of psycho-social clubhouses also exist to help people coping with serious mental illness to seek and attain employment. However, most such employment programs are more selective in the clients who they work with, serving only those clients who are “ready” for work (McKay, Johnsen & Stein, 2005). In comparison, the clubhouse based employment programs are more comprehensive and less exclusive with respect to target clientele (McKay, Johnsen & Stein, 2005). Further most clubhouses in the United States
report providing employment services to help members get and keep competitive jobs in mainstream community settings (Macias, et al., 1999).

The present study focuses on the role of members’ employment experiences and views of the clubhouse environment in understanding their reports of internal community integration within the clubhouse and their social integration within the greater non-consumer/client community, i.e. with those community members who do not identify themselves as mental health consumers.

To create a conceptual context for the present research, existing studies in the area of community integration are first reviewed. The primary source of research literature on community integration comes from the context of housing programs for people with serious mental illness. Secondly, research on both clubhouse employment programs and employment programs is presented. In general, such research has focused on outcomes such as length of employment, income, and mental health outcomes such as sense of well-being and psychiatric hospitalizations (Laird & Krown, 1991; Bond, 1987). Research findings in these areas will help to provide a foundation for the proposed study.

*Community Integration*

The emphasis on community integration in the United States is rooted in the broader Civil Rights Movement of the 1960’s that advocated for equal rights of all individuals (Segal & Aviram, 1978). Within the context of mental health, the goal of community integration is built on the notion of common citizenship, that is, people with mental illness should have the opportunity to live, work, study and participate in all aspects of life alongside non-disabled members of community (Wong & Solomon, 2002; Wong, Metzendorf, & Min, 2006; Racino, 1995). Although people with serious mental illness may be hospitalized for brief periods, they primarily reside in the community (Lemarie & Mallik, 2005). The integration of persons
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with psychiatric disabilities into the community is viewed as a principle value and major goal of mental health policy (Wong & Solomon, 2002; Carling, 1996).

Taylor, Racino, Knoll and Lutfiyya (1987) first articulated the principles of community integration in the context of developmental disabilities. Despite individual differences that people with developmental disabilities may have, the goal of community integration is that all people have the right to participate in their neighbourhoods, and feel part of a larger community. For such integration to take place, people and their families often require professional support, but such support should be offered in regular places in the community rather than in specialized settings. Taylor et al., (1987) further elaborate that community integration entails development of relationships between people with and without labels as such relationships allow for mutual respect, appreciation and learning to take place. Finally, another key principal of community integration proposed by Taylor et al. (1987) relates to greater involvement of service users and their families in the design and implementation and evaluation of services.

Although these principles of community integration were developed within the context of people coping with developmental disabilities, advocates contend that these principles apply equally well to individuals with psychiatric disabilities. Community integration entails helping people who are coping with mental illness to develop natural support networks, assume normal roles alongside non-disabled community members, and have greater choice and control over their treatments and lives (Aubry & Myner, 1996; Carling, 1996).

The concept of community integration for people with psychiatric disabilities has itself undergone a transformation over the past two decades. In the aftermath of deinstitutionalization in the 1960s and 70s, community integration was often defined narrowly by researchers in terms of “physical integration.” Physical integration refers to the
extent to which an individual spends time, participates in activities and uses goods and services in the community (Aubry & Myner, 1996). However, now there is an acknowledgement that the definition of community integration needs to expand to encompass not only the physical presence in the community of persons with psychiatric disabilities, but also the extent of their social and psychological community integration. Social integration refers to the maintenance of social relationships with other community members who are culturally normative. Psychological integration refers to the development of a sense of efficacy and belonging in relation to the community, i.e. psychological sense of community (Wong & Solomon, 2002).

For the most part, community integration has been defined by mental health researchers and professionals. However, some limited research has tried to understand the components of community integration from the perspective of people with mental health problems. Achieving subjectively meaningful social relationships in the community is seen as an important part of recovery and quality of life by people with psychiatric disabilities (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Jivanjee, Kruzich, and Gordon (2007) conducted focus groups to understand how young adults with mental health disorders define community integration. They found that forming connections with others, receiving support from family and friends, finding meaningful adult roles and education and training were some of the core elements that participants talked about in reference to community integration. Another study investigated patients’ perceptions of the values of social relationship during and following psychiatric hospitalization. They found that patients valued social relationships as it provided the patients with social approval and integration, material support, constancy, problem solving and ventilation (Breier & Strauss, 1984).
Social Policies that Support Community Integration

The mental health field’s emphasis on achieving community integration for people with serious mental illness can be seen, at least theoretically, in various policies, laws, practices and programs. However, because of paucity of research, it remains unclear to what extent various policies and laws have been successful in achieving the goal of community integration for people with serious mental illness.

Starting with the Community Mental Health Center Act of 1963, mental health policy aimed at restoring the lives of people with mental illness to their communities. This was to be accomplished by providing treatment to former state psychiatric patients in the community through these mental health centers. To further facilitate community integration the federal government also enacted legislations prohibiting discrimination in most area of community life (Linhoinrst, 2006). First the Rehabilitation Act of 1973 specifically identified mental illness as a disability that rehabilitation and employment assistance should address and provided consumers with direct assistance and opportunity for gainful employment (Cutler, Bevilacqua, & McFarland, 2003). Further the Fair Housing Amendments Act of 1988 also prohibited discrimination based on disability in public or private housing. Finally, the Americans with Disability Act of (ADA)1990 also addresses discrimination on the basis of disability in the areas of employment (Title I), access to transportation and public facilities (Title II), and access to a wide range of private facilities and services (Title III).

In 1977, the National Institute of Mental Health also created Community Support Program to enhance services provided by community mental health centers and to increase the community stability and tenure of people with mental illness (Turner & TenHoor, 1978). The Rehabilitation Act of 1973, the Fair Housing Amendments Act of 1998 and the American with Disabilities Act of 1990 provided the legal basis, while the community support program attempted to provide clinical efforts to support the meaningful participation...
of people with mental illness in life’s everyday activities. Another impetus for community integration came from the 1999 Olmstead v. L.C., during which the supreme court noted that "unjustified isolation" in institutions is a form of discrimination prohibited by the ADA and ruled that a state is required to provide community-based treatment to a person if: (1) it is appropriate; (2) the person does not oppose it; and (3) the state has the resources to provide it. The Court also noted that a state could defend a lawsuit by showing that it had a "comprehensive plan" for placing people in community-based treatment (Salzar, Kaplan, & Atay, 2006). Similar goals were expressed by the Rehabilitation Act of 1992, which aimed at assisting individuals with disabilities “to live independently; enjoy self-determination; make choices; contribute to society; purse meaningful careers; and enjoy full inclusion and integrations in the economic, political, social, cultural and educational mainstream of American Society” (Bond, Salyers, Rollins, Rapp, & Zipple 2004).

Four decades after the passage of Community Mental Health Center Act, and despite changes in policies and services, the extent to which people with serious mental illness have achieved true community integration as result of various programs and services remains a largely unanswered question. (Bond, Salyers, Rollins, Rapp, & Zipple 2004). Further, support and back up at the policy level do not automatically translate to community integration for people coping with serious mental illness. Research has shown that among those people coping with serious mental illness and counted as living in the community, many are leading lonely, isolated, barren lives, often without social or recreational outlets (Carling, 1995; Segal & Aviram, 1978; Wong & Solomon, 2002).

Research Literature on Community Integration

Specialized and supportive housing programs have been one of the most widely used mechanisms for promoting community integration of people with serious mental illness. Specialized housing refers to housing programs that link residency with support services for
people coping with serious mental illness (Lipton et al., 2000). A body of empirical research has emerged that examines the housing service correlates of community integration. Segal and Aviram’s research (1978) on former mental hospital patients in board and care homes in California for the first time focused on the joint influence of client, community and facility characteristics on clients’ social integration. They found community factors such as positive response from neighbours, urban location and proximity to community resources as factors that strongly influenced community integration. Other studies have confirmed that greater community acceptance and lower levels of rejection are associated with increased integration (Nelson, Hall, Squire & Walsch-Bowers 1992; Sherman, Frenkel, & Newman, 1986).

Program characteristics have also been found to influence community integration. Staff management styles that foster greater independence and less depersonalization are associated with greater community integration (Kruzich, 1985; Segal & Aviram, 1978) as are residences that offer a range of social skills training, provide intense support services and that encourage resident involvement (Segal & Aviram, 1978). Finally, residential arrangements that are more independent and more normalized (i.e. more like regular housing in the community) have been associated with aspects of improved community integration (Van Wel, Felling & Persoon, 2003).

Most prior research on housing programs focused on physical aspects of community integration. Further, most research on housing programs ignored the fact that neighbourhoods often comprise predominantly of other mental health consumers (Gulcur, Tsemberis, Stefancic, & Greenwood, 2007). Therefore, it has not been possible to get a true picture of the degree to which mental health consumers are integrated within the non-consumer community.

Research on comparison with community residents regarding physical, social, psychological integration was conducted by Aubry and Myner (1996). They compared 51 people with psychiatric disabilities with matched community residents on measures of
physical, social and psychological integration. They found comparable levels of physical and psychological integration for persons with psychiatric disabilities and general community residents, but found that physical integration does not translate into social integration, i.e. meaningful social contact with neighbours, for people with psychiatric disabilities. As participants for the research were recruited from comparable residential neighbourhoods, this research hints at the possibility that people living in residential community neighbourhoods with perhaps other non-consumer neighbours are not experiencing social integration. However, definitive conclusions cannot be drawn from the study, as it did not specifically assess community integration with respect to the non-consumer community. Further research is needed to understand consumers’ integration experience within the greater non-consumer community.

Research on community integration outside the housing context is relatively sparse. Some research investigating community integration of clients receiving case management services in Canada has been conducted. However, it has been difficult to find similar research in the United States. Prince and Prince (2002) studied perceived stigma and community integration among 99 clients receiving Assertive Community Treatment (ACT) services in Canada. Mean scores reported by study participants on psychosocial functioning and psychiatric symptomatology suggested that their sample was fairly high functioning. Yet, their study participants reported low levels of physical and social integration and moderate levels of psychosocial integration. Further, they found that clients’ perception of stigmatization was inversely related to their sense of belonging in the community, i.e. psychological community integration, particularly among individuals who perceived less support. In the above study, social integration was assessed as different kinds of social contact with neighbours. However, it is not clear from the study if neighbours are other consumers or general non-consumer community residents.
Prince and Gerber (2005) investigated the relationship between subjective well-being and community integration among 87 participants receiving ACT services in Canada. Although they found that subjective well-being was related to physical and psychological integration, when other variables were considered (e.g. self-esteem, social support) community integration failed to explain the relationship with subjective well-being.

One of the primary goals of community based programs has been to improve community integration of people coping with serious mental illness. Legal and policy level support also exists to achieve community integration for people coping with serious mental illness. Despite such emphasis, research has failed to focus on how various mental health programs and services impact community integration for its clients. Further, research on social networks has established that people with serious mental illness often have smaller social networks comprised primarily of family members and mental health professionals (Stein, Barry, Van Dien, Hollingsworth, & Sweeney 1999). However, true community integration for people coping with serious mental illness entails and implies integration with the greater non-disabled/non-consumer community. Unfortunately, previous literature evaluating the impact of housing programs on community integration has failed to pay attention to this important facet of community integration.

*Employment and Community Integration*

Competitive employment is seen as a key aspect in the attempt to achieve community integration for people coping with serious mental illness (Knisley, Hyde, & Jackson, 2003). In most societies employment serves many functions. It can provide individuals the opportunity to demonstrate mastery over their environment and to achieve a sense of personal control and direction (Linhorst, 2006). In the United States, competitive employment is also the principal means through which non-elderly adults obtain health insurance (Linhorst, 2006). In addition, employment plays a critical role in determining social class and social
living within communities (Hawkins & Thomas, 1999). Moreover, it is an important means which provides people with opportunities to develop social relationships. By working, individuals assume socially recognized roles and thus are able to meet societal expectations and conform to important social norms (Hawkins & Thomas, 1999).

Studies suggest that most people with serious mental illness want to work (Mueser, Salyers, & Mueser, 2001) and would prefer to be employed in integrated settings. Integrated work settings involve working alongside non-disabled co-workers, with salary and growth potential like rest of the co-workers (Loveland, Driscoll & Boyle, 2007). However, unemployment is common with rates of competitive work typically ranging between only 10% and 20% (Mueser, et al., 2001). Individuals with serious mental illness connect loss of work due to mental illness with lost status, both educational and financial, decreased self-esteem and motivation in job-seeking (Bassett, Lloyd, & Bassett; 2001).

Loss in previous employment or future employment opportunities are not only challenging for individuals coping with serious mental illness, but have significant implications for the economy. For example, a recent study estimated serious mental illness to be associated with a loss of $193.2 billion in personal earnings across the total population in the United States during 2002 (Kessler et al., 2008). Although people with psychiatric disabilities represent the largest disability group served by the vocational rehabilitation system, they are the least likely to secure employment (Anthony & Blanch, 1989).

Over the past four decades, a variety of rehabilitation models have been developed to improve work outcomes for people coping with serious mental illness. In decades following deinstitutionalization, vocational models included sheltered workshops, and pre-vocational work units which first provided training to people with serious mental illness who were interested in work, and then placed them in highly protected and segregated settings (Becker & Drake, 2003).
In the 1980s, another model was developed is Supported Employment (SE). Supported employment helps clients get competitive work in integrated settings with non-disabled workers in the community, and provides on-going support to help them succeed on the job or transition to another job (Becker & Drake, 2003). Unlike previous models of vocational rehabilitation which first provide training to get ready for work, SE emphasizes placing individuals with serious mental illness in real-world competitive employment settings, so they can experience the benefits and challenges of these situations and it then provides the necessary training and support to successfully maintain these placements. It has been designed to help adults with serious mental illness obtain competitive jobs in socially integrated settings (Macias, Rodicon, Hargreaves, Jones, Barreria, & Wang, 2006). Research studies have identified Supported Employment as evidence based practice to help people coping with serious mental illness get competitive jobs.

Another model that has received considerable attention is transitional employment, which consists of part-time, paid community jobs filled by clients for short period of time. The jobs are usually secured by the psycho-social rehabilitation (PSR) agencies rather than the client. Originally pioneered by Fountain House in New York (psychosocial clubhouse), transitional employment has been widely adopted and adapted among PSR centers throughout the United States (Beard, Propst, & Malamud, 1982; Lucca & Allen, 2001). Research on transitional employment in a PSR has shown positive outcomes such as greater earnings as compared to day programs, increased sense of well-being, and reduced psychiatric hospitalizations (Laird & Krown, 1991; Bond, 1987). Research comparing supported employment and transitional employment has also been conducted. Transitional employment programs have been found to be more cost-effective, have greater potential to serve long-term mentally ill clients and have found to have better rates of retention as compared to supported employment (Noble, 1991; Bond et al. 2004). On the other hand
supported employment has been found to have better rates of competitive employment, as research has shown that only a minority of clients participating in transitional employment progress to competitive work (Laird & Krown, 1991; Bond, et.al., 2004).

**Overview of Research on Employment**

Various employment models including supported employment and transitional employment have been subjected to research to understand their impact on vocational outcomes such as rate of competitive employment, length of employment, and income (Becker, Xie, McHugo, Halliday & Martinez, 2006). Non-vocational outcomes have also been studied such as rates of hospitalization recidivism, psychological well-being, self-esteem, quality of life (Laird & Krown, 1991; Bond, 1987). Further, research on employment models has also focused on predictors of employment outcome. These predictors include individual level factors (e.g. prior work experience, psychiatric diagnosis) agency/program level factors (integrated vs. parallel mental health services, fidelity and uniformity in implementation of services) and community or sociological factors such as disability policies, unemployment rates (Cook et al 2008; Loveland, Driscoll & Boyle, 2007).

However, literature on how employment impacts community integration for its clients is sparse. Banks, Charleston, Grossi, and Mank (2001) studied social integration for 243 clients served by mental health vocational programs. They equated social integration with social interaction at workplace and found that greater mean wages were associated with greater and ongoing social support. However, it is not clear from the study how social interaction was assessed and if social interaction at workplace can be equated with social integration. Banks et al.(2001) also report that over 50% of the people worked in individual jobs in companies that employed no other persons with disability. 26% of the participants worked with two to four co-workers with disability and 15.3% worked with five or more co-workers with a disability. However, the above study did not consider number of co-workers...
with a disability, as a variable. It would have been interesting to see if the relationship between mean wages and social integration would have held after controlling for number of co-workers with a disability.

Mueser et al. (2004) recruited 204 participants for their study and assigned them to one of three types of vocational services, standard employment services, psychosocial rehabilitation services and services that individually placed and trained people coping with serious mental illness. They found a trend for clients of psycho-social rehabilitation vocational programs to be more satisfied with their social relationships as compared to other vocational rehabilitation models. However, the study investigated a large number of other hypotheses, therefore due to limited sample size, could not find significance. Further the nature and compositions of these social relationships were not clear from the study. Although the study investigated the social relationships of people receiving different kinds of employment services, it did not throw light on how the different employment program directly impacted community integration of its participants.

**Psychosocial Rehabilitation Clubhouse**

Psychosocial clubhouses are community-based mental health initiatives that were originally implemented to transition individuals from hospital to community living. These clubhouses are intended to address concerns of social isolation, readjustment to society, and community integration primarily for people coping with serious mental illness (Mastboom, 1992). The services that come under the purview of clubhouses attempt to increase the community mental health system’s ability to achieve recovery and community integration for people coping with serious mental illness (Plotnick & Salzer, 2008). Serious mental illness impacts people’s developmental opportunities including social and relationship-building skills, vocational and employment skills, and the acquisition of a comfortable niche in the greater community (Anthony, 1993). The clubhouse intends to provide these developmental
skills for a wide array of members through a variety of meaningful and necessary every-day activities (Magaw, 2003).

Fountain House in New York, was the original clubhouse and was established in 1948 by a group of ex-patients as a program that offered psychiatric patients a place where they could make friends, relate to others, learn work skills, and become more independent (Dickerson, 1998). Fountain House eschewed the “medical-model” and instead embraced a rehabilitative approach consistent with the recovery model, emphasizing a resiliency and strengths-based perspective (Staples & Stein, 2008). The clubhouse is intended to operate as a milieu that facilitates the transition of people from the clubhouse to greater society.

The principles on which the clubhouse model is based, digresses from traditional mental health approaches in several ways. For example, the people who use clubhouse services are referred to as members, as opposed to consumers, or clients. This nomenclature is meant to be indicative of the clubhouse program having definite rights of membership. These rights are supposed to include members having a choice in type of work activities they want to engage in, whether members want to work at all, choice in the selection of a staff worker, access to all personal records kept by the clubhouse, and a life-time right of re-entry and community support services (Macias, Jackson, Schroeder & Wang, 1999). Along with these rights of membership, members are also to take ownership of many clubhouse responsibilities. For example, members are to be responsible for the day-to day running of the clubhouse and essential tasks such as answering the telephones, preparing meals, typing letters, and cleaning the program facility (Dickerson, 1999).

The model also proposes that clubhouses maintain a low staff- to-member ratio and egalitarian nature of relationship between staff and members (Mastboom, 1992). In the clubhouse environment, the typical provider- recipient roles are to be reversed, so that members and staff can work together in making decisions regarding clubhouse issues and
activities (Dickerson, 1998; Pernice-Duca, 2008). The relations between service users and providers are to be based on collaboration, trust and the sharing of power, with interactions characterized by genuineness, mutual respect, open communication, and greater informality. Such an emphasis is intended to facilitate greater member involvement in the program and is meant to communicate to its members that they are capable, competent and needed (Macias, Jackson, Schroeder & Wang, 1999). These principles of membership and equal and collaborative relationship between staff and members are consistent with an empowerment paradigm, which emphasizes helping former patients take a more active role in the healing process, developing new knowledge, skills, and greater self-confidence (Staples & Stein, 2008). These above clubhouse principles represent a radical shift from traditional mental health services, but because of paucity of research on the model, they represent ideals rather than norms.

**Services Offered by Clubhouses**

The clubhouse in itself is the central service as it is a place where people coping with serious mental illness can go to spend time and take part in meaningful activities. The clubhouses usually parallel a work week and are open for an average of approximately eight hours per week. In addition many clubhouses operate on evenings and weekends to provide an average of 10 additional hours of recreational and social activities (Macias, Jackson, Schroeder, Wang, 1999).

*Work-Ordered Day:* The heart of every clubhouse is the concept of “work-ordered” day, which is modelled after a task-oriented “9 to 5” workday schedule (Pernice-Duca, 2008). During the work-ordered day, members are to contribute to their clubhouse in meaningful ways. Members and staff in each clubhouse are to develop work units they need to get their club’s unique tasks accomplished. Members and staff can then work side-by-side on joint tasks within their clubhouse work units, contributing to the daily functions of the clubhouse.
These tasks can range from clerical work, food preparation, building maintenance, intake of new members, attendance recording, and telephone answering. Members can also carry out training, administrative and accounting tasks (Macias, Jackson, Schroeder, Wang, 1999).

_Transitional Employment:_ Transitional employment placements (TEPs) are non-segregated mainstream jobs in community businesses paying at least minimum wage which are reserved for clubhouse members through agreements with employers. The TEP is to be procured by the clubhouse and is to be followed by the staff and members from all work units collectively managing the TEP. They are to be responsible for hiring, training members for placement at these various TEPs. They also cover absences whenever employees are unable to go to work. Transitional employment is intended to be a temporary first step in preparation for independent employment and for this reason, each job is time limited (Lucca, 2000; Macias, Jackson, Schroeder, Wang, 1999). TE jobs are approximately 20 hours each week, and each member gets an opportunity to work six to nine months in the job (Magaw, 2003). This can provide the member with a chance to build his work skills and evaluate whether he or she is ready to seek permanent job. It also gives the Clubhouse a chance to recycle the TE job slot and give lots of members a chance to try it. Research has shown those clubhouses are as effective as other supported employment vehicles at returning persons with mental illness to work (Magaw, 2003).

_Independent Employment:_ Clubhouses also provide support services to help members get and keep competitive jobs in mainstream settings which are not reserved for clubhouse members. Therefore, clubhouses continue to provide services and support to members even after they attain independent employment to the extent that the members want support. The support services include help with finding jobs, job-site training, support visits to job site etc.

_Other Services:_ In addition to work-ordered day, transitional and independent employment, clubhouse services also include supported education for members seeking to
complete their GED or pursue college, supported housing, outreach to members with poor attendance, and community support assisting members with entitlements, advocacy, and service coordination (Lucca, 2000). Clubhouses also emphasize social interaction as an essential aspect of the program environment and as an active agent of psychiatric rehabilitation (Beard, Propst, & Malmud, 1982). Outside of the work-ordered day, the clubhouse provides a variety of social activities including the celebration of holidays, informal gatherings, and recognition of the growth and development of individual participants. People with serious mental illness are frequently perceived as having small social networks, comprised primarily of family members and mental health professionals, with few non-consumers peer relationships (Stein, Barry, Van Dien, Hollingsworth, & Sweeney, 1999). It is contended that social relationships can evolve from building strong, caring and international peer support communities, like clubhouses, to impact overall functioning. In general studies have documented that greater consumer support within the context of a community-based mental health program has been associated with positive mental health outcomes. Participants of consumer-based community mental health programs such as consumer run organizations, self-help groups, have typically reported larger and more diverse social networks as compared to those in self-contained day treatment programs (Hardiman & Segal, 2003).

The Clubhouse Model and Standards

For nearly 30 years after its formation, Fountain House remained the only program of its kind. However, aided by the deinstitutionalization and the consumer-survivor movement, there was a rapid expansion of the clubhouse model in the past three decades. Currently, there are over 300 clubhouses in 27 countries (McKay, Yates & Johnsen, 2005). As the clubhouse community continued to expand and evolve worldwide, the need was felt for an organization that could act as a central resource and governance body. In 1994, the
International Center for Clubhouses was established to support and coordinate the development of clubhouses and coordinate training and ongoing technical support. The ICCD was created to provide continuous training in the model, to provide consultation in program development, and certification that a clubhouse is operating in compliance with the Standards for Clubhouse Programs (Propst, 1992). These standards provide operational clubhouse guidelines in seven domains: (1) Membership, (2) Space, (3) Relationships, (4) Work-ordered Day, (5) Employment, (6) Functions of the House, (7) Funding, Governance and Administration. These ICCD standards form the foundation of a clubhouse certification process. Based on the extent to which the clubhouse has complied with the standards, the ICCD awards one- or three-year certification or defers certification (McKay, Yates & Johnsen, 2005).

Research on the Clubhouse Model

Research on the clubhouse model has compared its costs with the cost of other types of mental health services (McKay, Yates & Johnsen, 2005). Findings suggest that the annual per person cost of the clubhouse model is substantially lower than other integrated services delivery models such as Assertive community Treatment (ACT), Individual Placement and Support (IPS) and the annual costs of services provided by community mental health centers (CMHCs). The clubhouse model provides a wide array of services to members at an average of $3,203 per member per year (McKay, Yates & Johnsen, 2005) which is approximately half the annual costs of that associated with services provided by CMHCs and one-third of the cost of Individual Placement and Support model.

Research has also found that members’ engagement in clubhouse services can reduce the rate of hospitalization recidivism. For example, Di Masso, Avi-Itzhak and Obler (2000) randomly selected 117 members of a clubhouse and found that members with a higher rate of clubhouse attendance (defined as ranging from 116 to 264 days) showed a significant
decrease in rate of hospitalization recidivism as compared to those individuals with low rates of clubhouse attendance. Rate of hospitalization was assessed through medical records. Similarly in a study of 32 clubhouse members, Wilkinson (1992) found that participation in a clubhouse program significantly reduced both the number of psychiatric hospitalizations and length of stay during hospitalizations. Such research points towards the potential of clubhouse programs in reducing the rate of hospitalization recidivism.

Research has also shown that members with higher rates of attendance in clubhouse program demonstrated higher rates of employment attainment and more advanced employment status than those with lower rates of clubhouse attendance (Di Masso, Avi-Itzhak & Obler, 2000). Further, research comparing different program models showed that clubhouse members, were more likely to be employed, stayed employed significantly longer on the job and consequently had greater earnings than PACT or ACT clients (Schonebaum, Boyd & Dudek, 2006; Macias, Rodican, Hargreaves, Jones, Barreira, & Wang, 2006; Stein, Barry, Van Dien, Hollingsworth, & Sweeney, 1999). Schonebaum, Boyd and Dudek (2006) conducted a longitudinal study where they followed a group of 170 individuals with severe mental illness. The participants were randomly assigned either to the experimental design, a clubhouse program (N = 86), or to the control design, a Program for Assertive Community Treatment (PACT) team (N = 84). Study participants were tracked for 30 months, and employment outcome data were collected. They found that after 30 months, 72 clubhouse and 76 PACT participants remained active in the project. After 30 months, 74 percent of PACT participants and 60 percent of clubhouse participants had been placed in at least one job. The average clubhouse participant worked 21.8 weeks per job and earned $7.38 per hour, whereas the average PACT participant worked 13.1 weeks per job and earned $6.30 per hour. In another randomized controlled trial, a vocationally integrated program of Assertive Community Treatment (ACT) was compared with a certified clubhouse in the delivery of
supported employment services (Macias, et al, 2006). Employment rates, total work hours, and earnings for 121 adults with serious mental illness interested in work were compared with published benchmark figures for exemplary supported employment programs. The two programs were then compared on service engagement, retention, and employment outcomes. Results showed that outcomes for 63 ACT and 58 clubhouse participants met or exceeded most published outcomes for specialized supported employment teams. Further, although the results showed that ACT programs had significantly better service engagement (ACT, 98 %; clubhouse, 74 %) and retention (ACT, 79 %; clubhouse, 58 %) over 24 months, clubhouse participants worked significantly longer (median of 199 days versus 98 days) for more total hours (median of 494 hours versus 234 hours) and earned more (median of $3,456 versus $1,252 total earnings.

Employment status and psychiatric hospital recidivism rates are used in many empirical studies of clubhouses as indices of successful rehabilitation for people with serious mental illness (Linhorst, 2006). However, surprisingly little research has been concerned with another stated function of the psychosocial rehabilitation clubhouse model, the increase in social connectedness and community integration of clubhouse members.

Pernice-Duca (2008) studied the structure and quality of social supports of 221 clubhouse members recruited from across 15 clubhouses in a Midwestern state. She found that clubhouse members were likely to nominate an average of five social network members. She further found that after family members, friendships outside the clubhouse emerged as the second most nominated social network category, followed by clubhouse staff, professionals and lastly clubhouse members. Although the finding that clubhouse members nominated other members least frequently in their social networks is surprising, the study does suggest that clubhouse members do, in fact have social relationships outside the mental health system which may be indicative of greater community integration. They studied
further examined variability in network structure/composition across two diagnostic
categories, schizophrenia and related disorders of psychosis versus all other. The findings
indicated that members with a diagnosis of schizophrenia were less likely to nominate family
members in their networks, indicating they had other sources of support. However, apart from
diagnostic category, other possible correlates such employment status was not examined to
understand their impact on social networks.

Stein, Barry, Van Dien, Hollingsworth, and Sweeney (1999) compared vocational
activity, social relations and community integration amongst 38 members of clubhouse
program vs. 21 clients of Assertive Community Treatment Program (ACT) in Madison, WI.
They did not find significant difference between clients in the two programs. However, on
items designed to assess degree of community integration, they reported a trend among
clubhouse members to participate to a greater degree in activities such as going to church,
going to a movie/play, going to a social group. Similarly, although there were no statistical
differences between groups on vocational activity variables, they report a trend for clubhouse
members who worked more hours per week, and were more likely to be engaged in paid and
volunteer employment than ACT clients. However, the sample size in the study was small
and although the study assessed the participants frequency of social activities and with whom
they were active (mental health consumers, non-consumers and/or family members), the
findings are not discussed.

Summary

A primary goal of community based services has been to achieve community
integration for people coping with serious mental illness. Various policies and laws have also
been enacted to help achieve this goal such as Rehabilitation Act of 1973, Americans with
health services have been designed to target various areas of community living such as
supported housing, community based clinical services, supported employment and psychosocial rehabilitative clubhouses. Of these services, only supported housing has been the focus of empirical research to examine associations between housing and community integration. However, this literature has failed to make a distinction between integration of people coping with serious mental illness within the consumer community versus the broader non-consumer community. Further, literature on how employment status and membership of psychosocial clubhouses impact community integration has not been investigated. The clubhouse model encourages participation in work both within the clubhouse with other members and when appropriate in competitive employment (Stein, Barry, Van Dien, Hollingsworth, & Sweeney 1999). However whether or not such interaction improves consumers’ internal community integration and whether such integration experiences extend to the larger community remain unanswered questions.
CHAPTER II. THE PRESENT STUDY

The present study broadened the literature on community integration experiences of people coping with serious mental illness. A distinction was made between community integration within the clubhouse, i.e. internal community integration versus community integration outside the clubhouse with the larger non-consumer/client community, i.e. external integration. The distinction between two types of community integration allowed for comparisons to be made in the members’ report of being integrated within the consumer community versus reports of being integrated with members of the larger community who do not identify themselves as mental health consumers. The context of psychosocial rehabilitation clubhouses was used to understand how specific aspects of its environment and practices were associated differentially with members’ internal community integration with other consumers/clients and their social integration outside the clubhouse with members of larger community who did not identify as mental health consumers/clients. Within this context, the study had four overarching goals.

The first goal of the study was to examine the degree to which specific perceptions of clubhouse environment would be related differentially to internal community integration within the clubhouse and external community integration with the larger non-consumer/client community. Previous research has shown the program characteristics influence community integration (Kruzich, 1985; Segal & Aviram, 1978). In the present study, reports of the degree to which members perceived the clubhouse environment to be supportive and having a practical orientation were assessed. Specifically, it was hypothesized that greater perceptions of the clubhouse environment as supportive would account for significant variance in reports of internal integration within the clubhouse, whereas greater perceptions of the clubhouse as having a practical orientation, i.e. perceptions that members are being prepared for life
outside the clubhouse would account for significant variance in members’ reports of external integration with the larger non-member/client community.

Secondly, the study assessed how differences in employment status contributed differentially to community integration experiences of the members. Although considerable research has been conducted to demonstrate the impact of employment on well-being and quality of life, only sparse research exists to understand the association between employment and community integration. Some qualitative research has suggested that competitive and independent employment helps clients to reintegrate into society and helps to build self-esteem and social skills (Crain, Penhale, Newstead, Thomson, Heah & Barclay, 2009). The present study tested the association between community integration and members’ participation in one of four types of work activities (a) Unemployed (b) Transitional employment (c) Independent employment (d) Voluntary employment in the clubhouse WOD. Given that employment provides both financial resources, and opportunities for social interaction, specific hypothesis for the study were tested. It was expected that as compared to unemployed status, independent employment status would account for significant variance in members’ reports of external social integration with the larger non-consumer/client community.

A third goal of the study was to understand and explore how perceived family support would be differentially associated with reports of internal community integration versus external community integration. Research on families of people coping with serious mental illness has shown that people with serious mental illness often receive crucial help from family members (Brown & Birtwistle, 1998) and reciprocal nature of support has been associated with greater psychological well-being. However, no previous research has examined how family support is associated with community integration. Therefore no
specific hypothesis was proposed regarding how family support would be associated differentially with internal and external community integration.

Finally, the study explored the relative contributions of individual level variables such as self-reported psychiatric symptoms and self-esteem in accounting for variance in reports of internal and external community integration. Past research has been mixed with regards to demonstrating association between individual level variables and community integration. Although some research has demonstrated an association (Prince & Gerber, 2005), other research has found that community level characteristics play a greater role in community integration as compared to individual level characteristics (Yanos, Stefanic & Tsemberis, 2011). Therefore the present study explored the degree to which individual level variables including demographic variables, self-reported symptoms and well-being were differentially associated with members’ report of internal and external community integration.
CHAPTER III. METHOD

Participant Recruitment

Adults coping with mental illness were recruited from ICCD certified clubhouses in New York State. Clubhouses from which the participants were recruited were selected based on specific criteria to ensure that clubhouses share similar program characteristics and standards. Clubhouses that were (a) certified by the ICCD, (b) had been in operation for more than 10 years, (c) were located in a separate building and occupied more than 1000 square feet of space, and (d) had computerized record keeping system were contacted via phone and/or email to participate in the study. A total of 10 clubhouses were contacted and 8 clubhouses in the New York City area agreed to participate. The research was approved by the Human Subjects Review Board at Bowling Green State University.

The clubhouse director and staff from each clubhouse were asked to nominate interested participants who meet the inclusion criteria for the study to participate in the online survey. Those members who (a) are at least 18 years of age (b) have an Axis 1 diagnosis of Schizophrenia, Schizoaffective, Bipolar or Major Depression disorder (c) have not had a drug abuse or dependence problem for over the past six months (d) were currently active members of the clubhouse as defined by having at least one face to face contact with clubhouse staff during the most recent 30-day period (e) were willing to give their voluntary consent to participate in the study were invited to participate in online survey. All participants were offered the opportunity to be entered in a raffle to win one of twenty $25 cash prizes for their participation in this online survey research study.

A total of 114 adults coping with serious mental illness meeting the recruitment criteria responded to the online survey. Of these, a total of 22 were deleted as they provided partial responses to the survey. A total of 92 adults coping with serious mental illness who met the inclusionary criteria for the study participated in the research.
Participants

A total of 92 adults coping with serious mental illness from across eight ICCD certified clubhouses in the state of New York completed the study between December and May 2011. The participants \( n = 42 \) women, \( n = 50 \) men) reported a mean age of 46.4 years \( (SD = 11 \text{ years}) \). The sample was primarily Caucasian (41\%) and African American (41\%) with smaller proportions describing themselves Latino (9.7\%) and 7.6\% describing themselves as having other racial backgrounds including Asian/Pacific Islander and American Indian/Alaska Native. Majority of the sample was also single (69\%) with only few reporting that they were married (3.2\%) or in a romantic relationship (9.7\%). With respect to education, 23.9\% of the sample reported having graduated high school, 20.6\% reported having some college, and a smaller proportion reported having a Bachelor’s Degree (14.1\%) or Associate Degree (9.7\%). Table 2 presents the demographic characteristics of the sample.

Procedure

A World Wide Web link was provided to clubhouse directors and staff who provided the link to eligible members interested in participating in the study. This World Wide Web link directed participants to a website containing a brief description of the study and informed consent information. After indicating their informed consent, participants completed an online questionnaire. Collecting survey data via the web reduces the response time, lowers cost, increases the accuracy of data entry, and allows more flexibility of survey format than mail surveys (Granello & Wheaton, 2004).

The online questionnaire included self-report measures of internal social and psychological integration within the clubhouse community, external social community integration with non-consumer /member community, perceptions of the clubhouse
environment, self-reported mental health symptoms, well-being, satisfaction with employment status and members demographic information.

Measures

Table 1 describes the constructs and the measures used in the present study. The statistical outcome variables used in the study consist of internal community integration and external community integration. Internal community integration, i.e. the degree to which the clubhouse members report being integrated within the clubhouse community will be measured using the Client Interaction Scale (CIS; Brekke & Aisley, 1990).

Social Integration within the Clubhouse. The Client Interaction Scale (CIS; Brekke & Aisley, 1990) was used in the present study to measure members’ experience of the member-to-member interactive environment. Although the nomenclature of the scale refers to the respondents as clients, the authors have suggested that the terms residents, client, member, and patient can be used interchangeably, depending on the context (Brekke & Aisley, 1990). The CIS is a 12-item scale (Appendix B) that was completed by clubhouse members to assess their level of integration into the clubhouse milieu. It has five point Likert-type response categories ranging from “most or all of the time” to “rarely or none of the time” and the total scale score ranges from 12 to 60. Some sample items include “I really look forward to spending time with members here”, “I feel that the other members encourage me to join in around here.” The scale has demonstrated high internal consistency ranging from $\alpha = .89$ (Brekke & Aisley, 1990) to $\alpha = .93$ (Bradshaw & Brekke, 1999). The discriminant validity for the scale is established by its ability to distinguish between different community supports environments (e.g. psychosocial rehabilitation programs vs. board and care facility) with different socialization focus and client-to client milieus (Brekke & Aisley, 1990). In the present study, $\alpha = .89$. 
Social Integration in the Larger Community. The External Social Integration Scale (ESIS; Segal & Aviram, 1978) was used in the present study to measure member’s social integration. ESIS consists of a total of seven subscales and for the present study, 3 scales were adapted to measure the social integration of members. (i) Friendship-Access and Participation, consists of six items which measure both, the ease with which the respondent can reach out to friends, as well as the frequency of contact with friends. For the present study, this scale was adapted to specifically measure ease and frequency of contact with friends who are not mental health consumers. (ii) Social Integration through Community Groups consists of four items which assesses development of friendships through participation in Community groups. Two items from the scale overlap with Friendship-Access and Participation, and two items measure participation in social and volunteer groups. The items will be adapted to measure participation in non-consumer groups outside the clubhouse. (iii) Attending to Oneself consists of six items measuring the presence of respondent in the community. For the present study two of the six items were adapted for use (Appendix C). In previous research, the subscales have demonstrated adequate internal consistency ranging from $\alpha = .70$ to $ .91$ (Segal & Aviram, 1978; Segal & Kotler, 1993). In a construct validation study, the scale was also able to distinguish between people with serious mental illness, criminal justice patients, and the general population with differences in scores occurring in estimated direction (Segal, 1990). In the present study, internal consistency reliability for the subscales combined was $\alpha = .92$.

Perceived Social Support. The Social Provisions Scale (Cutrona & Russell, 1987) consists of 24-item designed to assess the extent to which the respondent’s social relationships provide social support. The respondent indicates on a 4-point scale the extent to which each statement describes her current social network for example “I feel a strong emotional bond with at least one other person”. Responses range from 1 (strongly disagree)
to 4 (strongly agree). For the present study a 4 item subscale that measured attachment and integration in respondents’ social relationship was used (Appendix D). The test has adequate psychometric properties with studies reporting internal consistency ranging from $\alpha = .70$ to .80 (Cutrona & Russell, 1987; Nelson, Janzen & Trainor, 2006). In the present study, the internal consistency reliability was found to be $\alpha = .74$.

**Perceived Familial Support.** Familial- Access and Participation, a subscale from The External Social Integration Scale (ESIS; Segal & Aviram, 1978) was used to measure participants perceived familial support. It consists of 6 items that measure both, the ease with which the respondent can reach out to members of his/her family as well as the frequency of contact with family (Appendix E). The responses are recorded on a 5-point likert scale. For the present study the internal consistency reliability for the scale was $\alpha = .82$.

**Time Spent in Clubhouse and Alone.** Two single items were adapted from the Attending to Oneself Subscale of the External Integration Scale (Segal & Aviram, 1978) to measure the time participants spent in the clubhouse between 8am to 5pm and to measure the time they spent alone between 5 pm and 11 am (Appendix F). In the present study 37% of the participants reported spending all or most of their time in the clubhouse between 8 to 5 pm, while 39.1% reported spending half of their time in the clubhouse between this period and finally 21.7% reported spending only “a little” of their time in the clubhouse between 8 to 5 pm. With respect to spending time alone, 25 % of the study participants reported spending all or most of their time alone between 5pm to 11 pm, while 21.7 % reported spending none of their time alone. 31.5% reported spending a little of their time alone and 17.4% reported half of their time between 5 and 11 pm alone.

**Perceived Clubhouse Environment.** The Community Oriented Programs Environment scale (COPES; Moos, 1973) was developed to assess the psycho-social environment of community program milieus. It consists of 100 items divided into ten, 10-item subscales. For
the present study, members were asked to respond to two of the ten subscales that related to (a) **Support**, i.e. measuring the extent to which members are encouraged and supported by staff and other members. Some sample items include “*The staff go out of their way to help new members get acquainted here*”, “*Members are given a great deal of individual attention here.*” (b) **Practical Orientation** that assessed the extent to which the member’s environment orients them toward preparing for life beyond the program. Some sample items include “*There is an emphasis on training for new kinds of jobs.*” (Appendix G). The subscales have been found to have adequate internal consistency reliability with an average alpha coefficient for all the subscales being .79. In the present study the Support and Practical Orientation Subscales had respective \( \alpha = .74 \) and \( \alpha = .78 \).

**Mental Health Symptoms.** The Colorado Symptom Index (CSI; Shern, Wilson, Coen, Patrick, Foster, Bartsch, et al, 1994) was completed by the members to assess for psychiatric symptomatology. The members responded to a 5 point likert scale ranging from 0= *Not at all* to 4= *At least every day*, with higher scores represent greater symptomatology (Appendix H). The CSI has been widely used in mental health services research in various settings as a respondent self-report measure of psychiatric symptomatology (Boothroyd & Chen, 2008). Sample items include “*In the past month, how often have you felt depressed*”, “*In the past month, how often did you have problems thinking too fast.*” The scale has demonstrated high internal consistency reliability with \( \alpha = .91 \) and test-retest for an average of 381 days being \( r = .61 \) (Boothroyd & Chen, 2008). The Concurrent validity of the CSI was established by its ability to distinguish in hypothesized direction between four different groups, namely people with no known disability, physical disability only, psychiatric disability only and co-morbid physical and psychiatric disability. It is convergent validity was established by high correlation in the expected direction with measures of daily activity functioning and the SF-12 (Boothroyd & Chen, 2008). In the present study the internal consistency reliability of the
scale was $\alpha = .91$. In addition, members were also asked to respond to questions regarding the number of past hospitalizations during the most recent nine month period and their history of past and present substance use treatment.

**Self-Esteem.** The Rosenberg Self-Esteem scale (Rosenberg, 1965) was used to assess members’ feelings of self-worth. Members responded to ten items along a 4 point scale ranging from strongly disagree to strongly agree. Some sample items include “I feel that I have a number of good qualities”, “At times I think I am no good at all.” (Appendix I). Validation studies report alpha coefficients ranging from .83 to .90, test-retest correlations coefficient value of .84. Confirmatory Factor Analysis also supports a unidimensional factor solution (Corbiere & Lesage, 2004). In the present study the internal consistency reliability for the scale was $\alpha = .84$.

**Demographic and Descriptive Information.** Self-reported demographic information (See Appendix J) was collected from members participating in the study. Members responded to questions pertaining to their age, gender, race, marital status, education, employment status, satisfaction with employment status, income, and length of clubhouse membership and frequency of attendance at their respective programs.
CHAPTER IV. RESULTS

Preliminary Analysis

Prior to assessing the main research questions, the variables of interest were examined for accuracy of data entry, missing values and fit with assumptions of multivariate analysis. None of the measures were missing more than 5% of the cases, so missing values were replaced with mean scores for all cases. Statistical tests of skewness and/or Kurtosis were significant for Colorado Symptom Inventory with evidence of positive skewness. This scale was transformed using log transformation which was subsequently used in analysis. Further, descriptive statistics for the study variables, correlations among the study variables, and mean differences on study variables based on clubhouse membership and certain demographic characteristics were examined. Table 3 contains the means, standard deviations and ranges for study measures. The following variables were dummy coded for the preliminary and subsequent analyses: participant gender (male=0; female=1), hospitalization in the past 9 months (0= no hospitalization; 1= at least one hospitalization), ever received treatment for substance abuse (0 = No; 1 = Yes), currently receiving treatment for substance abuse (0= N0; 1 = Yes).

Mental Health and Well-Being. In the present study, the majority of the sample (66.2%) reported no psychiatric hospitalization in the past 9 months, whereas 16.6% of the sample reported at least one hospitalization within this time period. Further, 31.5% of the sample reported having ever received treatment for substance abuse, with number of participants who reported requiring current treatment dropping to 9.7% of the sample. With respect to psychiatric symptoms, participants in the current study reported a mean of 1.93 (SD=.83) on the Colorado Symptom Index. This mean score is somewhat lower than the mean found in other studies of people coping with serious mental illness. For example, Oyserman and Bybee (2004) report a mean of 2.59 (SD=.78) for a sample of 317 mothers.
coping with serious mental illness recruited from Community mental health centers and
inpatient psychiatric facilities. Further, test of skewness revealed that scores were positively
skewed. This led to log transformation of the Colorado Symptom Index that was used in
subsequent analysis. The mean score for Rosenberg Self-esteem for the current sample was
3.02 (.54), with higher scores indicating higher self-esteem. In a study of 92 people coping
with serious mental illness recruited from mental health clinics and comprising of comparable
demographic characteristics, Dongen (1997) reports similar means with greater
preponderance towards positive self-esteem.

**Employment and Clubhouse Membership.** Table 4 provides information regarding
employment status of clubhouse members along with data regarding satisfaction with
employment status and annual income. For those who were employed, the mean income
reported was 6.63 dollars per hour (*Median* = 7; *SD* = 4.4) with the average numbers of hours
spent on the job per week being 13.54 (*SD* = 11.69). With respect to clubhouse membership,
the average membership for the current sample was 6.21 years (*SD* = 5.6) with 52.2% of the
participants reporting daily clubhouse attendance, 33.7% reporting attending the clubhouse at
least once or twice a week and 13% reporting attending once or twice a month.

**Mean Differences on Study Variables as a Function of Gender and Substance Abuse.**
To understand if participants’ reports and experiences on study variables differed as a
function of gender and substance abuse history, independent sample t-tests were used to
assess mean differences on study variables. In the present study, comparable number of men
(*n* = 50) and women (*n* = 42) responded. Therefore to rule out variance in study measures as a
result of categorical level demographic variable, participant gender was used for the
preliminary analysis. Similarly, to rule out variance in study measures due to comorbid
substance abuse and mental illness, substance abuse history was used to assess mean
difference on study measures. Levene’s test was used to assess the homogeneity of variance
between the two subsamples and results showed that the variances in both groups were approximately equal. No difference in participants self-reports on the study variables were found as a function of gender (Table 5). Participants who reported ever having received treatment for substance abuse reported higher perceptions of the clubhouse environment as supportive ($M=3.1, SD=.40$) as compared to those who had never been in treatment for substance abuse ($M=2.91, SD=.44$) $t(88) = -.22, p < .05$. No other differences as function of substance abuse treatment were found in participants’ scores on Client Integration Scale $t(89)= -.24, p < .8$, Family Access and Participation $t(89)= -1.16, p < .24$, Friendship Access and Participation $t(89)= -1.59, p < .11$, Perceived Social Support $t(88)= -.08, p < .93$, perceived clubhouse environment (practical orientation) $t(88)= -1.86, p < .06$, Rosenberg Self-esteem $t(89)= -.41, p < .67$.

**Mean Differences in Reports of Internal and External Community Integration.**

The study aimed to explore if there were differences in participants reports of internal integration within the clubhouse versus external integration with the larger non-consumer/client community. To this end, paired sample t-test was conducted to compare mean differences between reports of internal integration within the clubhouse community and perceived social support and external social integration within the larger non-consumer/client community. Result indicated that participants reported significantly greater internal integration within the clubhouse ($M=4.04, SD=.76$) than external social integration ($M=2.88, SD=.105$) $t(91) = 9.7, p < .001$. Similarly there was also a significant mean difference between reports of internal integration ($M=4.04, SD=.76$) and perceived social support from the larger non-consumer/client community ($M=2.92, SD=.69$) $t(90) = 9.7, p < .001$.

However, there was no significant difference in the reports of members’ external social integration, ($M=2.88, SD=.105$) and perceived social support from the larger non-consumer/client community ($M=2.92, SD=.69$).
Mean differences in Study variables as a Function of Clubhouse Membership and Ethnicity. A series of oneway ANOVAs were conducted to examine differences in self-reports on the study variables as a function of clubhouse membership, and ethnicity of participants. The current data was collected from over eight different clubhouses in New York State. Therefore mean difference in study variables as a function of clubhouse membership were examined to rule clubhouse membership as a source of variance. The clubhouses were grouped together based on their location in either one of the five boroughs of New York, namely Queens, Brooklyn, Manhattan, and Bronx or region outside the city. Levene’s test was used to assess the homogeneity of variance between the different groups. If the homogeneity of variance assumption was not met, then Welch’s F and Brown-Forsythe F statistic were examined for significance. No significant differences as a function of clubhouse membership were found on participants’ score on Client Integration Scale $F(4, 87) = .73, p < .57$, Family Access and Participation $F(4, 87) = .38, p < .82$, Friendship Access and Participation $F(4, 87) = 1.20, p < .31$, Perceived Social Support $F(4, 27.04) = 2.48, p < .06$, perceived clubhouse environment (support) $F(4, 87) = .93, p < .45$, perceived clubhouse environment (practical orientation) $F(4, 87) = .43, p < .78$, Rosenberg self-esteem $F(4, 87) = 1.12, p < .34$, Colorado Symptom Index (log transformed) $F(4, 87) = 2.09, p < .08$.

There was a significant effect of ethnicity on perceived familial support $F(2, 89) = 4.58, p< .05$. Participants who identified as African-American reported greater perceived familial support ($M= 3.3 SD = .94$) than those participants who identified as Caucasian ($M=2.7 SD = .91$). Similarly, people of other racial backgrounds reported greater perceived familial support ($M= 3.4 SD = .69$) than people who identified as Caucasian ($M= 2.7$).

Correlations among Study Variables. Pearson Bivariate correlations among the study variables were conducted for the entire sample (Table 6). Results indicate a relationship between measures of external social community integration, namely subscales from the
External Social Integration Scales (Segal & Aviram, 1978) and Social Provision Scale (Cutrona & Russell, 1987) were found to be correlated ($r=.57, p<.01$).

Further, member’s perceptions of self-esteem was significantly related to both reports of internal integration within the clubhouse and external social integration within the larger non consumer/client community with correlations ranging from ($r=.22$, to $r=.48, p<.01$).

Members self-reported psychiatric symptoms were significantly negatively correlated to measures of external social integration and perceived social support $r=.27, p < .01$ $r=.24, p <.05$ respectively.

Perceived family support was also related to both reports of internal integration within the clubhouse and external social integration within the larger non consumer/client community with correlations ranging from ($r=.37$, to $r=.50, p<.01$). Greater familial support was associated with greater friendships both inside the clubhouse community and outside within the larger non consumer/client community.

Level of employment was correlated with measure of external social integration $r=.21, p<.05$), however it was not related to measure of participants’ perceived social support from members of larger non-consumer/client community or with measures of internal community integration. Demographic variables were not found to be correlated with main study variables.

Employment, Perceived Family Support and Clubhouse Environment in Predicting Internal Community Integration in Clubhouses

Hierarchical regression analysis was conducted to assess the amount of variance in the scores of internal integration of clubhouse members accounted for by level of employment, perceived family support, and aspects of the clubhouse environment including time spent in the clubhouse. It was expected that voluntary employment in the clubhouse’s Work Ordered Day, the clubhouse environment and time spent in the clubhouse would be significantly
associated with reported internal integration within the clubhouse community. Level of employment represented a categorical variable consisting four groups of participants including (a) unemployed (b) independently employed (c) supported/transitional employment (d) voluntarily employed in the clubhouse’s WOD. Unemployed status was used as a baseline group and three dummy coded variables were created to accurately represent the level of employment as follows: (1=independently employed, 0= all other employment), (1= supported/transitional employment, 0= all other employment), (1=Voluntary employment, 0=all other employment). The first step of the regression equation contained participants’ scores on Colorado Symptom Inventory and Rosenberg Self-esteem representing perceived symptoms and well-being respectively. Scores on Familial Access and Participation, representing perceived family support were entered in the second step. Dummy coded variables for level of employment, were entered into the third step representing employment status. Finally scores on single item measuring time spent in the clubhouse and scores on perceived support and practical orientation of the clubhouse, representing the clubhouse environment were entered in the fourth step of the regression model. The criterion variable was participants’ score on the Client Integration Scale representing internal integration within the clubhouse.

The overall model predicting internal integration within the clubhouse was significant, $F (9, 76) = 5.05, p < .001, R^2 = .37$, Adj. $R^2 = .30$. Greater perceptions of the clubhouse as having a practical orientation, ($\beta = .44, p = <.01$), greater time spent in the clubhouse ($\beta = -.32, p = <.01$) and greater perceived familial support ($\beta = .31, p = <.01$) were associated with greater internal integration within clubhouse. However, perception of greater support from the clubhouse was not found to be significant. Further, level of employment was not significantly associated with internal integration within the clubhouse. Certain aspects of clubhouse environment accounted for a significant amount of variance
(Δ$R^2 = .19, p < .001$; Table 7) in internal integration within the clubhouse after controlling for covariates.

*Employment, Perceived Family Support and Clubhouse Environment in Predicting External Social Integration*

Two hierarchical regression analyses were conducted to assess the amount of variance in external social integration of clubhouse members accounted for by aspects of the clubhouse environment including the time spent in the clubhouse. It was expected that level of employment and perceptions of the clubhouse environment as having a greater practical orientation and lesser time spent in the clubhouse would be significantly associated with reported external social integration with non-consumers/clients in the larger community outside the clubhouse. Two regression analyses were separately conducted to assess the relative contributions of aspects of the clubhouse environment and time spent in the clubhouse on two measures used in the study to assess perceived social support and the ease of access and participation in friendships with people without mental illness. The first step of the equation contained participants’ scores on Colorado Symptom Inventory and Rosenberg Self-Esteem Scale, representing perceived symptoms and well-being respectively. Scores on Familial Access and Participation, representing perceived family support were entered in the second step. Three dummy coded variables for level of employment as described above were entered into the third step representing employment status. Finally scores on single item measuring time spent in the clubhouse and scores on perceived support and practical orientation of the clubhouse, representing the clubhouse environment were entered in the fourth step. The criterion variables were participants’ report of external integration and perceived social support from the non-consumer/client. The order of entry of the variables into the hierarchical regression analyses was identical for the two measures of external social integration and perceived social support.
For the measure representing the ease and access to participation in friendships with non-consumer/clients, the regression model at step three was significant $F(6, 79) = 9.81, p < .001, R^2 = .42$, Adj. $R^2 = .38$ (Table 8). Greater perceived family support ($\beta = .5, p = < .001$), independent employment ($\beta = .26, p = < .001$) and greater self-esteem ($\beta = .22, p = < .05$) were associated with reports of greater external social integration within the larger non-consumer/client community. The addition of the fourth step, i.e. variables representing the clubhouse environment did not add significant amount of variance in external social integration.

For the measure representing perceived social support from friends outside in the larger non-consumer/client community, the model at second step was significant $F(3, 81) = 14.95, p < .001, R^2 = .35$, Adj. $R^2 = .33$ (Table 9). Greater self-esteem ($\beta = .54, p = < .001$) and greater perceived family support ($\beta = .29, p = < .01$) were associated with greater perceived social support for the participants. The third and fourth step, i.e. addition of variables representing level of employment and the clubhouse environment did not add significant amount of variance in perceived social support.

Although no initial hypothesis were formulated, results indicated that perceived familial support was a significant predictor of both integration within the clubhouse community and external integration within the larger non-consumer/client community. Further, although aspects of the clubhouse environment were significantly associated with reports of internal integration within the clubhouse, they did not account for significant variance in external social integration and perceived social support within larger non-consumer/client community. Conversely, although independent employment was significantly associated with participations and ease of access to friendships with non-consumers/clients in the larger community, employment status was not associated with perceived social support from community members who do not identify as mental health
consumers or clients and neither was it associated with perceptions of internal integration within the clubhouse. Finally results indicate that although self-esteem was not associated with internal integration within clubhouse, it accounted for significant amount of variance in perceived social support and external integration with non-consumer/client community.
CHAPTER V. DISCUSSION

The present study expanded the literature on community integration for people coping with serious mental illness. It made a conceptual distinction in community integration to differentially examine aspects of participant’s internal community integration with other consumers/clients, versus their social integration with members of larger community who did not identify as mental health consumers/clients. The context of psycho-social clubhouses was used to understand participant’s experiences of integration with other members coping with serious mental illness within this particular milieu. Further, the study investigated how different employment activities and clubhouse involvement were associated with internal and external community integration experiences of participants.

Main study findings indicate that members report greater degree of integration within the clubhouse as compared to social integration outside the clubhouse with members of the larger non-consumer/client community. Further, findings also indicate that aspects of clubhouse environment including greater time spent in the clubhouse and perceptions of clubhouse as having a practical orientation were associated with reports of greater internal social integration within the clubhouse. However, these variables were not related to external social integration outside the clubhouse with larger non-consumer/client community. Level of employment, specifically independently employed participants as compared to unemployed participants, reported greater participation and ease of access to friendships in the larger non-consumer/client community. However level of employment was not related to perceived social support from non-consumers/clients or with experiences of internal integration within the clubhouse. Similarly, greater self-esteem was significantly associated with participants’ reports of both greater external social integration and perceived social support from members of non-consumer/client community but it did not play a significant role in accounting for variance in participants perceptions of internal integration within the clubhouse community.
Finally, greater perceived family support was related to both reports of greater internal integration within the clubhouse and to greater external integration with the larger non-consumer/client community.

**Community Integration and the Clubhouse Environment**

One of the main study goals of the present research was to examine whether the perceptions of clubhouse environment were differentially associated with reports of internal community integration within the clubhouse and reports of external social community integration and social support outside in the larger non-consumer/client community. As expected, those members who spent greater time in the clubhouse also reported greater perceptions of integration within the clubhouse community. Greater perceptions of the clubhouse environment as having a practical orientation were also associated with greater internal integration. Together these aspects of the clubhouse environment accounted for 15% of the total amount of variance in the reported internal integration of members within the clubhouse after controlling for other covariates. However, perceptions of clubhouse environment as supportive were not related to greater integration within the clubhouse. Similarly, the clubhouse environment did not play a role in external community integration with non-consumer/client community.

These findings are not directly comparable to previous research, as no prior work has examined similar program level correlates of community integration within clubhouse settings. However, research has suggested that the social environment can have stronger associations with treatment outcomes as compared to individual level variables (Schutt, Rosenheck, Penk, Drebing & Siebyl 2005). For example, in a study of 130 members attending a psychosocial clubhouse, Di Masso, et al (2000) found that greater clubhouse attendance was associated with positive outcomes such as higher rates of employment attainment, more advanced employment status and reduced hospitalization recidivism. In
another study, Kruzich (1985) studied the association between the program level characteristics of residential care settings for people with mental illness and their level of community integration. Community integration was defined as behavioral involvement in activities outside the individual's residence, including both leisure and work-related activities (e.g. going shopping, to movies and concerts, sporting events, church etc.). The results of a multiple classification analysis indicated that programs that provided opportunities for learning skills such as cooking, budgeting, use of transportation were associated with greater community integration for its residents.

Surprisingly in the present study, perceptions of the clubhouse environment as having a practical orientation, i.e. the degree to which members perceived that the clubhouse prepared them for life outside was not related to greater integration outside of the clubhouse community with non-members/client. Rather these perceptions were associated with greater integration within the clubhouse community. On the other hand, perceptions of the clubhouse environment as supportive were related to neither internal nor external integration. Bradshaw and Brekke, (1999) investigated the associations between program level factors of community based programs including psychosocial rehabilitation programs and subjective experience of self-esteem and life-satisfaction in 103 clients diagnosed with schizophrenia or schizoaffective disorder. The program level variables consisted of perceptions of the environment as having anger, support, involvement, spontaneity and clarity in the overall interactive milieus. They found that although lower perceived anger in the milieu was related to higher self-esteem, perceptions of support did not have any associations with participants’ subjective experiences.

It maybe that activities and the structure that are associated with practical goals and tasks provide members greater opportunities to engage with other members. Members may come together and rely on each other to achieve and problem-solve around such activities,
tasks and goals. This may consequently lead to greater integration within the clubhouse community. However, currently the results of the present study indicate that although members perceive the clubhouse environment as helping them to prepare for life outside the clubhouse, such clubhouse practices are not actually associated with members’ life outside the clubhouse with respect to forming social relationships with community members who do not identify as mental health consumers and clients.

A primary goal of psychosocial clubhouses remains to facilitate community integration and readjustment to society for people coping with serious mental illness (Mastboom, 1992; Plotnick & Salzer, 2008). However the degree to which such programs are able to achieve this objective has not been investigated in research literature. Employment status and psychiatric hospital recidivism as they relate to clubhouse membership have been the primary outcomes that have been empirically investigated in research literature (Linorst, 2006). Further although some sparse literature exists on social networks (Pernice-Duca, 2008) and community integration of clubhouse members (Stein et al 1999), this literature does not investigate program level correlates of community integration. Neither is a distinction made between community integration within clubhouse community and outside the clubhouse community. The results of the present study indicate that greater time spent in the clubhouse and perceptions of clubhouse environment as having a practical orientation were associated were some program level factors associated with greater integration within the clubhouse. Further, results indicate that the magnitude of association was stronger for perceptions of clubhouse environment as having a practical orientation than for spending greater time in the clubhouse.
Community Integration and Employment

A second goal of the current study was to examine the degree to which different kinds of employment activities are differentially associated with reports of internal community integration within the clubhouse and reports of external social community integration and perceived social support outside from the larger non-consumer/client community. As expected, level of employment added significantly to the total amount of variance in the reported external social integration after controlling for other covariates that included psychiatric symptoms and well-being, and perceived family support. Specifically, the results of the current study indicate that as compared to unemployed participants, those who are independently employed report greater participation and ease of access to friendships outside the clubhouse with members of the larger non-consumer/client community. Research has shown that limited social settings and limited resources are a major contributing factor to impoverished social networks (Sørgaard et al., 2001). However employment, especially independent employment addresses both these issues as it provides new arenas for social interaction and relationships as well as financial resources in form of wages. Although independent employment was associated with reports of greater participation and ease of access to friendships outside the clubhouse in the present study, it was not associated with perceived social support from members of the larger community. Further, level of employment was not found to have an association with reported level of integration within the clubhouse community.

Once again it is difficult to compare the results of the present study with existing literature, as employment has rarely been studied to evaluate its association with community integration. In a study by Mueser et al. (2004) of 204 participants, a trend was found for clients of psycho-social rehabilitation vocational programs to be more satisfied with their social relationships as compared to other vocational rehabilitation models. However due to a
large number of hypothesis investigated and limited sample size, the trend did not reach statistical significance. In the present study, it is somewhat surprising that although independent employment predicted variance in greater participation and ease of access to friendships outside the clubhouse with members of the larger non-consumer/client community, it was not associated with perceived social support from members of the larger community. This may be a result of the composition of the sample where only a small number of people who were employed participated in the study. Further, it may also be that the context of independent employment, especially if it takes place in integrated community settings, provides members actual opportunities to interact with and form friendships with other people, specifically co-workers who do not identify as consumers/clients. However independent employment did not necessarily extend to perceptions of support from larger non-consumer/client community. It may be that as compared to participation and ease of access to friendships with members of larger community, perceived social support may emanate from more enduring relationships. Therefore it is possible that although the context of independent employment contributes to social relationships, it does not necessarily increase perceptions of social support.

*Community Integration and Perceived Family Support*

Results of the present study also indicated that greater perceived family support was associated with both reports of greater internal integration within the clubhouse as well greater external social integration and perceived social support from the larger non-consumer/client community. Perceived family support accounted for 11% of the total amount of variance in internal integration within the clubhouse, 20% of the total amount of variance in external social integration and 7% of the total amount of variance in perceived social support from non-consumers/clients in the larger community.
Research has indicated that family members often provide crucial support to people living with serious mental illness (Brown & Birtwistle, 1998; Pernice-Duca 2008). Further perceived family support has been related to greater psychological well-being especially when such relationships involve mutuality and reciprocity of support (Horwitz, Reinhard, & Howell-White, 1996). Pernice-Duca (2008) investigated the influence of family network support on recovery among 169 clubhouse members coping with serious mental illness. She found that participants in general nominated an average of 2.6 family members, indicated weekly contact with family members, and reported being quite satisfied with the nature of their interaction. Further the results indicated that family support and reciprocity were associated with aspects of recovery including personal confidence and hope, goal and success orientation and relational dimensions including willingness to ask for help and reliance on others. Froland, Brodsky, Olson and Stewart (2000) examined the types and characteristics of relationships that were instrumental in providing social support to mental health clients and that were associated with the client’s social adjustment. They recruited 107 clients from across state hospital inpatient ward, a day treatment program, and an outpatient clinic and general population. The results indicated that family ties were the major source of support for all groups except for participants recruited from the hospital. Further, individuals who identified family members as sources of support were also less likely to report psychological distress and greater perceptions of availability of help.

The results of the present study indicate that perceived family support is contributing to members’ report of integration with other consumers in the clubhouse over and above individual variables of self-esteem and psychiatric symptoms. Similarly perceived family support is adding significant amount of variance to both reports of external social integration and perceived social support from members of the larger community. Although causal inferences cannot be made due to cross-sectional nature of the present study, research has
shown that family support tends to be perceived as more enduring, whereas people who receive support from friends and acquaintances tend to experience changes in the social network (Froland et al., 2000). Similar to finding of previous research, it could be that support from family may provide members with social skills, confidence and positive self-perceptions that may aid in forming social relationships outside the family network.

Community Integration and Self-Esteem

Results of the current study also indicate that self-esteem accounted for a significant amount of variance in accounting for external social integration and perceived social support with larger non-consumer/client community. However, self-esteem was not associated with reports of integration within the clubhouse community. Some research has shown a link between self-esteem and quality of life and social network variables. For example, in a study of 219 people with serious mental illness received community based mental health services, Goldberg, Rollin and Lehman (2003) found an association between self-esteem and larger social networks. Eklund and Hansson (2007) investigated the sociodemographic, clinical and self-perceived health-related factors for social interaction among 103 individuals with serious mental illness in community outpatient setting. As in the present study, Eklund and Hansson (2007) used Rosenberg’s 10 item scale was used to assess participants Self-esteem. Social integration was assessed with respect to availability attachment as well as satisfaction with social networks. They found that greater self-esteem was the biggest predictor in explaining the reports of satisfaction or adequacy of social interaction. However in the studies cited above, information regarding composition of network was not made available. Compared to above studies, the results of the present study however are able to point to how self-esteem is differentially associated with internal integration with other clubhouse members as compared to perceived social support and external social integration with the larger non-consumer/client community. People with greater self-esteem also reported greater perceived
social support and external social integration, whereas self-esteem did not play a role in integration with peers in the clubhouse community. Although once again, due to the cross-sectional nature of the study, causal relations cannot be drawn, pre-existing literature on stigma points towards how expectations and fear of rejection from others can lead to avoidance of social contact or constricted and uncomfortable social contact with potential stigmatizers (Farina & Felner, 1973; Link, Francis, James, & Wozniack 1987). Further, perceptions of social rejection are itself tied to negative or low self-esteem. In a study of self-esteem and social rejection in 88 people with serious mental illness, Wright, Gronfein, and Ownes (2000) found that experiences of rejection increased participants’ self-deprecating feelings. Similarly in a study of 95 clients receiving Assertive Community Treatment, Prince and Prince (2002) found that greater perceptions of stigma were related to decreased perceptions of psychological community integration. It maybe that the members who experience rejection or find it difficult to develop and maintain social relationships with non-consumer/client members of the community develop less positive evaluations about themselves whereas those who are able to develop and maintain such relationships also are able to view themselves in more positive light.

Overall, the results of the present study point towards important correlates of community integration. By making a conceptual distinction between integration with other members within the clubhouse community and integration with larger non-consumer/client community, the present study was able to highlight different correlates of each type of integration. Previous studies have not made such a conceptual distinction, although a few previous studies have compared community integration experiences of mental health consumers with matched community members. This research has pointed that people coping with mental illness have lower psychological, social and physical integration (Abdallah, Cohen, Sanchez-Almira, Reyes, and Ramirez, 2009). Similarly, participants in the current
study reported lower experiences of external social integration and perceived social support from the larger non-consumer/client community as compared to experiences of internal integration within the clubhouse community. Further, internal community integration within the clubhouse community was associated with the greater perceptions of clubhouse environment having a practical orientation, time spent in the clubhouse and greater perceived familial support. Together these variables accounted for 37 % of the total variance in internal integration within the clubhouse. On the other hand, integration outside the clubhouse, with members of the non-consumer/client community was associated with perceived family support, independent employment status and greater self-esteem. Together these variables accounted 42 % of the variance in external social integration. Similarly, perceived social support was associated with greater self-esteem and perceived family support, and these variables accounted for a third of the variance in perceived social support. Perceived family support was the only variable that was associated with internal integration with the clubhouse members and external social integration and perceived social support from members of the larger non-consumer/client community. Further, although it was expected that program level characteristics such as perceptions of practical orientation, i.e. perceptions that the clubhouse environment prepares members for life outside the clubhouse would be associated with greater external social integration and perceived social support, it was only related to greater internal integration. Although psychosocial rehabilitation programs such as clubhouses purport to facilitate community integration and readjustment to society for people coping with serious mental illness (Mastboom, 1992) current findings suggest that participants were more integrated into the clubhouse setting with other peers as compared to in the larger community outside the clubhouse. Further, self-esteem was the only individual- level variable that was associated with community integration. Specifically, greater self-esteem was related
to reports of greater external social integration and perceived support from members of non-consumer/client community.

Limitations

Although the present study adds to the literature on community integration in novel ways, several limitations of the study should be considered. First, the composition of the sample limited the study in several ways. For instance, a higher proportion of unemployed clubhouse members participated in the study as compared to those who were employed. Participants who met the inclusion criteria were nominated and recruited by clubhouse staff during normal working hours. Therefore, it may have made it difficult for employed members to participate in the research. The fewer number of employed participants in the current study may have made it difficult to detect statistically significant results in certain analysis.

To protect confidentiality of participants, the data was collected online. Although research has shown that collecting survey data via the web reduces the response time, lowers cost, increases the accuracy of data entry (Granello & Wheaton, 2004), it may have precluded certain members who are not comfortable with using computers from participating. Clubhouse staff were encouraged to provide technical assistance to members who were not internet savvy, however this may not have always happened. Further as participants were selected from a community based psycho-social program, i.e. clubhouses, the finding may not generalize to the larger population of people coping with serious mental illness not currently availing similar community based services.

Finally, the cross-sectional nature of this research makes it impossible to infer causality among variables. Future longitudinal research with before-after design may elucidate the impact of program level characteristics and employment variables on community integration more definitively.
Directions for Future Research

The present study is an important first step in understanding community integration experiences of clubhouse program members who were coping with serious mental illness. Based on previous research, the study investigated specific program level factors that may be related to community integration. The results indicated that program level factors such as time spent in the clubhouse and perceptions of clubhouse environment as having a practical orientation were only specifically associated with internal community integration but not with external community integration and perceived social support from larger non-consumer/client community. Further empirical investigation is needed to understand if other specific clubhouse characteristics, such as types of community based activities, and specific types of social programing are associated with external community integration experience of participants. Further, research comparing the association between external community integration and membership in different types of program e.g. clubhouse vs. ACT programs can throw light on if clubhouse membership specifically promotes external community integration. Longitudinal research examining reports of community integration before and after enrolment in psychosocial rehabilitation programs may also address the limitation of cross-sectional research and help to throw light on the impact of program level characteristics on community integration.

Independent employment was found to be associated with reports of greater external community integration with members of non-consumer/client community. However, this association did not extend to perceived social support from the larger non-consumer/client community. Given that the present study may have failed to detect significant results due to limited participation of members who were independently employed, future research is needed to verify above findings. Further once again cross-sectional nature of the present research limits inference of causality. Longitudinal and randomized designs are needed to
clarify the direction of relationship between employment activities and community integration with non-consumer/client community.

In the present study, the only individual-level study variable related to community integration was self-esteem. Qualitative and phenomenological research can further elucidate how self-esteem is related to external community integration experiences of people coping with serious mental illness. Finally, one of the surprising findings of the study is the degree to which perceived family support was associated with both internal integration within the clubhouse and external social integration and perceived social support from larger non-consumer/client community. Future research on families of people with serious mental illness should investigate the nature and quality of family support and the mechanisms by which such relationships can promote community integration outside the family network.

*Implications for Community Practice*

Although as mentioned above, additional research in this area is needed to draw firm conclusions, the findings of the present study have important implications for community practice. Community integration remains an important goal for most community based treatment programs including psychosocial rehabilitation clubhouses. Further true community integration entails development of relationships between people with and without labels. However, current research shows that specific perceptions of clubhouse environment are primarily associated with integration within the clubhouse community but not with the larger non-member/client community. Further, since the research indicated that participants reported greater internal integration as opposed to external integration, clubhouse programs need to make greater attempts to implement programs and activities to promote greater external community integration. Results also show that activities such as independent employment, perhaps due to their ability to provide new social contexts and increase members financial resources, improve their participation and access to friendships with
people who do not identify as mental health clients or consumers. Therefore programs may
do well to incorporate or aid members towards achieving independent level of employment in
community settings. Incorporating activities, programs and partnerships with the larger
community may similarly provide greater opportunities for members to expand and diversify
their social networks to include those that do identify as mental health consumers/clients.

Present research shows that participants report greater internal integration within the
clubhouse community and these reports were associated with greater time spent in the
clubhouse and perceptions of program environment as having a practical orientation. Thus,
for new members to be integrated into the clubhouse milieu, involving them in practical tasks
and goals, especially when these activities involve group goals, task or activities may
increase members’ integration within program milieu. Along with providing necessary skills
and goal oriented activities, targeting member’s mastery and self-perception may also be
important as present results point to the importance of association between self-esteem and
integration experiences within the larger non-consumer/client community.

Finally, findings of the present study suggested that perceived family support was
associated with both internal integration and with external social integration and perceived
social support from members of the non-consumer/client community. In light of this finding,
programs can collaborate to encourage greater family involvement and to create and model
interventions that can incorporate aspects of family support that promote greater community
integration for people coping with serious mental illness.
REFERENCES


APPENDIX A.
LIVING IN THE COMMUNITY WITH SERIOUS MENTAL ILLNESS- INFORMED CONSENT FORM
HSRB ID# H11D072GFB (Effective 12/17/2010; Expires 11/2/11)

- You are invited to participate in a research study examining clubhouse members’ views of employment activities, social relationships, and perceptions of the clubhouse environment.

- You are invited to participate, if you are at least 18 years old, and are a member of your clubhouse, and have not already completed this survey.

- Your participation will involve answering a series of questions about your experiences in work activities, relationships with others, and being a clubhouse member. The survey should take 45 minutes to complete.

- The research is being conducted by Shinakee Gumber, a doctoral student in the Department of Psychology at Bowling Green State University, under the supervision of Dr. Catherine Stein, who is Professor of Psychology at Bowling Green State University.

- The benefits of participating in the research are to help us understand more about how member’s view clubhouse activities. In addition, being a part of the study can give the opportunity to reflect on and share your personal experiences. Furthermore, you will have an opportunity to participate in a drawing to win one of twenty, $25 cash prizes, with the odds of winning being approximately one in every five participant.

- The anticipated risks to you are no greater than those normally encountered in daily life.

- Please note that you are free to change your mind and stop participating at any time, even if you begin to complete the online survey. You may click on the X at the top right-hand corner of your computer window to exit the survey at any time. Your responses will not be saved till you click the submit button at the end of the survey. If you exit and then decide later that you would like to participate, you can visit this web address again by asking the clubhouse staff members for the link to the study.

- Please note that your participation is completely voluntary and you are free to skip any questions you do not want to answer. If you choose not to participate in this study, it will not impact your relationship with any other agency or the clubhouse of which you are a member.

- Please note that your survey answers are confidential. Any personal information that you provide will NOT be linked to your survey answers; it will be stored in a password-protected on-line database separate from your survey responses and will be used only to enter your name in drawing for cash prizes/gift certificates. Any information you provide will be accessed only by the research investigators.

- Since the Internet is not 100% secure in terms of privacy, please do not leave the partially completed survey open or unattended if completing it on a public computer. You should clear the browser page history and cache when finished with the survey. Please note that if you require technical help from an assistant, that person may see your responses to your survey in the process of assisting you.
- We hope to publish an article summarizing the overall results of this study, but no one person's answers to close-ended questions will be presented - only a summary of data from many participants will be included in any publications or presentations.

- In addition, if you have any questions about the study, you may contact the principal investigator: Shinakee Gumber, M.A., Graduate Student, Department of Psychology, BGSU, (419)-377-4889, sgumbe@bgsu.edu; or the faculty advisor for this project, Catherine Stein, Ph.D., Professor of Psychology, Psychology Department, BGSU, (419) 372-2301, cstein@bgsu.edu.

- You may also contact the Chair of the Human Subjects Review Board at Bowling Green State University, (419) 372-7716, hsrb@bgsu.edu, if you have questions about participant rights.

Your completion of this online survey indicates your voluntary consent to participate in this research investigation. You may refuse to participate in this investigation or withdraw your consent and discontinue participation in this study without penalty. If are eligible to participate and if you wish to give your consent and continue, please select the following option, then click the button labeled "Next."

- I have been presented with and have read the above statement of risks and benefits of participating in this project and I agree to participate.
APPENDIX B.
CLIENT INTEGRATION SCALE  
(Brekke & Aisley, 1992)

The following questions concern your relationship with other members of the clubhouse. Using the scale that follows, please indicate which response best answers each question.

1. Rarely or none of the time
2. Not very often
3. Occasionally
4. Somewhat often
5. Most or all of the time

1. Really look forward to spending time with the members here
2. When I have a problem, I can count on the members to help me out
3. I feel the other members don’t like me very much.
4. The time I spend with other members is very important to me
5. When I am feeling confused, the members help me to sort things out
6. When I spend time with the other members I can really be myself
7. It’s not much fun to talk to the other members
8. I feel a lot better when I spend time with the members here
9. The other members help me to reach the goals I set for myself
10. I can really rely on the other members when I need cheering up
11. The other members encourage me to join in around here
12. I feel the other members really want me to do well
Appendix C.
EXTERNAL SOCIAL INTEGRATION SCALE - Friendship Access and Participation
(Segal & Aviram, 1978)

The following questions concern your social relationship with your friends who do not have a diagnosis of any type of mental illness. When answering these questions, please think about friends who, as far as you know are not coping with a mental illness. Then using the scale that follows, indicate which response best answers each question.

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>Easy</td>
<td>Not much trouble</td>
<td>Difficult</td>
<td>Very difficult</td>
</tr>
</tbody>
</table>

How easy would it be, if you want to:

1. Telephone and just talk to a close friend outside the clubhouse who is not coping with a mental illness
2. Telephone and just talk to an acquaintance outside the clubhouse who is not coping with a mental illness
3. Get together with a close friend not a member of this clubhouse or another like it and who is not coping with a mental illness
4. Get together with an acquaintance not a member of this clubhouse or another like it and who is not coping with a mental illness

On a typical day how often do you visit with:

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
</tr>
</tbody>
</table>

5. Visit with close friends who are not members of this clubhouse and who are not coping with mental illness
6. Visit with acquaintances who are not members of this clubhouse and are not coping with mental illness
7. Do volunteer work outside the clubhouse
8. Join in the activities of social or political groups outside the clubhouse with people who are not coping with mental illness.
9. Go out to a coffee shop or restaurant with friends who are not members of this clubhouse and are not coping with mental illness
10. Go to the shopping center or local shopping areas with friend/s who are not members of this clubhouse and are not coping with mental illness
APPENDIX D.  
SOCIAL PROVISIONS SCALE  
(Cutrona & Russell, 1987)

The following questions concern your social relationship with people who do not have a diagnosis of any type of mental illness. When answering these questions, please think about people who, as far as you know are not coping with a mental illness or providing any mental health services. Then using the scale that follows, indicate which response best answers each question.

Other than people who provide me with mental health services or are other people coping with mental illness ...

1  2  3  4
1. Strongly Disagree Agree Strongly
2. Disagree Agree

1. I feel that I do not have close personal relationships with other people.
2. There is no one who likes to do the things I do.
3. I feel a strong emotional bond with at least one other person.
4. I feel part of a group of people who share my attitudes and beliefs.
APPENDIX E.
EXTERNAL SOCIAL INTEGRATION SCALE- Familial Access and Participation Subscale
(Segal & Aviram, 1978)

The following questions concern your relationship with members of your family. Using the scale that follows, please indicate which response best answers each question.

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>Easy</td>
<td>Not much trouble</td>
<td>Difficult</td>
<td>Very difficult</td>
</tr>
</tbody>
</table>

How easy would it be, if you want to:

1. Telephone and just talk to a member of the immediate family
2. Telephone and just talk to a more distant relative
3. Get together with a member of your immediate family
4. Get together with a more distant relative

On a typical day, how often do you visit with:

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>Often</td>
<td>sometimes</td>
<td>Rarely</td>
<td>Never</td>
</tr>
</tbody>
</table>

5. Members of your immediate family
6. More distant relatives
APPENDIX F
EXTERNAL INTEGRATION SCALE- Attending to Oneself Subscale
(Segal & Aviram, 1978)

Please answer the below questions using one of the following response that best describes you.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>A little</td>
<td>Half/half</td>
<td>Most</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>

1. How much of your time between 8 A.M and 5 P. M is spent at the clubhouse.
2. On a typical day how much of your time between 5 pm and 11 p, do you spend *alone*. 
APPENDIX G.
COMMUNITY ORIENTED PROGRAMS ENVIRONMENT SCALE
(Moos, 1973)

Please read the following statements carefully and indicate whether it holds true or false as it relates to your clubhouse

(Support)
1. Some members here help other members who may be going through a tough time.
2. Staff have very little time to encourage members
3. Members seldom help each other
4. Staff are very interested in following up members once they leave the program
5. Staff always compliment a member who does something well.
6. The staff know what the members want
7. Staff sometimes do not show up for their appointment with members
8. There is relatively little sharing among the members.
9. Members are given a great deal of individual attention here.
10. The staff go out of their way to help new members get acquainted here.

(Practical Orientation)
1. There is an emphasis on training for new kinds of jobs.
2. There is not a lot of focus on finding solutions to practical problems that members have.
3. Members are expected to make specific, detailed plans for the future
4. There is not a lot of discussion about how members can get involved in activities outside of the clubhouse.
5. Members are usually spend more time thinking or talking about the past than they do thinking or talking about the future.
6. Members usually receive a lot of help in making specific plans for getting more involved in community life outside of the clubhouse.
7. Members are expected to make goals for their future and work towards achieving them.
8. Members learn specific new skills.
9. Members aren’t really interested in doing new activities in the community.
10. Members are expected to help other members when problems come up.
APPENDIX H.
COLORADO SYMPTOM INDEX
(Shern, et al, 1994)

The following questions ask you about any psychological or emotional difficulties you may have had during the PAST MONTH. For each question, there are four possible responses ranging from Not at all (0) to At least every day (4). For each question, look at the response choices and pick one that best describes how often you have had the problem in the past month.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Once during the month</td>
<td>Several times during the month</td>
<td>Several times a week</td>
<td>At least every day</td>
</tr>
</tbody>
</table>

1. In the past month, how often have you felt nervous, tense, worried, frustrated or afraid?

2. In the past month, how often have you felt depressed?

3. In the past month, how often have you felt lonely?

4. In the past month, how often have others told you that you acted “paranoid” or “suspicious”

5. In the past month, how often did you hear voices, or hear or see things that other people didn’t think were there?

6. In the past month, how often did you have trouble making up your mind about something, like deciding where you wanted to go or what you wanted to do, or how to solve a problem?

7. In the past month, how often did you have trouble thinking straight, or concentrating on something you needed to do like worrying so much, or thinking about problems so much that you can’t remember or focus on other things?

8. In the past month, how often did you feel that your behaviour or actions were strange or different from that of other people?

9. In the past month, how often did you feel out of place or like you did not fit in?

10. In the past month, how often did you forget important things?

11. In the past month, how often did you have problems with thinking too fast?

12. In the past month, how often did you feel suspicious or paranoid?

13. In the past month, how often did you feel like hurting or killing yourself?

14. In the past month, how often did you feel like seriously hurting someone else?
APPENDIX I.
ROSENBERG SELF-ESTEEM SCALE
(Rosenberg, 1965).

Below is a list of statements dealing with your general feelings about yourself. For each statement, please select the response option that best describes your feelings about yourself.

1. I feel that I am a person of worth, at least on an equal plane with others.
2. I feel that I have a number of good qualities.
3. All in all, I am inclined to feel that I am a failure.
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I take a positive attitude toward myself.
7. On the whole, I am satisfied with myself.
8. I wish I could have more respect for myself.
9. I certainly feel useless at times.
10. At times I think I am no good at all.
APPENDIX J.
DEMOGRAPHIC INFORMATION

1. What is your gender? (circle one)  M  F

2. What is your age? _________

3. What is your ethnicity?
   □ African American
   □ Caucasian
   □ Hispanic
   □ Asian
   □ Pacific Islander
   □ American Indian
   □ African
   □ Middle Eastern
   □ Biracial
   □ Other - Please Specify _______________________________________

4. What is your highest educational background?
   o Less than 7 years
   o Junior high school
   o Partial high school (10th-11th grade)
   o High school graduation
   o Partial college/post-high school training (1 year or more)
   o Standard college graduation
   o Graduate/professional degree

5. What is your current marital status?
   □ Single (never married)
   □ In a romantic relationship
   □ Cohabiting
   □ Married
   □ Separated
   □ Divorced
   □ Widowed

6. How many psychiatric hospitalizations have you had in the past 9 months? ___ times

7. Have you ever received treatment for substance abuse or dependence? ___ Yes ___ No

8. Are you currently in treatment or do you need treatment for substance abuse or dependence? ___ Yes ___ No
9. In the past 30 days how many times have you attended the clubhouse

☐ Almost daily
☐ Once or twice a week
☐ Once or twice a month
☐ Not at all

10. Which of the following best describes your employment status

☐ Unemployed
☐ Employed through Transitional Employment (TE) Program
☐ Group placement
☐ Employed through Supported Employment (SE) Program
☐ Independently Employed
☐ Voluntary Participation in Clubhouse Work Order Day or activities
☐ Other, Please specify ________________________________

11. If you are employed, please state the length of your current employment ____________

12. Please indicate your position or designation in your current employment ____________

13. Please indicate the average numbers of hours you spend on the job per week _________
    hours/week

14. Please indicate your hourly wages $ ______/ hour

15. What is your approximate annual gross household income?

☐ $10,000 or less
☐ $10,001-25,000
☐ $25,001-50,000
☐ $50,001-$75,000
☐ $75,001-100,000
☐ $100,001-130,000
☐ $130,001 or more

NEED FOR CHANGE SELF-RATING SCALE
(Casper, 2003)

If you are unemployed, please skip to the next question. If you are employed, please read the statements below carefully. Then check the ONE the best describes how you feel about your job.

- I am very dissatisfied with my job, and feel an URGENT NEED to change it.
- I am dissatisfied with my job and feel a STRONG NEED to change it.
- I am not so sure how I feel about my job, and NOT SURE if I want to change it.
I am satisfied with my job, and DON’T WANT to change it now, but maybe in the future
I am very satisfied with my job, and DEFINITELY DON’T WANT TO change it.

If you unemployed please answer the following question. Read the statements below carefully. Then check the ONE the best describes how you feel about being unemployed.

- I am very dissatisfied with being unemployed, and feel an URGENT NEED to change it.
- I am dissatisfied with being unemployed and feel a STORNG NEED to change it.
- I am not so sure how I feel about being unemployed, and NOT SURE if I want to change it.
- I am satisfied with being unemployed, and DON’T WANT to change it now, but maybe in the future
- I am very satisfied with being unemployed, and DEFINITELY DON’T WANT TO change it.
Table 1
*Constructs and Measures Used in the Study*

<table>
<thead>
<tr>
<th>Construct</th>
<th>Definition</th>
<th>Measures Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Community Integration</td>
<td>The degree to which clubhouse members report being integrated within the clubhouse community</td>
<td>Client Interaction Scale (CIS; Brekke &amp; Aisley, 1990)</td>
</tr>
<tr>
<td>External Community Integration</td>
<td>The degree to which clubhouse members perceive social support and being socially integrated within the larger community outside of the clubhouse and the consumer/member community</td>
<td>Subscales adapted from External Social integration Scale (ESIS; Segal &amp; Aviram, 1978), Social Provision Scale (Cutrona &amp; Russell, 1987)</td>
</tr>
<tr>
<td>Perceptions of Clubhouse Environment</td>
<td>Members perception of the psychosocial environment of the clubhouse as supportive and as having a practical orientation</td>
<td>Subscales from the Community Oriented Program Evaluation Scale (COPES; Moos, 1973)</td>
</tr>
<tr>
<td>Level of Employment</td>
<td>Four different kinds of employment statues will be studied, (a) Transitional Employment or Group placement (b) Independent Employment (c) Unemployed but participates in clubhouse activities</td>
<td>Questions, 10-15 of Appendix J</td>
</tr>
<tr>
<td>Mental Health Symptoms</td>
<td>Members current self-reported psychiatric symptomatology</td>
<td>Colorado Symptom Index (CSI; Shern, et al, 1994), No. of hospitalizations.</td>
</tr>
<tr>
<td>Well-being</td>
<td>Members self-reported global self-worth</td>
<td>The Rosenberg Self-Esteem Scale (Rosenberg, 1965)</td>
</tr>
<tr>
<td>Demographic Variables</td>
<td>Demographic information obtained from members pertaining to their age, gender, ethnicity, education, marital status, income</td>
<td>Appendix J</td>
</tr>
</tbody>
</table>
Table 2

Demographic Characteristics of the Sample (N= 92)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (%) or M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>46.4 (11)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>50</td>
</tr>
<tr>
<td>Female</td>
<td>42 (45.6 %)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White/European</td>
<td>38 (41%)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>38 (41%)</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>9 (9.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (7.6%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>64 (69.5%)</td>
</tr>
<tr>
<td>Romantic Relationship</td>
<td>9 (9.7%)</td>
</tr>
<tr>
<td>Married</td>
<td>3 (3.2%)</td>
</tr>
<tr>
<td>Separated/Divorced/Widowed</td>
<td>16 (17.3%)</td>
</tr>
<tr>
<td>Educational Status</td>
<td></td>
</tr>
<tr>
<td>12th Grade or less</td>
<td>22 (23.9%)</td>
</tr>
<tr>
<td>Graduated High School/Equivalent</td>
<td>22 (23.9%)</td>
</tr>
<tr>
<td>Some College</td>
<td>19 (20.6%)</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>9 (9.7%)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>13 (14.1%)</td>
</tr>
<tr>
<td>Post Graduate Degree</td>
<td>7 (7.6%)</td>
</tr>
</tbody>
</table>
Table 3

*Construct and Descriptive Statistics for Study Measures*

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measure</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration within the Clubhouse</td>
<td>Client Integration Scale</td>
<td>4.05</td>
<td>.77</td>
</tr>
<tr>
<td>Perceived Familial Support</td>
<td>(ESIS)Family Access and Participation Subscale</td>
<td>3.08</td>
<td>.94</td>
</tr>
<tr>
<td>Social Integration in the Larger Community</td>
<td>(ESIS)Friendship Access and Participation Subscale</td>
<td>2.88</td>
<td>1.05</td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td>Social Provision Scale</td>
<td>2.92</td>
<td>.70</td>
</tr>
<tr>
<td>Clubhouse Environment</td>
<td>(Copes)Support Subscale</td>
<td>3.06</td>
<td>.42</td>
</tr>
<tr>
<td></td>
<td>Copes Practical Orientation</td>
<td>2.98</td>
<td>.43</td>
</tr>
<tr>
<td>Mental health</td>
<td>Colorado Symptom Index</td>
<td>1.93</td>
<td>.82</td>
</tr>
<tr>
<td>Well-Being</td>
<td>Rosenberg- Self Esteem Scale</td>
<td>3.02</td>
<td>.54</td>
</tr>
</tbody>
</table>
Table 4

Employment and Clubhouse Membership

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>39 (42.4%)</td>
</tr>
<tr>
<td>Voluntary Participation in Work Ordered Day</td>
<td>23 (25%)</td>
</tr>
<tr>
<td>Transitional/Supported</td>
<td>16 (17.4%)</td>
</tr>
<tr>
<td>Independently Employed</td>
<td>11 (12%)</td>
</tr>
<tr>
<td>Missing</td>
<td>3 (3.2%)</td>
</tr>
</tbody>
</table>

Income

<table>
<thead>
<tr>
<th>Income</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10, 000 or less</td>
<td>44 (47.8%)</td>
</tr>
<tr>
<td>10, 001-25, 000</td>
<td>34 (37%)</td>
</tr>
<tr>
<td>25, 000-50, 000</td>
<td>1 (1.1%)</td>
</tr>
<tr>
<td>Missing</td>
<td>13 (14.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>92</td>
</tr>
</tbody>
</table>

Satisfaction Level

<table>
<thead>
<tr>
<th>Satisfaction Level</th>
<th>Employed</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Not Sure</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 5

*Independent Sample t-tests: Differences on Study Measures as a Function of Gender*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Male (n= 50) Mean (SD)</th>
<th>Female (n= 42) Mean (SD)</th>
<th>Independent Sample T-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Integration Scale</td>
<td>4.07 (.73)</td>
<td>4.01 (.81)</td>
<td>t (90)= .37, p &lt; = .71</td>
</tr>
<tr>
<td>ESIS (Family Access and Participation)</td>
<td>3.00 (.97)</td>
<td>3.19 (.92)</td>
<td>t (90)= -.92 p &lt; = .36</td>
</tr>
<tr>
<td>ESIS (friendship Access and Participation)</td>
<td>2.93 (1.04)</td>
<td>2.81 (1.06)</td>
<td>t (90)= .55 p &lt; = .58</td>
</tr>
<tr>
<td>Social Provision Scale</td>
<td>2.95 (.70)</td>
<td>2.89 (.69)</td>
<td>t (89)= .40 p &lt; = .68</td>
</tr>
<tr>
<td>COPES (Support)</td>
<td>3.08 (.42)</td>
<td>3.04 (.43)</td>
<td>t (89)= .42 p &lt; = .67</td>
</tr>
<tr>
<td>COPES (Practical Orientation)</td>
<td>3.02 (.44)</td>
<td>2.90 (.41)</td>
<td>t (89)= 1.09 p &lt; = .27</td>
</tr>
<tr>
<td>Rosenberg Self-esteem</td>
<td>2.99 (.57)</td>
<td>3.07 (.5)</td>
<td>t (90)= -.72 p &lt; = .47</td>
</tr>
<tr>
<td>Colorado Symptom Index (Log transformed)</td>
<td>.58 (.43)</td>
<td>.57 (.37)</td>
<td>t (90)= .07 p &lt; = .94</td>
</tr>
</tbody>
</table>
Table 6
*Bivariate Correlations among Study Measures*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 CIS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 ESIS (FAMILY)</td>
<td>.37**</td>
<td></td>
<td></td>
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Hierarchical Regression Analysis Predicting Internal Integration

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* p < .05, **p < .01
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Hierarchical Regression Analysis Predicting External Social Integration

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* p < .05, **p < .01
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