Michigan

Psychosocial Rehabilitation Clubhouse Programs

Evaluation Report

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Michigan Department
of Community Health

MDCH

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Overview

In 1998, the Michigan Department of Community Health, in partnership with Michigan State University, launched an initiative to evaluate the implementation and outcomes of the state's Medicaid funded psychosocial rehabilitation clubhouse programs. The evaluation was supported by a major grant from the Ethel and James Flinn Family Foundation, a Michigan based foundation that supports research efforts on the treatment of persons with schizophrenia. A primary mission of the Ethel and James Flinn Foundation is the development of new and/or more appropriate treatment models for persons with schizophrenia and to improve the quality of mental health service delivery practice. Therefore, a primary objective of the Michigan Clubhouse Evaluation project was to evaluate the effectiveness of the clubhouse model of psychosocial rehabilitation for persons with a primary diagnosis of schizophrenia as well as those with other serious and persistent mental illness. The evaluation of the clubhouse programs is focused on discovering the complex interplay between mental health service consumers, staff and organizational factors that determine the impact of clubhouse programs.

What is a psychosocial rehabilitation clubhouse?

The clubhouse was designed to address the needs of people with psychiatric disabilities who often encounter a sense of loss including such things as loss of friendships, family connections, jobs, completion of formal post-secondary education, and certain abilities to manage living in the community (Mastboom, 1992). The stigma (Corrigan, 1999), the hierarchical treatment based on a medical model (Peckoff, 1992), and marginal roles accorded to people with psychiatric disabilities (Beard, Propst, & Malamud, 1982) are directly addressed in the design of clubhouses. The clubhouse offers members a welcoming place, where meaningful tasks need to be accomplished. The relationship of professional staff to members is not a hierarchical one, but one that is more egalitarian, emphasizing the equality between clubhouse members and clubhouse staff. That is, members and staff "work side-by-side" to complete necessary tasks for the club (Mastboom, 1992). A central tenet of clubhouse programs is what is known as the "work-ordered day" which uses activities to empower members, create competency, and promote recovery from serious mental illness (Beard, Propst, & Malamnd, 1982). It is contended that through clubhouse work and participation, individuals regain a sense of meaning in their lives, decrease isolation, increase skills, and thereby move toward a process of recovery.

Fountain House in New York City provided the original model for clubhouses and is the program on which model fidelity is based. The International Center for Clubhouse Development (ICCD) defines a clubhouse as:

> "A clubhouse is a community organized to help people living with serious mental illness as they manage their illness and rejoin the worlds of employment, education, family and friends. People who come to a clubhouse are called members; they are men and women of all ages who work within the clubhouse to promote and achieve recovery from

> schizophrenia, bipolar disorder, major depression, or other serious and persistent forms of mental illness" (Propst, 1982).

A logic model for Michigan clubhouse programs is presented in Figure 1. The core values that guide Michigan clubhouse programs emphasize empowerment through recovery; partnerships and choice and control; and competency through skills and abilities and community integration and advocacy. The logic model provides a 'road map' to how a clubhouse program operates and what activities or processes are linked to program outcomes. It also provides the research team with a conceptual blueprint of the program and evaluation strategy.

Michigan clubhouses have a variety of activities that take place in an average day. However, there is core set of components that each clubhouse has, which form the work-ordered day. The work-ordered day parallels the "normal work day" in the informal and supportive environment of the clubhouse. Program staff and members work side-by-side to generate and accomplish the individual or team tasks and activities necessary for the development and operation of the program and to support its members. The main components of the work ordered-day found in most clubhouses are listed in Table 1.

Employment services also tend to be a large part of the services provided by clubhouses. The great majority Michigan clubhouses (83.8 percent) provide services such as job supports, placements and job development. Only 16.2 percent of the clubhouses do not provide employment services.

Social recreational activities are not typically part of the 'work-ordered day' of clubhouses, but are a very important aspect of the clubhouse services. Nearly 40 percent of all clubs hold weekly social events, while 43 percent have monthly activities.

Transportation services are an integral part of the clubhouse program. Transportation to and from work and the clubhouse is provided in many clubs. Approximately 97 percent of the clubs reported providing members with transportation services on a daily to weekly basis.

Table 1. Core Program Characteristics that are Part of Daily Activities
or the Work -Ordered Day

Core Components of the 'Work-Ordered Day"	Percentage of Clubhouses that Perform Activity on a Daily Basis	Percentage of Clubhouses that Perform Activity on a Weekly Basis
Planning & preparing daily meals (food service)	97.3	2.7
Reception of members & guests	94.6	2.7
Maintenance work	94.6	5.4
Clerical work	89.2	10.8
Snack Bar	97.2	28.0

N = 37 clubhouses

Members' roles are defined in part by their participation and individual characteristics. Clubhouse programs' average daily attendance ranges from 12 to 80 members with a median of 22 members. Most clubhouse members have a diagnosis of serious mental illness with the percentage of members with schizophrenia ranging from 28 percent to 85 percent with a median of 56 percent. Members live in a variety of settings with a range of 3 to 70 percent of members living in dependent care settings (e.g., group homes) with a median of 30 percent. Members range in age from 18 to over age 65 but the majority of members are between the ages of 21 and 50.

Staff roles are defined by their professional competencies and personal characteristics. ICCD training is an essential mechanism that transfers knowledge of the model to staff and increases the effectiveness of their professional skills within the clubhouse environment. However, over half the clubhouses (54.3 percent) have no staff who had been to ICCD training despite the ongoing support of the Michigan Department of Community Health for training.

Clubhouse members are adults of working age who have lost many of the skills required for independent living and self-sufficiency due to their illnesses. The outcomes from clubhouse participation are expected to address these issues. The project examined outcomes in the areas of employment, benefit of membership, sense of community, interpersonal relationships, life satisfaction and recovery for clubhouse members. Other outcomes that are expected are increased competencies in adult roles or daily living skills, independent community living skills, and community tenure (time in the community).

Project Objectives

Clubhouse programs are widely accepted and defined as part of the required continuum of care in Michigan's public mental health system. As the state of Michigan reshapes its system of care for person with serious and persistent mental illness, practice guidelines

and outcomes for psychosocial clubhouses have not yet been defined. Therefore, the purpose of this project was to conduct the necessary research to provide a basis for developing practice guidelines to improve the quality of service delivery in clubhouse programs

The overall objectives of the project were to determine the fidelity of these programs to the original model and to identify clubhouse practices that are linked to positive outcomes for clubhouse members with schizophrenia and other persistent psychiatric disabilities. More specifically, the objectives were to:

- Identify key elements of the clubhouse model

- Assess Michigan's clubhouses' fidelity on these key elements

- Evaluate the outcomes in terms of members' vocational outcomes, quality of life, and psychological functioning.

- Disseminate project results in the form of policy recommendations and practice guidelines.

Figure 1. Logic model for clubhouse programs
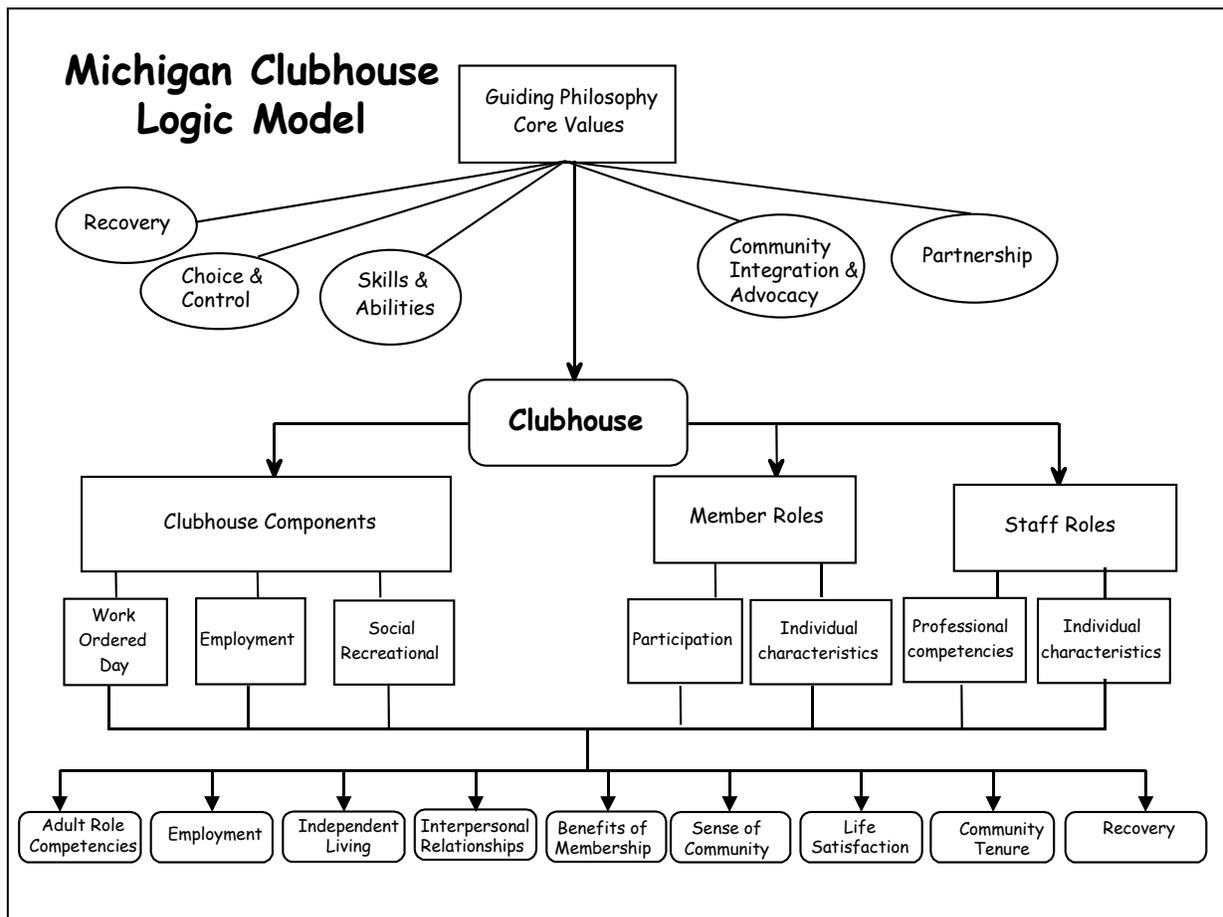
Policy Implications

Michigan has had a unique history of clubhouse development. The Department of Community Health (DCH) initiated the statewide dissemination of Michigan's adaptation of the clubhouse model in 1983 to further support the development of community based alternative services. Due to the scarcity of new state and local funding resources, DCH deployed a unique implementation strategy. Local community mental health administrative agencies (CMHSPs) were encouraged to develop clubhouse programs by re-directing existing staff resources or transitioning both staff and consumers of existing programs to the adapted clubhouse model. CMHSPs targeted traditional programs, such as day treatment, partial hospitalization and vocational rehabilitation programs, for transition in order to provide the capacity for the new program. DCH provided technical assistance and support for this development strategy that resulted in immediate staffing and site resources for the new clubhouse programs.

The strategy resulted in several adaptations to the Fountain House model. The major adaptation was to the clubhouse as a freestanding program. This adaptation was necessary in order to effectively integrate the new clubhouse programs into local system of community mental health services and to make use of existing resources. The Fountain House model emphasizes organizational separation of the clubhouse and other mental health services. A clubhouse program adhering to the Fountain House model is a freestanding corporate entity with non-profit status, a board of directors, and control over all aspects of the clubhouse budget and membership. Integration of the clubhouse into the local system of community mental health services resulted in programs with less administrative autonomy with regard to budgets and membership recruitment and greater reliance on services provided by other components of service system (e.g., case management and employment services).

Policy Recommendations

The following policy recommendations to DCH are the result of clubhouse program survey analysis as well as site observations and member and staff interviews. The recommendations target the continuation of existing department efforts and identifiy new initiatives needed to address areas of adaptation that have resulted in less than optimal clubhouse program performance.

♦ **Continued Department commitment through contract, policy and Medicaid requirements to the clubhouse model of psychosocial rehabilitation as a viable model for persons with schizophrenia.**

The clubhouse model of psychosocial rehabilitation service should continue as an essential required component of a recovery based mental health system particularly for individuals with schizophrenia as well as individuals with other serious and persistent mental illness. The following project findings suggest the effectiveness of clubhouse elements and overall program in improving

psychological functioning, vocational outcomes, and quality of life for individuals with schizophrenia.

- ◆ *Utilization of Clubhouse programs.* Utilization of clubhouse services by members with schizophrenia is no different from any other diagnostic group. Please see page 36 for additional demographic information regarding the characteristics of clubhouse members with schizophrenia: age, sex, marital status, residential; education; employment; and, prior hospitalization.

- ◆ Hospitalization. Clubhouse members with schizophrenia were less likely to be hospitalized than other members (page 39).

- ◆ Medications. Members with schizophrenia take fewer types of psychotropic medications than those with other diagnosis (page 20).

- ◆ Clubhouse Utilization. Clubhouse participation did not differ for members with a diagnosis of schizophrenia (page 13).

- ◆ Staff/Member Relationships. Staff/member relationships do not differ for clubhouse members with schizophrenia than members without schizophrenia (page 22).

- ◆ Employment. Members with schizophrenia had an equal likelihood of being employed as members without schizophrenia (page 42).

- ◆ Adult Role Competencies. Members with schizophrenia and without schizophrenia did not differ in the degree to which they could fulfill adult role competencies (page 37).

- ◆ Social Supports. Members with schizophrenia did not have more or less people listed on their social networks than members without schizophrenia (page 39).

- ◆ Recovery and Life Satisfaction. Members with schizophrenia rated themselves as further along in the recovery process than members without. Further, members with schizophrenia had greater satisfaction with their quality of life than other members (pages 25 and 27).

♦ **Continued DCH support for Clubhouse Intensive Training**

Clubhouse mangers who participate in clubhouse intensive training appear to be more successful in integrating the operational and organizational values of the clubhouse model into their programs. This particularly results in positive program outcomes such as employment. Since clubhouse programs are not traditional mental health programs, clubhouse managers and their agency supervisors benefit significantly by understanding clubhouse core values so that organizational and operational program features are congruent and beneficial to club members.

♦ **Increase intensive training options with the certified clubhouse training sites**.

Currently, intensive training is only available in a single format: 3 weeks in another state. This represents a major obstacle for clubhouse staff with family responsibilities. Since training is a significant factor related to performance out comes, the DCH should continue to advocate and explore changes in the intensive training format.

♦ **Establish specific employment related requirements in DCH Site Review Protocols for clubhouse programs**

Current DCH Annual Site Review protocols for clubhouse programs do not specifically review the vocational component directly provided by the clubhouse. Establishing appropriate protocols would assist local CMHSPs in addressing this deficit.

♦ **Increased emphasis on clubhouse units as key to successful employment outcomes.**

It is essential that clubhouse units and their effective functioning are perceived as primary components to overall success in clubhouse employment. Strong functioning clubhouse units supply the relational and skill building opportunities for members to be engaged in varying levels of decision making and activities that are significant to the program's operation. Unit staff who are also involved in supporting members' employment are more likely to understand the relationship between unit activity and operations and the potential for member recovery and confidence related to work.

♦ **Health Awareness and Recovery**

Members reported physical health problems as a primary obstacle for those interested to employment. Clubhouse programs can increase health awareness and prevention practices as part of the overall clubhouse environment particularly supporting healthy food choices in clubhouse units related to food services**.**

♦ *Elimination of paid member work*

Influenced by consumer-focused DCH initiatives, clubhouse programs have unadvisedly hired members to also function as clubhouse staff. (Note. These positions are staff positions, not transitional employment positions.) The anecdotal accounts of several consumers in these roles suggests that not only may paid member work conflict with the clubhouse value that all work in the club is equal, it creates role confusion and diminishes a function of the clubhouse as a place of long term support for those members who are paid to work in the club. Members interested in working should be assisted to locate employment in integrated community settings – not the clubhouse.

Adaptations to the Clubhouse Model

Innovative models frequently are modified and adapted to fit local needs and situations. Given this inevitability of model adaptations, it is not surprising that the Clubhouse Model as designed by Beard and associates (1982) has been adapted in the context of Michigan and its Medicaid requirements. When adaptations to models occur, evaluating the consequences of these changes to the outcomes desired from the model is critical. Whether these adaptations led to fairly widespread adoption of community based psychosocial programs is a core question of this study.

The evaluation project examined Michigan's clubhouse policy to identify the impact of major adaptations to the original Fountain House clubhouse model. The International Center for Clubhouse Development (ICCD) developed a screening tool for assessing clubhouse program fidelity to the Fountain House clubhouse model (Macias, Propst, Rodican & Boyd, 2001). That is, ICCD published a list of key clubhouse characteristics by which clubhouses can compare their own practices. The ICCD screening tool was used to compare Michigan clubhouse policy against 33 key clubhouse model characteristics cited in the fidelity measure. A total of four adaptations to the ICCD clubhouse model were identified. These were:

1. Clubhouses in Michigan are integrated rather than freestanding services.
2. The clubhouse model, which is based on an urban service model, is applied in rural settings.
3. Michigan clubhouses provide multiple employment options including clubhouse owned transitional employment positions.
4. Auspice agencies influence membership referral rather than clubhouses exercising direct control over who is offered membership – including members with schizophrenia.

These adaptations were the result of a conscious decision on the part of the Michigan Department of Community Health, based on a values system that prioritized:

- Statewide rather than limited program development.
- Regulatory criteria and mandates that encouraged development in rural and urban areas.
- Development through conversion of existing mental health resources, i.e., staff, space, rather than requiring usual new program costs.
- Ongoing funding for clubhouse programs as a Medicaid covered service.
- Integration of clubhouse programs into the local community mental health service system rather than freestanding.

In the following sections, empirical evidence supporting Michigan's adaptations to the ICCD clubhouse model will be presented. Evaluations findings will discuss policy issues related to implementing clubhouse practices.

Adaptation 1: Clubhouse as an integrated rather than freestanding services

Michigan's adaptation of the freestanding requirement played an important role in the rapid implementation of clubhouse programs throughout the state. In order to affect rapid statewide dissemination, Michigan maximized local CMH interest in clubhouse development by minimizing the initial fiscal risk and the complexity of locating, purchasing or leasing a separate clubhouse facility. At the state level, the freestanding model criterion was seen as a potentially cost prohibitive barrier to DCH's goal of broad model dissemination across Michigan's mental health system. This was an adaptation of the Clubhouse standard requiring the clubhouse to be a physical and organizational freestanding program. In Michigan, the adaptation supported (1) the use of existing agency space with environmental modifications to support the concept of "separate identify" and (2) the use of agency staff, who were already assigned to the program to be converted, or staff who were redirected from other agency work to the new clubhouse program.

Evaluation Findings

In Michigan, all clubhouse programs are part of the public mental health system and are housed within a community agency under the auspice of county CMHSP. About 65 percent of the programs were converted from a previous treatment, vocational rehabilitation program or other type of mental health service. Over time, many clubs (63 percent) have re-located to locations in the community away from mental health center operations; 32 percent are located in the community at sites shared with other community based mental health services and only a small minority (5 percent) are located within a community mental health center.

Use of existing space. Model fidelity was estimated for the 18 clubs with whom site visits were conducted using a modified version of a 15-point implementation fidelity measure (Lucca, 2000). Clubs were compared based on the type of start-up: five new off-site programs, nine programs converted from day treatment programs, and four programs converted from vocational rehabilitation and drop-in programs and staff redirection. Table 2 presents the means and standard deviations for each group on the Lucca fidelity measure. Clubhouses converted from day treatment programs had significantly higher model fidelity scores than did new program start-up clubs or clubs converted from other models. The latter two types of start-ups did not differ statistically.

Table 2. Model Fidelity by Program Start-Up

Startup	Mean (SD)
New	9.00 (1.73)
Day Treatment	11.22(1.31)
Other	5.75 (2.06)

F = 16.44, df = 2,15, p<.0001

Conversion from a day treatment program did not diminish the model fidelity of clubhouse programs. Michigan's adaptation to permit existing programs that were on-site with other mental health programs to convert to clubhouse programs appears to have been positive.   This permitted the rapid development of clubhouse programs statewide. It suggests that staff from existing mental health programs can be re-trained to adopt a new model of practice and can successfully implement the new model. It also suggests that consumers of existing services can be responsive to the role change that requires their active participation in the day-to-day operation and decision-making that are hallmarks of the clubhouse model. The presence of staff with established relationships with consumers as well as experience in working with persons with serious mental illness appears to promote better program development than is achieved with all new staff that may be less experienced.

Use of existing staff.   The adaptation of existing programs to the clubhouse model required a transformation from a hierarchical staff/client dependent role to one of collegial interdependence based on the tenants of the Fountain House model. In order to facilitate the transformation process, DCH directed federal block grant funds to support intensive three week training for clubhouse staff and members offered by the International Center for Clubhouse Development (ICCD).   Our program assessment found that most clubhouse staff have not taken part in specific ICCD training. Table 3 presents the percentage of clubhouse staff that attended training.

Table 3. Percentage of Clubhouses with Staff ICCD Trained
(Including clubhouse managers)

ICCD Training	Number of Clubhouses (N=35)	Percent of Clubhouses
No Staff with ICCD Training	18	45
One staff with ICCD Training	12	30
2 or more staff with ICCD Training	10	25

Analysis of member outcomes indicated that at clubhouses where the managers had received ICCD training the number of hours that members attended was higher and members had a greater sense of community. As the number of ICCD trained staff increased, however, the effect of staff-member relationships on sense of community

decreased. This suggests that clubhouses with greater numbers of staff who have been through the ICCD training are able to create an environment independent of specific relationships between staff and members for members to feel a sense of belonging and community within the clubhouse. Training then seems to be an essential ingredient, especially for the leadership, to maintain a culture of support and sense of community among members.

Adaptation 2:   Use of an urban service model in rural settings

Typically, clubhouses have a high member-to-staff ratio. The Fountain House model was developed in a large urban setting (New York City) where the potential membership is large. In rural areas, such as much of Michigan, the potential membership is much smaller. This may result in a small member-to-staff ratio in order to have a minimum number of staff to operate the program efficiently and safely.

Evaluation Findings

Michigan clubhouse programs operate on a continuum of urban to rural areas: 47.1 percent are in rural areas; 26.5 percent are in area with a medium size city and rural lands; 26.5 percent are in urban centers. Michigan clubhouse programs vary in size with average daily attendance ranging from 12 to 80 members with a median attendance of 19 members. Michigan clubhouses have between 2 and 15 staff, with a median number of 4.5 staff. The member-to-staff ratio ranges from 2.83 members per staff to about 34 members per staff with a median of 5.3 members to each staff. Table 4 presents the member-to-staff ratios by geographical location for 35 Michigan clubhouses.

Table 4. Member-to-staff ratios

Geographic Area	Ratios*
Rural	3.00 to 17.00
Medium city & rural mix	2.83 to 34.00
Urban	3.13 to 11.43
All areas	2.83 to 34.00

*Number of members to every one staff person

## Adaptation 3:   Multiple employment options including clubhouse owned transitional employment positions

The Fountain House model uses transitional employment placements (TEP) as the primary supported employment option for clubhouse members. Transitional employment (TE) is model of supported employment specific to clubhouse programs and involves multiple part-time work placements with community based employers, paid by the employer. These positions are owned by the clubhouse rather than by individuals. Clubhouse

ownership permits the positions to be rotated to other interested members about every six months. Clubhouse staff develop agreements with employers for specific TE part-time jobs. In turn, the clubhouse agrees to fill the TE positions with members who are interested in employment. The clubhouse also agrees to train members filling the position(s) and to cover absences by having staff fill-in when a member is unable to work. Long-term supports are provided to the member through his or her continued concurrent involvement in the clubhouse program while working in the TE position. Contrary to the model, TE placements often become permanent jobs when an employer offers the member regular employment after the TE rotation has ended.

Evaluation Findings

The number of members holding TE positions by clubhouse is shown in Figure 2. These positions do not include member staff positions (page 7). Most clubhouses had relatively few members in TE positions.   No significant relationships were found between transitional employment outcomes and clubhouse employment support practices.   The data suggest that the policy focus on broader supported employment rather than on TE only has resulted in less emphasis on this aspect of the clubhouse model.   However, analyses of member employment outcomes suggest that this policy focus resulted in more members working in competitive jobs and receiving supported employment than in transitional employment.

Figure 2. Number members holding transitional employment (TE) positions
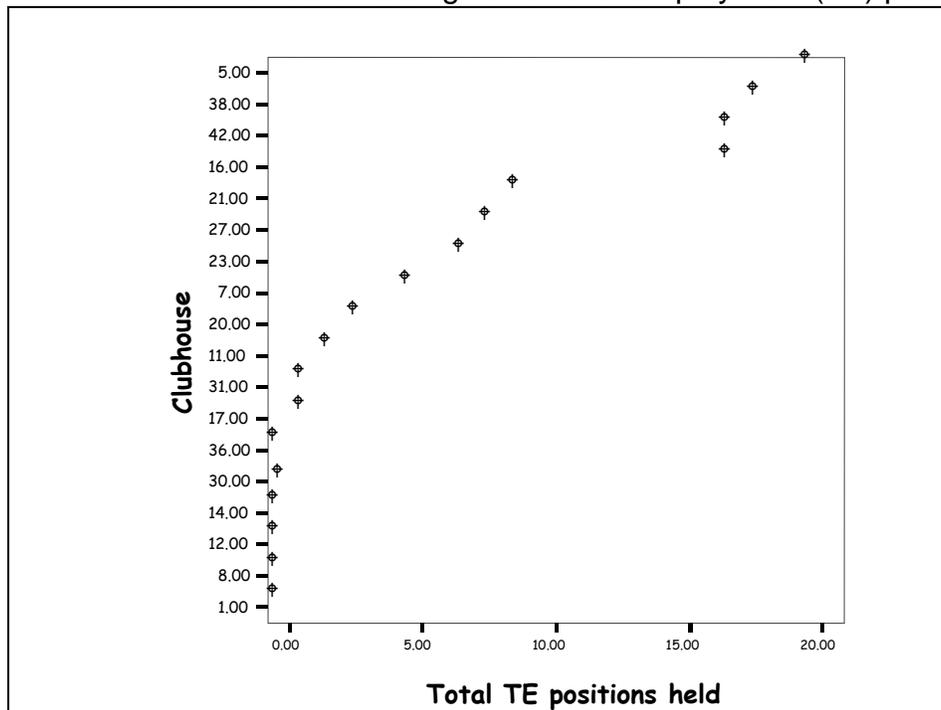
Adaptation 4:   Auspice agency influence over member referral rather than direct clubhouse control - including people with schizophrenia

In the Fountain House model, the clubhouse has direct control over the acceptance of new members. Michigan clubhouse programs are part of a local CMH system that control access to public mental health services. Under the CMHSP contract with DCH, persons with serious and persistent mental illness, who are eligible for Medicaid, are prioritized as recipients of state funded mental health services. Michigan CMH agencies are single gatekeepers and fiscally responsible for all community based and inpatient services. As a result, clubhouse membership tends to be from the prioritized population. Therefore there is some interface between the auspice CMH agency and clubhouse regarding who is served.

Evaluation Findings

The requirement to address the CMHSP priority service population has resulted in a predominance of clubhouse members who are persons with serious and persistent mental illness and eligible for Medicaid. Over half of all clubhouse members have diagnoses of schizophrenia and a third have diagnoses of major depression or mood disorders (Table 5). Although most clubhouse members have a history of hospitalization, few have recent hospitalizations (Figure 3). This adaptation to the model has not negatively impacted clubhouse development or model fidelity.

Table 5. Percentage of clubhouse members by diagnostic category

Clubhouse Member Diagnoses	Percent
Schizophrenia-Psychotic disorder	53.9
Mood disorders	32.8
All others	13.3

Figure 3. Percent of Members that Reported Year of Most Recent Hospitalization by Diagnosis

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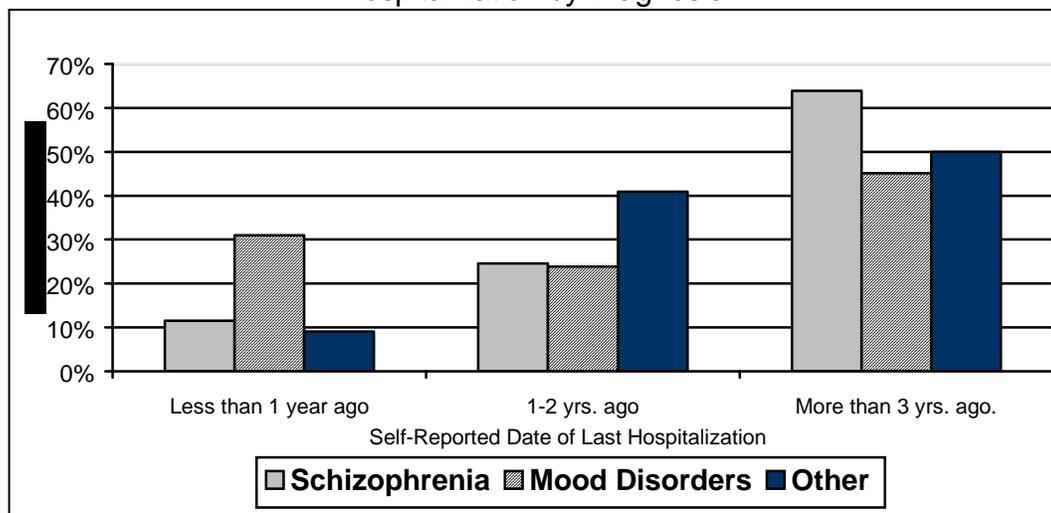
Project Identified Issues

Issue 1:   Contributors and barriers to success for clubhouses programs

In order to understand the challenges that clubhouses in various communities face, as well as the successes they celebrate, we conducted a 'force field' survey with clubhouse managers to reflect on the things that contribute to a clubhouses success and those that are barriers to that success. The 'force field' method is a paper and pencil measure designed to help the respondent think about the various factors that contribute to the overall success of a clubhouse, as well as the challenges. Information presented here is from the sub-sample of 17 clubs who were visited by the Flinn research team and to whom clubhouses returned Force Field surveys

The information was analyzed for common themes across the clubs. The content of the 'force fields' yielded information about the overall internal and external barriers that contributed to the overall success of the clubhouse. That is, clubhouse staff reported a variety of attributes that were either specific to the clubhouse program or the surrounding community. Table 6 lists attributes perceived as overall successful and contributing to the success and Table 7 lists attributes perceived as challenges to clubhouse programs. Community mental health agencies transition to managed care was seen as a source of uncertainty that was seen as a barrier. The transition to managed care also introduced delays at some clubhouses in obtaining authorization for members to attend. This was also seen as a barrier resulting from changes in mental health policy.

Table 6. Clubhouse and Community Attributes Perceived
to Contribute to Overall Clubhouse Success

Within Clubhouse Clubhouse Attributes	Outside Clubhouse Community Attributes
• Energy, positive attitudes, experience of staff and members	• Pubic awareness of club
• Member participation	• Support of auspice agency
• Building or physical layout	• Community acceptance of club
• Location	• Certification and accreditation
• Interns or volunteers at the club	• Connections to other services and organizations
• Clubhouse atmosphere	• Positive involvement with the community
• Relationship between members and staff	• Taking field trips with the club
• Members attendance	

Table 7. Barriers to Clubhouse Success: Attributes within and outside the clubhouse

Within Clubhouse Clubhouse Attributes	Outside Clubhouse Community Attributes
• Involuntary attendance of members	• Uncertainties of the new managed care environment
• Low attendance of members	• Lack of auspice agency support
• Poor communication	• Lack of communication between service provider and auspice agency
• Inadequate resources	• Overwhelming bureaucratic requirements
• Negative staff characteristics	• Lack of housing for community members
• lack of staff training	• Community stigma and discrimination
	• Lack of transpiration

Issue 2: Training & Leadership

Clubhouse leadership that includes having a vision for the clubhouse model are essential elements in effective clubhouse programming. Having a leader that understands and values key clubhouse components identified as the core of clubhouse philosophy, coupled with a vision of what the ideal clubhouse may "look like," and being able to translate that vision to the clubhouse staff and members are critical skills and attributes of a clubhouse leader. Training provides the information unique to clubhouse programming and appears to be needed for effective leadership to occur. Having policy that includes manager and supervisor training appears to be critical for new clubhouses as well as clubhouses with new leadership.

Issue 3: Employment

Leadership in Employment Practices

Clubhouse leadership has played a significant role in shaping the structure and processes of clubhouse programming. For example, how employment is valued within programs varied across the clubhouses. The leader's perception about how employment contributes to the lives of members became evident through the responses elicited through the interviews of managers and employment specialist at the club. One manager clearly values employment for members.

> "(employment) plays a very large role in the clubhouses. It's throughout the clubhouse. Our unit leaders each have a transitional employment site that they manage. So it isn't just with one department or a couple of people; it's with every staff in the clubhouse supporting employment of members."

The strong value placed on employment as a factor that positively influenced member well-being is evidenced in one of the active and supportive clubhouses.

"I think we saw what work did for people. I think that made a difference. Increased self-confidence, less symptoms, much more involved in their community in terms of their neighbors or they felt like they could be involved because they were productive. I think work normalizes. I hear from families all the time. 'If they could just get a job.' I've seen people whose families thought they would do nothing, and now they've got a job."

The manager also sets the expectations of staff's role regarding employment.

"…we have somebody that cleans at a fast food, does the windows and picks up the parking lot and was struggling. That was a TE, and I had one of my women staff walking in three mornings in a row and having to turn around, put her coat and mittens on and go do that job. But there was no question that she was going to do that job; I think if you get that going with the staff in the club, you're going to have that kind of employment that we do because we just say it's important and we'll cover this job because we think this job's important."

Consistency in the value placed on employment across staff is important. The employment specialist asserts,

"Employment is available to all members in the clubhouse regardless of their disability. Regardless of how long it's been since they've worked or how frequently they've worked. It's not something that all members are forced to do. We encourage them to work."

In some clubs, the notion that employment is valued and important to members does not necessarily cut across all clubhouse staff or across clubhouse units. In one clubhouse, quite the opposite was found. It was apparent from the employment specialist's response that implementing successful employment practices required the whole clubhouse; that is, all staff valued and welcomed employment opportunities, thus integrating into various clubhouse functions.

"Whenever there is an employment opening, we find out about the job type. It's talked about in program meeting; it's talked about in community meetings, and it's talked about in unit meetings."

Furthermore, opportunities for employment are communicated in multiple forms.

"We put (job openings) into our daily newsletter." "We have an employment board."

When work is valued in the club, staff have knowledge and take care in working with members on the specifics of Social Security benefits.

> "We try to figure out whether they have SSI or SSDI or nothing at all. We talk specifically about the work rules - how the work incentives affects them. We're always available to answer questions. We will go to Social Security with them. We will help them write letters and assist them in understanding as fully (as we can). We do worksheets with them. We'll sit down and calculate what their benefits may be."

Some clubhouse staff and managers reported that when members hold jobs, they stop coming to the clubhouse. However, in clubhouses that follow the goals and practices of the model, connections continue with members even after they get a job.

> "I couldn't say that most people drop out. I just couldn't say that because we encourage them to stay connected because that connection helps them maintain (employment). So I say that a third of the people we currently support are alumni, and they stay connected through TE diners and through worker support nights."

Clubhouses in which employment flourishes have managers with strong value and commitment to paid work for members. The responsibility and value of employment for members is shared across staff. The staff are knowledgeable and provide the various supports for finding a job, working through Social Security benefits and helping people continue to work through long term supports for working members.

Practices

The value of employment for clubhouse members needs to become a part of the clubhouse culture. Specifically, the club manager, staff and members need to demonstrate their interest and commitment to member employment. Thus employment cannot be a task that is singularly assigned to an individual; rather all or most staff should share tasks for job coaching or job development. Staff assigned to each of the units should be talking with unit members about their interest in employment. Thus encouragement to work and supporting those who are employed need to be present in every aspect of the work ordered day.

Prior work experience, level of comfort with performing, and levels of skills varied across members in the clubhouses. Thus alternative ways of finding and keeping employment needs to be provided for members to meet their varying employment needs. For example, transitional employment is an excellent option for people who want to work, but are unsure of how to begin the journey or unable to secure immediate employment. It is a good way form members to experience having a paid job. With the rotational procedure of moving from one transitional employment to another every six-months, transitional employment provides members with experiences in multiple jobs and across different work settings. When a transitional position ends because an employer chooses to hire a member permanently, new transitional positions need to be developed with knowledge about members' skills and areas of interest. Having no transitional employment options for members diminishes the clubhouse capacity to fully assist all members in seeking paid work. Supported employment provides members with

opportunities to obtain a job in an area of interest along with providing necessary job development and coaching supports as needed. Finally, competitive employment provides members with opportunities to seek and obtain individual jobs fairly much on their own. Yet, the clubhouse may support them by assisting with applications and practice interviews, and by providing a place where job openings are posted.

Finally, supporting employment for clubhouse members requires staff to be knowledgeable and comfortable in addressing employment related issues. Thus staff and manager education about employment is critical. Knowledge about how Social Security payments interface with earnings, how health insurance or Medicaid impacts earnings, how jobs can be developed and how employees can be supported through job coaching are all critical areas of expertise.

Issue 4: Health concerns

There are many dimensions that make up quality of life. Physical health, including the impact physical health can have on other areas of one's life is an important component of quality of life and can influence one's ability to work.

Participants were asked a number of questions regarding their physical health including, their perception of their own physical health, how their physical health impacts their life, and what type of physical illnesses they currently experience. Thirteen percent of the participants reported that their general health was excellent, 15 percent of the participants reported that their general health was very good, 36 percent reported that it was good, 26 percent reported that it was fair, 9 percent reported that it was poor, and 1 percent indicated they did not know. The average rating of general health was "good."

The number of physical health conditions listed by participants ranged from 0 to 10 with an average of 1.6 physical health conditions listed across participants. The number of medications taken for both psychiatric and physical health conditions ranged from 0 to 16 across participants.

Health Conditions. The number of physical health conditions participants reported was significantly different across diagnostic categories (F = 5.44, df =3, p<.01),. Members with schizophrenia (N=128) had an average of 1.23 physical health conditions, while participants diagnosed with a mood disorder (N=79) had an average of 2.3 physical health conditions and individuals with other diagnoses (N=33) had an average of 2 physical health conditions.

Members were asked about specific health problems they experienced. Figure 4 shows the most frequently noted health conditions among the members we interviewed. The most frequently noted were high blood pressure (24 percent), diabetes (18 percent), respiratory disorders (16 percent), and obesity (13 percent). In addition, 79 percent of the participants stated that they were concerned about their weight

Health Behaviors. Health behaviors, such as smoking, exercise, and substance use, were also explored. The majority of participants (50 percent) reported that they smoke

tobacco or use other tobacco products. The majority of participants (54 percent) also reported that they do not exercise vigorously 3 or more times a week for at least 20 minutes and that they are concerned about their weight (79 percent). Weight issues are especially salient for persons with psychiatric disabilities because the medications they take often have the side effect of weight gain.

Figure 4. Most Frequently Self Reported Health Conditions
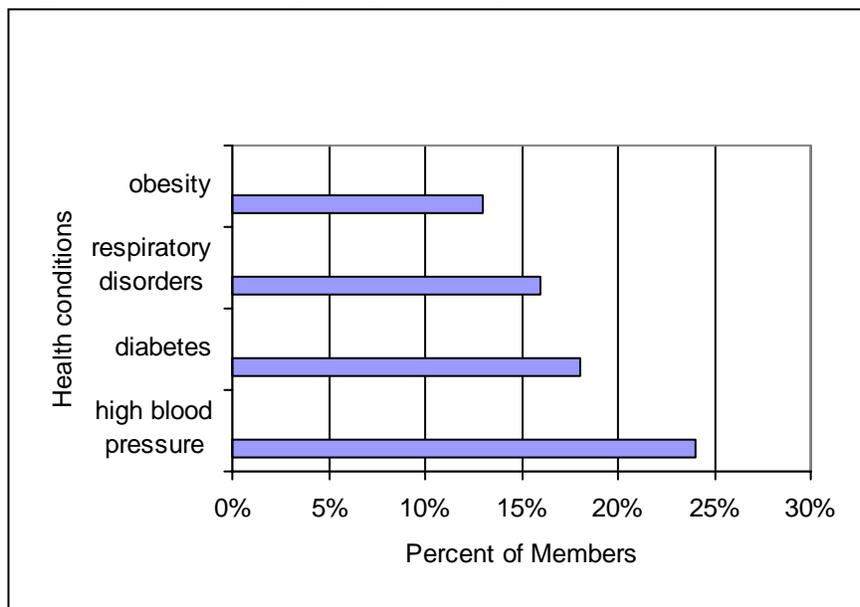
Physical Health Status and Health Behaviors. Nearly half the members interviewed indicated sleep problems affected their ability to work and accomplish daily activities Table 8).

Table 8. Health Problems Limiting Daily Activities

	Percent of members
Accomplished less in last 4 weeks due to physical health	45
Limited in work or other activities in last 4weeks due to physical health	44
Overall Problems with Sleep	47
Without sleep for a day or a week	30

One finding of the evaluation indicated that members have multiple co-occurring medical conditions. Nearly half of the members reported physical health problems that decreased their ability to work and carry out daily activities. There is a need to address physical wellness for clubhouse members. Most members take psychiatric medications and over half report negative side effects. Clubhouse staff should be taking a more active role with members around medication education and symptom management.

Medications. Half (54 percent) of the clubhouses assist with medication issues on a daily to weekly basis, however, only 10 percent of the clubhouses provide weekly or

monthly medication awareness services or education. Most of the participants take psychiatric medications (95 percent) and the number of years that participants have been taking psychiatric medications ranges from under 1 year to 44 years. Participants with a diagnosis of a mood disorder took an average of 4.7 medications, while participants with a diagnosis of schizophrenia and participants with other diagnoses took slightly less, with an average of 3 medications.   Participants with a diagnosis of mood disorder reported having a greater number of physical health conditions and taking a greater number of medications than participants with other diagnoses.

Of those taking psychiatric medication, the majority (53 percent) reported experiencing side effects such as drooling, stiffness, or weight gain. Of those taking psychiatric medications, 73 percent are responsible for taking their own medications. Of those not responsible for taking their own psychiatric medications (24 percent), 69 percent are supervised by mental health staff.

Issue 5:   Paid consumers as providers of services versus no paid member work

The voluntary and cooperative nature of members' participation in clubhouse programs reinforces the values of all members' contribution regardless of their level of recovery. Members are not paid for their efforts as part of the work-ordered day. However, after the initial stage of clubhouse program development in Michigan, DCH policy shifted in response to state and national focus on consumer-run programs. Although the policy focused on consumer drop-in programs and hiring peer advocates in mental health programs, some CMHSPs and clubhouse programs responded to this new priority by hiring of clubhouse members as paid staff on a part-time basis while maintaining their member status during non-paid hours at the clubhouse. This change in practice is not the same as a member being hired as staff and no longer functioning in the clubhouse as members.

Evaluation Findings

Although the evaluation does not have quantitative data to address the effect of this adaptation, observations and conversations with members suggest a negative effect on clubhouse programs where members are also employees. Several clubhouses had members who had paid part-time jobs at the clubhouse. In most cases there were two to three positions occupied by members. Two clubhouses paid members as drivers. In these jobs, members drove other members to and from the clubhouse and appointments. Two clubhouses employed members in quasi-professional roles. In these roles, members performed staff functions such as record keeping, administrative support, and case management support. The quasi-professional roles were the source of role confusion and stress for member employees.   These part-time positions combined with being a member when not paid led to confusion and awkwardness about their role. There appeared to be role ambiguity among the employed club members, other members, and staff. In addition, the use of member employees created a hierarchy among members that essentially devalued the major of members and their contributions to the work-ordered day.

Outcomes for Members

Why members come to clubhouse

We asked participants to tell us three reasons why they attend the clubhouse, listing their top reason first. From these reasons, we developed eight categories that capture why participants attend the club (Table 9). Socializing or making friends and having something positive to do to occupy one's time were the two most frequently listed reasons for both the first (top) reason and the second reason. Members come to the clubhouse because it provides an environment that addresses the loss of social connection that characterizes serious mental illness. This suggests that the quality of the relationships within the clubhouse community are an important component of clubhouses.

Table 9. Reasons Member Reported for Attending the Clubhouse

Category	1st (top) Reason Frequency (percent)	2nd Reason Frequency (percent)	3rd Reason Frequency (percent)
Socialize or Make Friends	75 (31%)	74 (33%)	31 (17%)
Something Positive to Occupy Time	52 (22%)	47 (21%)	36 (20%)
Gain Skills/Work on Getting Job	23 (10%)	25 (11%)	38 (21%)
Enjoy the Club Program/Structure	24 (10%)	29 (13%)	34 (19%)
To Gain a Sense of Purpose/Meaning	24 (10%)	30 (13%)	25 (14%)
To have assistance with Mental Health Issues	20 (8%)	10 (4%)	3 (2%)
Support from Staff & Members	13 (5%)	9 (4%)	10 (5%)
Meet Service System Requirement (e.g., Medicaid spend down, court-ordered)	9 (4%)	1 (less than 1%)	4 (2%)

The clubhouse community

It is believed that the clubhouse environment fosters a psychological sense of community among members and staff. Leading authors in the area of community psychology have defined the concept of 'psychological sense of community' as "strong feelings of belongingness, integration of needs, reciprocal influence, and a shared history toward a particular reference group (McMillian & Chavis, 1986)." Clubhouses may strive to create an environment that celebrates individual empowerment and recovery, while acknowledging the interdependence with others in this process. Members and staff may feel that they are part of a larger and dependable structure, such as the clubhouse community (Sarason, 1977).

Different measures were used to first reveal, if in fact, a general sense of community existed in clubhouse programs. Second, various measures to assess the psychological sense of community were used to examine member outcomes.

The Staff Relationship Scale (Hornik, 1999) was used to measure the extent to which clubhouse members perceived their relationship with staff as positive or negative. The scale is comprised of 20 statements that are scored on a 5-point scale (1 = strongly disagree to 5 = strongly agree). Some of the items included on scale are as follows: a) staff do not understand me, b) staff recognize my abilities, c) staff give me hope about my future, d) staff encourage my independent thinking. Four subscales were developed that describe the type of member-staff relations. These are:

- *Understanding*: the extent to which members perceive staff as understanding of the member and the member's mental illness.

- *Credibility*: the extent to which member's perceive staff as believing what members say, are able to freely complain to staff, and the extent to which staff encourage members' independent thinking.

- *Empowering:* the extent to which staff empower members by recognizing and reinforcing members' abilities, interact with members in a respectful and encouraging manner, maintain confidentiality, and maintain a helping relationship despite incongruent perspectives between members and staff.

- *Supportive*: the extent to which members perceive staff as helpful, encouraging and supportive in their interactions. This includes the extent to which staff listen to members, are able to help members, and provide hope of recovery for the membership.

Table 10. Staff relationship scale means by diagnostic group

Staff Relationships Scale	Schizophrenia (n = 138)		Mood Disorder (n = 84)		Other Disorders (n = 34)	
	Mean	SD	Mean	SD	Mean	SD
Understanding	4.13	.58	4.1	.61	3.96	.62
Credibility	4.10	.71	4.17	.64	3.94	.71
Empowering	4.19	.66	4.15	.64	3.95	.80
Supportive	4.38	.50	4.30	.50	4.21	.57
Total Score	83.86	11.02	82.76	10.58	80.11	13.27

Means and standard deviations are presented in Table 10 across three diagnostic categories. Overall, there were no significant differences between diagnostic categories on the staff relationship subscales or the total score (F = 1.55, df = 2, 253; ns). No differences emerged between minority or non-minority clubhouse members (F = .09, df = 1, 255; ns) or minority and non-minority clubhouse members across diagnostic categories (F = 1.05, df = 4, 249; ns).

Sense of community was defined as the extent to which individuals felt as though they belonged to a community, were accepted, and perceived themselves to be part of a culture. Sense of community was measured using the Sense of Community scale developed by Buckner (1998). The scale contains 13 statements that are measured on a 5-point Likert-type scale (1 = strongly disagree to 5 = strongly agree). Seven items, based on the results of concept mapping (Onaga & Herman, 1999) were used to measure benefits of clubhouse membership. For example, some statements on the scale included items such as: (a) I feel like I belong to this clubhouse, (b) being part of this clubhouse helps me deal with my mental illness, (c) being a member of this clubhouse helps me have hope for the future. Means and standard deviations are presented in Table 11 across three diagnostic categories. There were no significant differences on any of the subscales or the *score* between the three diagnostic groups. There were also no gender differences.

*Table 11. Sense of community mean scores by diagnostic group*

Sense of Community Scales	Total Sample (n = 260)		Schizophrenia (n = 138)		Mood Disorder (n = 84)		Other Disorders (n = 34)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Sense of community	257	.51	4.41	.49	4.41	.48	4.49	.50
Benefits of membership	2.18	.56	4.26	.56	4.15	.50	4.31	.52

Sense of community outcome. Members' level of sense of community was related positively to their degree of recovery, their level of independent abilities, number of hours they attended the club per week, and they type of relationship with staff (Figure 5). Members who were further along in their recovery process were more likely to report a stronger sense of community. Likewise, members with more independent abilities (more able to carry out the activities of daily living) were more likely to report a strong sense of community. The more hours per week a member attended, the clubhouse, the greater the sense of community reported. The more positive a member was about his or her relationship with staff, the greater the sense of community reported. Members who said they came to the clubhouse for their mental health problems expressed higher sense of community than those who did not indicate this as a reason. Members with schizophrenia expressed lower levels of sense of community.

Clubhouse level variables modified several of these relationships. As the level of model fidelity increased, the relationship between sense of community and level of recovery also increased. This means that at clubhouse with higher model fidelity, persons further along in the recovery process had a greater sense of community than did persons who were less advanced in their recovery. At clubhouses where the managers had received ICCD training, the number of hours members attended the clubhouse was higher which resulted in a greater sense of community among members. However, as the number of ICCD trained staff increased, the effect of the relationship between members and staff on sense of community decreased. This suggests that clubhouses with more ICCD trained staff are able to create an environment that is less dependent on relationships

between members and staff for members to feel a sense of belonging and community within the clubhouse.

Figure 5. Sense of Community
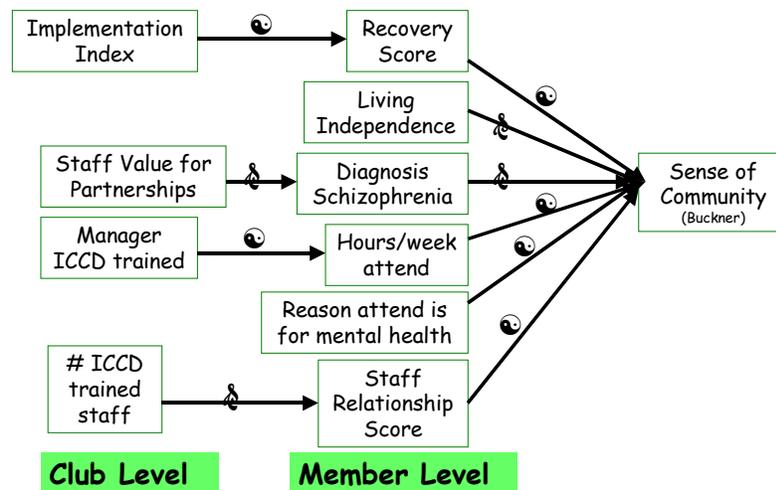
Benefits of membership outcome. The degree to which members indicated a sense of benefit from clubhouse participation was related positively to their degree of recovery, level of daily activities in the community, number of hours attended the club per week, and positive relationship with staff (Figure 6). Members who were further along in their recovery process were more likely to report a stronger sense recovery and benefit from club attendance. Likewise, members who reported more frequent activities in the broader community were more likely to report greater benefits from clubhouse membership. The more hours per week a member attended the clubhouse, the greater the reported sense of benefit; and the more positive a member was about relationships with staff, the greater the sense of benefit that was reported.

Clubhouse level variables modified several of these relationships. As the degree to which staff valued sense of community as a clubhouse outcome increased, the relationship between sense of benefit from club membership and level of recovery also increased. This indicates that at clubhouses where the staff valued sense of community as an outcome, persons further in the recovery process experienced greater membership benefits than did persons who were not as far along in their recovery. At clubhouses where the managers had received ICCD training, the number of hours members attended was higher which resulted in a greater sense of benefit from club membership. As the intensity of the clubhouse program increased (e.g., more units and activities within the clubhouse), however, the effect of member-staff relationships on sense of membership benefit decreased. This suggests that clubhouse with more active programs, there is less reliance on staff to create an environment that members find beneficial because there are more meaningful tasks and/or opportunities available to members. That is, more active programs have been able to create a milieu that

members see as beneficial. With in this type of milieu, the impact of relationships between members and staff is less.

Figure 6 . Benefits of Membership
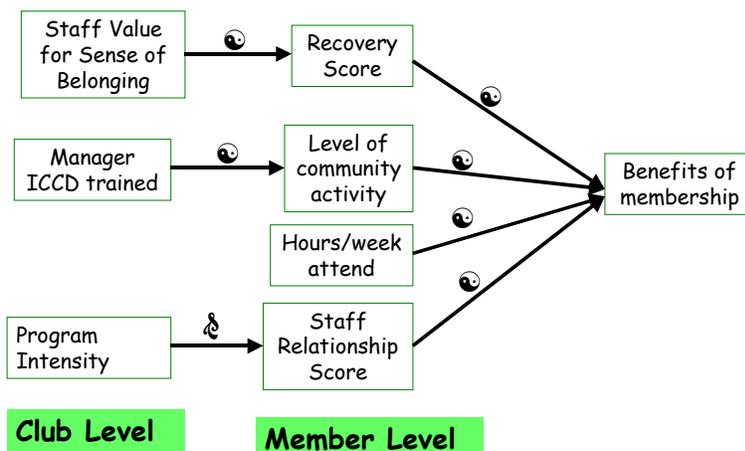
Recovery from mental illness

Members were asked to rate their recovery from mental illness in the personal interviews. The Corrigan Recovery Scale was used to measure the extent to which members agreed or disagreed with 41 statements reflecting different domains of recovery. For example, the interview contained statements such as, "I can identify what triggers the symptoms of mental illness," "Fear doesn't stop me from living the way I want to," and "I can handle it if I get sick again." Each item was scored on a five-point scale (i.e., 1 = strongly disagree to 5 = strongly agree). The scale was grouped into five recovery subscales: (1) Managing the Illness, (2) Sense of Hopefulness, (3) Self-efficacy, (4), Purpose in Life, and (5) Social Support. The Recovery Scale was designed to measure progress toward recovery from mental illness. Higher scores on the scale indicate a more advanced stage of recovery. The average score on these sub-scales across the three diagnostic groups are presented in Table 12.

Table 12. Recovery scale scores by diagnostic group

Recovery Scales	Total Sample (n = 258)		Schizophrenia (n = 138)		Mood Disorder (n = 84)		Other Disorders (n = 34)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Managing the Illness	3.78	.71	3.8	.71	3.6	.69	3.7	.66
Hopefulness	3.87	.78	4.0	.71	3.6	.80	3.8	.77
Purpose in Life	4.36	.53	4.4	.50	4.2	.51	4.4	.61
Self Efficacy	4.20	.55	4.3	.53	4.0	.51	4.1	.58
Social Support	4.24	.62	4.3	.69	4.1	.53	4.1	.68
Total Score	164.24	23.6	169.1	23.24	157.9	21.9	162.6	23.6

Comparisons of these subscales by diagnostic categories revealed that members with schizophrenia reported significantly greater sense of hopefulness and self-efficacy than members with mood disorders. That is, members with schizophrenia indicated a greater sense of hope for the future, as well as control over their lives. Further, members with schizophrenia reported greater perceptions of 'overall' recovery from mental illness than individuals with mood disorders. There were no significant differences between members with schizophrenia and other types of psychiatric diagnoses.

Members' scores on the Recovery Scale were higher at clubs with larger average daily attendances. After controlling for average daily attendance, a number of member characteristics predicated members' recovery scores (Figure 7). Members with college educations or college experience had lower recovery scores. Members possessing more independent abilities (more able to carry out the activities of daily living) had higher recovery scores, as did members who reported more frequent activities in the community. Members who had a diagnosis of schizophrenia also had higher recovery scores. Members who indicated they came to the clubhouse for vocation reasons had higher recovery scores than did members who did not. The more positive a member was about his or her relationship with staff, the higher their recovery scores. Clubhouse level variables modified several of these relationships.

At clubhouses where the managers had received ICCD training, members who attended for vocational reasons had increased scores on the recovery scale. As clubhouse model fidelity increased, the effect of member-staff relationships on recovery also increased. The effect of positive relationships with staff on level of recovery increased as model fidelity increased.

Figure 7. Recovery

Figure 7. Recovery
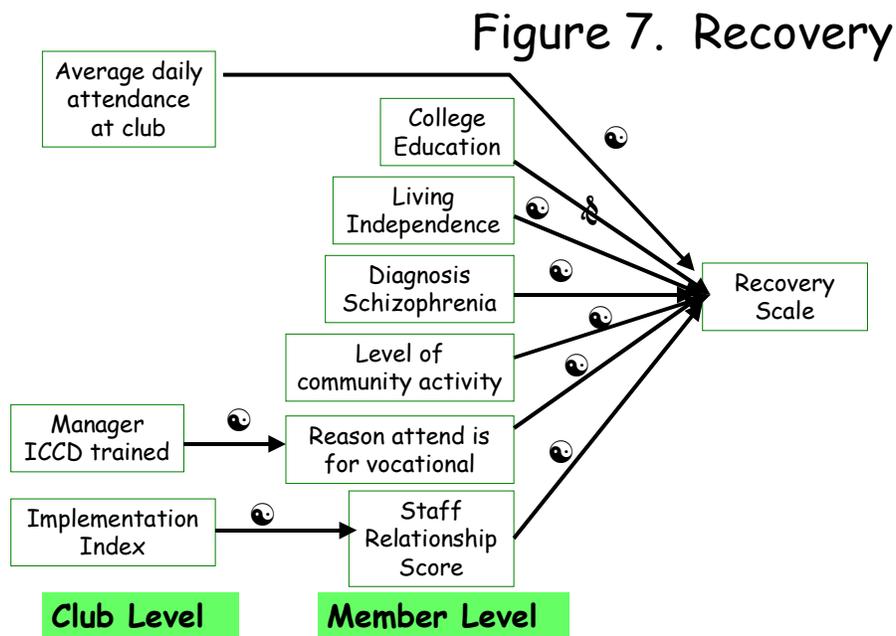
Satisfaction with Quality of Life

We asked members to reflect upon their life as a whole and provide a rating of how satisfied they were with the overall quality of their life at the time of the interview. Members rated their life satisfaction with their overall quality of life using a seven-point scale where one was the most satisfied and seven was the least satisfied. Table 13 presents the means and standard deviations on the Quality of Life Satisfaction Scale by diagnostic group. Members with schizophrenia were more satisfied with their overall quality of life than persons with mood disorders. None of the other comparisons were significant. Recovery was significantly related to members' ratings of their satisfaction with their overall quality of life. The results revealed that members who had reached a higher level of recovery were more likely to report greater satisfaction with their overall quality of life (r =.53).

Table 13. Life satisfaction scale scores by diagnostic group

Total Sample (n = 254)		Schizophrenia* (n = 138)		Mood Disorder (n = 84)		Other Disorders (n = 34)	
Mean	SD	Mean	SD	Mean	SD	Mean	SD
2.84	1.44	2.59	1.37	3.12	1.48	3.14	1.49

* F(2,251) = 4.48, p < .01

Several member characteristics were predictive of satisfaction with overall quality of life (Figure 8). Members with college educations or college experience had less satisfaction with their quality of life. Those who were older reported greater satisfaction with their quality of life. Members who were employed and members who reported more frequent activities in the community had greater life satisfaction. Members who reported a greater sense of community also reported greater satisfaction with their quality of life. Satisfaction with quality of life was higher for members with a diagnosis of schizophrenia. Life satisfaction was also higher for members who came to the clubhouse for vocational reasons.

Clubhouse level variables modified several of these relationships. As the observed level of activity within the clubhouse increased, the effect of being employed on life satisfaction increased. At clubhouses where the managers had received ICCD training, the effect of sense of community on life satisfaction is increased.

Figure 8. Life Satisfaction

Club Level   Member Level
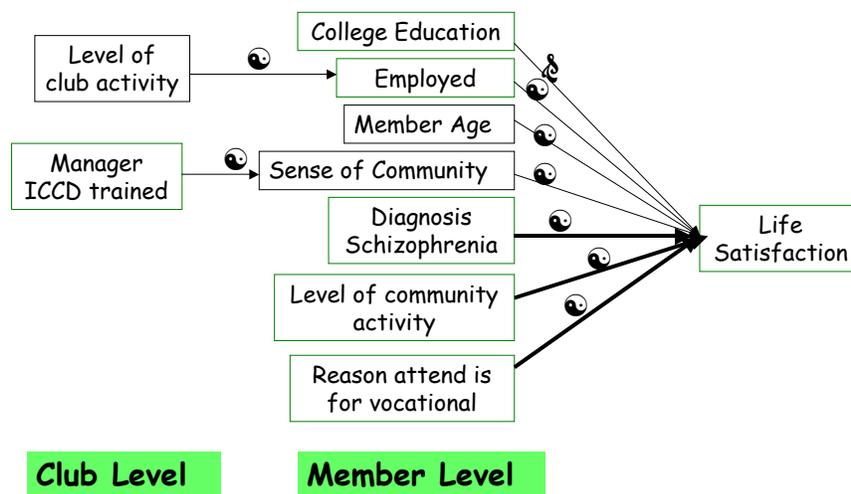
Clubhouse Employment

The role of employment in the lives of people with psychiatric disabilities is no different than with others in society. In our society, employment is a significant component of adult role identity. It provides identity, status, income and a sense of meaning. However, for many people with psychiatric disabilities employment is often an illusive phenomenon.

In Michigan, clubhouse programs used a wider variety of employment strategies. Following are the descriptions of these various types of supported employment defined by the Michigan Department of Community Health:

- Transitional employment (TE) is defined as a "model of supported employment specific to persons with mental illness. It involves multiple part-time work placements with community based employers, paid by the employer. Support services are provided by a clubhouse program prior to and concurrent with the transitional employment experiences. Long term support would be available through the psychosocial clubhouse for subsequent full-time placement."

- Individual supported employment (SE) is defined as "…services for which ongoing, long-term supports that would generally include two contacts per month with mental health staff that that assist an individual maintaining employment."

- Mobile crew "consists of a small group (8 or fewer individuals) which move from site to site to perform work. The crew has their own equipment and job training and supervision are usually the responsibility of the service provider agency."

- Competitive Employment (CE) is work paying at least minimum wage and located in integrated, mainstream settings (Dept. of Labor, 1998; Workforce Investment Act, 1998).

Ridgeway and Rapp (1998) identified several dimensions of clubhouses that are critical to achieving competitive employment. These are (1) organizational climate and culture that supports work, (2) facilitation of employment, (3) emphasis on member preferences and strengths, (4) on-going flexible, individualized support, and (5) covering employee absences. This model was used to guide the analysis of employment outcomes for Michigan clubhouse programs. We specifically examined the organizational culture and the supports for employment in relation to the number of members employed. We examined clubhouse employment practices and their relationship to employment outcomes, such as having an increased or decreased number of members who were employed during specified time period (i.e., October 1, 1998 to March 31, 1999= 1.5 years) as measured by a survey administered to Michigan Medicaid enrolled clubhouse programs

Practices associated with increased employment placements in clubhouses

<u>Organizational culture and climate that supports work</u>. The conversion of existing programs to the clubhouse model required the transformation of existing mental health practices around employment and the introduction of new practices, such as vocational supports and employment activities. In order to facilitate the transformation process, clubhouse managers, staff, and member representatives were sent to an intensive three week training offered by the International Center for Clubhouse Development. In part, this training is aimed at creating an environment that supports partnerships between members and staff, facilitate recovery from mental illness, supports and facilitates employment of members.

Is there a relationship between employment outcomes and the clubhouse manager's training in the clubhouse model, i.e., participated in three-week intensive clubhouse trainings?

Managers who participated in the intensive clubhouse training had more members in competitive employment outcomes than clubs with managers who were not trained ($F = 4.74$, $p < .01$).

Work Related Supports. The 1998 clubhouse program assessment survey, asked clubhouse managers to indicate the frequency of the type of work supports provided to clubhouse members. Providing such support is assumed to be associated with increased employment, yet such an association has never been tested. Type of work supports included the following:

Table 14. Types of work related supports provided

Work-Related Supports	
Finding transitional jobs for members	Assisting members in getting jobs
Career planning	Resume/interviewing skills preparation
Job development	Advocacy with employer
Linkage with information on SSI work incentive	Coverage of member absences from jobs
Life skills	Job performance assessments
Transportation to/from work	Holding employee dinners
Supporting members to work independently	Job Club

Does providing more work-related supports increase the likelihood of employment?

All surveyed clubs except one, reported providing 8 or more work-related support activities (97 percent). However, there was no relationship between the number or intensity of employment supports and the number of members employed during the surveyed time period.

Overall, the number or intensity of work-supports were not directly related to an increased number of members employed in supported, transitional, or competitive work settings. It appears that the quality and type of support are more indicative of greater member employment, especially for supported and competitive employment outcomes. This suggests that clubhouses should focus more effort in those practices that lead to more successful outcomes, including providing a clubhouse environment that supports work, practical practices that facilitate employment and employment opportunities (e.g., job development, finding transitional employment opportunities), and providing ongoing, flexible work supports (e.g., job performance feedback, coverage of member's absences).

> **What practical practices are associated with increased employment of clubhouse members?**

Supported Employment.   We found three practices related to increased number of members in supported employment positions.

- Clubs that support members to work independently are more likely to have members who participate in supported employment jobs than clubhouse that do not use such practices. Other positive practices associated with an increased likelihood of supported employment positions in clubhouses were found for clubhouses who support members to work in competitive employment ($\chi^2 = 4.62$, df = 1, p<.05).

- The role of "job clubs" in clubhouses is used to help members become acquainted with a variety of job opportunities, learn skills in resume writing, and participate in job-related activities. Yet, it is unclear how having a job club is related to increased supported employment outcomes. According to the results based on 35 clubhouses, it appears that clubs without "Job Clubs" are just as likely or slightly more likely to have more supported employment outcomes ($\chi^2 = 3.34$, df = 3.34, p< .07). This suggests that the mere presence of operating a job club does not necessarily increase the likelihood of having increased supported employment outcomes.

- Career planning is another way in which clubhouses attempt to prepare members for jobs in the community, and to plan for long-term job success. However, career planning is not uniquely associated with increased job outcomes for supported employment ($\chi^2 = 4.54$, df =1, p<.05). That is, clubs without much emphasis on career planning are 9 times more likely to have members working in supported employment positions than clubhouses that use career planning as a source of increasing job placement.

Competitive Employment. Assisting members to work in the community, independently, is one goal that clubhouses strive to achieve.   We found five practices related to increased number of members in competitive employment.

Practices associated with increased numbers of members with competitive employment include:

- Clubhouses that provide fewer supported employment options were 2.6 times more likely to have greater competitive employment outcomes ($\chi^2 = 7.55$, df = 1, p<.01). It may be that clubhouses that do not have an emphasis on supported employment job opportunities "jump right into" helping members acquire competitive employment positions in the community.

- Clubhouses that provide members with opportunities to enhance their life skills (e.g., skills in budgeting, cooking, hygiene, etc) have increased numbers of members in competitive employment ($\chi^2 = 4.53$, df =1, p<.05).

- Clubhouses that provided members with <u>information and direct linkage to SSI work incentive</u> programs were 3.7 times more likely to have greater competitive employment outcomes than clubs that did not provide such supports (χ^2 = 3.11, df = 1, p<.08.

- Clubhouses that practice <u>covering member employee absences</u> were 5 times more likely to have a greater number of members in competitive employment than clubs that did not engage in this (χ^2 = 3.77, df =1, p <.06).

- In contrast to the supported employment findings, <u>career planning</u> appeared to be somewhat related to an increased likelihood of competitive employment outcomes, 6.5 times more likely for clubs that used career planning to help members move into competitive employment positions. (χ^2 = 3.23, df = 1, p< .08).

<u>Clubhouse model fidelity.</u>   Measuring clubhouse model fidelity is important to understanding how various clubhouses across Michigan conform or deviate from standard clubhouse programming. A fidelity score was generated from 61 items based on the ICCD fidelity scale (Macias, et al., 2001) to indicate the extent to which clubhouse programs conform or deviate from standard practices. The score is used as an index to determine whether a clubhouse has "high" or "low" model fidelity. Scores were created for the 18 clubhouse where site visits were conducted. Individual employment outcomes were examined against this index to explore whether high fidelity clubhouses differed from low fidelity clubhouses on employment outcomes. The 18 clubhouses were classified as low fidelity (below 50th percentile, n = 10) and as high fidelity (above 50th percentile, n = 8). A total of 101 clubhouses members reported being currently employed at the time of the interview.

Clubhouses with greater model fidelity were significantly associated with greater percentage of the clubhouse <u>membership working</u> in supported and transitional employment positions (r[18] = .49, .52, respectively). Further, in terms of the member-level data, significantly more (t = -2.79, df = 258, *p< .05)* clubhouse members from high fidelity clubhouses (48 percent n =55) as compared to low fidelity clubhouses (31 percent, n= 45).

Model fidelity does not appear to be related to number and intensity of clubhouse <u>work supports</u> provided to the membership. This finding is further corroborated by data at the member level. No differences were found between high and low fidelity clubhouses and how clubhouse members sought and obtained work. Overall, 53.5 percent of working members reported that the clubhouse had assisted them in obtaining their current employment, 23.2 percent reported obtaining the job on their own, and 17.2 percent reported assistance from other (e.g., friends, family). A little over 6 percent reported assistance from Michigan Rehabilitation Services.

There was also no difference between high and low model fidelity clubhouses and self-reported <u>clubhouse work-supports</u>. Out of the 101 working members interviewed across the 18 clubhouses, only 21 percent reported not utilizing clubhouse work-

supports in helping them keep their current job. The remaining number of members reported the following top four supports that helped them keep their current employment: (1) skills learned from the work ordered day and (2) learning how to get along with other at work, (3) transportation, and (4) job training.

Job accommodations provide individuals with opportunities to transition to new employment positions and increase the likelihood for success. Overall, 58 percent (n = 56) of working members reported flex-time options, 67 percent (n = 66) were working in environments that provided job assistance (e.g., cues or assistance from supervisors and co-workers), while 36 percent (n = 34) indicated an opportunity to modify their work conditions.

High fidelity model clubhouses had fewer members who were working in environments where co-workers or supervisors provided continued job assistance (F = 4.9, df = 1, 97; p <.05).

There were no differences between high or low model fidelity clubhouses and self-reported assistance in maintaining employment over time. That is, who helped members keep their job was not different between clubhouses that scored high or low on model fidelity. Overall, the most frequently endorsed items in terms of 'who helps members' keep their job were (1) club staff or job coach at the club (54 percent), and (2) boss or co-workers at the job site (48 percent), (3) family members (26 percent), and (4) club members (22 percent).

Clubhouses were categorized as high or low on employment fidelity practices. There were again, 10 (n = 145 members) clubhouses that fell into the low group and 8 clubs (n= 115 members) in the high group. A significant relationship was found between high employment fidelity clubs and number of members who were employed (Figure 9). More members were found working in clubhouses that had high fidelity in practicing clubhouses employment services (χ^2 = 9.12, df = 1; p < .01).

Figure 9. Number of members employed
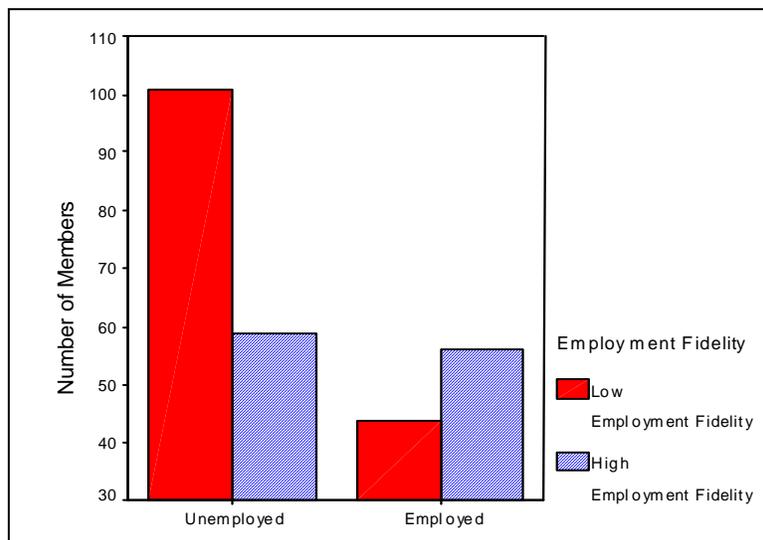
Members were asked what supports helped them keep or maintain their job. The use of these supports was examined with employment type as the independent variable. A relationship was found between specific job supports and employment type (e.g., TE, SE, Competitive, etc). First, skills learned from the work-ordered day were reported significantly more often for members working in TE positions as compared to members working in competitive employment. Second, job instruction was also reported significantly more often for TE's than for members working in competitive employment. (See Figure 10 and 11 for the proportion of members endorsing work-ordered day and job instruction by employment type.) Table 15 presents a list of supports that helped them keep their jobs.

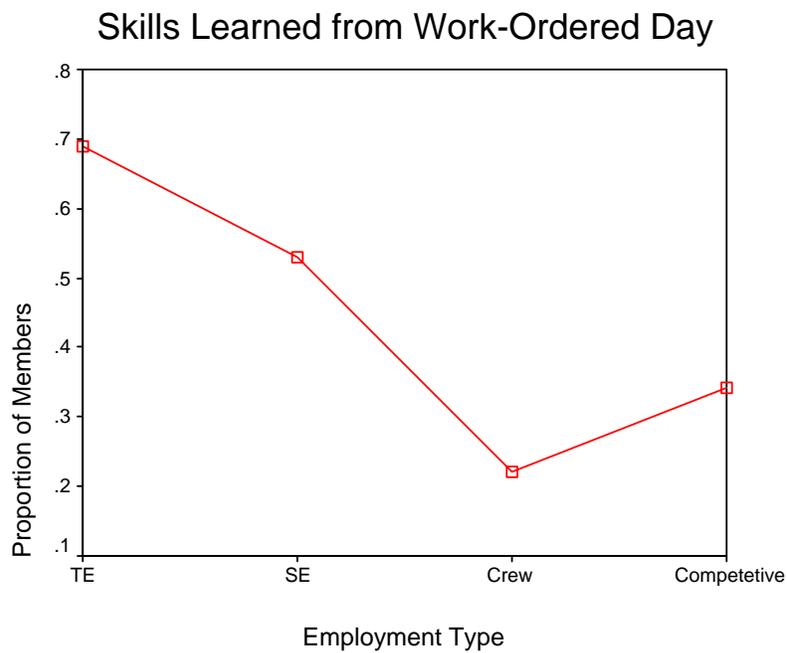Figure 10. Proportion of working members by employment type
for work-ordered day skills

Skills Learned from Work-Ordered Day

Figure 11. Proportion of working members by employment type
for job instruction
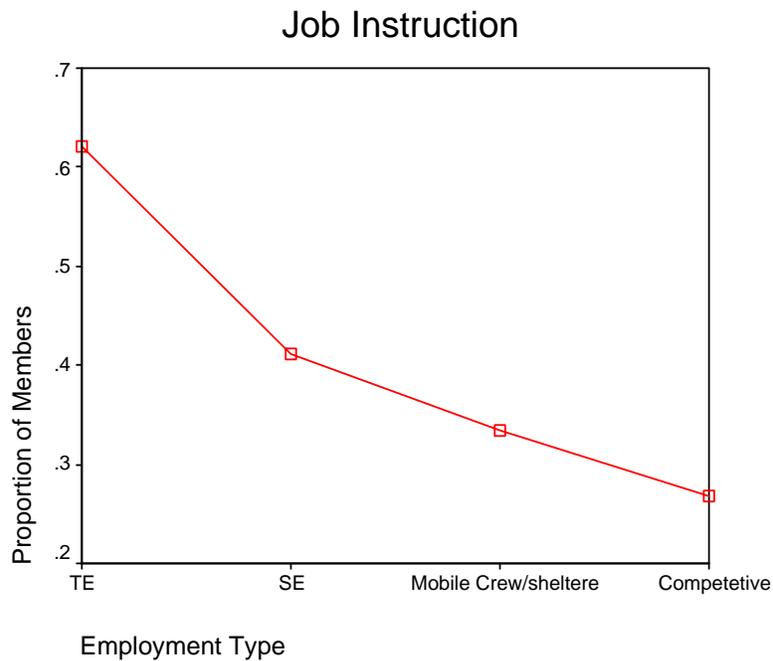
Job Instruction

Table 15. What helps you keep or maintain your job?

Item	Number of members	Percent
Skills learned form work-ordered day	46	46.9
Job instruction	40	40.8
Obtaining transportation	41	41.8
Medication adjustment	29	29.6
TE dinner	32	32.7
Learning how to work with others	46	46.9
Getting housing situation in order	27	27.6
Emotional and behavioral self-management tools	37	38.5

Clubhouse Members

Member demographics

Demographic data were collected from 260 clubhouse members who were interviewed at 18 clubhouses. The demographics of these members were compared to the demographics of all persons receiving clubhouse services in FY 99 and no differences were found. This indicates that the sample of 18 clubhouse visited by the research team adequately reflects the overall composition of the clubhouses across Michigan.

Table 16 presents gender, ethnicity, and age data of the members who were interviewed. Clubhouse members who participated in the personal interviews ranged between 18 and 66 years of age, with an average age of 43. A majority of the clubhouse members interviewed were Caucasian members. African American members comprised the second largest group at 8.9 percent.

Table 16. Member demographic characteristics

Member Characteristics	Percent
Gender	
Male	49.6
Female	50.4
Ethnicity	
Caucasian	82.6
African American	8.9
Native American	3.1
Latino	0.4
Multiracial	4.2
Other	0.8
Age categories in years	
18 to 30	10.8
31 to 40	24.7
41 to 50	42.5
51 to 60	17.7
61 or older	4.3

Table 17 summarizes the level of education across participants. Approximately 38 percent of the sample had received a high school diploma or equivalent, and nearly 30 percent have had some college education, while a total of 17 percent had a professional

or college degree. At the time of the interview, 13 percent of the members were enrolled in some type of educational program such as GED courses, community college, or vocational training. While the majority of the respondent (87 percent) were not enrolled education program, more than half indicated that they would like to continue their education.

Table 17. Members' education levels

Member Education Level	Percent
Less than high school	18.9
High school or equivalent	37.8
Some college, less than degree	26.7
College or associate degree	16.6

Members most frequently reported $6,000-6,999 as their yearly income (31.3 percent). Income ranged from less than $500 to $25,000 or more. Nearly all members reported that their main source of income was from Social Security or Social Security Disability (93 percent) and only 31 percent of the sample cited employment wages as their main source of income. Less than 2 percent of the respondents indicated a yearly income of $25,000 or more, and less than 20 percent make more than $10,000 a year.

Information regarding marital status and living arrangements was also collected. The majority of clubhouse members were unmarried (87.3 percent) at the time of the interview. Only 9.5 percent were married and 3.5 percent indicated a live-in partner. A great majority (69 percent) of members live in independent living situations such as a home or apartment, or living with other family members in a private residence. Only 29 percent reported living in a dependent living situation, such as an adult foster care home (n=47), a supervised living arrangement in a home or apartment (n = 26), or a residential treatment facility (n = 1). Two members were homeless at the time of the interview, and three members were in transitional or temporary living arrangement. Table 18 illustrates present living arrangements for all members and within diagnostic categories.

Table 18. Percent of members by living arrangements within diagnostic category

Living Arrangements	Total Sample	Schizophrenia	Mood Disorder	Other Disorders
Own home or live in apartment	56.9	50.0	60.8	67.7
Group Home	18.1	22.2	15.2	12.9
Private Residence with Family	10.4	11.9	10.1	9.7
Homeless	.8	.8	-	3.2
Other	13.8	15.1	13.9	6.5

Diagnosis and history of mental illness

Diagnosis. **The diagnoses obtained from the 256 members interviewed are representative of the diagnoses reported in the Michigan Department of Community Health's management information system. Member diagnoses were represented in three major groups of categories: schizophrenia, & other psychotic disorders; mood disorders; and, all other Axis I & II Disorders. Permission to obtain diagnostic information was collected at the time of the interview from each respondent. Table 19 presents the distribution of the members' diagnostic category.**

Table 19. Percent of members across three types of diagnostic categories**.**

Primary Diagnostic Category	Percent
Schizophrenia & other psychotic disorders	53.9
Mood Disorder	32.8
All Other	13.3

Diagnostic categories are based on the Diagnostic Statistical Manual Version 4

History of mental illness and hospitalization. Members were asked about their mental health history and previous hospitalizations. Overall, the median age at which people began experiencing mental health problems was at 21 years of age. Figure 12 shows the number of members by age of first experience with mental health problem. Most (95.7percent) of members interviewed reported being hospitalized at least once for mental illness. Only 18.2 percent of members reported being hospitalized in the last year, 21.5 percent indicated being hospitalized one to two years ago, and 55.8 percent reported their last hospitalization as more than three years ago.

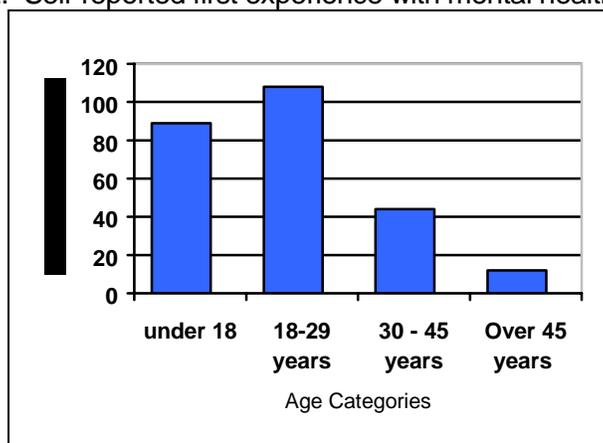Figure 12. Self-reported first experience with mental health problems

Figure 13. Percent of members that reported year of most recent hospitalization by diagnosis
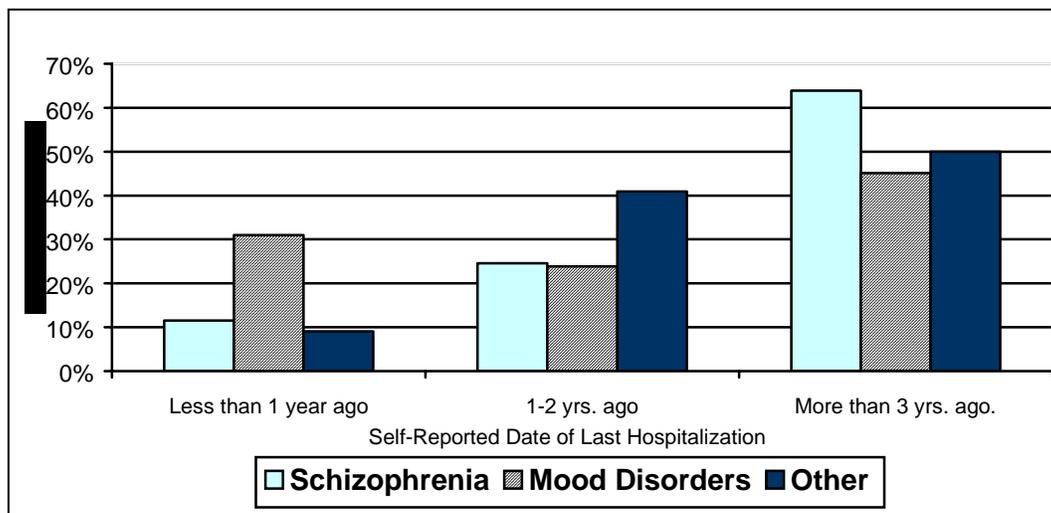

Figure 13 displays the time since the most recent hospitalization by diagnosis. Percentages are based on the number of members who reported the date of their last hospitalization. Members diagnosed with a mood disorder were more likely to have been hospitalized in the last year than members with schizophrenia. Members with schizophrenia were more likely to have been hospitalized more than three years ago. Further, when date of most recent hospitalization was examined by how long each member was coming to the club, it appears that members who had been coming to the clubhouse for more than a year had significantly fewer hospitalizations in the previous two years than members who had been attending the clubhouse for less than a year.

Social networks

In order to determine the extent of member's social networks, members were asked to reflect about all people in their lives who provide some type of instrumental or emotional of support. Each member was asked to list as many people they wished. Nearly every member (99.2 percent or 243) identified at least one person in his or her social network (see Figure 14). Family members made up a large part of the member's social network. Club staff were less frequently identified as part of members' social network than family members or friends (Table 20).

Table 20. Member Social Network Relationships

Type of Relationship	Percent of Members' Social Network
Family/ Spouse	75
Friend outside of Clubhouse	45
Clubhouse Staff	40
Professional (e.g., caseworker, doctor)	33
Clubhouse Member	28
Neighbor	3
Co-worker	3
Group Home Member	2
Other type of relationship (e.g., pastor, pets, guardian)	5

Figure 14. Social Network Size
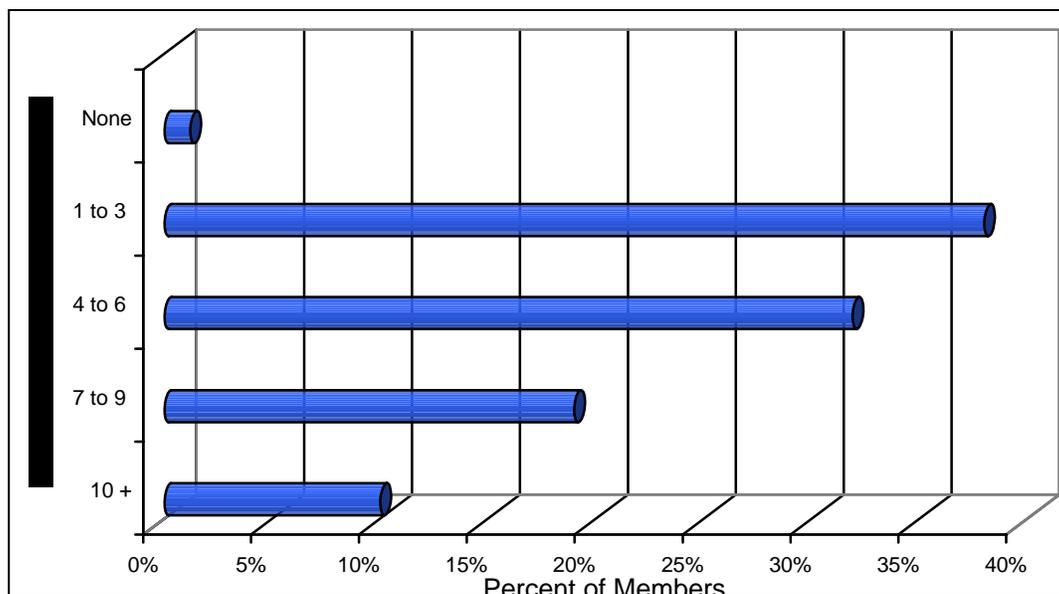
What members and staff value

A survey to assess the importance of club values was mailed to members and staff. The survey was used to validate the logic model; that is, to identify which parts of the logic model stakeholders thought were most important to a clubhouse being a very good club. The values assessed were recovery, choice and control, community integration, skills and abilities, and partnerships. Responses were received for 313 members, 136 staff, and 40 managers. Responses were then aggregated to obtain a clubhouse rating of importance for each value.

The way in which clubhouse members and staff perceived 'clubhouses values' varied across all 35 clubs. For some clubs, members and staff tended to place great value on partnerships, and community integration, while for a small minority of clubs, certain core values were not important to a good clubhouse.   The 'Values Survey' was also used in part to determine which clubs the Flinn Research Team was going to visit.   All clubhouses were ranked from lowest to highest on the way they scored the survey. The sub- sample of 18 clubhouses was selected to represent clubhouses with value scores from low, middle and high ranges. Table 20 provides the mean ratings by member and staff on five core clubhouse values.

Table 21. Mean for the Importance of these Values

Clubhouse Value	Member Responses	Staff Responses
Partnerships between Members & Staff	4.14	4.54
Community Integration and Advocacy	3.86	4.36
Gaining Skills & Abilities	4.18	4.46
Choice & Control	3.82	4.25
Recovery of Mental Illness	4.24	4.50

Clubhouse participation

Members were asked about their participation in terms of length of membership (i.e., total number years attended) and the weekly attendance. We looked at how long members had been part of the clubhouse program by asking them how long they had belonged to the clubhouse. We found that there were three different membership categories; (1) members who were coming for less than a year, (2) Members who belonged to the clubhouse for 1 to 5 years, and (3) long–term members who belonged to the clubhouse for more than 5 years (Figure 15).

Figure 15. Number of years members reported coming to the clubhouse
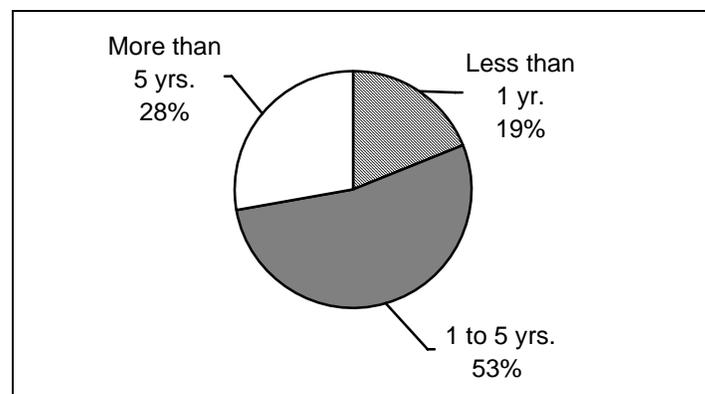
Most members with schizophrenia had been participating at in clubhouse programs between one and five years.   Figure 16 shows the percentages of member's participation by diagnostic category. On average, members with schizophrenia have significantly greater clubhouse tenure (i.e., have been clubhouse members longer) than persons with a mood disorder diagnosis. The members we interviewed with schizophrenia reported an average membership of 4 years, while members with depression or bipolar disorders reported an average membership of 3 years. Although membership tenure was significantly different between these two groups, daily to weekly participation (i.e., length of time spent at clubhouse) did not significantly differ. On average, members spend an average of 18 hours a week at the clubhouse, with a

range between 0 and 42 hours a week. Overall, members come approximately 4 days a week and spend an about five hours a day at the clubhouse.

Figure 16. Length of Clubhouse membership by diagnostic categories
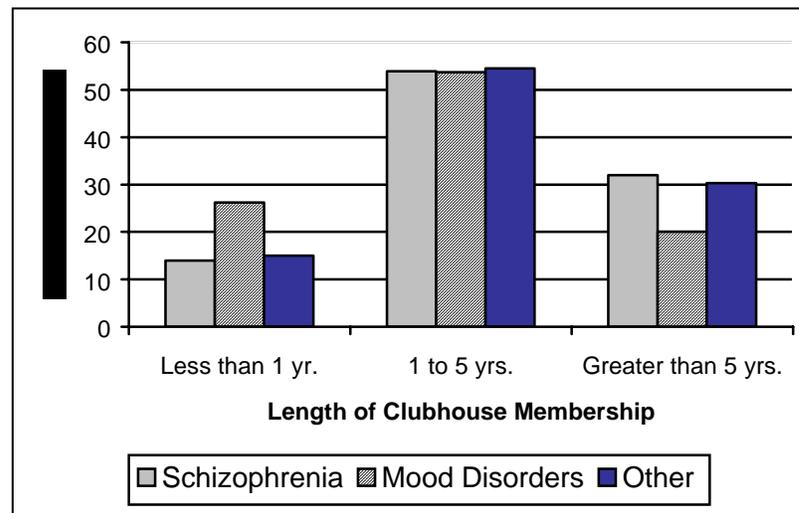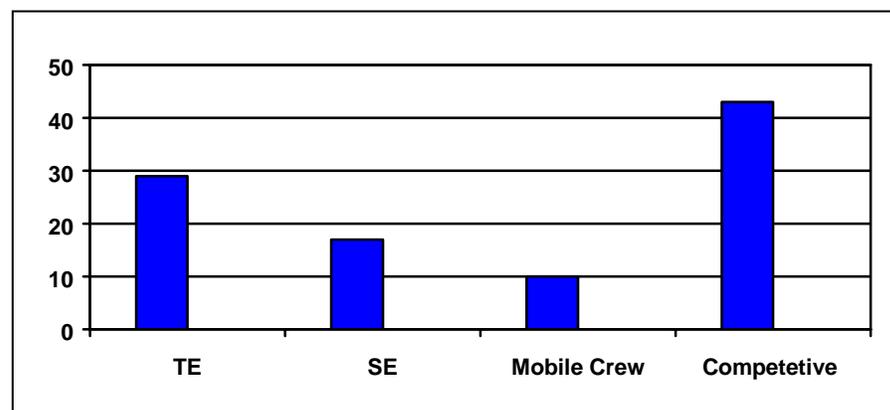

Employment

Member Employment Characteristics

The Member Interview contained a large section that inquired about individual employment experiences, available employment supports, and basic characteristics describing working members. Out of the 260 member interviewees, a total of 101 (39 percent) were working at the time of the interview. Below is a summary of the characteristics that make up our sample of working members.

- Gender. There is no difference between men and women and likelihood of employment. That is, both men and women were equally employed. A total of 47 women (46.5 percent) and 54 men (53.3 percent) were working in a job.
- Age. Working members' age ranged from 18 years to 63 with a mean age of 41 years.
- Diagnosis. Out of 84 members diagnosed with mood disorders, 32 percent reported they were working. Of the 138 members with schizophrenia, 42 percent were working, and 15 of the 34 (44 percent) members with a diagnosis other than mood disorders or schizophrenia were employed.
- Living arrangements. A total of 76 members are living in a dependent living arrangement, and 184 in an independent living situation.
  - A total of 29 working members were living in a dependent living arrangement (e.g., adult foster home, supervised living situation) and 72 members were living in an independent living situation.

- o Members living in a dependent living arrangement were more likely to be working in a TE position and less likely to hold a competitive job in the community than members in independent living situations in this sample (χ^2 = 11.69, df = 3, *p* <.01).

- o Members living in an independent or dependent living situation were equally likely to be working in this sample.

- Recent Hospitalization. 86 working members reported a hospitalization, 129 non-working members also reported hospitalization to yield a sample size of 215 members who reported dates of their first hospitalization and their most recent hospitalization date. Overall, there were no differences between working and non-working members and the number of years since their last hospitalization. Members reported an average of five years since their last hospitalization.

- Length of employment. Data was collected for 100 individuals on their length of employment. On average, most members have held their current job for a little less than 2 years (mean = 21.18, SD.= 27.9, median = 12) with a range of less than one month of employment to 15 years.

- Number of hours per week. Data was available for 99 members on the number hours members worked on their job per week. Members reported working an average of 13.7 hours per week (mean = 13.7, SD = 11, median = 10) with a range of 1 to 70 hours per week.

- Wages. The great majority of working members reported earning minimum wage or above (84.9 percent).

- Employment Type. An employment specialist or clubhouse staff familiar with the clubhouse member's employment status collected type of employment at the time of the interview. For members with missing employment type information, the type of job and name of employer was used to determine whether the job fell into a particular category (e.g., TE, SE

Figure 17. Number of members by employment category

Member – Level Factors Associated with Employment

Independent t- tests were performed on a number of member- level variables to examine differences between working and non-working status. A total of 101 members were employed at the time of the interview, while 158 members were not.

- Physical Health*.* In terms of physical health, there was no difference in the number of self-reported medical conditions between employed and unemployed members. Members reported an average of two physical health conditions.   However, employed members reported significantly less medications than unemployed members (t = -3.46, df =258, *p* <.01). Unemployed members took an average of 1.2 more medications.

- Social Supports*.* There was no difference between the number of social supports reported on the social network between employed and unemployed members. Both groups reported an average of 5 people on their social network.

- Adult Role Competencies*.* Employed members indicated greater adult role competencies (e.g., living independently, level of daily functioning) than unemployed members (t = 3.24, df =258, *p*< .01).

- Daily Activities There was no difference in the degree to which employed and unemployed members participated in a range of daily activities. On average, both groups endorsed at least 10 items on the daily activities scale.

- Sense of Recovery from Mental Illness*.* Employed members scored higher than unemployed members on sense of recovery (t =2.38, df = 256, *p* < .05).

- Life Satisfaction*.* Life satisfaction was higher for unemployed than employed members (t = -2.18, df = 256, *p* < .05).

- Clubhouse membership*.* Club tenure appears to be greater for working members than non-working members (t = 1.95, df = 258, *p* <.06).

- Sense of Clubhouse Community*.* No difference in sense of community total score between working and non-working members.

- Clubhouse Participation*.* As predicted, non-working members come to the clubhouse more often than working members (t = - 2.47, *p* < .05).

- *Past employment and current employment status. There is no relationship between current employment status and whether member had a job in the last 2 years from date of interview, but the more jobs reported in the past 2 years, the greater the likelihood member is currently employed (r[135] = .19, p<.05).*

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Study Methods

Advisory committee

A working advisory committee was established in the first year of the project. It members included two national clubhouse program researchers, a research expert on measuring model fidelity, a community mental health agency evaluator, and a clubhouse program director. This group met to review the evaluation design, fidelity measures, and a strategy for identifying factors within clubhouse programs that contribute to the sense of community that characterizes clubhouse programs. The group provided telephone consultation on methodological issues over the course of the project.

A stakeholder advisory group was also established in the first year of the project. Members of this group were selected from responses to an invitation to all club members, staff, and administrators to participate in the group. Twenty-two participants were invited, including 6 members, 8 clubhouse mangers/directors, 2 clubhouse staff, and 6 community mental health administrators associated with clubhouse programs. The group met annually or as needed to provide feedback on instruments and methods for conducting the evaluation in clubhouse settings.

Values Survey

A survey to assess the importance of club values was mailed to members and staff of the clubhouses. The survey was used to validate the logic model; that is, to identify which parts of the logic model stakeholders thought were most important to a clubhouse being a very good club. The values assessed were recovery, choice and control, community integration, skills and abilities, and partnerships. Responses were received from 313 members, 136 staff, and 40 managers. Responses were then aggregated to obtain a clubhouse rating of importance for each value.

Program assessment survey

In Michigan, a new clubhouse program is established through a Medicaid enrollment process that insures that minimum program components and other requirements are in place. It may take a new clubhouse up to six months to a year before all components are developed. For the purpose of the study, the 40 clubhouse programs that were Medicaid enrolled in 1998 were invited to participate in the project. The first stage of the evaluation was the development of The Michigan Clubhouse Program Assessment, a three-part survey that covered administrative and organizational aspects of the club, a description of club activities, and demographic information about the membership. The survey was designed to gather a variety of program level information about the clubhouse including staff training, location, program components, activities and vocational services. It was also was used to determine the characteristics of the people who participate in clubhouse programs, i.e. average attendance, diagnostic characteristics, ethnicity, housing and age. Thirty five clubs or 87.5 percent of all eligible

programs completed the three part survey. Compensation of $100 was provided in recognition of the time and effort required.

Force field

In order to understand the challenges that clubhouses in various communities face, as well as the successes they celebrate, we conducted a 'force field' survey with clubhouse managers to reflect on the things that contribute to a clubhouses success and those that are barriers to that success. The 'force field' method is a paper and pencil measure designed to help the respondent think about the various factors that contribute to the overall success of a clubhouse, as well as the challenges.

Site visits

The clubhouse site visit is an important component of the overall design of our evaluation of Michigan Clubhouse programs. The purpose of the site visit was to assess the clubhouse environment, organization and social climate through observations by the research team. At the environmental level, the physical setting, space and location of the clubhouse including its accessibility to members and proximity to other mental health and social services were observed. The organization of the clubhouse program was examined with respect to: the units of the work ordered day; employment services; educational/skill learning supports; housing supports; and the internal and external clubhouse sponsored social opportunities including the involvement of external groups or resources. The social climate of the clubhouse was assessed through observation of member-to-member, member-to-staff, and, staff-to-staff communications, interactions, roles and activities.

The map in Figure17 displays all clubhouses and indicates which clubs were visited. All 35 clubs that completed the Program Assessment Survey also volunteered to participate in a site visit. A purposeful sample of 18 clubhouses was selected using scores from the values survey, daily member attendance, total members employed, location, and the percent of members with the diagnosis of schizophrenia. These clubs represent the range of size, location, and clubhouse environments. Table 22 presents the characteristics of all clubs visited. In order to maintain clubhouse confidentiality, clubs were categorized based on rural or urban location.

Figure17. Michigan clubhouse programs and site visit locations

Table 22. Organizational characteristics of 18 clubhouses visited by Research Team

Clubhouses Visited by Flinn Research Team (N=18) Location - Auspice	Value Score Rank	Average Daily attendance (Number of Members)	Active Membership (Number of Members)	Number Employed members	% of members with Schizophrenia
1. Rural - CMH	1.20	26	71	1	54
2. Urban - CMH	4.60	25	145	25	60
3. Rural – CMH	11.2	51	51	11	75
4. Rural – CMH	14.6	30	75	33	75
5. Rural – CMH	14.6	19	58	18	49
6. Urban – Non-profit	15.4	43	75	45	58
7. Urban – Non-profit	15.4	18	129	29	55
8. Urban – CMH	18.6	45	205	71	45
9. Urban – Non-profit	24.1	37	100	16	69
10. Urban – CMH	25.4	34	159	42	75
11. Urban – Non-profit	26.0	24	76	9	65
12. Rural – Non-profit	26.2	36	75	26	53
13. Urban – Non-profit	29.8	80	186	19	40
14. Rural - CMH	29.8	40	105	48	50
15. Rural – CMH	30.6	17	42	20	45
16. Rural –CMH	30.6	21	53	17	28
17. Urban – Non-profit	32.2	40	112	33	38
18. Rural - CMH	34.8	25	25	4	50

Prior to developing a protocol for the site visits, the team piloted a visit with a clubhouse that volunteered. In addition, the team presented the protocol to the Advisory Committee that is comprised of staff and members of the clubhouse for their review and comment on the site visit itself and preparations for the site visit. The committee was asked to examine the approach that was to be used for asking clubhouses to volunteer, the payment of $100 for allowing the visit, and the role that site visitors would play in the clubhouse. The final approach and protocol for the site visit was thus designed with information from the pilot site visit and from the advisory committee.

Three to four research team members conducted a one-day site visit. Following the site visit, each team participated in discussions about the various aspects of the one-day visit.   The day's agenda included: formal interviews with staff, observations in clubhouse unit activities, observations of the beginning of the work-ordered day and the

close of the work-ordered day, informal conversations with members, and a focused observational checklist of a variety of clubhouse characteristics, and a period of reflection among the site team. The site team developed the observational checklist through consensus about key areas observed during the site visit.

Prior to the site visit, a phone call was placed to the club manager and a follow-up letter and consent forms were mailed. The manager was asked to give the letter and consent form to the club members for discussion. If the members or staff had any questions, they were instructed to call the research team. The consent form and letter indicated that this was purely voluntary and that $100 would be given for compensation at completion of the site visit. If the clubhouse agreed to invite the research team for a site visit, then a club member and the club manager signed the consent form. Once a clubhouse volunteered, a phone call was placed to the club manager to schedule the visit and to obtain the names of the people to be interviewed.

Three formal interviews were conducted as part of the site visit. They included an interview with the manager, the employment staff, and a clubhouse staff. The manager typically arranged the times for each of the interviews. The interviews lasted about 1 hour and were conducted in a private space within the clubhouse. Each of the interviews was audiotaped with the permission of the interviewee. The interview questions included each participant's perception about their roles in the clubhouse, their vision for the club, their relationships with each other as staff and with members and their networks into the community.

The typical a site visit included the following types of observations. The team members arrived at the clubhouse around the time members arrived. They chatted informally with the members and attended a house meeting. Each team member spent time in different units of the clubhouse. Team members ate lunch with the members and sometimes team members worked in the units.

A team member took photographs of the internal and external physical environment of the clubhouse, and members were photographed with their written permission. Following the site visit, such photographs were sent to the members for their personal use.
The end of the site visit day was spent in a quiet, private room to allow the team members to share their reflections of the day. Throughout the day, the team members chatted with members, read material posted on bulletin boards, observed the various activities and interactions in the clubhouse.

Member interviews

Each clubhouse visited by the research team was also invited to participate in the member interview. Clubhouses interested in participating notified the research team and a date was selected for the interview visit. Clubhouses were provided flyers advertising the project, as well as "consent to contact" sign-up forms for members. Club managers were asked to assist in getting the information about the interviews to increase the

likelihood that participants would be representative of the clubhouse population on diagnosis, employment, and length of membership. A maximum of 15 interviews were allocated for each clubhouse. The volunteers were selected on a 'first-come, first serve basis.' A waiting list with alternates was used in case that scheduled interviewees failed to show for an interview. Interviews were conducted in a private area at the clubhouse or at a nearby location. Each interview was approximately one hour in length. Interviewees were paid $20 for their completed interview and the clubhouse was paid $100 for hosting the on-site interviews for the day.

The structured in-person interview is comprised of the following content areas: 1) clubhouse participation, 2) relationships with staff and members, 3) employment, 4) social support networks, 5) health & medications, 6) history of mental illness, 7) mental health service use, 8) extent of daily functioning, 9) sense of recovery, 10) sense of community, 11) staff relationships, and 9) demographic information.

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