Stepping Stone Evaluation Project

Final Report

Contents

Acknowledgement of Country

We acknowledge the Traditional Custodians of the land that we live and work on, the Jagera and Turrbal peoples. We pay our respects to all Elders and peoples past and present.

In being involved as evaluators on this project, we also want to acknowledge the strength and resilience of Aboriginal and Torres Strait Islander families who face disproportionate challenges to mental health as a result of past and current day colonial systems. We honour the strength of First Australian peoples and their rights to self-determination and sovereignty.

Acknowledgement of Lived Experience

We acknowledge the individual and collective expertise of those with lived experience of mental illness. We recognise their contribution and value the courage of those who share this perspective for the purpose of learning and growing to support better outcomes for all.

Acknowledgement of Participation

We thank all the Stepping Stone members and staff who contributed to this Project through engaging in an interview, survey or focus group. We also thank the management team of Stepping Stone for their tremendous support in advocating for and implementing this Project and to our Evaluation Reference Group for willingly giving your expertise and time to guiding this Project. We thank Queensland Health's Mental Health, Alcohol and Other Drugs Branch for funding Stepping Stone to undertake this evaluation and the Queensland Mental Health Commission (QMHC) for providing oversight of the project and being a member of the Evaluation Reference Group.

Document Version Control

Version	Created by	Reviewed by	Reviewed on
Draft 1.0	BF, KV, TL (ehc)	Evaluation Reference Group	14th Nov 2023
Draft 2.0	BF, KV, TL (ehc)	Evaluation Reference Group	28th Nov 2023

Aims of this project

The Stepping Stone Evaluation Project (the Project) occurred between August 2022 and August 2023. The Project aimed to:

1. Capture the impact of Stepping Stone on members' physical and mental health and wellbeing, social participation, and civic participation.
2. Communicate the impact of Stepping Stone on members to funding bodies, current and prospective members and other people interested in understanding Stepping Stone.
3. Use the evidence generated in this evaluation to suggest improvements for Clubhouse.
4. Build capacity within Stepping Stone so that evaluation becomes part of Clubhouse thinking and practice.

Aims of this report

This is the Final Report in a suite of reports already created in the Project:

- The Evaluation Framework for this project was first produced in June 2022 (and has been updated throughout the Project). This Framework contains details on how the Project was designed collectively with Clubhouse and the deeper details on what was measured and how.
- Interim Report 1 was created in September 2022 and described the sample recruited and reflections on the Project's processes that were working well and those that needed refining.
- Interim Report 2 was created in March 2023 and described the sample recruited and reflections on the Project's processes that were working well and those that needed refining.

This Final Report aims to address the evaluation questions established for the Project. This Final Report is designed to be comprehensive and is accompanied by a:

- Brief Report using lay language for Stepping Stone members and for time-pressured readers
- Infographic to facilitate efficient communication of key findings to multiple audiences

Language matters

The words we choose to use matter. Language can influence our views and understanding, can carry hope and possibility, or can be divisive when used to stigmatise and discriminate. It is difficult to get a shared understanding and consistent use of key terms across such a broad range of government departments and vast sectors of organisations across mental health. We are conscious of ensuring respectful, inclusive, and compassionate language, but are equally mindful that language is continuously evolving, with preferences and meanings often inconsistent across stakeholders.

We recognise that the term "mental health" is often used interchangeably to refer to mental illness.

In this report we use three different and distinct terms:

- mental health and wellbeing refers to a state of cognitive, emotional and social wellness,
- mental ill-health occurs when an individual's cognitive, emotional and social abilities are negatively affected, and
- mental illness is when an individual has been diagnosed with a mental illness by a medical or health professional.

The term mental ill-health includes people with a mental illness but is also a broader term and includes people without a formal diagnosis. This report uses the term 'lived experience' to refer to individuals with either a current or ongoing (living) or previous (lived) personal experience of mental ill-health, and experience of engaging with services, supports and the broader health and wellbeing sector.

Adapted from: Shifting Minds: The Queensland Mental Health, Alcohol and Other Drugs, and Suicide Prevention Strategic Plan, 2023–2028

Throughout this report we also use different language to refer to Stepping Stone.

- Where we are referring to the service, we will use Stepping Stone.
- Where we are talking about it from members' perspectives and experience, we will use Steps.
- Where we are talking about the model or the physical space, we will use the Clubhouse Model or the Clubhouse, respectively.

A word on diagnoses

We value and acknowledge the members of Stepping Stone and understand the importance of accurately naming their mental illness diagnoses. The accurate recognition of these diagnoses is vital to the effectiveness of the support and resources offered to them. Inaccurate or stigmatising labels can lead to profound social and psychological consequences for people living with a mental illness.

In this report, we have made an informed decision after discussion with the Evaluation Reference Group to categorise members' primary mental illness diagnoses according to the classifications used in the National Mental Health and Psychoses Surveys, as employed by the Australian Bureau of Statistics (ABS) and the Australian Government's Department of Health. This re-categorisation allows for our evaluation sample to be compared to the broader Australian population for research and policy purposes.

It is essential to emphasise that this re-categorisation is purely for the purpose of making the evaluation sample comparable to the Australian general population, even if it may not necessarily align with how certain diagnoses are explicitly defined in other recognised criteria or classifications

(e.g., ICD-10, DSM-V). It does not undermine the importance of correct and nuanced diagnoses, nor does it detract from the complexity and uniqueness of individual mental health challenges.

It is also important to note that although a majority do, members of Stepping Stone do not require a formal mental illness diagnosis, but rather can identify as experiencing mental ill-health. This inclusivity stems from the understanding that mental health exists on a spectrum, and individuals facing various mental health challenges, even without a formal diagnosis, deserve support and community. Making mental health support services accessible to those who feel they need it is essential for early intervention, preventing escalation of issues, and promoting overall wellbeing. Acknowledging that one barrier to obtaining a diagnosis is the cost of seeing healthcare professionals, Stepping Stone aims to provide a supportive space for individuals to engage in psychosocial rehabilitation regardless of their diagnostic status, emphasising the importance of accessibility and inclusivity in mental health support.

Positionality

This Project was conducted collaboratively with staff, members, and external stakeholders of Stepping Stone and with consultants from Enable Health Consulting (ehc). There were four different consultants from ehc who engaged in this project across the evaluation period. None of the four consultants identified as living with a mental illness. All consultants could relate to experiencing mental ill-health throughout stages of their lives. All consultants reflected that they had learned a great deal throughout this Project through working with members and staff of Stepping Stone.

What we did.

What is the Clubhouse Model of Psychosocial Rehabilitation?

The Clubhouse Model of Psychosocial Rehabilitation has been in existence for over 65 years, has worldwide presence, and has positively affected thousands of people diagnosed with mental illness.[iii] There are currently 326 Clubhouses located across 33 countries and there are 3 accredited Clubhouses in Australia. Clubhouses are intentionally formed, non-clinical, integrated therapeutic working communities composed of adults with mental illness or ill-health (members) and staff who are active in all Clubhouse activities. Membership is voluntary and without time limits. Being a member means that an individual is a critical part of the community and has both shared ownership and shared responsibility for the success of the Clubhouse. Basic principles of the Clubhouse Model include the belief that every member has individual strengths to recover from the effects of mental illness sufficiently to lead a personally satisfying life; and a belief that work, and work-mediated relationships are restorative. The Clubhouse Model is established through the practice of 37 International Standards, shown in Appendix A.

What is Stepping Stone?

Stepping Stone is an accredited Clubhouse. It is a community that has been organised to integrate people who are living with the effects of mental illness or ill-health into support systems that improve their quality of life in a sustainable way. Stepping Stone was established in 1994 and the Clubhouse is located in Coorparoo, Brisbane. Stepping Stone members can choose which supports and services they participate in and how regularly they participate. This flexible approach allows for individualisation, enabling Stepping Stone to cater for people of different ages, backgrounds, and needs. The focus of Stepping Stone is on highlighting the strengths of each member to empower them to engage with the opportunities for fun, employment, and social connection, and additional services and supports that are needed to thrive and develop purpose.

"It's not the building, it's the people inside it" - member of 10 years, March 2022

Participation

Members are defined as an adult living with mental illness or ill-health (no diagnosis is required) who have voluntarily become a member of Stepping Stone. Membership is not time-limited, in that members are able to return to Stepping Stone without recommencing the orientation process, regardless of length of absence from the Clubhouse.

A key driver of the Clubhouse Model is the reciprocity in impacts that the Clubhouse gains from the members and that the members gain from the Clubhouse. This "give-and-take" relationship has been

described in previous research exploring how the Clubhouse Model impacts members through peer support and is graphically represented in Figure 1.[iii]

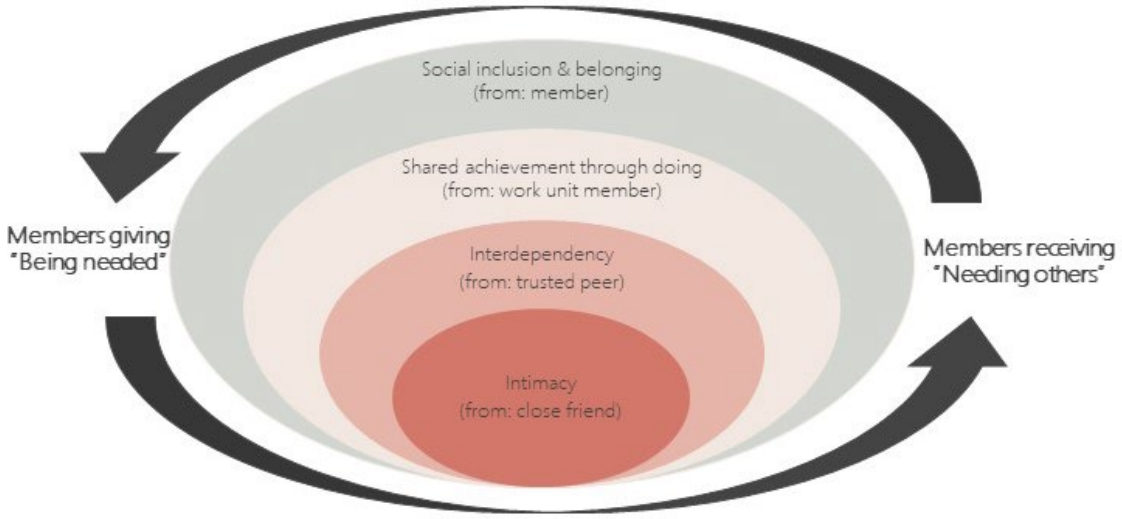


Figure 1. Levels of support from Clubhouse sources creates reciprocity (adapted from Coniglio et al, 2012[ii]).

Our approach to the evaluation

Values for the project

The Evaluation Reference Group discussed how to approach the project and agreed on core values that they held at the centre of decision-making processes. These values were to:

- involve members in every step of the Project, including the evaluation design
- take a strengths-based approach to evaluation
- conduct an ethical evaluation, where members are given choice in how they engage
- be pragmatic in data collection and create impactful outputs targeted at specific audiences
- consider the "Value" of the Clubhouse goes beyond the economic meaning of value.

Why this project?

The key drivers for this evaluation were to:

- generate evidence in order to communicate the value of Stepping Stone to potential funders and collaborators
- contribute to the international evidence of the impacts of the Clubhouse model
- give members an opportunity to talk about and acknowledge the value of the Clubhouse
- provide clear feedback on ways to improve the Clubhouse for members.

Who is involved in this project?

Project Funding: Queensland Health's Mental Health, Alcohol and Other Drugs Branch funded Stepping Stone to undertake this evaluation. The Queensland Mental Health Commission (QMHC) supported Queensland Health by providing oversight of the Project and were a member of the Evaluation Reference Group.

The Stepping Stone community is made up of:

- Members of Stepping Stone are self-referred, referred by family or friends or professionally referred. Membership is open to any person aged over 18 years who has either been diagnosed with a mental illness or believes their mental ill-health requires support.
- Staff at Stepping Stone are dedicated and passionate people who coordinate the service delivery and psychosocial care of the members.
- Management Team: are a group of 7 Stepping Stone staff who hold responsibility for the management of operations at Stepping Stone. They have specialised roles within the Management Team.
- Placement students: the Clubhouse offers placement opportunities for students completing a degree in Social Work or Human Services from several local universities.
- Management Committee: has a President, Vice-President, Treasurer and 7 board members. This committee holds responsibility for governance, financial and legal oversight of Stepping Stone. The committee ensures the vision of Stepping Stone is maintained; monitors and approves budgets and expenditures; and, establishes, reviews and implements Clubhouse policies for the success of the organisation.
- Enable Health Consulting (ehc) are a Brisbane-based consultancy firm that specialise in planning and evaluation services for clients in the public health sector. They were competitively commissioned to undertake the evaluation of Stepping Stone.

For this Project there were the following governance groups.

- Project Working Group: This group was responsible for day-to-day implementation of the Project. They had autonomy to make operational decisions regarding the way the evaluation was delivered within the Clubhouse. Membership of this Group included: 4 members, 3 staff from the Stepping Stone management team and 3 ehc consultants.
- Evaluation Reference Group: This group had oversight for the design decisions of the evaluation. They were responsible for reviewing all deliverables from the project and providing ehc with feedback. They were also required to contribute to planning and reflective processes throughout the project. Membership of this group included the Project Working Group plus a representative from the QMHC, The University of Queensland and 3 representatives from the Stepping Stone Management Committee.

Evaluation Design

The design of this evaluation used both cross-sectional and longitudinal data comparisons with data collected in three waves at Wave 1 (Aug 2022); Wave 2 (Feb 2023) and Wave 3 (Aug 2023; Figure 2). The evaluation questions examine self-reported outcomes for members at two time points: Intake and Follow-Up (Figure 2). To ensure that we captured the impact of the Clubhouse for people who had not yet experienced Stepping Stone and those who had, we recruited both:

- Existing members: people who were Clubhouse members before August 2022
- New members: people who became a Clubhouse member after August 2022

For new members, there was a rolling 12-month period of recruitment collecting Orientation Surveys during the Orientation Session, which is the point at which an interested person becomes a member (Figure 2).

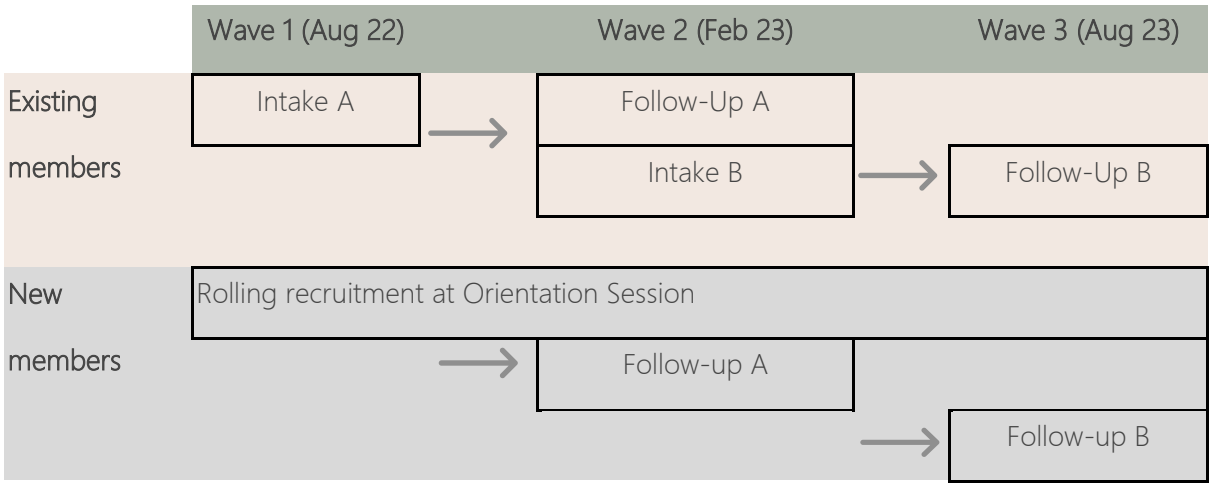


Figure 2. Data collection waves for the Stepping Stone Evaluation Project.

Methods

This project was reviewed by The University of Queensland's Human Research Ethics Committee. It received ethical clearance in August 2022 (2022/HE000887).

Data Collection

There were four sources of data collected throughout the Project:

New Member Orientation & Follow-Up Survey
- self-completed OR
- supported by ehc staff OR
- interview-administered by ehc staff

Existing Member Intake & Follow-Up Survey
- self-completed OR
- supported by ehc staff OR
- interview-administered by ehc staff

Member Interviews, Staff Interviews or Staff Focus Groups
- one-to-one, semi-structured interviews OR group focus groups
- audio-recorded

Lumary™ Member Database
- Pre-existing data collected through Clubhouse processes (e.g., Demographic data, Attendance data)
- Linked to survey data where consent was provided by a member

Consent

We provided a variety of ways that members and staff could participate in the Project, and we also provided opportunities to people at different time points (three data waves, Figure 2) to acknowledge that members could change their mind and want to participate or withdraw over time. Participants in this Project provided consent in multiple ways:

Surveys

- Members provided written consent if they completed the survey independently, or verbal consent if they completed an interview-administered survey.

Lumary™ Database

- Members were asked to provide written permission in the survey to opt-in for their surveys being linked to their service engagement data (linked via their Lumary ID).

Interviews

- Members and staff provided written consent to be interviewed and were given the option for the interview to be audio-recorded or not.

Focus Groups

- Staff provided written consent to participate in the focus groups. There were different ways of contributing to the focus groups (talking, writing) to allow for different levels of participation.

Case Studies

- Three members who completed an interview were asked if they would consent to having their story shared in the report as a case study. They were given different options to consent to:
    - I consent to ehc using my interview as a case study without any identifying information (e.g., we will use a fake name for the case study)
    - I consent to ehc using my interview as a case study and I give permission for my first name being used
    - I consent to ehc using my interview as a case study and I give permission for my first name and my picture to be used (please send us a cool picture of you at the Clubhouse if you have one)

Impact Outcomes

The outcomes selected in this Project speak to the heart of the Clubhouse Psychosocial Rehabilitation Model: a recovery model. *"Recovery"* from mental illness, as defined by people with lived experience, is different from cure or symptom amelioration and refers to *"a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness"* [iv] Whilst the term recovery is used widely in the published literature, our Evaluation Reference Group felt that the term *"progress"* was a better descriptor of the outcomes being captured in this evaluation as it had fewer negative connotations and less assumptions about *"returning to normal"*.

Figure 3 shows the eight key outcomes being assessed in the Project to capture the impact of Stepping Stone on members. These eight outcomes are grouped under the concepts of Clubhouse supporting members: physical and mental wellbeing; social participation and civic participation.

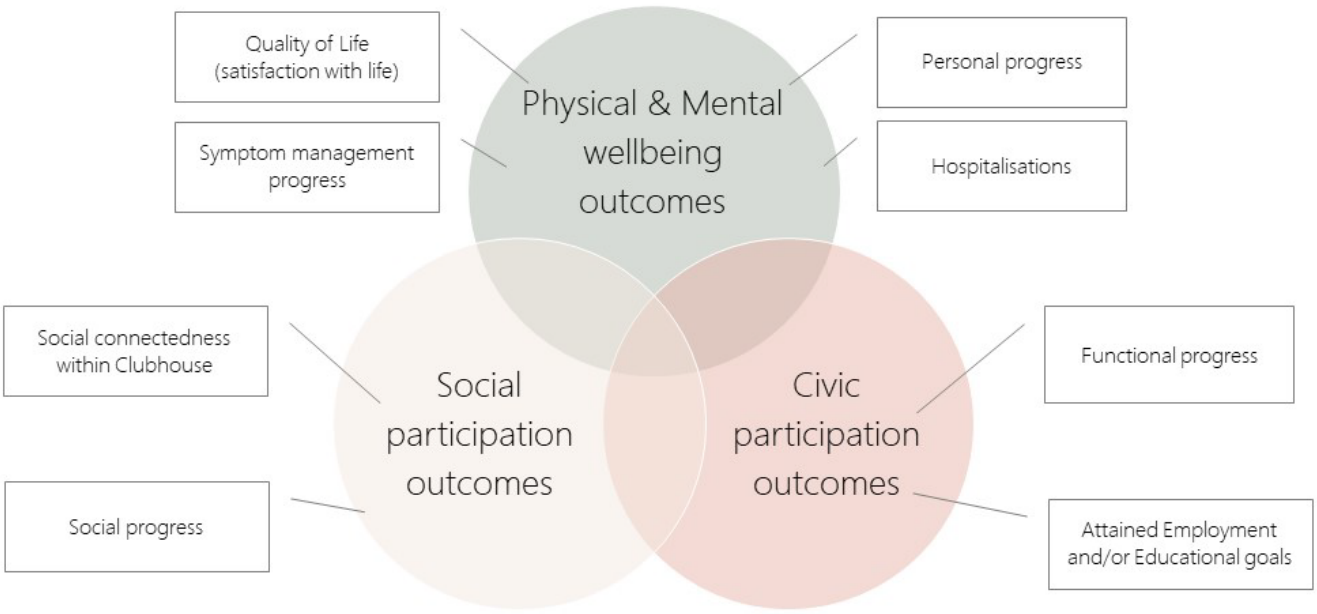


Figure 3. Outcomes measured in the Stepping Stone Evaluation Project to capture impact on members.

The outcomes shown in Figure 3 were organised into a "roadmap" that was collaboratively created by the Project Reference Group (Figure 4). This roadmap provided a framework to structure the proposed way that Stepping Stone generates the input, activities and participation required, to elicit the short-term, medium-term, and long-term impacts of being a Stepping Stone member.

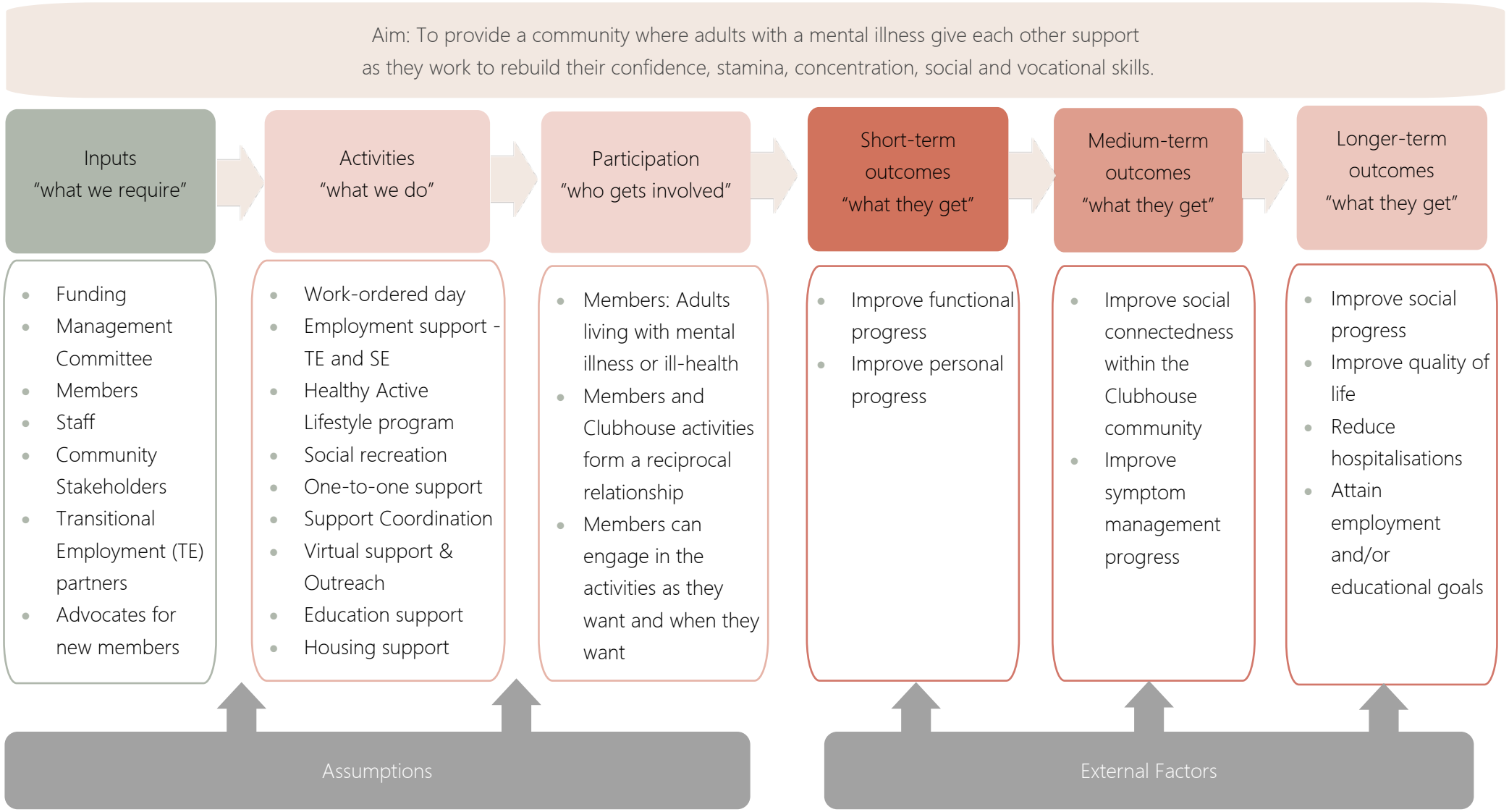


Figure 4. The Stepping Stone Roadmap to Impact.

Assumptions

In developing the "roadmap" (Figure 4), the Evaluation Reference Group established some assumptions that are required for members to be able to participate, which are:

- When members first come to the Clubhouse they're not in need of acute care
- Members are able to physically access the Clubhouse
- Members want to engage in the Clubhouse
- Members are able to honestly provide feedback about the Clubhouse
- It is possible to keep the Clubhouse doors open 365 days/year (e.g. COVID, natural disasters)

Data sources

Table 1 shows all the variables collected in this evaluation and the source of the data.

Table 1. Data sources of quantitative outcomes measured in the Stepping Stone Evaluation Project.

Type of data	Specific Outcomes	Source
Demographic characteristics	Age	Lumary™ Database
	Residential Suburb	Lumary™ Database
	Gender	Lumary™ Database
	Country of birth	Lumary™ Database
	Ethnic group identification	Lumary™ Database
	Aboriginal or Torres Strait Islander identification	Lumary™ Database
	Employment status	Lumary™ Database
	Housing Type	Lumary™ Database
Mental Health characteristics	Primary diagnosis of a mental illness ^	Lumary™ Database
	Secondary diagnosis of a mental illness	Lumary™ Database
	NDIS status	Lumary™ Database
	Medical conditions	Lumary™ Database
Attendance	Date of Tour	Lumary™ Database
	Date of Orientation	Lumary™ Database
	Referral source	Lumary™ Database
	Days attended clubhouse (date stamped)	Sign-in data
	Days attended clubhouse (by program)*	Sign-in data
	Stage of Stepping Stone Journey (see below)	Member Survey- Bespoke Question
Funding	Sources of Clubhouse income	Management data

Type of data	Specific Outcomes	Source
Short-Term outcomes	Functional Progress	Member Surveys- Recovery Assessment Scale- Domains and Stages (RAS-DS)[v] (Doing things I value)
	Personal Progress	Member Surveys- RAS-DS[Error! Bookmark not defined.] (Looking forward)
Medium-term outcomes	Social connectedness within Clubhouse	Member Surveys- Client Interaction Scale (CIS)[vi]
	Symptom Management Progress	Member Surveys- RAS-DS [Error! Bookmark not defined.] (Mastering my illness)
Long-term outcomes	Social Progress	Member Surveys- RAS-DS [Error! Bookmark not defined.] (Connecting & Belonging)
	Quality of Life	Member surveys- Manchester short assessment of quality of life (MANSA)[vii]
	Hospitalisations	Member surveys- Bespoke question
	Employment aspirations and status	Member surveys- Bespoke question
	Educational aspirations and status	Member surveys- Bespoke question

^ For this Project we only used Primary Diagnosis, not Secondary Diagnosis. These diagnoses are self-reported, and members can decide which diagnosis they report as primary. One in two members (54%) in our evaluation sample reported a secondary diagnosis. We acknowledge that having more than one diagnosed mental illness is complex and contributes to a different lived experience.

* Due to human error, not all services delivered will have been entered and not all services delivered will have been entered correctly. Support provided from member to member is not reflected in the data.

During the Project, we added an outcome to this evaluation – a qualitative descriptor for the stages of the Stepping Stone Journey. Following Wave 1, it emerged that linear duration of membership was not a useful outcome to classify members at different stages of their Stepping Stone Journey. The 11 member interviews conducted at Wave 1 helped us to create the five categories of the Stepping Stone journey:

- "I'm finding my feet at Clubhouse"
- "I'm in a routine of coming to Clubhouse"
- "I'm out in community achieving my goals and I access Clubhouse as I need"
- "I'm becoming a mentor"
- "I'm moving on"

This question was added to all members surveys collected at Wave 2, and these stages were used to adjust the evaluation questions (which were originally comparing members based on how long they had been a member for).

Evaluation questions

This Project addressed the following questions:

1. What are the services and supports on offer at Stepping Stone and how are they funded and delivered?
2. Who chooses to not become a member (after completing a Clubhouse tour)? Who chooses to become a member but not use the services and supports?
3. How do members describe their experience of Stepping Stone? And what do members perceive to be the impacts of belonging to Stepping Stone?
4. How do staff describe their experience of working at Stepping Stone? And what do staff perceive to be the impacts of Stepping Stone for members?
5. What do members, staff and students on placement think could be improved about Stepping Stone?
6. Who uses the services and supports at Stepping Stone? How do members use the services and supports on offer at Stepping Stone?
7. To what extent do new members' experience short, medium and longer-term outcomes:
    1. compared to Existing members (cross-sectional)
    2. between Orientation and Follow-Up (longitudinal)
8. To what extent do New and Existing members experience outcomes at different stages of the "Stepping Stone Journey":
    a. Early stage (I'm finding my feet at Clubhouse)
    b. Mid stage (I'm in a routine of coming to Clubhouse)
    c. Later stages (I'm out in community achieving my goals and I access Clubhouse as I need OR I'm becoming a mentor OR I'm moving on)
9. Are there any demographic or engagement characteristics of members that predict change in short-term, mid-term or longer-term outcomes?

Sample Size Targets

Cross-sectional Comparisons (comparing Orientation/Intake surveys between groups): A minimum of 60 New members and 60 Existing members were required to complete an Intake survey in order to provide a representative cross-section of the approximately 1,440 members that annually access a Stepping Stone service to detect a meaningful difference at sufficient power (α =0.05, with 95% confidence level).

Longitudinal Comparisons (comparing Orientation/Intake to Follow-up surveys within groups): A minimum of 34 New members to complete an Orientation and Follow-up Survey and 34 Existing members to complete an Intake and Follow-up survey to detect a significant within-group difference in the RAS-DS - total score of 152 (assuming SD ±15) at sufficient power (α =0.05, with 95% confidence level). Assuming 35% of members who completed an Orientation/Intake Survey would also do a Follow-up Survey, **we aimed to recruit 100 New Members at Orientation and 100 Existing Members at Intake.**

Data Analysis

Quantitative data were cleaned and analysed in Microsoft Excel and R version 4.3.1, as appropriate. For cross-sectional comparisons, descriptive statistics, such as means, medians, and frequency distributions, were computed to provide an initial view of the distribution of variables. Subsequently, bivariate analysis was performed, utilising chi-squared tests, and t-tests as suitable, to explore relationships between variables. The analysis progressed to multivariate techniques, chiefly regression analysis, to assess the influence of multiple predictor variables while accounting for potential confounding factors. Hypothesis testing, involving ANOVA, chi-squared tests, or non-parametric tests, was then carried out to ascertain the statistical significance of observed relationships or differences between groups. For longitudinal comparisons, this involved the cleaning and organisation of data into longitudinal datasets, ensuring the alignment of time points and addressing missing data at Follow-Up. Descriptive statistics were computed to summarise data at the two time points. Change analysis assessed individual or group-level changes using paired t-tests or repeated measures ANOVA for impact outcomes.

Regression Analysis: The outcomes of interest in the regression were Progress Scores (RAS-DS), Social Connectedness (CIS), and Quality of Life (MANSA). The following variables were tested as predictors of the outcomes of interest.

Predictor Variable	Variable Type	Variable Icon
Age (years)	Continuous	
Gender	Categorical	
Length of Membership (years)	Continuous	
Diagnosis	Categorical	
Accessed services during evaluation period	Binary (Y/N)	
Clubhouse Attendance	Categorical	
Stage in Stepping Stone Journey	Categorical	
Interactions of all of the above	-	-

*Hospitalisation was initially included as a predictor variable in the regression model but was removed due to multicollinearity.

Qualitative data was thematically analysed by two independent consultants. These two analysts read the entire interview/focus group script and independently coded the qualitative data for meaning. The two coders discussed differences and similarities throughout this process as they built consensus on the descriptive codes and worked to develop latent interpretations within and across the data (i.e., identified themes). The purpose of this iterative analysis was to offer a deeper understanding of the Stepping Stone experience guided by (and pushing beyond) the evaluation questions.

Data interpretation

Throughout this report we will define a **statistically significant difference** as one that generates a p-value of less than 0.05. We will also define **meaningful difference** as a difference in an outcome either between two groups of people at one point in time (cross-sectional comparison), or within people over time (longitudinal comparison) that has practical or noteworthy implications.

As such this will differ for each tool:

- for RAS-DS, meaningful difference will be based on classification according to the thresholds for Area of Work (0-50%), Transition (51-74%) and Area of Success (≥75%).
- for CIS, meaningful difference will be determined by deciles.
- for MANSA, meaningful difference will be determined by rounding the average score to the nearest anchor, and looking for groups that have different anchors.

An important aspect of this evaluation was the comparison of findings to other evaluations of the International Clubhouse Model. Where possible, we will interpret the magnitude of impact in this Project to other studies that have used the tools in similar settings and/or populations.

What we found.

How did members engage in the Evaluation Project?

Before we answer the evaluation questions, we need to understand how members chose to engage with the Project. In total, 237 members actively engaged in some element of the Project. Table 2 shows the total number of surveys, interviews and focus groups completed.

Table 2. Number of surveys, interviews and focus groups completed over the Evaluation Project.

	Wave 1	Wave 2	Wave 3	Total collected	Total cleaned[1]
Existing member Intake survey	108	57	-	165	161
Existing member Follow-up survey	-	46	31	77	76
New member Orientation survey	33	8	38	79	76
New member Follow-up survey	-	11	19	30	28
Non-member Survey	0	0	0	0	0
Member interview	14	9	-	23	23
Staff interviews	11	0	-	11	11
Staff focus groups	-	-	2*	2	2

*Across the 2 staff focus groups, there was a total of 28 staff who attended.

Survey engagement

The staff and members of Stepping Stone were highly engaged in this evaluation project. There was a relatively even distribution of members who chose to complete the survey via interview-administration with an ehc staff member (57%) and members who chose to complete the survey independently via the emailed link (43%). As nominated in the Intake or Orientation Survey (n=237), the majority (87%, 68 New Members and 138 Existing Members) of respondents gave permission to link their survey data with their engagement data from the Lumary™ database.

Power of follow-up recruited sample

We exceeded the sample recruitment targets for all surveys and interviews, except for the sample size target set for New Members completing paired orientation and follow-up surveys (target of n=34). A post-hoc power calculation showed that with the recruited sample (n= 27 paired surveys), we still had a highly acceptable power of 90.1% to detect a significant within-group difference in the RAS-DS (total score of 152, assuming SD ±15).

[1] Survey responses removed: 4 Existing Member Intake surveys due to non-completion, 1 Existing Member Follow-up survey for not having completed an Intake survey, 3 New Member Intake surveys and 1 New Member Follow-up survey due to non-completion, and 1 New Member Follow-up survey for not having completed an Intake survey.

Interview engagement

When we first started data collection, all existing members were offered the opportunity for an interview in the Intake Survey. New members were offered the opportunity for an interview in their follow-up survey. By Wave 2, we reached data saturation and closed off the opportunity for an interview. In total, 104 members were offered an interview opportunity. Of those who were offered, 52.4% (54 members) requested an interview via the survey, and of these 54 members, 23 members completed an interview with an ehc consultant.

Representativeness of evaluation sample to Stepping Stone population

The demographic characteristics of the evaluation sample (Existing Members and New Members) and the entire group of members active as of August 2022 (All Members) are shown in Table 3. Importantly, the sample recruited into this Project were similar to the broader group of members who were active as of August 2022 (Table 3). This means that the evaluation findings are coming from a group of members that largely represent the broader group of Stepping Stone members (Table 3).

Within our evaluation sample, New and Existing members were different. New members were younger, and less likely to have a diagnosis of Schizophrenia/Schizoaffective disorder (Table 3). Both New and Existing members were similar in the distribution of gender across samples (majority male).

Shifting the focus on who joins Stepping Stone

This represents an interesting trend for Stepping Stone, potentially attracting different kinds of people to come to Stepping Stone compared to the historic reach of the service. Historically, Stepping Stone received funding from the Schizophrenia Fellowship. This means there is a strong presence of members living with Schizophrenia, however this image of the traditional Stepping Stone member may be shifting as the new member data indicates a diagnosis profile more like that seen in the general adult population living with mental illness.

Table 3. Demographic and mental health characteristics of people who participated in the evaluation compared to all active members as of August 2023.

	Existing members (n=161)	New members (n=76)	p-value	Evaluation sample (n=237)	All members (n=1,440)	p-value
Age, mean (SD)	49.7 (12.2) n=159	39.7 (13.3) n=65	<0.01	47.1 (13.5) n=224	47.6 (12.9) n=1,406	0.11
Length of membership when completed Orientation/Intake Survey, median (SD)	8.0 years (7.2) n=157	0 days (3.9) n=73	<0.01	6.4 years (7.4) n=230	9.1 years (6.8) n=1,166	0.13
Gender, n (%)						
Male	97 (61)	45 (64)		142 (62)	840 (60)	
Female	60 (38)	21 (30)	0.18	81 (35)	537 (39)	0.54
Non-Binary/Transgender	2 (1)	4 (6)		6 (3)	13 (1)	
Primary Mental Illness Diagnosis, n (%)*						
Depression	39 (26)	19 (26)		58 (26)	351 (32)	
Other affective problems	29 (19)	6 (8)		35 (16)	149 (14)	
Anxiety disorders	13 (9)	7 (10)	0.01	20 (9)	91 (8)	
Other anxiety-related problems	3 (2)	6 (8)		9 (4)	37 (3)	0.68
Schizophrenia/schizoaffective disorder	55 (37)	14 (19)		69 (31)	391 (36)	
Other mental & behavioural problems	7 (5)	17 (24)		24 (11)	80 (7)	
Other psychoses	4 (3)	3 (4)		7 (3)	2 (<1)	
Postcode						
Coorparoo & Surrounding Suburbs	37 (27)	19 (30)		56 (28)		
Southside	68 (49)	30 (47)	0.76	98 (48)	-	-
Northside	34 (24)	15 (23)		49 (24)		

Table 3. Demographic and mental health characteristics of people who participated in the evaluation compared to all active members as of August 2023.

	Existing members (n=161)	New members (n=76)	p-value	Evaluation sample (n=237)	All members (n=1,440)	p-value
Housing						
Boarding House	4 (2)	3 (4)		7 (3)		
Brisbane Housing	11 (7)	6 (8)		17 (7)		
QLD Housing/Housing Commission	32 (20)	12 (16)		44 (19)		
Shared Housing	5 (3)	0 (0)		5 (2)		
Community Care Unit	4 (2)	6 (8)	0.24	10 (4)	-	-
Family	23 (14)	16 (21)		39 (16)		
Private Ownership	34 (21)	8 (11)		42 (18)		
Private Rental	40 (25)	19 (25)		59 (25)		
Homeless/Couch Surfing	3 (2)	4 (5)		7 (3)		
Other/I prefer not to say	5 (3)	2 (3)		7 (3)		

*Diagnosis was available for n=150 of existing members, n=72 of new members, and n=1,101 of all active members at Clubhouse.

What are the services and supports on offer at Stepping Stone and how are they funded and delivered?

Short answer: There are a wide range of supports on offer at Stepping Stone, and they are funded by service-based income streams, as well as a mix of recurrent and non-recurrent funding. Stepping Stone services are offered on an "as needed or requested" basis, which enables personalisation to an individual's recovery journey and efficiency of resources.

Types of services and supports

Stepping Stone is a psychosocial rehabilitation program that provides a range of services and supports to individuals living with mental illness. The key services and supports offered at Stepping Stone include:

- **Work-Ordered Day:** Stepping Stone operates on a "work-ordered day" (WOD) model, where members are actively involved in supporting one another with the daily operations of the Clubhouse. This may include working in various units like clerical, culinary, or maintenance, helping to build vocational skills and a sense of purpose.
- **Individual & Employment Support:** Individual Support (IS) offers members one-on-one assistance from a staff to address specific personal and recovery-related goals. IS workers support members to identify their unique needs, strengths, and aspirations. The Clubhouse also provides Employment Support (ES) for members to set goals, build employment skillsets, and to find and maintain employment in the community that align with their skills and goals.
- **Transitional Employment:** Transitional Employment (TE) services encompass vocational assessment, job development, and supported employment initiatives. Stepping Stone staff assess members' skills and interests, collaborate with local employers to create suitable job opportunities, and provide ongoing support, including job coaching and skill development. The focus is on individualised job placements, career development and aiming to help members integrate into competitive employment, in order to promote independence, confidence, and overall wellbeing.
- **Outreach:** Outreach services aim to engage and connect with members who have not accessed Clubhouse services at the frequency they typically would. The Clubhouse will initiate contact with these members via phone, text-message, email, or mail just to check in and see how the members are doing, offer support as required, and to let them know of any upcoming opportunities at Clubhouse that may be of interest. They also provide Outreach on members' birthdays and when they are aware that a member is in hospital.

- **Social Recreation:** The Clubhouse organises social and recreational activities to promote social connections and leisure opportunities for members.
- **Support Co-ordination and Psychosocial Recovery Coaching:** Support Coordination (SC) involves helping members who are participants of the National Disability Insurance Scheme (NDIS) to understand NDIS processes and to navigate and engage with the various NDIS-funded and mainstream services and resources available in the community. Thereby, NDIS participants are supported to use their NDIS funding plan to access reasonable and necessary supports/services which address the impact of their disabilities, in line with their goals. Psychosocial Recovery Coaching (PRC) fulfills a similar role to SC, whilst also focusing on fostering psychosocial recovery, resilience, and overall wellbeing in members' lives. Recovery coaching takes a holistic approach, considering not only clinical aspects but also social, vocational, and personal dimensions of recovery.

Funding Sources

Stepping Stone receives funding from two recurrent sources, multiple non-recurrent sources, and service-based fee sources (Table 4). The relative distribution of these income sources changes over time, and as discussed later is a key driver to the way that services are shaped at Clubhouse. The relative distribution of the income streams for financial year ended June 2023 are shown in Table 4.

Table 4. Income sources for Stepping Stone for 2022-23 financial year.

Income Source	Mechanism	Timing	Relative % of overall income
Re-current funding			
Commonwealth Psychosocial Support Program (CPSP)*	Administered via Brisbane South Primary Health Network (PHN)	2-year funding agreement	12.4%
Queensland Health	General, block funding	2 or 3-year funding agreement	7.7%
Non-recurrent funding			
Queensland Health, Brisbane South PHN, Charity	Election funding, project-specific funding, or charitable trust grants	Once off	20.9%
Service-based funding			
National Disability Insurance Scheme (NDIS)^	NDIS funds via eligible members being supported to apply and then supported to create a NDIS Plan.	As members with NDIS utilise services	55.2%

Income Source	Mechanism	Timing	Relative % of overall income
Other types of income			
Hospitality income from Clubhouse	Trading income from hospitality unit	Variable throughout year	1.6%
Donations	Donations received from businesses and individuals	Variable throughout year	0.7%
Fundraising	Based on efforts of Stepping Stone members and staff conducting fundraising activities	Variable throughout year	0.7%
Clubhouse training	Received for training other Clubhouse teams in the Model	Dependent on training	0.8%

*Commonwealth Psychosocial Support Program (CPSP). Funding provided to programs that connect people living with severe mental illness with community services and strengthen their social, educational and vocational skills. This funding is not available to people who receive similar support from NDIS or a state or territory-funded service.

^National Disability Insurance Scheme (NDIS). Funding provided to eligible people with disability to gain more time with family and friends, greater independence, access to new skills, jobs, or volunteering in their community, and an improved quality of life. NDIS also connects people with a disability to community services. The eligibility criteria include: aged 9-65 years, Australian citizen, permanent resident, or protected special category visa, and experience disability caused by a permanent impairment.

The largest income source for Stepping Stone is from service-based income from members with NDIS plans, representing 55% of the overall income for the Clubhouse. The two recurrent income sources that are not attached to service delivery, represent 20% of overall income for Stepping Stone. This funding is essential to the operations of the Clubhouse as it does not fluctuate with service-delivery and is often committed for 2–3-year funding cycles. Another key source of income is non-recurrent funds, which represent 21% of overall income, however these funds cannot be relied upon annually and require advocacy work or funding applications to be submitted by Stepping Stone.

In later sections, we discuss the tension that members and staff feel as a result of these different income sources and how they incentivise different service offerings.

Who chooses to become a member? Who chooses to become a member but not use the services and supports?

Short answer: People who become a Stepping Stone member are different to other adults living with mental illness in Queensland. For people who become a member we found:

- 11 people per month become a Stepping Stone member.
- 72% of those who do a Tour become a Stepping Stone member.
- 53% of members return to the Clubhouse within 2-months of joining.
- On average members waited 105 (±43) days after their Orientation before returning.
- Generally, people who choose to become a member are more likely to be male (63%), aged 48 years on average, and most commonly diagnosed with Schizophrenia (20%).
- However, new members in the past year were younger and less likely to be diagnosed with Schizophrenia when compared with All Members.

Representativeness of Stepping Stone members to Queensland population

People who choose to become Stepping Stone members are **different** to the broader group of Queensland adults who have a diagnosed mental illness (Table 5). Stepping Stone members are more likely to be male; more likely to be diagnosed with Schizophrenia; and less likely to be diagnosed with Anxiety Disorders compared to Queensland adults who have a diagnosed mental illness (Table 5).

Table 5. Members compared to the Queensland population living with a mental illness.

	Mental illness diagnoses in Qld* (n=1,620,917)	Stepping Stone Members (n=1,440)	p-value
Age	35-64 years	47.6 (±13) years	-
Gender	52% female	63% male	-
Diagnosis*	37% Depression 3% Other affective problems **41% Anxiety disorders** 2% Other anxiety- or trauma-related problems **<1% Schizophrenia** 16% Other mental & behavioural problems <1% Other psychoses	32% Depression 14% Other affective problems **8% Anxiety disorders** 3% Other anxiety- or trauma-related problems **36% Schizophrenia** 7% Other mental and behavioural problems <1% Other psychoses	<0.01

*Individuals may have been diagnosed with one or more mental illnesses, however we used self-reported primary diagnosis. Statistically significant differences bolded.

Gender

The gender difference in the Stepping Stone population may be explained by differences in the types of services accessed by males and females. Based on data from 2020-22 in Australia, females were much more likely to have seen a health professional for their mental health than males (51.1% compared with 36.4%),[viii] which is in contrast to those seeking support from Stepping Stone. In Queensland, there are public mental health services, private mental health services, non-government organisations, and mental health community support services. Across these services are different levels of clinical and psychosocial support provided by clinicians, social workers, and peers. Stepping Stone is positioned as a community-based organisation that provides psychosocial support services and access to opportunities for employment, education, housing, and social recreation. There is some evidence to support the idea that females are less likely to engage in vocational programs[ix]; the work-oriented structure of Stepping Stone may be more appealing to males. Services like Stepping Stone may be an important touch point for males experiencing mental illness as a way to address typically lower help-seeking in males.

Diagnosis

The high proportion of members diagnosed with Schizophrenia is consistent with previous literature comparing Clubhouse members to broader mental health populations[ix]. This research suggests people with a Schizophrenia diagnosis are more likely to be immersed in the public mental health system than people with other diagnoses, and therefore more likely to receive professional referrals to Clubhouse services. For Stepping Stone specifically, the service has a history of funding from the Schizophrenia Fellowship and a reputation of servicing people with this diagnosis. There is also the additional context of funding models for Stepping Stone. A primary funding source for Stepping Stone is service-based income from the NDIS, and a severe and complex diagnosis like Schizophrenia is more likely to be eligible for a NDIS package than some other mental health diagnoses.

Number of people interested in Stepping Stone

The journey to Stepping Stone starts with a Tour of the Clubhouse, to gain a basic understanding of the opportunities that are available to people, and if they would like to, they can then continue to an Orientation. At Orientation, people receive more in-depth information about Stepping Stone's service offering and how the Clubhouse works, as well as their rights and responsibilities as a member. People are considered a member upon completion of an Orientation.

From August 2022 to August 2023, the Clubhouse hosted 187 Tours (16 people per month on average) and 135 Orientations (11 people per month on average). Of these orientees, 72 members returned to the Clubhouse within 2-months of joining. This means that:

72.2% of people became a member after completing a Tour at the Clubhouse

53.3% of new members returned to the Clubhouse within 2-months of Orientation

How does this compare?

The Stepping Stone Operational Plan 2022-23 sets Key Performance Indicators (KPI):

- 7 new member per month - EXCEEDING
- 60% of members returning within 2-month of their orientation – NOT MEETING

In Figure 5a, we mapped the number of people who attended Tours, Orientations and those who returned to the Clubhouse within 2-months. People were counted in the month that the event occurred (i.e., if a tour or orientation occurs in August then they are counted in August, if someone who returns to Clubhouse within 2-months of their orientation comes back in October then they are counted in October). The number of people who attend Tours, Orientations, and are Returners varies greatly from month-to-month, but the relationship between these groups was relatively consistent over time (Figure 5a).

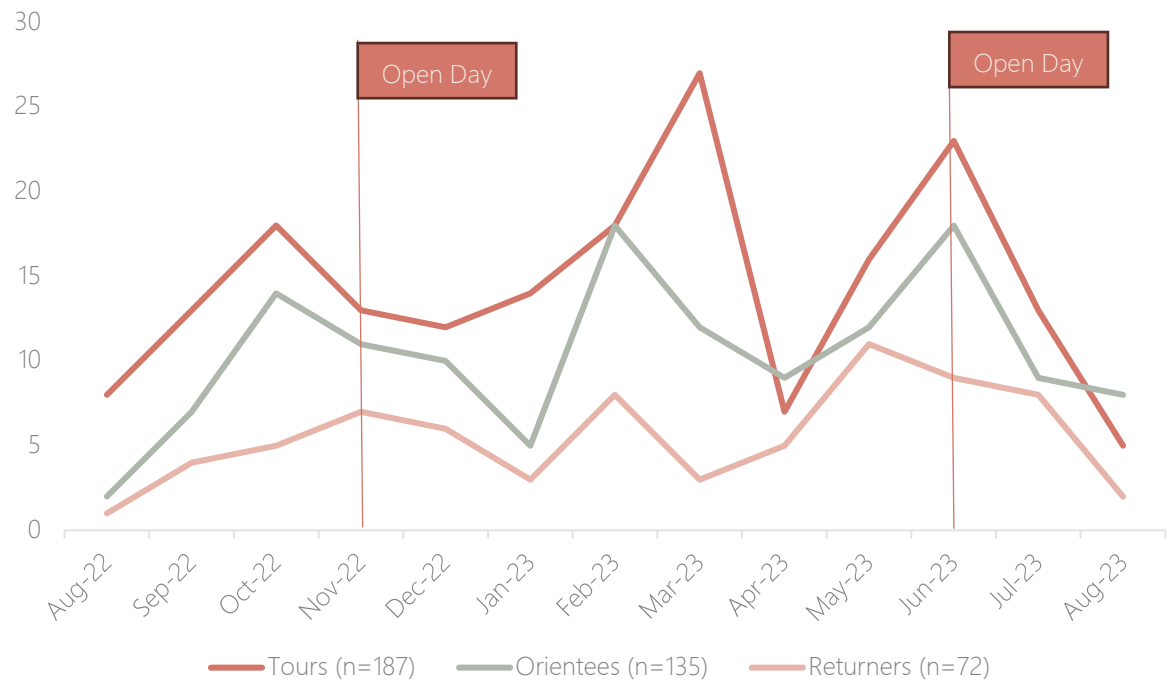


Figure 5a. Number of people who complete a tour, orientation and return within two months of their orientation between August 2022 and August 2023.

There were higher numbers of Tours in October 2022, February-March 2023, and June 2023. There were Clubhouse Open Days in November 2022 and June 2023, which are designed to engage the broader community, including local residents, families, mental health-related services and advocates, and potential supporters. Open Days are a great opportunity to recruit new members who might benefit from Stepping Stone. It appears that the Open Day in June was successful in bringing in more people for Tours, however it will be important to track this relationship over more than one year to track the natural peaks and troughs in Tours and Orientations.

Number of people who return to the Clubhouse after Orientation

We take a closer look at how many members return to the Clubhouse from the group of people who completed an Orientation (n=135) between August 2022 and August 2023 (Figure 5b).

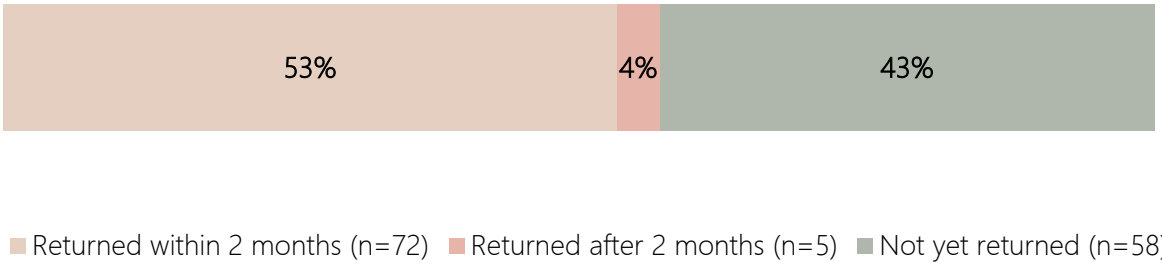


Figure 5b. Breakdown of people who complete an Orientation (n=135) between August 2022 and August 2023 and whether they returned to the Clubhouse

In Figure 5b, we can see that:

- 72 out of 135 (53%) have returned to the Clubhouse **within 2-months**
- 5 out of 135 (4%) have returned to the Clubhouse **after** 2-months
- 58 out of 135 (43%) have **yet to return** to the Clubhouse

When combining these group of Orientees together, the average period of time between their Orientation and their first time coming back to the Clubhouse was **105 (±43) days**.

When we look at these groups of Orientees individually, on average:

- those who **return within 2 months**, returned 12 (±13) days after their Orientation date
- those who **return after 2 months**, returned 163 (±97) days after their Orientation date
- those who **have yet to return** to the Clubhouse, it has been 140 (±70) days since their Orientation date.

Characteristics of members

People who come for a Tour are **similar to** those who continue to Orientation and those who Return to the Clubhouse within two months. There were no statistically significant differences in the demographic characteristics or mental health characteristics between these groups (Table 6). This means that there is no indication that specific groups (e.g., females) are not choosing to become a member after a Tour or return to the Clubhouse at a different rate.

Table 6: Demographic and mental health characteristics of people who completed a tour, an orientation and returned within 2-months of orientation between August 2022 and August 2023

	Tours (n=187)	Orientees (n=135)	Returns within 2-months (n=72)	p value
Age, mean (SD)	40.5 (13.8) n= 150	40.4 (13.9) n=122	40.6 (13.9) n=65	0.76
Gender, n(%)				
Male	101 (64)	79 (65)	43 (56)	
Female	50 (32)	38 (31)	15 (19)	0.72
Non-Binary/Transgender	6 (4)	5 (4)	4 (5)	
Diagnosis, n(%)*				
Depression	28 (18)	24 (20)	14 (17)	
Other affective problems	16 (10)	13 (11)	4 (5)	
Anxiety disorders	24 (16)	18 (15)	11 (13)	0.89
Other anxiety-related problems	9 (6)	8 (7)	7 (8)	
Schizophrenia/schizoaffective disorder	36 (23)	27 (22)	17 (20)	
Other mental and behavioural problems	37 (24)	30 (24)	16 (19)	
Other psychoses	4 (3)	3 (2)	1 (1)	

*Diagnosis was available for n=154 of those who completed a tour, n=123 of those who completed an orientation, and n=70 for those who completed returned within 2 months of orientation.

The average age of people who become a member at Stepping Stone was 40 years old (±SD 14) and they were generally male (61%). The most common mental illness that members were living with when they joined was schizophrenia (20%) and depression (19%).

How do members describe their experience of Stepping Stone?

Before we describe how people engage with the different services, let's explore what it *feels like* to engage with Stepping Stone from the voices of members and staff.

We use the term **'Steps'** in this section where members talked about the collective impact that Stepping Stone services, the physical Clubhouse, and the staff and members provide. Members often talked about Steps without referencing a specific aspect.

Who did we talk to? We interviewed 23 members. In this group, duration of membership ranged from one month to 22 years (7 years on average), and ages ranged from 29 years to 69 years (45 years on average). There was a wide range of primary diagnoses in this group of interviewees.

Members follow their own pace and their own pathways to progress

The Stepping Stone Journey is not linear and is not one size fits all - it is unique to the needs of the member. There was a sense among members that Stepping Stone was a service that met them where they were at. Members expressed a feeling of being supported (not pressured) to progress. This meant they were offered many diverse opportunities (employment, education, work-ordered day, social recreation, recovery coaching, housing, service navigation), and not made to feel bad if they weren't ready to take up the opportunities. There was no guilt or shame when members described what they chose to engage in or not engage in. Members found that because they could access services differently than their peers and also differently over time, they could get the help they needed no matter where they were in their journey. On a longer-term scale, members talked about stepping away from Clubhouse and then stepping back in with no judgment.

"It's been a road to recovery…it's like learning to walk again; you get your endurance back, you get your confidence back, you get your motivation back" – 39-year-old male, member for 4 years.

Many members talked about their journey of finding their pace, finding where they fit, and figuring out what they needed. They often talked about their current stage of their journey by referencing where they had been when they started at Steps to show how much progress they felt they had made. There were specific milestones that members spoke of that helped explain the journey through Steps. These milestones are a way of understanding the nonlinear journey (see later section, Figure 18). This nonlinear journey is well-supported by the flexibility of the Clubhouse model. The ability for members

to choose how they participate really seemed to empower members to take charge of their own journey. Members told us that through this model they did things they never expected of themselves, like volunteering, peer mentorship, and going back to work. One member even described the journey as a complete identity shift, from being the person who needed to be helped by Steps to being the helper and mentor that other members and even staff could learn from.

"Stepping Stones didn't put any pressure on me or expectation. It was here when I wanted it. It was here as much or as little as I wanted." – male (age not provided), member for 1 year.

"It's up to me when I come and what I do. That's really cool. There's no pressure to do anything or take part in anything. It's just a genuine open invitation you know?" – 59-year-old male, member for 1 year.

Steps provides a safety net.

A core experience of being a member is that you are safe. Safety is provided in many ways. The membership without time-limits and ability to step in and out as needed is deeply valued by members. They articulated that their journey is not up and up, but always changing. Stepping Stone is their constant, always open with no judgement. Some members talked about when they did have rough times, they did not need hospitalisation (like they had in the past), but that Stepping Stone was enough of a safety net for them. An important part of the safety net is the Outreach service that Stepping Stone provides to all members. Outreach made members feel a part of Stepping Stone even when they were not physically present at the Clubhouse.

"Most places if you don't put in the time, you get left behind. I could take three months off and not come in here if I needed to get over an injury. I could come in on that first day after not being here for three months and it's like I never left. I'd be just as welcomed. Just as valued." – male, member for 1 year.

"They say you're a member for life. So, if I was to go for a couple of years then come back I'm still welcome with open arms. I don't need to fill out paperwork or nothing, I just walk in the door. That's an amazing thing, you don't see that in other organisations." – 36-year-old female, member for 8 years.

The opening hours of the Clubhouse offers safety, knowing that members can go there when most other services are not available (e.g. weekends, holidays) is a safety net.

The safety to enter the workforce (through work-ordered day or transitional employment) in a supported way. Members talked about how they felt protected by Stepping Stone in their transitional employment (TE), which was not what they had experienced in previous independent employment.

I can "go for my goals a safe bit at a time, just a bit at a time…with the TE there are safe jobs where staff can be around you, so I think yeah it's just allowed me to go out of my comfort zone and work through day to day

things that I struggle with… It's a guaranteed place of safety. Especially for myself and others out there working, feeling safe is really important" – 32-year-old male, member for 7 years.

Acceptance is at the core of recovery

Many members expressed that they still experience shame and stigma around their mental illness when they are out in the community, however in contrast, **the Clubhouse was a place of acceptance**. Members spoke about feeling accepted when they came to the Clubhouse, that it was *"a safe place, to be yourself, at any time"*. One member explained this experience of acceptance in a new friendship – she explained that her new friend was someone who *"just gets it"* and so there was less pressure when they would spend time together to act a certain way or put in extra effort. Another member explained this experience of acceptance as not having to wear a mask because there was no "social jockeying or asserting egos" in the Clubhouse. When members felt safe enough to remove this mask, they were able to take the time to better understand what was going on for them mentally because they weren't having to deal with shame and guilt. The acceptance of mental illness symptoms by Stepping Stone staff made people feel safe to engage – these symptoms were not red flags for excluding people. Staff were able to accept these as part of a member's experience and mostly cater for them, which helped members feel safe.

"I'm 20 years down the journey of my mental health journey since first getting unwell and it's not a case of you get miraculously healed. You get challenged, I've been challenged in my journey with the ebbs and flows…this is a place I can come to, so I trust that reassurance, because of my condition it's imperative to feel like you've got some place, not just to get support but to come to that gets it… you know when your symptoms are playing out, you still feel safe, you still feel secure, and I think that security, being a chronic condition, is reassuring." – 50-year-old male, member for 15 years.

It is also a place that is not just about acceptance of differences but celebrating people's differences. It was not just that members experienced that their symptoms or perceived limitations were 'tolerated', instead, they were empowered and supported by Stepping Stone to figure out how to achieve something starting from where they were at. Members expressed that they could build their confidence, knowing that they would be supported and accepted regardless of the outcome or how long it took to get there.

"Without the shame, there is more space in my head to understand why I do the things I do so then I can work on it" – 40-year-old male, member for 4 years.

Members and staff work together.

Members described the accomplishment they experienced when working alongside staff in the WOD tasks. They often talked about working alongside staff, however there was an often-unspoken assumption that staff were in charge or that there were limits to what they could do as a member. There was also a view that sometimes telling apart the staff, students and members had led to confusion for members when they needed support.

"You can't always tell who's a staff member, who's a member, or the multiple different students that come in and go… I don't always know who you can go up to and approach, like if I need help, you don't know if it's the blind leading the blind." – 60-year-old female, member for 2 years.

Some members who were further along their Steps journey identified that they were struggling to identify how to engage with staff. Whereas they used to need services like individual support and social recreation, they acknowledged that they no longer need this kind of help and do not need as many resources as "other members earlier in their journey that are still learning". They were navigating this new dynamic where what they were seeking was acknowledgement from staff of their progress and their contribution to Steps. This was hard for members to articulate because it is not a clear-cut service or part of the model necessarily.

"My role has been reversed, I feel like the Clubhouse needs me more than I need the Clubhouse…I spoke to [staff member] about me possibly trying out for a staff position, maybe teaching members how to do certain tasks, I think that would be a great contribution to see if I could become a staff." – 29-year-old male, member for 7 years.

"I'm at a position along with some other peers I'm friends with where we've graduated… when you come into it for the first time it's all new, it's a new experience, you learn, but what happens once you've learnt that you need to learn, and my peers and I, we're trying to navigate, we've been part of the system for 20 years or more, and we've learned what we've needed to learn with what's on offer…. what we are doing is we're trying to go out into the broader community and either participate in broader community activities outside the mental health sector or we're actually involved in trying to be a voice for, we're doing some public speaking and we're doing projects and we're trying to reduce the stigma around mental health and I think that's just, I don't know if we get the appreciation that that's where we're at, um, it's not to say that they should provide that next step because this is just part of our journey, but to get the understanding that we're still vulnerable and we're trying to navigate around what comes next in our journey…I think if we got a bit of a spotlight on some of the things we've achieved." - 50-year-old male, member for 15 years.

Members can feel overwhelmed at first and during "crisis events"

Members spoke about two different parts of the journey where they felt overwhelmed when attending Clubhouse: when they first arrived and on occasions when they experience a negative behaviour/reaction from another member. Members reflected on when they first started and how they felt it wasn't clear what they should do when they arrive or how they should engage. This was particularly pertinent for members with sensory processing issues, who noted that there was no quiet space to gather their thoughts. However, most reflected that this eased over time as they found their place at Steps. There is tension between the value and importance of the flexibility of the model, the ability to choose to opt-in to activities or not, which members agree is a strength, and feeling uncertain about where to start or who to talk to for help.

"If I'm perfectly honest I'm still slightly intimidated just cause you come in and there's always stuff going on and it's always busy and you don't necessarily know what you're going to be doing or where to go next. I think that's also one of the enjoyable things about it, is having the experience of being taken into something and sort of fitting in to whatever's going on in the day." – 36-year-old male, member for 8 months.

"Six years ago yeah I'd be constantly sitting downstairs in the kitchen by myself on the sofa, every day for probably about a month or so, not really talking to anyone, not participating in the work ordered day … but gradually I started fitting in and um, found a place upstairs in the EECAT unit and um, yeah just do a lot of administration work" - 29-year-old male, member for 5 years.

Another time that members experienced overwhelming feelings was when another member acted in an anti-social or aggressive way either towards them or towards another member or staff. A few members described situations they felt uncomfortable with and described varying levels of satisfaction with how the staff members had handled the situation. Members expressed that how these situations were handled seemed very dependent on which staff handled it and whether they "understood" the perpetrating member.

What do members perceive to be the impacts of Stepping Stone?

Life-changing impacts

The magnitude of impact that Stepping Stone had for members was a core theme. Many members described how Stepping Stone has changed their lives, and for some, **saved their lives**. Some members became overwhelmed by the emotions of describing the impact that Steps has had on their lives. The impacts ranged from suicide prevention, to engaging in meaningful work, to learning new skills, to be needed or recognised in a community space. Every member could describe some way that Steps had improved their lives.

"Ended up coming back in [to Stepping Stone], and bit by bit went from driving around with the means of suicide, to not having it six months later, then about three and a half four years later I done something that I thought I'd never ever do in my life, and I went back to work." – 68-year-old male, member for 9 years.

"I'm significantly better than how I was before I was coming … a lot of stuff I didn't think I'd be able to do I can do now… I had never held down full-time work before, so that's massive [to now be independently employed]" – 32-year-old male, member for 7 years.

Suicide Prevention

We acknowledge the higher rate of suicide for men who experience mental illness, and we also acknowledge there is a higher proportion of men that access and engage with Stepping Stone (p. 32). While we did not measure suicide prevention, there were stories shared by members during the interviews about going from thoughts of suicide to their life doing a *"180…it [Steps] changed my life so much."*

Feeling valued

Members described being **confident to be themselves** at Steps, to be seen as more than their mental illness diagnosis. It was not just that symptoms or limitations were 'tolerated', but that members were celebrated for just being themselves. This made them feel valued, which was in contract to how they felt in other community settings at times.

Members felt their **skills were valued** at Steps and needed to complete the WOD tasks. They felt a sense of identity in being known for certain skill: like the guy who makes coffee/ the swimming guy/ the admin person.

"It was like a really kind of new age service where you were valued, you added what you had. If all your skills will kind of brought to the table and you're encouraged and you were just sort of like you know I was a driver, I got to pick up parcels, I got to go to mental health units with people I used to work in the cat unit, I had, I did the supported employment" – 69-year-old female, member for 16 years.

"In my life, I've never had people feel like I could do anything…I got asked by one of the staff if I wanted to get up and speak [for a presentation], and I'd never been asked before. I thought I wasn't worthy of anything like that. I still talk about it because I was so ecstatic to have been asked." – 63-year-old female, member for 17 years

Members felt valued through outreach. Members told us that being in the Clubhouse is important, but being a member is more important. Because it's when you're not attending Clubhouse that the feeling of being needed and valued really shines through. Members told us about feeling "in the dark" or feeling low and that a Clubhouse Outreach call or message had been the hook to pull them through.

"Even though I don't come here very often, I still feel a part of Stepping Stone. Especially during COVID, they would send a daily text, and my support worker would still reach out and say, have you heard of this or that coming up? I came back a couple of weeks ago but I forgot how much I love it here so I'm planning on coming back in more often." – 31-year-old female, member for 5 years

Feeling connected

Members frequently talked about the relationships they had formed with staff, which was typically with only 1-2 of their "chosen staff". These relationships were often referred to fondly but did also bring comments about feeling lost/abandoned when staff left the Clubhouse. Some members also talked about the friendships they had formed with other members and that it was easier to meet people because of the lack of judgment between members. One member described her friendship as a "relief" to have someone who just "gets it" (see Case Study with a Member, p. 58). Some members also expressed that they saw themselves as being "different" to the other members that attended and implied that it was hard to form connections with other members.

"I used to be really shy, didn't talk to any people, kept to myself, and when I started coming here, I started making friends, communicating, you know, all that kind of stuff, it just changed literally my whole world." – 36-year old female, member for 8 years.

Stepping Stone creates life-changing impacts. These impacts are felt inwardly through feeling worthy and valued, and outwardly through being more connected to others. These two mechanisms – feeling valued and feeling connected – often created positive momentum across different parts of member's lives, empowering members to take on new challenges and integrate into their chosen communities.

Case study of a Member: Michael

Michael had been a member of Stepping Stone for about four years, and he described his journey as completely life-changing; starting at Stepping Stone has been the catalyst for change across many parts of his life. He went from having a very low self-esteem to no longer feeling ashamed of who he is, from believing he would never work again to now working independently. He can walk into the Clubhouse and feel like it's a safe place where he isn't misunderstood, which allows him the space to start working on deeper issues because he issn't using his energy to hide or get people to understand.

"You know coming to Stepping Stone you can just be yourself and I guess that's now resonating into other aspects of my life and I'm not saying I'm fixed, I'm not saying that I don't, you know, still even last week getting that, sometimes still getting that feeling that I need to die and like I'm going to be alone for the rest of my life... but I'm definitely making progress forward, I'm in my own place now, uh, I have a stable job... there's so much less anxiety.... since coming to Stepping Stone, that's when everything started changing."

For Michael, going back into the workforce was a source of anxiety because of previous experiences. But with the support he received from Steps staff members through a Transitional Employment (TE) opportunity he was able to re-enter the workforce and was eventually offered independent employment from the same workplace. He has also grown in confidence to ask for what he needs at his job and has slowly built up the stamina to now be working most days of the week for 4-6 hours.

"When I first came here people approached me about doing a TE and work was the last thing I wanted to do. I don't want to go back to my previous experiences because you know that's all I know is nastiness, people wanting to dominate you and assert themselves over you. At one point I think I'd been here for maybe 6 or 7 months and I did apply for one of the TEs here which was at the PA hospital, that was doing the sharps job and it was two hours a day, 5 days a week and it was, I mean it's so great because when you go into one of the TEs here you're kind of like a protected person because you have Stepping Stone behind you.... I could embrace who I am, and say, I do have psychological problems and I am weird and I'm not good at socialising especially with people that I don't know, I'm scared a lot of the time, I have a lot of anxiety and depression, and so I guess, yeah it was the first job I've had where I could be straight up with people...."

It was really powerful for Michael to come to a place where there was no "social jockeying or asserting egos" as it gave him a place to just be himself; **"a safe space."**

How do staff describe their experience of Stepping Stone?

Who did we talk to? We interviewed 11 staff members. In this group, experience at Stepping Stone (as of August 2022) ranged from two months up to 26 years, and qualifications included Bachelor of Social Work, Graduate Diploma in Psychological Science, Bachelor of Behavioural Science, Advanced Diploma in Transpersonal Therapies and Master of Social Work. There were 5 staff interviewed from the Management Team.

It either works for you, or it doesn't

Staff reflected on the unique nature of the Clubhouse Model. Many celebrated this approach and expressed that this is why they chose to work at Stepping Stone. Others talked about still trying to figure out the Model, or whether they personally fit within the Model. Staff and members talked about a time when there was a high staff turnover, and many staff attributed this to some staff just "not fitting" the Model.

"It works because of the work of the Clubhouse and the work-ordered day, but I think it's more that, it works because we have the right people, the right staff, and we have members who've been here for a really long time and so they support other members" – staff member for 8 years

When staff feel connected to the Model they talk about the meaning of their work, the way it lights up their lives and the fulfillment they sense from working alongside members with a common goal. Often these staff talked about challenging parts of the role that just had to be accepted, because they were fundamentally aligned with the Clubhouse Model, and the staff member believed in the Model. Examples of these challenges were embracing the chaotic nature of Clubhouse routines.

"It's chaotic, which can be relenting, but it is what it is and I think that you come in knowing that, but you work it out, and you're welcome to leave- the place is not for everyone." – staff member for 18 months

"You just have to be ready to work on your feet" – staff member for 1 year

Another example of a challenge that staff expressed must be embraced was being patient and taking tasks slowly. Some staff reflected that their natural tendency is for efficiency of getting tasks done, but that it is reiterated in the Clubhouse Model that they must engage members in all things.

"Engagement with members is more important, rather than getting the job done" – staff member for 11 months

"Sometimes I struggle with the length of time of doing tasks with a member rather than alone and I have to be reminded from start to finish it's member involvement" – staff member for 5 months

When staff or students did not fit the Model they often talked about not being clear on the intentions of the Clubhouse, or concerns that the Clubhouse was enabling unhealthy behaviours of members to continue without questioning or offering alterative behaviours to those members.

"I do wonder if the idea is to let people live their lives how they want to live them OR sort of being an intervention and suggest maybe there is another way to live" – staff member for 2 months

Funding models and the Clubhouse Model intersect and create tension which impacts experience and service offerings

There is a tension created between two driving forces that shape Stepping Stone operations: The International Clubhouse Model and the funding mechanisms that allow Stepping Stone to operate. Funding streams and the security of these streams was discussed by many staff as a core tension of operating Stepping Stone.

"Ever since I've worked at Stepping Stone funding has been an issue." – staff member for 4 years

Staff also discussed that different funding streams encouraged different types of services or approaches to supporting members. One of the key funding streams that was mentioned was the National Disability Insurance Scheme (NDIS). A lot of staff spoke about the impact of the introduction of NDIS on Stepping Stone. They explained that the NDIS encourages fee-for-service delivery of certain types of psychosocial supports. On one hand, the introduction of NDIS meant that for some members there is more support available to them. However, for those who are eligible for NDIS they are required to articulate and prove their functional deficits, which is in direct contradiction to the strengths-based approach that Stepping Stone takes. This can be a difficult conversation between members and staff, as some language in the NDIS application process is problematic for people on a mental health journey. Staff also pointed out that it is important to acknowledge that there are other members who are not eligible for NDIS and this may mean that they have less access to particular supports that are at Stepping Stone, which again contradicts the Clubhouse Model of inclusive service delivery.

"NDIS is fee-for-service, [so] we're able to deliver more services to particular individuals, whereas with block funding we're able to stretch out and determine where the needs are, but that being said with the block funding we have flexibility and ability to take on people without the admin and paperwork" – staff member for 4 years

"The biggest problem is that here we talk about building people up and focusing on the positives, but with the NDIS it's about proving how disabled you are. Really at the end of the day that's it." – staff member for 8 years

The Clubhouse Model is grounded in sharing the work of the Clubhouse between members and staff. Staff discussed that this type of service provision does not lend itself to the types of data capture or KPI that are typically required for clinical one-to-one service models. The NDIS, Queensland Health block funding and Commonwealth Psychosocial Support Program (CPSP) funds all require service data to be recorded in different ways - all reporting requirements are based on more one-to-one models of service delivery. This misfit of funding requirement to Clubhouse operations creates tension for staff and members because they feel pressured to collect and enter detailed service data to support the funding stream requirements.

"We are generalists, but maybe there is a better way?"

Staff discussed that they are in generalist roles that are expected to act across a wide range of Clubhouse activities. This was celebrated by some, but critiqued by others who felt that recent progress towards specialist staff (i.e. NDIS Director, Employment and Education Director) was a better approach to using a strengths-based approach to identify where staff skills may be best used so they aren't stretched too thin.

"The diversity in staff roles is a great opportunity for learning but brings with it challenges of staff having to be across so many different things, have the knowledge and skills in several different functions, and limits the opportunity for specialisation of skills". – staff member for 4 years

[opportunity for growth is] "increasing structure within the leadership team and further clarification of roles, reducing the need for the leadership team to wear so many hats" – staff member for 4 years

Staff discussed the breadth and depth of the management team, which has grown to include specialist management roles. This increase in the management team was praised in terms of specificity of roles and also in terms of increased access to staff supervision.

"It's so great to have people who can focus on looking after employment or NDIS or one thing – and do it really well" – staff member for 8 years

Staff and member relationship

An important part of the Clubhouse Model is the side-by-side relationship between members and staff. There are many standards in the Model supporting this (Appendix A). Staff spoke fondly of their relationships with members and the shared work they undertook each day to run the Clubhouse. Staff also spoke about learning from members, and not always assuming they knew more.

"We're on the same level and no one knows more than the other one, staff and members can learn from each other." – staff member for 11 months

"When it gets messy, we get messy together, we're in it together" – staff member for 18 months

As evaluators, we were present in the Clubhouse for two weeks at a time for three periods. At times it was difficult to distinguish staff from members, and this was reflected by members. There are benefits and challenges of this unique relationship between staff and members.

"Member involvement, whilst often reliant upon staff facilitation, can achieve significantly more at lower resourcing costs, for example volume of outreach calls, organic peer-to-peer support and sharing of resources, peer facilitation of programs, and training of staff by members."- staff member for 4 years

The staff to member ratio is a delicate balance

Many staff talked about the need to have the right ratio of staff to members in order to make the Model work. By design, the Clubhouse is under-staffed (Appendix A). This approach drives the need for members to work with staff to make the Clubhouse function. There is a delicate balance that must be struck between the number of staff and members present at the Clubhouse and receiving support through home/community-based care. Many staff talked about times in Stepping Stone history when this balance was off. It led to staff feeling overwhelmed, and members feeling neglected or taken for granted.

"Balance when [staff] burn out is not managed, leaving members vulnerable if they have developed a relationship with a staff member who then leaves." – staff member for 5 years

There is also a balance between staff. There is a reliance on management roles to distribute and coordinate the work of the Clubhouse. Some staff expressed that there was not much autonomy in how their workdays play out, which made them feel like they were having to react to last minute changes leaving them feeling unprepared to provide support. It was noted by staff that they did not always feel appreciated by management and wanted a space to have their concerns heard.

"We need to encourage staff to talk about what it feels like to work here – support them to stay" – staff member for 5 years

What do staff perceive to be the impacts of Stepping Stone for members?

The staff easily and proudly described the benefits that members experience at Stepping Stone. Staffs' expressions of member benefits aligned with the members views almost entirely- including using the same language to describe the benefits that the members used. One difference that we noted was that staff were quick to identify *"friendships between members"* as an impact of Stepping Stone, however, members were less likely to talk about this aspect of impact. This may be because the impact of "friendships" may be included in what members broadly discussed as *"feeling connected"* but without using the term "friendships" to express this. In addition, friendships may be less salient for members compared to the life-changing and life-saving impacts they prioritised to talk about as key Stepping Stone impacts.

Who uses the services and supports at Stepping Stone? How do members use the services and supports?

Short answer: Existing and new members engage with Clubhouse in different ways.

- Existing members most frequently access support co-ordination and psychosocial recovery coaching by total counts of occurrence and WOD by total hours spent.
- New members most frequently access WOD by total counts and by total hours spent.
- Outreach was the most commonly experienced type of service for new and existing members.

For all members who gave permission to access their Lumary data, we collated their engagement with services between August 2022- August 2023. New members had been accessing the Clubhouse for a shorter period than existing members, so we calculated their attendance volume relative to the opportunity that they had to attend.

Outreach is the most commonly experienced service by members, new and existing (Figure 6). A key finding of the qualitative interviews was that Outreach was a key part of the "safety net" of Stepping Stone. It makes people feel a part of Stepping Stone even when they are not at the physical Clubhouse, and an Outreach was sometimes the catalyst for brining members back into the Clubhouse when they were struggling.

Across the other services there are different patterns by new and existing members. Compared to existing members, a higher proportion of new members accessed WOD in the past year, and a lower proportion accessed Support Coordination & Psychosocial Recovery Coaching and Social Recreation.

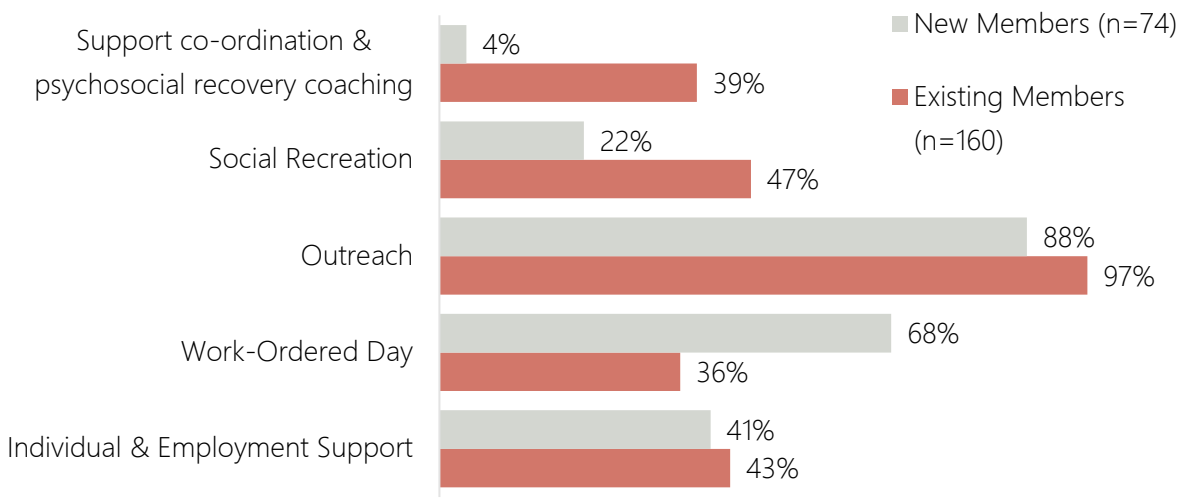


Figure 6. Proportion of members who accessed each service type for new and existing members between August 2022 and August 2023.

When looking at the volume of services accessed as a proportion of total occurrences (Figure 7):

- New members most frequently accessed: WOD (38.0%) and Individual & Employment Support (21.1%).
- Existing members most frequently accessed: support co-ordination and psychosocial recovery coaching (44.4%) and Individual & Employment Support (19.1%).

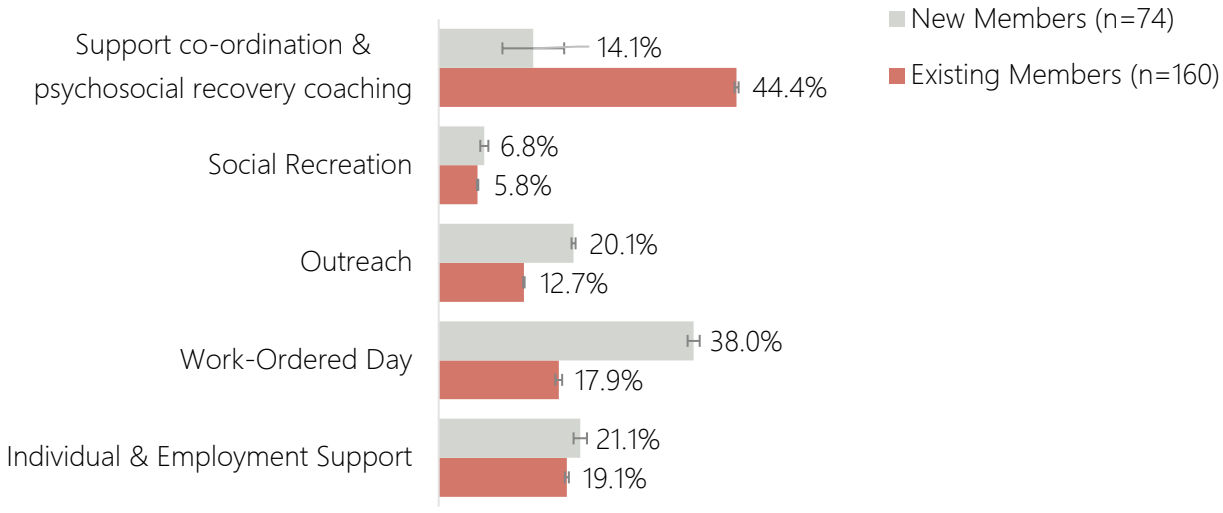


Figure 7. Proportion of total number of occurrences in each service type for New and Existing members between August 2022 and August 2023. Error bars indicate standard deviations.

However, when we look at the total hours spent (not just frequency of occurrences/access), the patterns of engagement shift for existing members (Figure 8).

- New members most frequently accessed: WOD (67.9%) and Individual & Employment Support (18.9%).
- Existing members most frequently accessed: WOD (38.6%) and Individual & Employment Support (22.6%).

Although Outreach has relatively high number of total occurrences for both new and existing members, the hours spent receiving Outreach is very small in comparison to the other services.

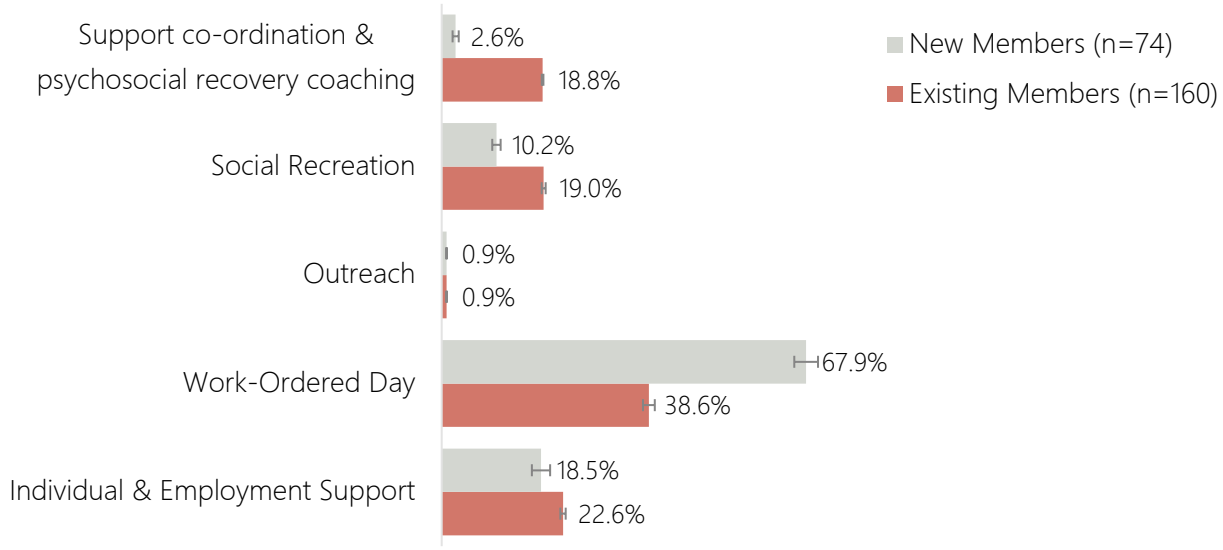


Figure 8. Proportion of total hours spent in each service for New and Existing members between August 2022 and August 2023. Error bars indicate standard deviations.

Education and Employment Services

Education and employment are cornerstones of the Clubhouse International Model (see Appendix A). Within the evaluation period, Stepping Stone re-introduced a separate unit for Education and Employment. This came out of feedback from members that they wanted more support in these areas.

For employment, Stepping Stone typically offers between 12-15 transitional employment (TE) opportunities at a time. These positions are rarely unfilled, and there can be wait times upwards of a month for members to get into TE positions depending on demand for the position or requirements of the position itself.

For education, there are members who are currently studying, formally or informally, and Stepping Stone supports these members through study groups, one-on-one support, and by providing computers and free space to work. Some members expressed in their interviews that Steps was an important alternative to a library for them to study. We explore members' aspirations for further employment and education later in this report (see pp. 65-67).

Do members' location effect their engagement with Stepping Stone services and supports?

Short answer: Stepping Stone reaches nearby suburbs and the Southside very effectively; people living on the Northside have the lowest proportion of members.

- Location did not affect the total number of Stepping Stone supports and services that members accessed.
- Members accessed the different types of supports and services differently based on where they lived.

In our evaluation sample, 203 members provided a residential postcode in their surveys. We divided them into the three following categories to indicate their living proximity to the physical location of Stepping Stone Clubhouse:

- Coorparoo and immediate surrounding suburbs*
- Southside and beyond – including Ipswich, Logan and Redlands^
- Northside and beyond – including Moreton Bay†

*We acknowledge that Coorparoo and immediate surrounding suburbs are still considered to be part of the Southside in Brisbane, Queensland. However, it is important to highlight these separately to the rest of the Southside as members who live in this area may be within walking distance or have shorter public/private transport times when physically accessing services at the Clubhouse.

^Postcodes in Ipswich, Logan and Redlands were grouped with the remaining Southside postcodes as there were too few members living in these postcodes to make another category.

†Postcodes in Moreton Bay were grouped with the Northside postcodes as there were too few members living in these postcodes to make another category.

Most members lived in the Southside and beyond area, followed by Coorparoo and the immediate surrounding suburbs, and then the Northside and beyond.

- 27% (n=56) lived in Coorparoo and the immediate surrounding suburbs,
- 48% (n=98) lived in the Southside and beyond, and
- 24% (n=49) lived in the Northside and beyond.

Members who lived in the Southside and beyond accessed 48% of total services and supports delivered during the evaluation period, while members who lived in Coorparoo and immediate surrounding suburbs accessed 30%, and members who lived in Northside accessed 22% (Figure 9). Location does not affect the proportion of total services accessed.

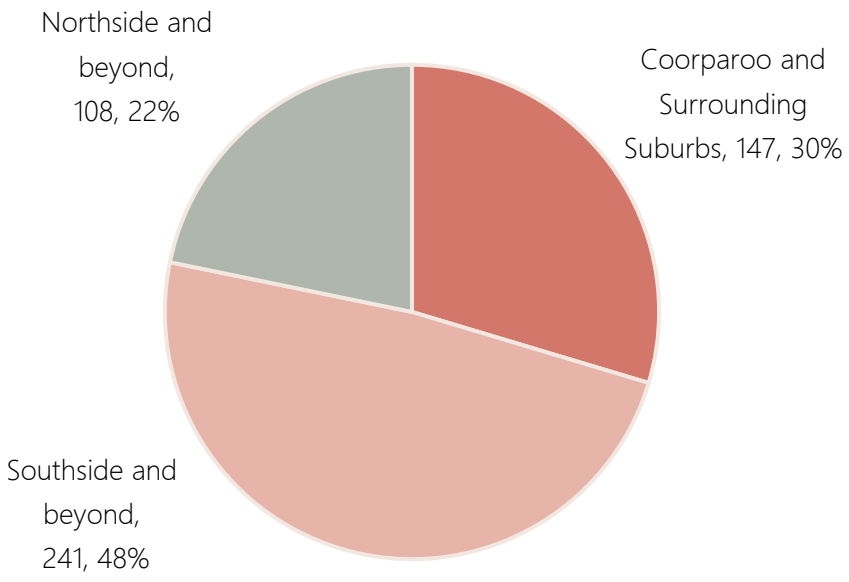


Figure 9. Proportion of total service and support access by postcode between August 2022 and August 2023.

When looking at the volume of services accessed as a proportion of total occurrences (Figure 10), the most frequently accessed services by location were:

- **Coorparoo and immediate surrounding suburbs:** Work-ordered Day (33.8%) and Support Coordination & Psychosocial Recovery Coaching (28.8%).
- **Southside and beyond:** Support Coordination & Psychosocial Recovery Coaching (49.0%) and Individual & Employment Support (25.7%).
- **Northside and beyond:** Support Coordination & Psychosocial Recovery Coaching (42.7%) and Work-ordered Day (22.5%).

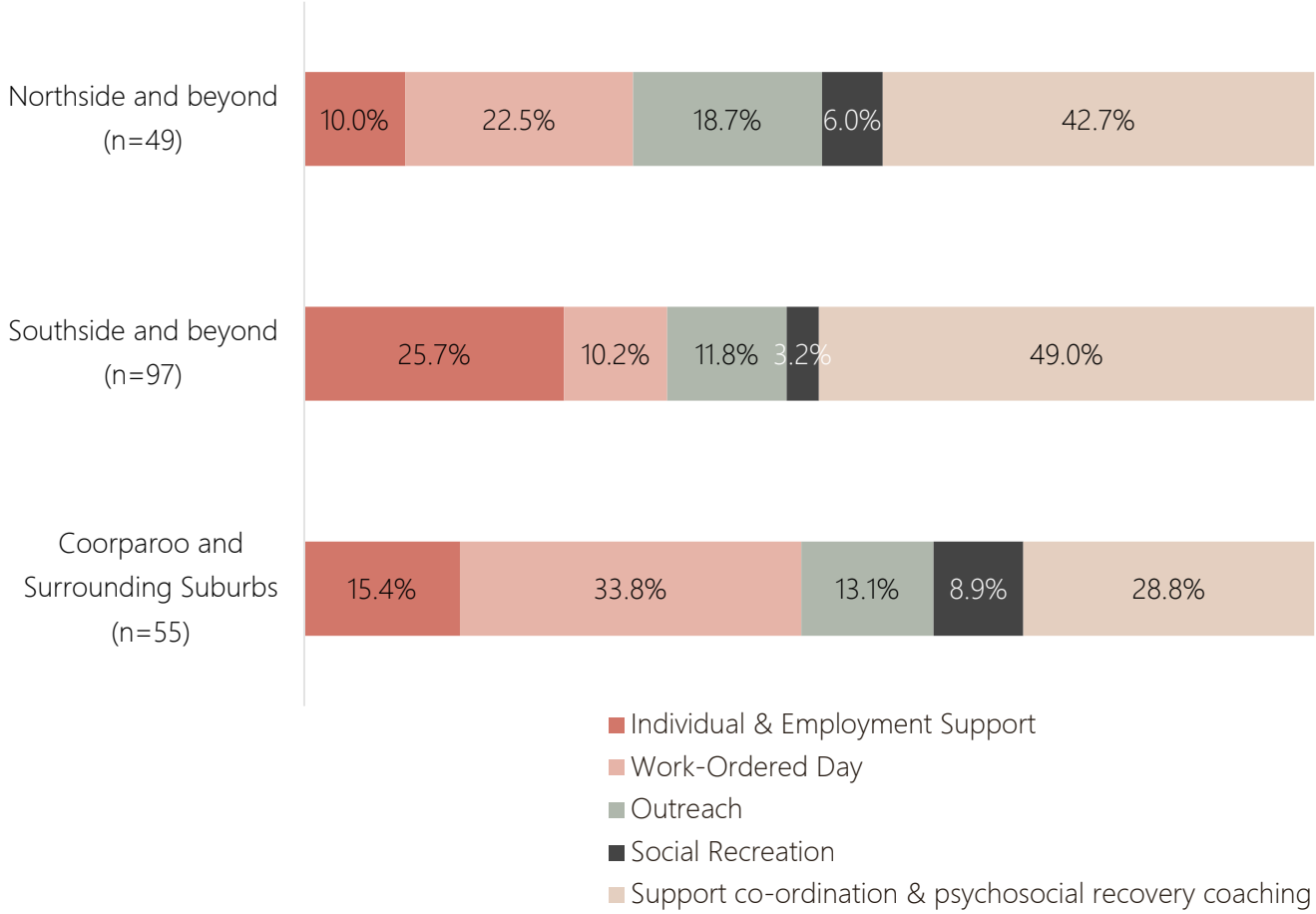


Figure 10. Proportion of total number of occurrences in each service type by postcode between August 2022 and August 2023.

When we look at the total hours spent (not just frequency of occurrences/access) in each type of service, the patterns of engagement shift (Figure 11). The supports and services where members spent the most time by location were:

- **Coorparoo and immediate surrounding suburbs:** Work-ordered Day (55.5%) and Social Recreation 23.0%).
- **Southside and beyond:** Individual & Employment Support (37.5%) and Work-ordered Day (28.3%).
- **Northside and beyond:** Work-ordered day (57.4%) and Social Recreation (17.7%).

Work-ordered Day and Social Recreation are on-site only services at the Clubhouse, so it is encouraging to see that these are still accessed frequently by members who live outside of Coorparoo & surrounding suburbs.

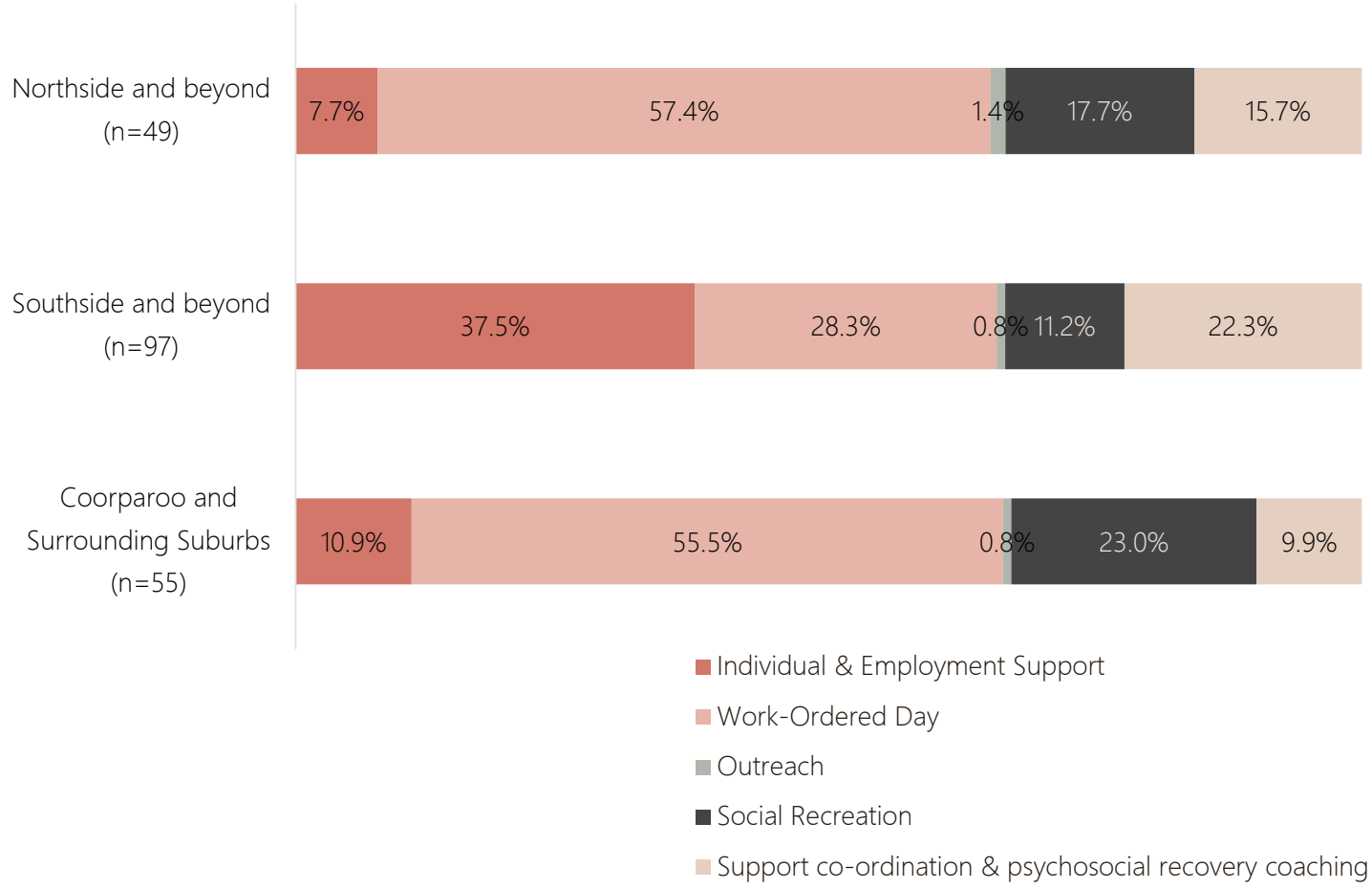


Figure 11. Proportion of total hours spent in each service type by postcode between August 2022 and August 2023.

Star Ranking of Stepping Stone

Now that we understand how members are experiencing and engaging with Stepping Stone, we can start to look at how satisfied they are with their experience. Members were asked to rate out of five stars how they felt Stepping Stone is doing in:

- giving them the support they need
- improving their mental health
- helping them do the things they want to do

Both new and existing members rated Stepping Stone relatively high, averaging at 4 out of 5 stars:

Giving you the support, you need - 

Improving your mental health - 

Helping you do the things you want to do - 

Each of these statements were ranked similarly by new and existing members:

- "giving you the support you need" (mean ±SD: new: 3.9±1.2; existing: 4.1±1.2)
- "improving your mental health" (mean ±SD: new: 3.8±1.2; existing: 4.0±1.2)
- "helping you do the things you want to do" (mean ±SD: new: 3.6±1.3; existing: 3.9±1.3).

This is a positive finding, that new members are satisfied with the support they receive from Stepping Stone in those early 3-6 months of membership.

To what extent do members' experience short, medium and longer-term outcomes?

Short answer: Overall, existing members experience **better** outcomes than new members.

- Existing members scored higher than new members across all progress domains, social connectedness and quality of life
- Higher proportion of new members had accessed a hospital for their mental illness in the past 6 months than existing members.
- Over 3-6 months, new members experience a meaningful reduction in hospitalisations and a meaningful increase in functional progress.
- Over 6 months, existing members experienced no significant or meaningful changes in recovery, social connectedness, and quality of life – indicating stable outcomes.

Progress Outcomes

New and existing members ranked how they felt about statements related to their personal (looking forward), functional (doing things I value), symptom management (mastering my illness) and social progress (connecting and belonging) on the RAS-DS.[Error! Bookmark not defined.] We use the term progress here to describe each of the constructs, not recovery, because of member preference. Higher scores indicate better progress, and a score:

- below 50% represents an area for work
- between 50-75% represents a transitional area (beige in Figure 12)
- above 75% represents an area of success[x] (green in Figure 12)

In our Stepping Stone Roadmap (Figure 4), Personal and Functional Progress were considered short-term outcomes, Symptom Management Progress a medium-term outcome and Social Progress a longer-term outcome. We report on them together here.

Cross-sectional comparisons: new v. existing (left of Figure 12)

Existing members had meaningfully higher Functional Progress scores than new members. Progress scores were significantly higher for existing members across all domains except Personal Progress.

Longitudinal comparisons: 3-6 months later (middle and right of Figure 12)

There were no statistically significant differences over time for new or existing members across the progress domains. **New members experienced a meaningful increase in Functional Progress scores**.

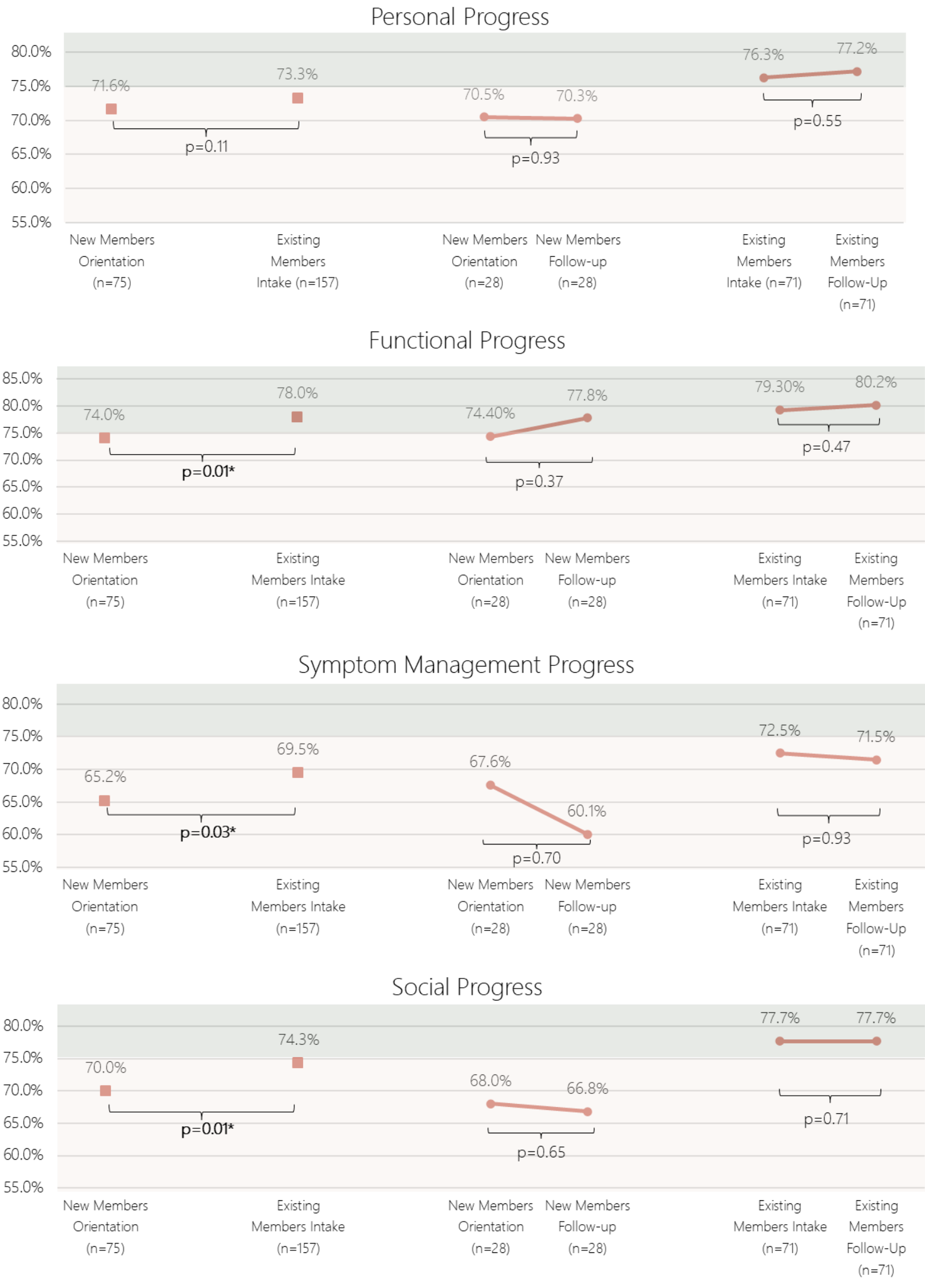
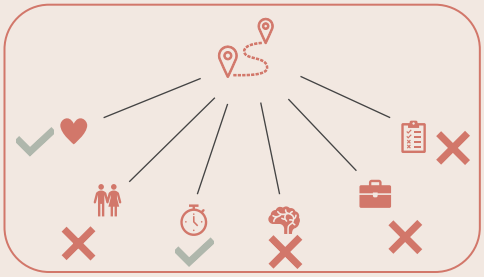


Figure 12. Scores for existing and new members for Recovery Progress domains of the RAS-DS.

Stepping Stone members, even new members, have relatively high progress scores compared to other similar populations. In a similar psychosocial model, Scanlan et al (2018) found that in a group of adults diagnosed with schizophrenia, depression, anxiety, bipolar disorder and personality disorder, that their pre-service progress scores started at 64.1% for Personal Progress, 66.0% for Functional Progress, 61.5% for Symptom Management Progress, and 67.7% for Social Progress.[xi] Stepping Stone members, regardless of their length of membership, may be in a stage of their recovery where the act of coming to Clubhouse is indicative of good progress and readiness for change. This finding also means that capturing improvements in progress for new members in the short timeframe of follow-up (3-6 months) was less likely than if they had started from a lower progress score.

With regards to distribution of progress scores, new members had a wider range of scores (in comparison to existing members for most progress domains (Appendix Table A1 shows the means and standard deviations for each score for each group). This finding speaks to a more diverse range of experiences of recovery for new members starting at Stepping Stone compared to existing members who have a narrower range of recovery experiences.

Symptom Management Progress was the lowest domain of recovery for both existing and new members (Figure 13). This indicates that symptom management takes a long time to improve due to the complexity and chronic nature of the diagnoses we see at Stepping Stone, and the psychological factors and comorbidities that must be considered when developing skills and strategies to address these. Although Stepping Stone services may not appear to be as influential in this domain of recovery, improvements may take longer than 3-6 months to be observed. Hence, Stepping Stone should continue to emphasise and support symptom management within and across their services comprehensively to encourage and ensure sustained progress over time.



What predicts progress?

We conducted a predictors analysis for each of the progress outcomes (see p.21 for details). No predictors or any of their interaction terms were statistically significant for any progress domain, except Personal Progress, where:

- having longer membership predicted better progress (p=0.04)
- being older predicted better progress (p=0.03)

Social Connectedness of members

We measured members' level of social connectedness within the Clubhouse using the Client Interaction Scale (CIS) [Error! Bookmark not defined.], which separated out connection with other members from connection with staff. For our purposes, the term client was changed to member to be consistent with the context of the Clubhouse environment. In this scale, higher scores reflect stronger social connections. In our Stepping Stone Roadmap (Figure 4), we positioned social connectedness as a medium-term outcome.

Existing members scored higher than new members in social connections with both other members and staff, and the cross-sectional comparisons (shown in Figure 13 by the square points) were statistically significantly higher scores.

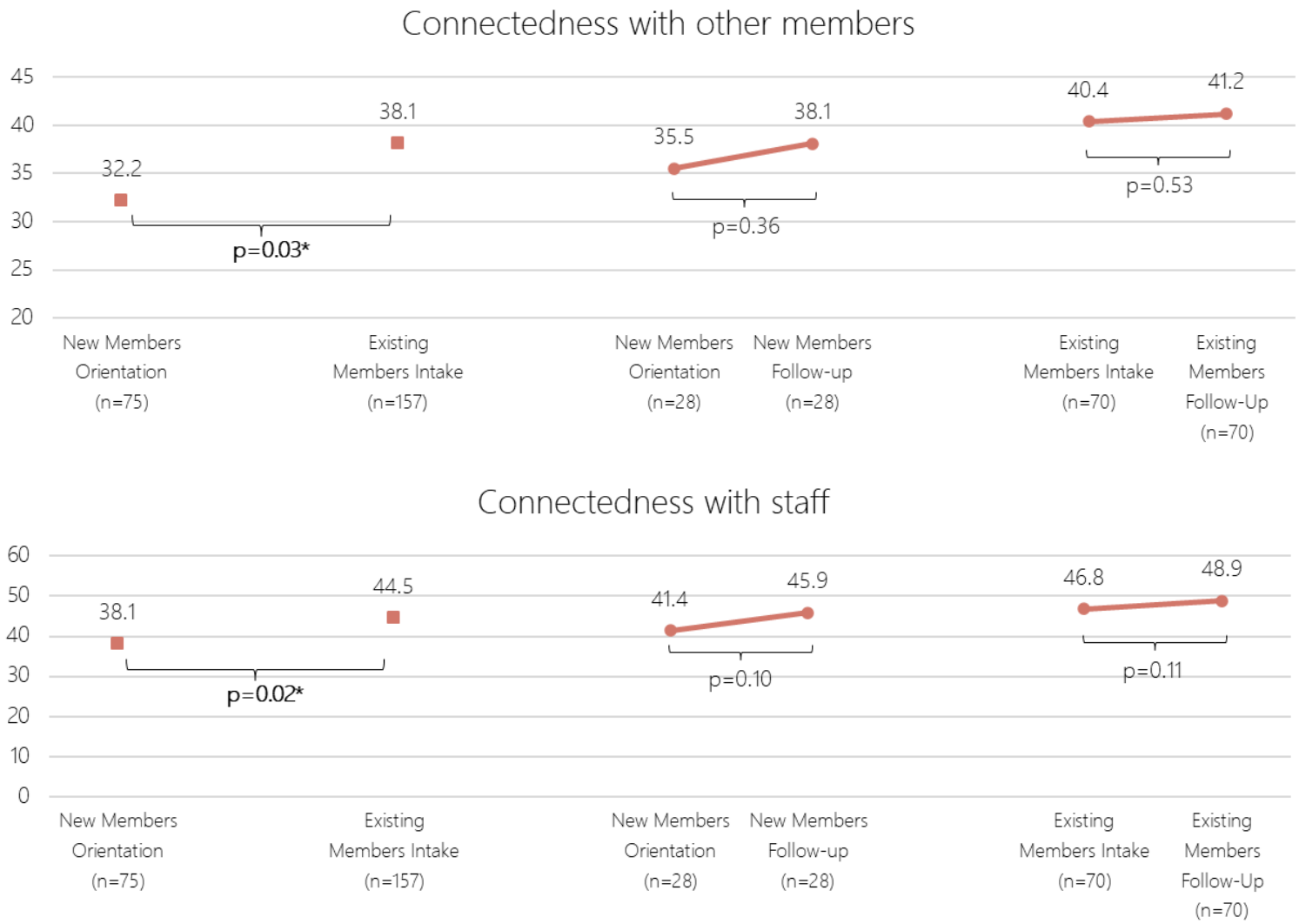


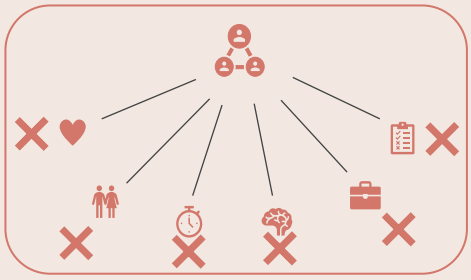
Figure 13. Scores for existing and new members for social connectedness with other members (top) and staff (bottom).

Previous studies have used the CIS tool with similar psychosocial rehabilitation services. They reported social connectedness scores of 45.3 and 47.2 at psychosocial rehabilitative sites that relied on client-to-client interactions compared to 33.2 at a care facility that had less socialisation focus and low interactive environment.[vi,xii] At the Intake Survey, we can see for existing members that they have comparable social connectedness to those within psychosocial rehabilitation programs in previous literature. Whereas new members in their Orientation Survey are more comparable to those at a less social, low interactive environment care facility.

Encouragingly, at Follow-up (3-6 months after Orientation) we see that new members have social connectedness scores that are more comparable to the existing members *and* those within psychosocial rehabilitation programs in previous literature. Existing members reported stable levels of social connectedness between their Intake Survey and Follow-up Survey (Figure 13). Appendix Table A1 shows the means and standard deviations for each group.

Both new and existing members have consistently higher social connectedness with staff compared to other members (Figure 13). Many members in their interviews expressed that there was a special relationship formed between themselves and one (or only a few) staff members when they joined Stepping Stone. They would often speak of the one or two staff members as being especially important in the first year or so as they were finding their feet. Some members appreciated being around other members who just "get it", while other members still felt that they were *different* from other members. We explored social connectedness and belonging more in the qualitative analysis (pp. 36-41).

A recent review explored the social networks and social support of Clubhouse members and how this impacted their recovery[xiii]. This review found that perceived levels of support and reciprocity, greater family support, a positive relationship with one highly supportive person, and connection to more mental health professionals were all associated with higher recovery scores (using the RAS scale). Future evaluations of Stepping Stone may need to consider a broader definition of *social connectedness* than was used in this project to include perceived social support and belonging, and potentially social integration with members' broader chosen communities.



What predicts social connectedness?

We conducted a predictors analysis for social connectedness outcomes (see p.21 for details). No predictors or any of their interaction terms were statistically significant for connectedness with other members or staff.

Case Study of a member: Annette

What it's like to feel connected to the Clubhouse…

When we interviewed Annette, she had been a member of Steps for just over a year but had only been coming into the Clubhouse for three weeks. There were a lot of ups and downs in her journey to Steps – she had just moved from Gold Coast to Brisbane and did not have anywhere to live when she came to Steps for a tour and orientation. She didn't come back for a long time and was admitted to hospital twice. During this time when she was in hospital, she received Outreach calls that made her feel connected to Steps even though she wasn't going to the Clubhouse.

"Getting those phone calls made me feel like, hey ***we want you here****, you know we want you to be a part of what we do here…. having them still reach out to me even though I don't come in it just makes such a difference, you feel less alone, you feel more supported, you feel like there's people you can talk to…With mental health, you go into yourself kind of, it's almost like your life caves in, you lose contact with the real world because in your head you're stuck, and you get that call… it kind of pulls you out of that cave a bit… "When I was in hospital, they called and said, well why don't we come and visit, so someone came a visited me in hospital."*

Outreach as a connection between her and the Clubhouse was an important thread in Annette's story. Now that she has been attending, she has also made deeper, face-to-face connections that are improving her quality of life. A staff member has encouraged her to pursue study with the support of the Clubhouse and she has made a close friend in one of the other members as well.

"I made friends here, my friend Mary, we sat next to each other at lunch, and we got talking, we're both single with kids the same age, boys, we exchanged phone numbers, and we catch up twice a week. You know you make, you find somebody who is, we've actually both got bi-polar as well… and we can talk about that and knowing that we met through Clubhouse and we don't talk about that sort of stuff with anyone else, so* ***our friendship is based on how things work here at Stepping Stone, but then we take it out*** *and we have coffee… it's just nice."*

Annette described that the social connection at the Clubhouse is just different; sometimes with mental health, friends and family can struggle to understand, but at the Clubhouse there is "no pressure" because they just "get it".

When we followed up with Annette to make sure we were telling her story the way she wanted it to be told, she added, *"The Clubhouse really has helped me connect and has supported me with my decisions to pursue studies and with my own personal goals. I've been attending Clubhouse even more since you did this questionnaire. It's been almost a year that I have been going into Steps and I haven't had any hospital admissions in that time."*

*pseudonym

Quality of Life

New and Existing members ranked how they felt about statements related to their quality of life on the Manchester Short Assessment of Quality of Life (MANSA).[Error! Bookmark not defined.i] From this scale we can get an overall satisfaction core and we can examine 12 domain-specific scores. In the MANSA, higher scores indicate greater satisfaction with life, and score interpretations are anchored as:

7 – couldn't be better
6 – pleased
5 – mostly satisfied
4 – mixed
3 – mostly dissatisfied
2 – displeased
1 – couldn't be worse

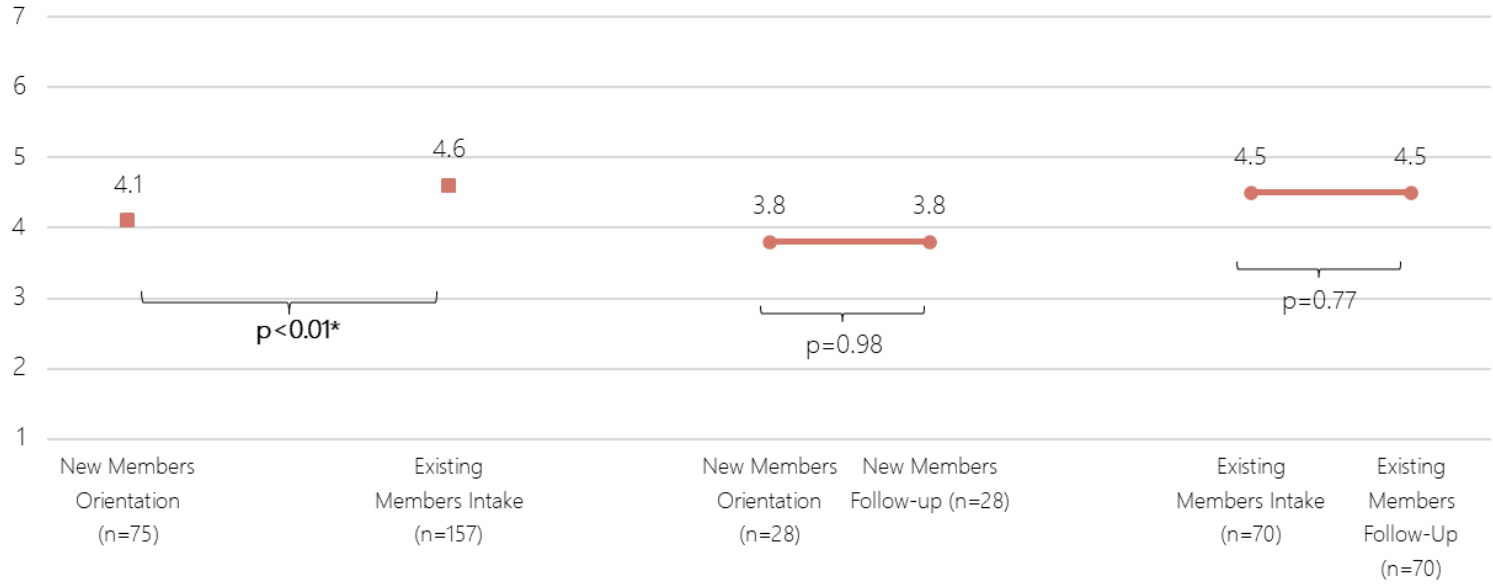


Figure 14. Scores for existing and new members for quality of life.

Existing members had higher quality-of-life scores than new members, and this cross-sectional comparison (shown in Figure 14 by the square points) was statistically significant. Existing members are closer to feeling 'mostly satisfied' with their quality of life, and new members on average report feeling 'mixed'. There was no change at follow-up (3 to 6 months later) for new or existing members. We expect existing members to remain stable, and we suggest that 3-6 months may be too soon to see changes in quality-of-life for new members. Appendix Table A1 shows the means and standard deviations for each score for each group.

Previous studies have used the MANSA tool with similar psychosocial rehabilitation services or similar populations. They report quality of life scores of 4.2 and 4.0 at psychosocial rehabilitation services,

compared to 3.9 at usual care.[xiv,xv] New members are comparable to the quality-of-life scores in previous literature, and existing members are slightly higher.

Beyond the summary score, we can understand more about members satisfaction with specific domains of their lives (Figure 15). Both new and existing members were most satisfied with their personal safety (Figure 15). New members were least satisfied with their financial situation and existing members were least satisfied with their sex life. Existing members were significantly more satisfied than new members for:

- life as a whole today ($p<0.01$)
- leisure activities ($p=0.02$)
- mental health ($p<0.01$)
- employment status ($p<0.01$)
- financial situation ($p<0.01$)

These differences between groups were also meaningful (rounding to different anchors on the MANSA scale) for all except the mental health domain (where both groups rounded to 4).

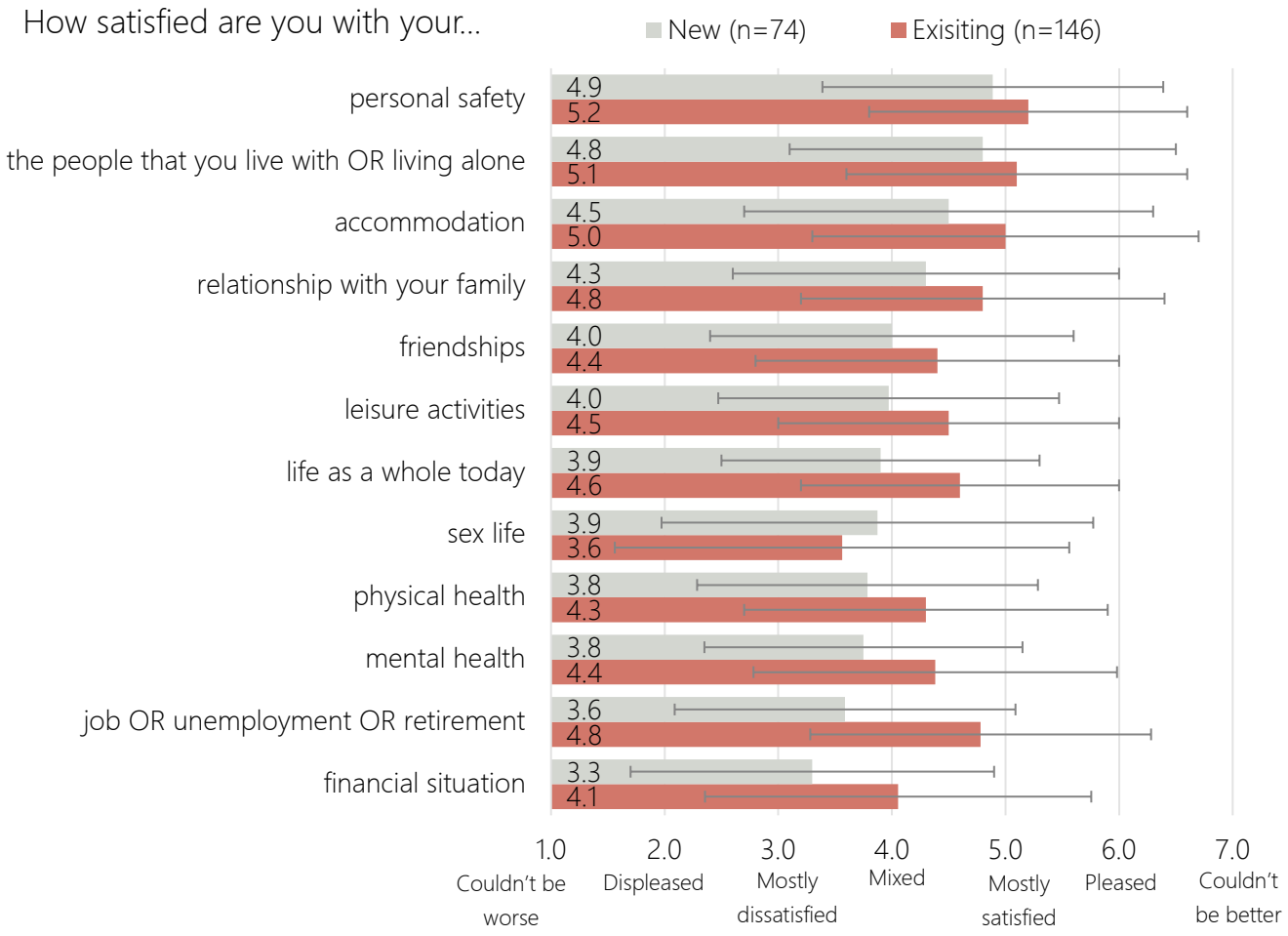
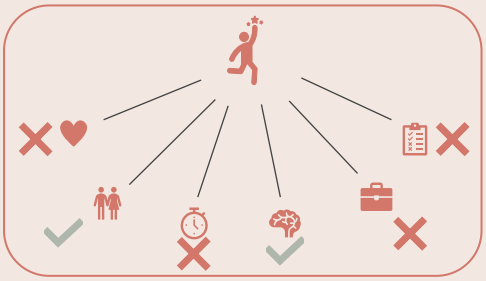


Figure 15. Scores for existing and new members for quality-of-life domains. Error bars indicate standard deviations.

The domain-specific findings align with the areas of life where Stepping Stone is best positioned to make a difference through the services and supports that they offer. At Clubhouse, services such as Transitional Employment and Social Recreation best address areas such as leisure activities and employment/retirement, which in turn influences members' financial situation, mental health, and life as a whole.



What predicts quality of life?

We conducted a predictors analysis for quality of life outcomes (see p.21 for details). No predictors or any of their interaction terms were statistically significant, except:

- being male predicted better quality of life (p=0.04)
- being diagnosed with other affective problems (p=0.03) when compared to other diagnoses predicted better quality of life.

Case Study of a Member: Tracey

Steps improves quality of life and builds resilience to mental health struggles.

Tracey has been a member of Steps for 23 years and talked about Steps as a "safe haven", somewhere to go that you were "treated with respect", where you "weren't known by your illness." Her journey at Steps has "transformed" her life…

"When I started coming I had been in hospital most of the time for nearly 15 years so I hadn't been working or anything, within about a month of starting to come they helped me find a job, and it was independent employment but they helped give me the courage to actually I guess believe that I could work and they supported me right through 20 odd years of working… It has transitioned me from being in a position where I was never going to work, never have any sort of independence, to basically getting work, finding my feet basically, and knowing that they're always there…it's transformed me, and ***even though I've come back I'm still nowhere near as sick as I was, and I still haven't needed hospital.*** *"*

Tracey explained that all of this was possible because the people at Steps believed in her, and how capable she was to contribute to and be a part of her community again.

"I do think one of their main things is that they do build a person up to believe in themselves and to I guess start to believe, whether it's getting a job, whether it's just functioning in the community, I think they, that's been a really big thing for me, ***so quality of life is pretty much what they gave back to me.. I was participating in life again.*** *"*

Something that is really special about Tracey's story is the full circle moment when she was able to organise a transitional employment position for other members at Steps at the place she worked. She really appreciated the opportunity to give back to Steps and the other members at Steps. The journey from finding her feet, to building her confidence, to independence in work and community, to giving back, gave her more meaning in her life and has shown her that no matter what stage of her journey she is, she always has somewhere she can turn to… "it has always been a safe place for me."

Hospitalisations

A Note on Hospitalisations

In the member surveys, hospitalisations were reported by members as:

- whether they had been to hospital for their mental health in the last 6 months
- nature of hospital occurrence (i.e., called emergency services, presented to emergency department and/or admitted to hospital)

Thus, hospitalisation data in this evaluation does not distinguish between ongoing treatment (e.g., visiting for monitored medication change) and presentations due to symptom acuity or crisis events.

New members had significantly higher rates of hospitalisation (41%, 31 out of 76 members) than existing members (16%, 26 out of 161 members); this difference is meaningfully and statistically significant ($p<0.01$; Figure 16). These significant differences in hospitalisation rates between new and existing members is a positive sign of the clinical impact Stepping Stone is having on members mental health journeys. Over time for new members, we see a meaningful decrease of 11% in hospitalisations from Orientation to Follow-up ($p=0.37$). Over time for existing members, the rates of hospitalisation remain under 20% at both Intake (14%) and Follow-up (18%), which was not statistically significant ($p=0.83$) nor meaningfully different (Figure 16).

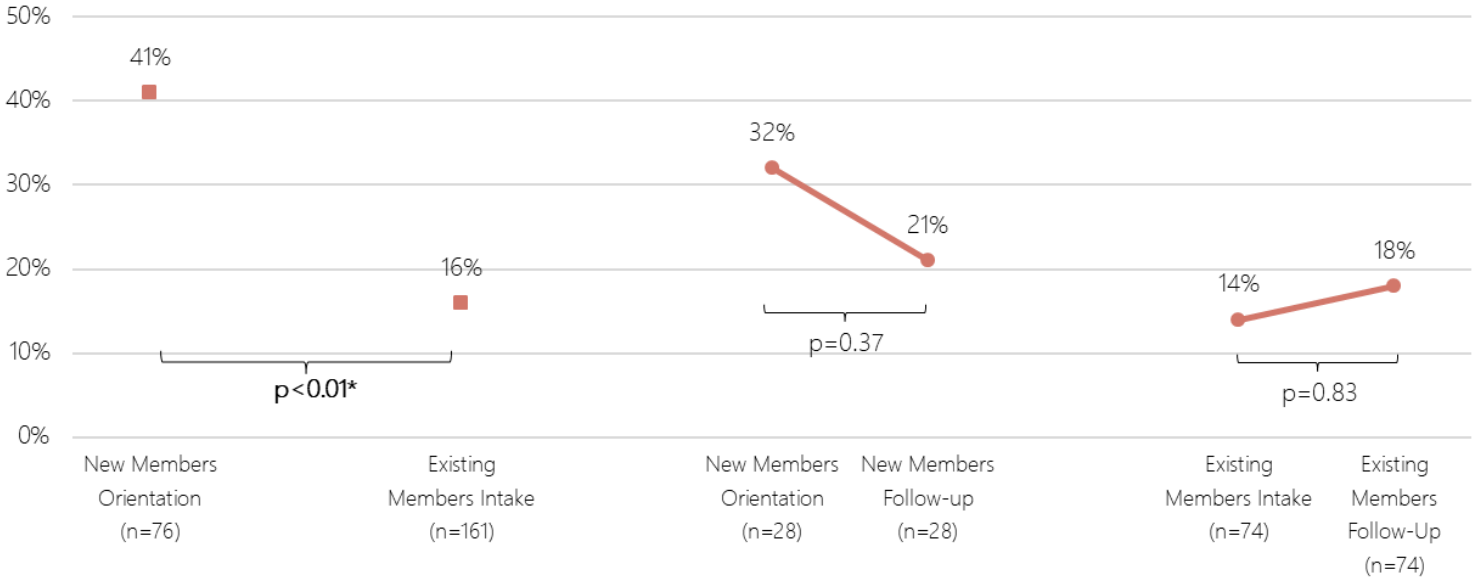


Figure 16. Proportion of and new members who had been hospitalised in the last 6 months at Orientation/Intake and Follow-up.

In Figure 17, of the 31 new members (represented by green bars) who reported being hospitalised prior to their Orientation survey, 68% (n=21) were admitted to hospital, 52% (n=16) presented to emergency services and 23% (n=7) called emergency services. Of the 26 existing members (represented by red bars) who had been hospitalised, 77% (n=20) were admitted to hospital, 38% (n=10) presented to emergency services and 23% (n=6) called emergency services but did not present nor were admitted to hospital. These differences in the nature of hospitalisations were not statistically significant between the cross-sectional comparison of these two member groups (p=0.71).

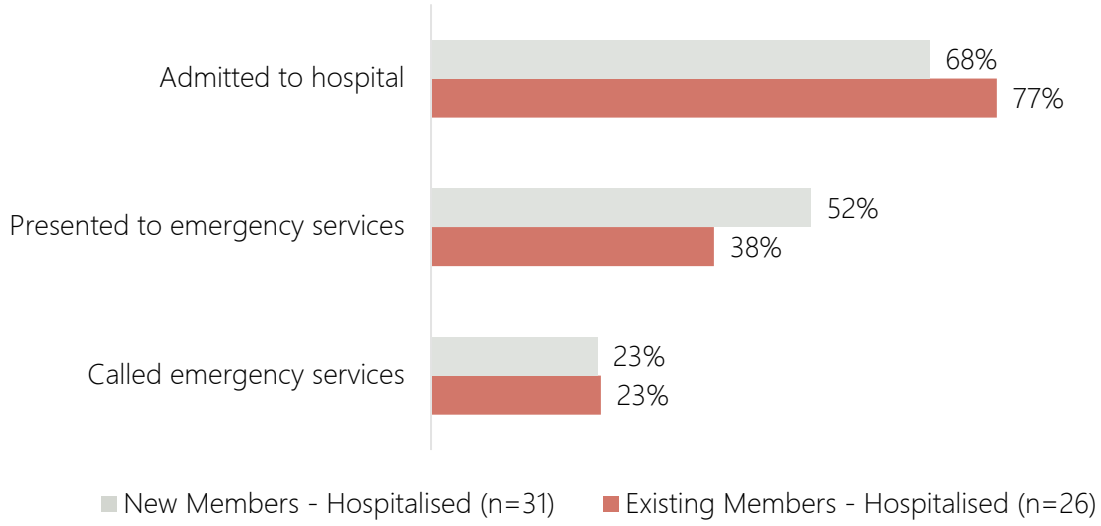


Figure 17. Breakdown of forms of hospitalisations for existing and new members who had been hospitalised in the past 6 months.

We acknowledge that in the longitudinal comparisons the decrease in the proportion of new members being hospitalised may be due to new members who were accessing hospital services not completing a Follow-up survey, going from 76 new members at Intake to only 28 at Follow-up. However, the corroboration of the cross-sectional and longitudinal findings both showing that new members were more likely to be hospitalised in the past 6-months compared to existing members gives confidence that this is a real finding and not a missing data artefact. We further explore this drop-off in new members at Follow-up on pg. 71.

NB: We wanted to look at hospitalisations as an outcome and a predictor in the predictors analysis. Although it was initially included, it was ultimately removed from the model due to multicollinearity.

Multicollinearity occurs when two or more variables in a statistical model are strongly related, making it difficult to separate and identify the individual effects of each variable on the outcome. For us to be able to continue identifying the independent impacts of the other predictors in the model, the variable of hospitalisations was removed.

Employment aspirations

New and existing members were asked to state their current employment status, as well as their aspirations for employment. In our evaluation sample, 160 existing members and 74 new members responded to these questions (Table 7).

Table 7. Employment statuses and aspirations for existing and new members at Intake.

	New Members (n=74)	Existing Members (n=160)	Group difference p-value
Current			
Form of employment*	13.0%	24.5%	
Work-ordered day	0%	13.3%	**0.01**
Unemployed	44.7%	14.6%	
Aspirations			
Form of employment*	58.9%	44.3%	0.61
Work-ordered day	6.9%	7.4%	

*Includes independent, supported and transitional employment.

Current employment

For existing members, 24.5% were currently in a form of employment, 13.3% were doing WOD, and 14.6% were unemployed. While for new members at Orientation, 13.0% were in a form of employment, none were doing WOD, and 44.7% were unemployed. These different forms of employment between new and existing members were statistically and meaningfully different (Table 7). Detailed breakdowns are shown in Appendix Table A2.

Employment aspirations

Of the 160 existing members, 44.3% had a goal of maintaining or acquiring some form of employment, and 7.4% would like to do WOD. Of the 74 new members, 58.9% had a goal of maintaining or acquiring some form of employment, and 6.5% would like to do WOD.

We can see that existing members have higher rates of employment and WOD than new members. This speaks to the Clubhouse Model supporting employment by providing specific employment services (such as, transitional employment) and supports (such as, individual & employment support). Transitional employment helps members identify their strengths and interests through vocational assessments. The Clubhouse Model also emphasises a WOD, offering real-world work experiences within the Clubhouse environment as a stepping stone towards transitional, supported, or independent employment. This structured approach is evident in the differing proportions that we

observe between existing and new members, enabling members to transition into competitive employment in the community. This is also reflected in the aspirations of both new and existing members, with a majority of both groups expressing wanting to participate in a work-ordered day or attaining some form of employment.

Educational aspirations

New and existing members were asked to state their highest attained education, as well as their aspirations for further education (Table 8). Education is crucial for populations with mental ill-health as it empowers individuals, reduces stigma, improves decision-making, enhances coping skills, increases employment opportunities, fosters social integration, provides cognitive stimulation, encourages advocacy, and contributes to an overall improved quality of life.[xvi]

Table 8. Educational statuses and aspirations for existing and new members at Intake.

	New Members (n=74)	Existing Members (n=160)	Group difference p-value
Current			
Did not finish high school	26.6%	15.4%	
Complete high school	14.7%	15.5%	0.09
Certificate/Diploma	33.3%	29.5%	
Tertiary qualifications	24.0%	36.6%	
Aspirations			
Do not want further education	25.3%	37.8%	0.17
Want further education*	58.7%	58.1%	

*Includes completing high school, and acquiring post-secondary^ or tertiary-level[†] education.

^Post-secondary education includes Certificate II/III/IV.

[†]Tertiary-level education includes Diploma/Advance diploma, Bachelor's degree, Graduate Certificate/Graduate Diploma, and Postgraduate degree.

*"I became more aware that **learning is more important for me for my mental health than work**, and I was able to stumble across a university programme that offered some part time study to get through some university courses and **I used Stepping Stone as an alternative to going to the library...so I was able to get support from the staff.** So you know it went from the social aspect to the learning aspect for me and now it's more a place to come for me to do my own projects, I find I can come in here and utilise the resources and computers and so forth." – 50-year-old male, member for 15 years*

Current education levels

For existing members, 15.4% did not finish high school, 15.5% completed high school, 29.5% have certificates or diplomas, and 36.6% have tertiary qualifications – only 2.8% preferred not to report their education. For new members, 26.6% did not finish high school, 14.7% completed high school, 33.3% have certificates or diplomas, and 24.0% have tertiary qualifications – only 1.3% preferred not to say (Table 8). Detailed breakdowns are shown in Appendix Table A2.

Education aspirations

Of these 160 existing members, 37.8% did not want further formal education while 58.1% expressed wanting further formal education of some sort – only 4.1% preferred not to say. Of the 74 new members, 25.3% did not want further formal education while 58.7% expressed wanting further formal education of some sort – only 16.0% preferred not to say (Table 8).

In terms of education, both new and existing members are comparable not only in current qualifications, but also in wanting further education. Again, this finding speaks to the Clubhouse offering educational support services, including assistance with enrolment, navigating academic requirements, and accessing resources. The model recognises the importance of education in personal development and vocational success. This finding shows that Stepping Stone is encouraging members to explore educational opportunities, and that there is room to strengthen how these aspirations are supported.

A Note on Follow-Ups

We want to address the proportion of members who completed a Follow-up survey, particularly for new members. On Page 24, we described how we reached our target for Intake and Follow-up surveys for existing members: we had 161 Intake surveys and 76 Follow-up surveys (a 47% retention rate).

For new members, we had 76 Orientation surveys and only 28 Follow-up surveys (a 37% retention rate). We acknowledge that it is unlikely to get a 100% retention rate at Follow-up, particularly for members at a service like Stepping Stone, when members come as much or as little as they want.

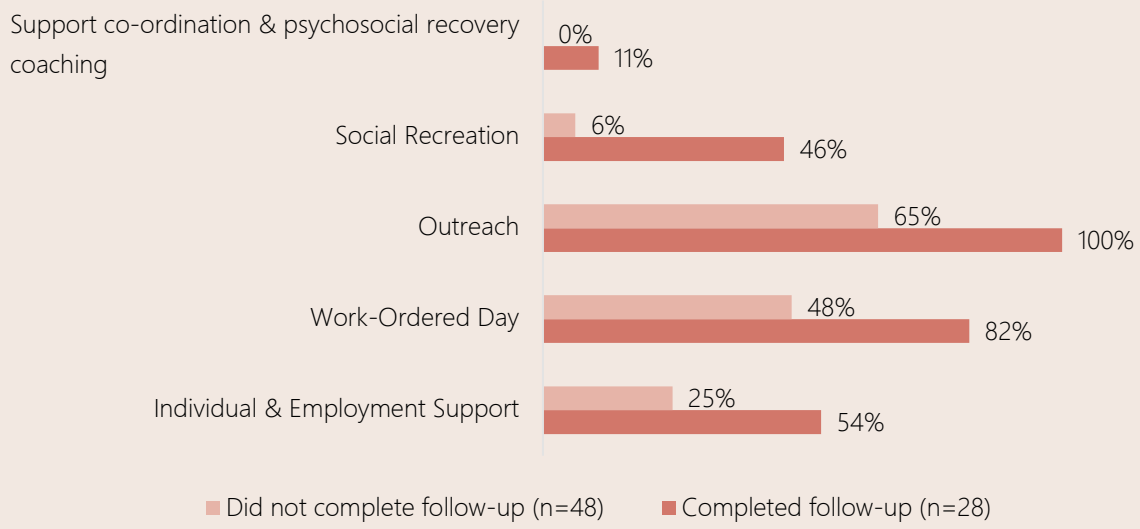
However, we wanted to describe the demographics and patterns of service engagement of the new members who did and did not complete follow-up to see if these will illuminate why we are seeing the longitudinal outcomes that we do.

Demographics

	Completed Follow-Up (n=28)	Did not complete follow-up (n=48)	p-value
Age, mean (sd)	41.9 (12.2) | n=26	38.3 (13.7) | n=39	0.35
Gender, n(%)	n=26	n=42	
Male	16 (62)	28 (66)	0.66
Female	8 (30)	12 (29)	
Non-Binary/Transgender	2 (8)	2 (5)	
Diagnosis, n(%)	n=27	n=43	
Depression	8 (31)	10 (23)	
Other affective disorders	3 (12)	2 (5)	
Anxiety disorders	3 (12)	4 (9)	0.01
Other anxiety related problems	1 (4)	4 (9)	
Schizophrenia/Schizoaffective disorder	4 (15)	9 (33)	
Other mental and behavioural problems	7 (27)	10 (19)	
Other psychoses	0 (0)	1 (2)	

We can see in the table above that new members who did and did not complete Follow-up did not significantly or meaningfully differ in age (p=0.35) or gender (p=0.66). They do, however, differ in diagnoses; new members who completed a Follow-up were more likely to have a diagnosis of Depression (31%), while new members who did not complete a Follow-up more likely to have a diagnosis of Schizophrenia (33%; p=0.01).

Patterns of service engagement



We can see in the graph above that new members who did not complete a Follow-up engaged with the Clubhouse considerably less overall than new members who did.

In summary, we can see that new members who did not complete a Follow-up were also lower engagers and were more likely to have a differing diagnosis, which may affect their motivation or interest to return to Clubhouse within 3 to 6 months, or to even come back into the Evaluation Sample. We cannot extrapolate whether these individuals have differing short-, medium-, or long-term outcomes compared to the new members who remained in the sample as we cannot deduce if their lack of engagement is due to their symptom severity/specific characteristics of their illness or if they are simply at a stage where they are not yet ready to fully engage with the Clubhouse.

To what extent do members at different stages of the "Stepping Stone Journey" experience outcomes?

Short answer:

- The stages of the Stepping Stone Journey differ by length of membership and by the volume and types of services people engage with.
- These different patterns of engagement meet the needs of people at that stage. As a result, members largely experience similar positive outcomes across most stages.
- The two stages that experience different outcomes are 'I'm moving on 'and 'I prefer not to say' who both report lower satisfaction with Stepping Stone and experience worse outcomes than the other stages of the Stepping Stone Journey.

What stages are members at in the Stepping Stone Journey?

The most common stages for members to identify with were "I'm out in community and accessing Clubhouse as I need it" and "I'm in a routine of coming to Clubhouse" (Figure 18).

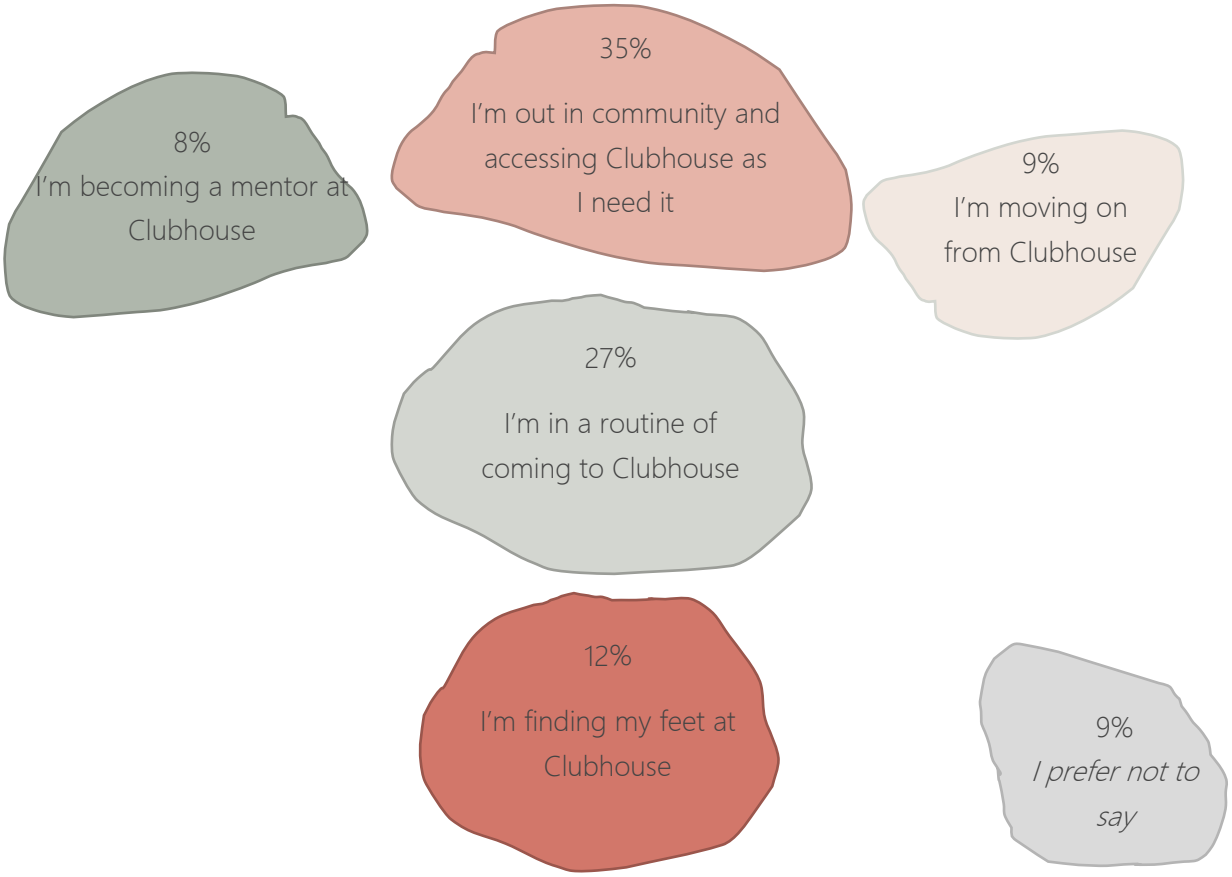


Figure 18. Proportion of evaluation sample (n=127) by their stage of the Stepping Stone Journey

We explored whether members in the different stages of the Stepping Stone Journey differed by age, gender, length of membership and types of diagnosis (Table 9). Members in the different stages did not differ meaningfully or statistically by age (p=0.14), gender (p=0.11) or types of diagnosis (p=0.23). Length of membership does significantly differ, specifically between 'I'm becoming a mentor' and 'I'm finding my feet' (10.1 vs 3.6 years, p<0.01), and between 'I'm becoming a mentor' and 'I prefer not to say' (10.1 vs 1.2 years, p<0.01).

Table 9. Demographics of members by stage of the Stepping Stone Journey

Stage	Age (n=117) mean (SD)	Years of membership (n=118) mean (SD)	Male (n=127) n(%)	Most common diagnosis
I'm finding my feet	43.14 (15.64)	3.57 (5.58)	9 (60)	29% Other mental and behavioural problems
I'm in a routine	46.28 (11.78)	6.05 (6.28)	23 (68)	42% Schizophrenia /Schizoaffective disorder
I access Clubhouse as I need it	50.42 (12.27)	8.53 (8.51)	25 (56)	29% Schizophrenia /Schizoaffective disorder
I'm becoming a mentor	54.44 (12.23)	13.56 (7.76)	6 (67)	56% Schizophrenia /Schizoaffective disorder
I'm moving on	53.00 (13.92)	10.10 (8.61)	7 (58)	60% Depression
I prefer not to say	44.5 (11.39)	1.23 (1.75)	6 (50)	25% Depression, Anxiety disorders OR Other mental and behavioural problems

We also explored whether members at different stages of the Stepping Stone Journey engaged differently with services at Stepping Stone. Figure 19 shows that there are different patterns of the volume of engagement (total number of occurrences) across the five stages. WOD is most frequently accessed by those 'finding their feet', Support Coordination and Psychosocial Recovery Coaching for those members 'in a routine', 'accessing Clubhouse as they need it', 'becoming a mentor' and those 'moving on'. Individual and Employment Support was most frequently accessed for those who 'prefer not to say' (Figure 19).

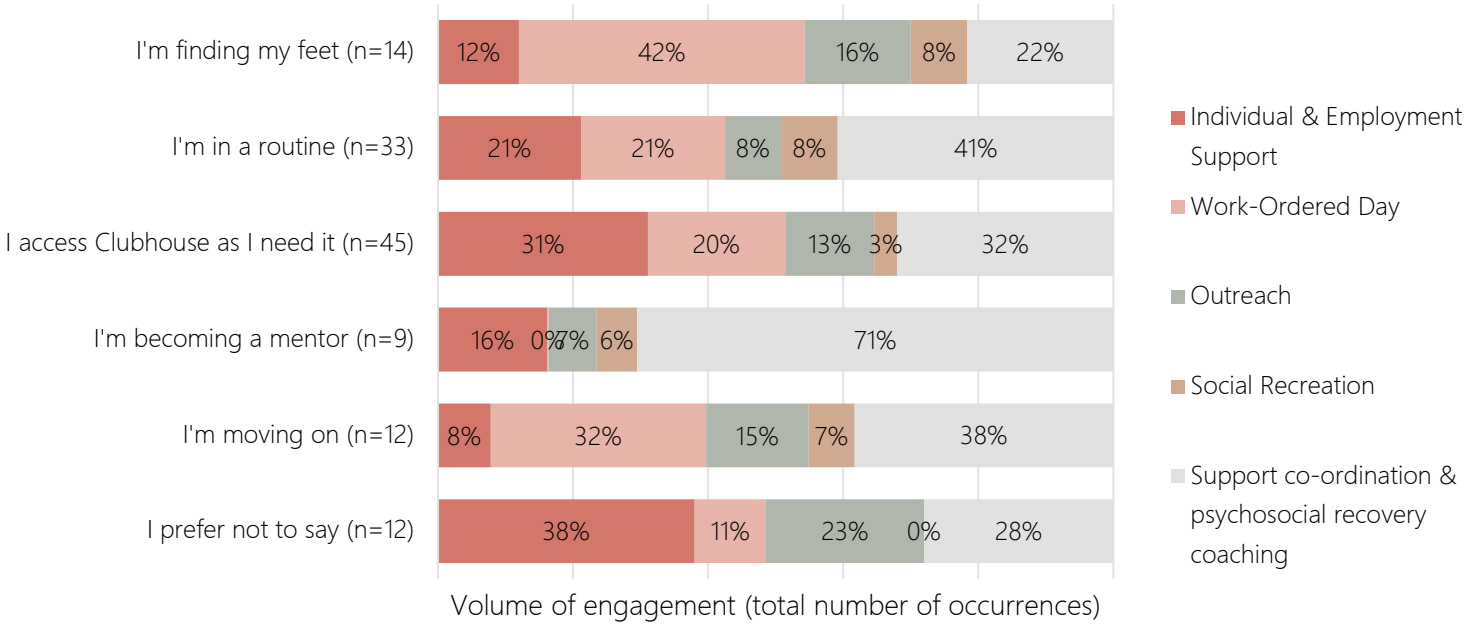


Figure 19. Proportion of total occurrence of engagement within service types by stages of Stepping Stone Journey.

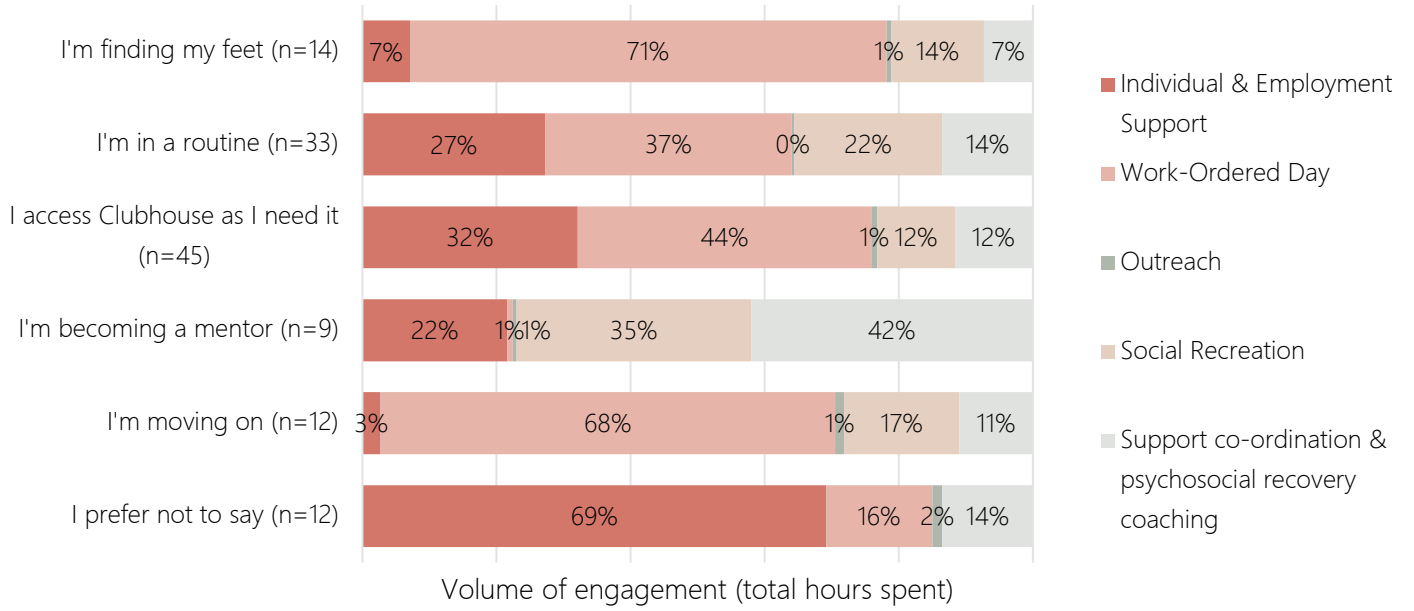


Figure 20. Proportion of total hours of engagement within service types by stages of Stepping Stone Journey.

As in the earlier analysis of the whole evaluation sample, the patterns of engagement shift when examining total hours spent, instead of volume of engagement by occurrence. WOD was most frequently accessed by those 'finding their feet', 'in a routine', 'accessing Clubhouse as they need it', and 'moving on'. Support Coordination and Psychosocial Recovery Coaching continues to be most frequently accessed by those 'becoming a mentor', and Individual and Employment support for those who 'prefer not to say' (Figure 20).

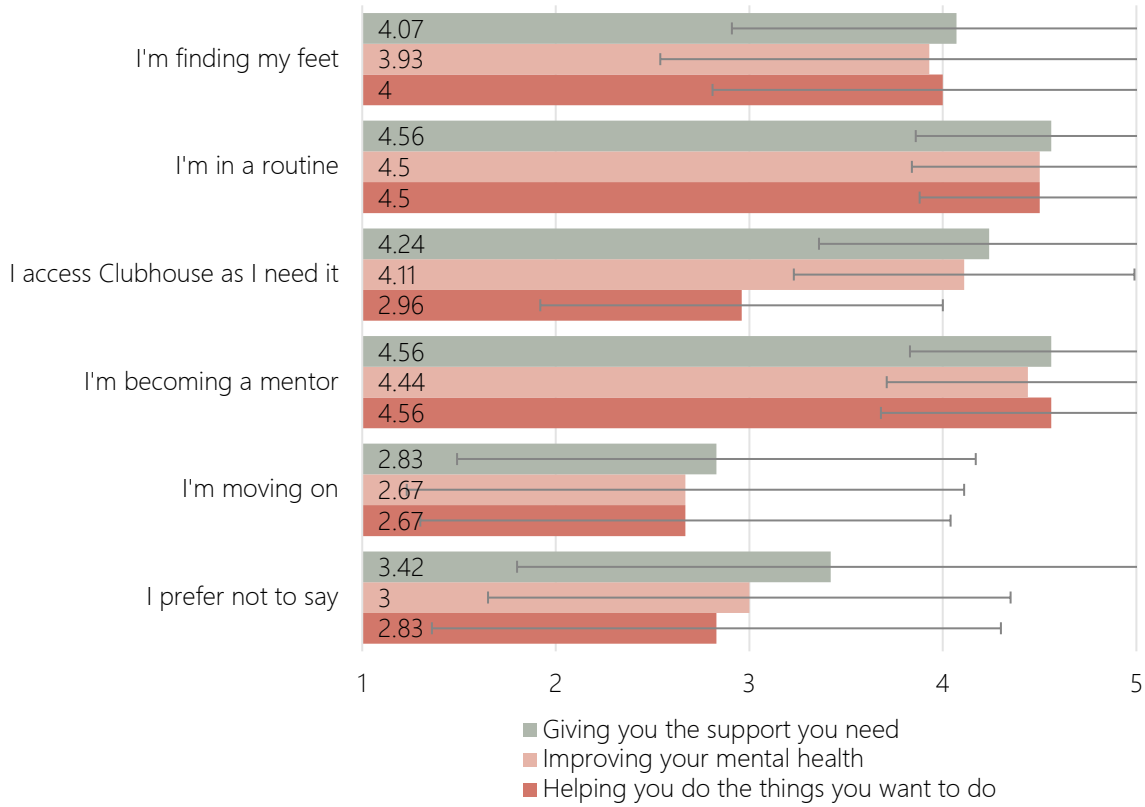


Figure 21. Mean rankings for satisfaction with Stepping Stone (out of 5 stars) by stages of the Stepping Stone Journey. Error bars indicate standard deviations.

There were also differences in member satisfaction across the stages of the Stepping Stone Journey (Figure 21). On average, members who 'preferred not to say' or were 'moving on' ranked Clubhouse three stars or below across different aspects. Those who are 'finding their feet' and 'accessing Clubhouse as they need it' consistently ranked Clubhouse, on average, between 3 to 4.2 stars across all aspects. Only those who are 'in a routine' or 'becoming a mentor' consistently ranked Clubhouse above 4.5 stars. This suggests that those members who are 'moving on' are not finding what they need at Stepping Stone.

Progress Outcomes across the stages of the Stepping Stone Journey

Here we re-visit Progress Outcomes, previously defined and discussed on pp. 57-59, across the stages of the Stepping Stone Journey. Figures 22a and 22b show the four Progress domain scores for each group of members by their nominated stage of the Stepping Stone Journey. For Personal Progress all groups, except those who are 'moving on' and 'prefer not to say', scored 74% or above (Figure 22a). Those who 'prefer not to say' were significantly lower than those who are 'in a routine' or 'becoming a mentor' (p=0.01).

For Functional Progress, all groups scored between 78-87%, indicating that all groups were in an 'area of success' for functional progress (Figure 22a). There were no meaningful or statistically significant differences between stages of the Stepping Stone Journey for Functional Progress (p=0.55).

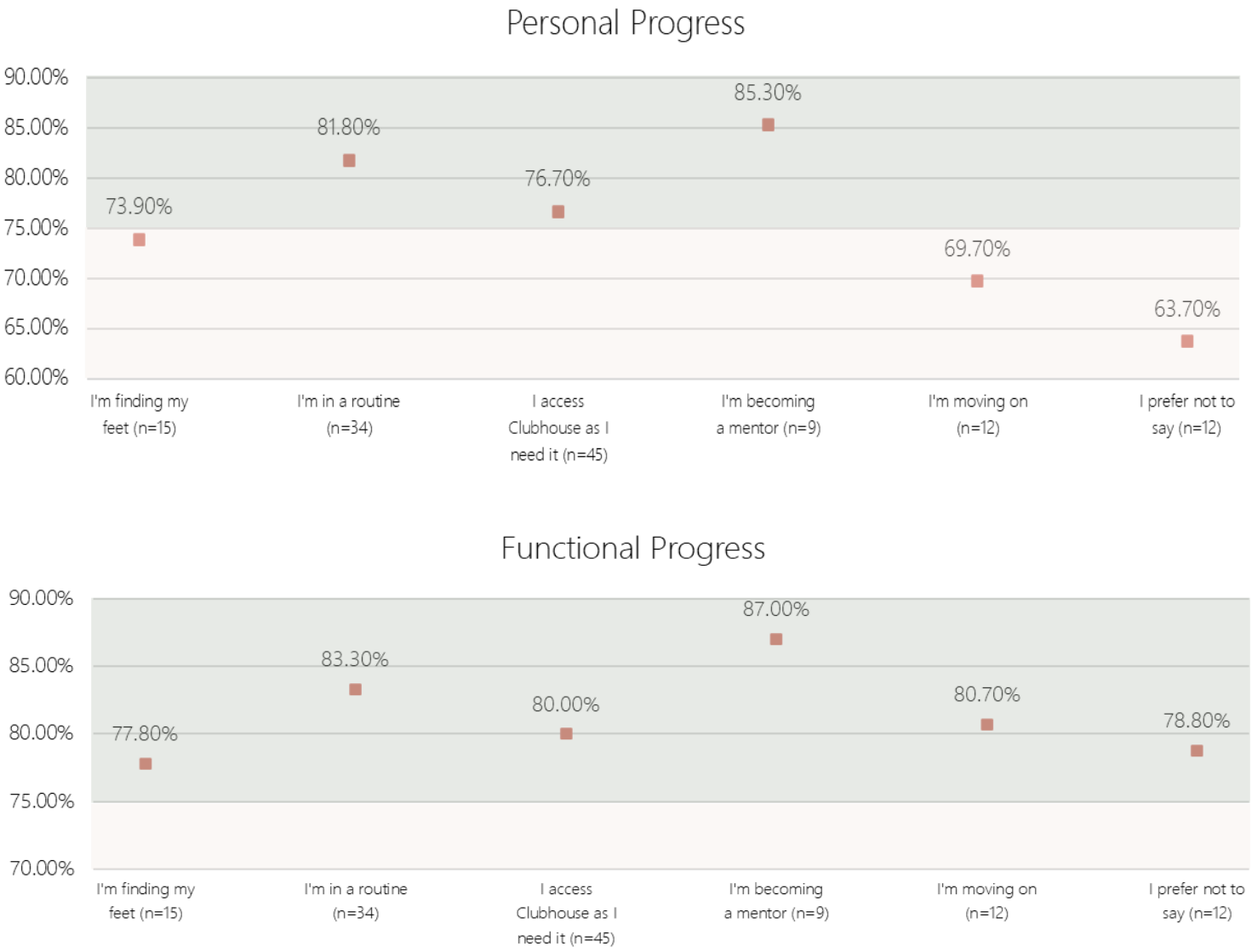


Figure 22a. Scores by stage of the Stepping Stone Journey for Recovery Progress domains of the RAS-DS.

In Figure 22b, for Symptom Management Progress, all groups scored between 69-79%, except for those who 'preferred not to say' (53%). Those who 'preferred not to say' significantly differed from those who are 'in a routine' or 'becoming a mentor' (p=0.04). In addition, members who were 'finding my feet' and 'moving on' meaningfully differ from members who were 'becoming a mentor'.

For Social Progress, all groups scored between 71-82%, except for those who 'preferred not to say' (62%). Those who 'preferred not to say' significantly differ from those who are 'in a routine' (p=0.04). Members who were 'finding my feet' and 'moving on' meaningfully differ from members 'in a routine' (Figure 22b).

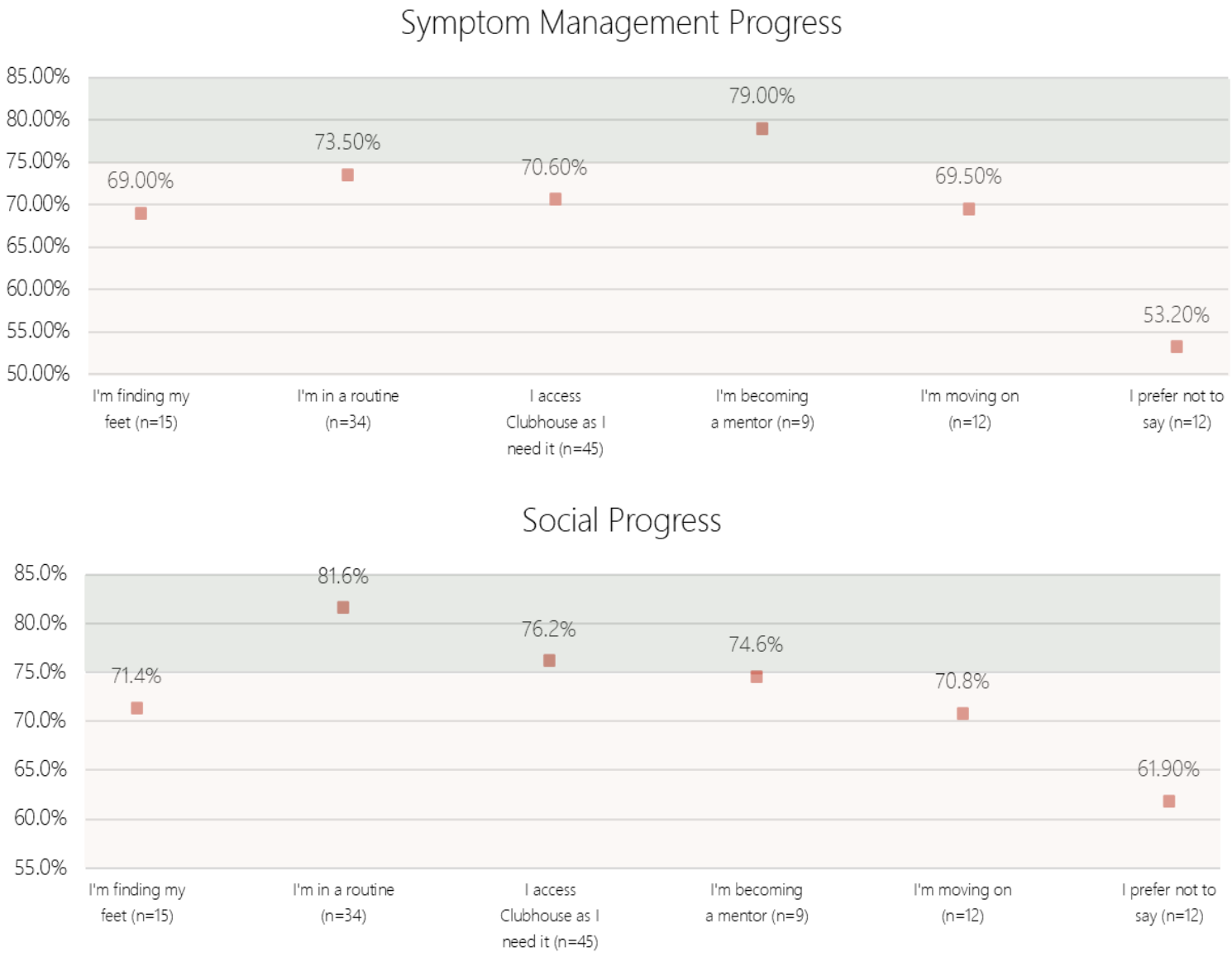
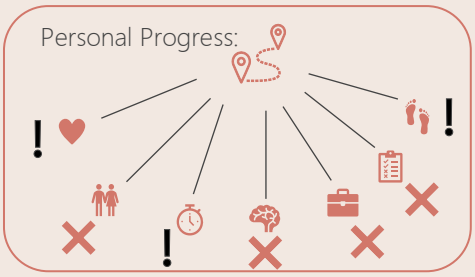
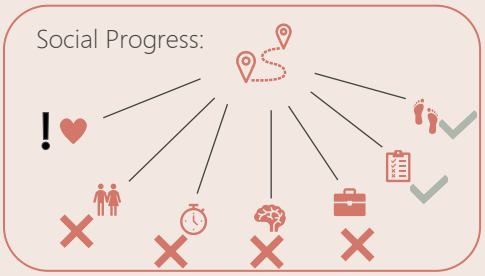


Figure 22b. Scores by stage of the Stepping Stone Journey for Recovery Progress domains of the RAS-DS.





What predicts progress?

We conducted a predictors analysis for each of the progress outcomes (see p.21 for details). No predictors or any of their interaction terms were statistically significant for any progress domain, except Personal Progress and Social Progress.

For Personal Progress:

- being older and identifying as 'finding my feet' predicted better progress ($p=0.03$)
- being older and 'in a routine' predicted better progress ($p<0.01$)
- longer membership and identifying as 'in a routine' predicted worse progress ($p=0.02$)
- longer membership and identifying as 'prefer not to say' predicted worse progress ($p=0.04$)

For Social Progress:

- identifying as 'accessing Clubhouse as one needs it' predicted better progress ($p<0.01$)
- identifying as 'finding my feet' predicted worse progress ($p=0.04$)
- attending Clubhouse less than one wanted predicted worse progress ($p=0.01$)
- being older and identifying as 'moving on' predicted worse progress ($p=0.04$)

Social connectedness across the stages of the Stepping Stone Journey

There were different levels of social connectedness with other members at Clubhouse across the stages of the Stepping Stone Journey (Figure 23). Those members who were 'in a routine' or 'becoming a mentor' scored above 45 out of 60, indicating higher connectedness. Members who were 'moving on' had a significantly lower connectedness score compared to the other stages ($p=0.04$). Social connectedness was previously defined and discussed on pp. 60-61; please refer back to these pages for further scoring information.

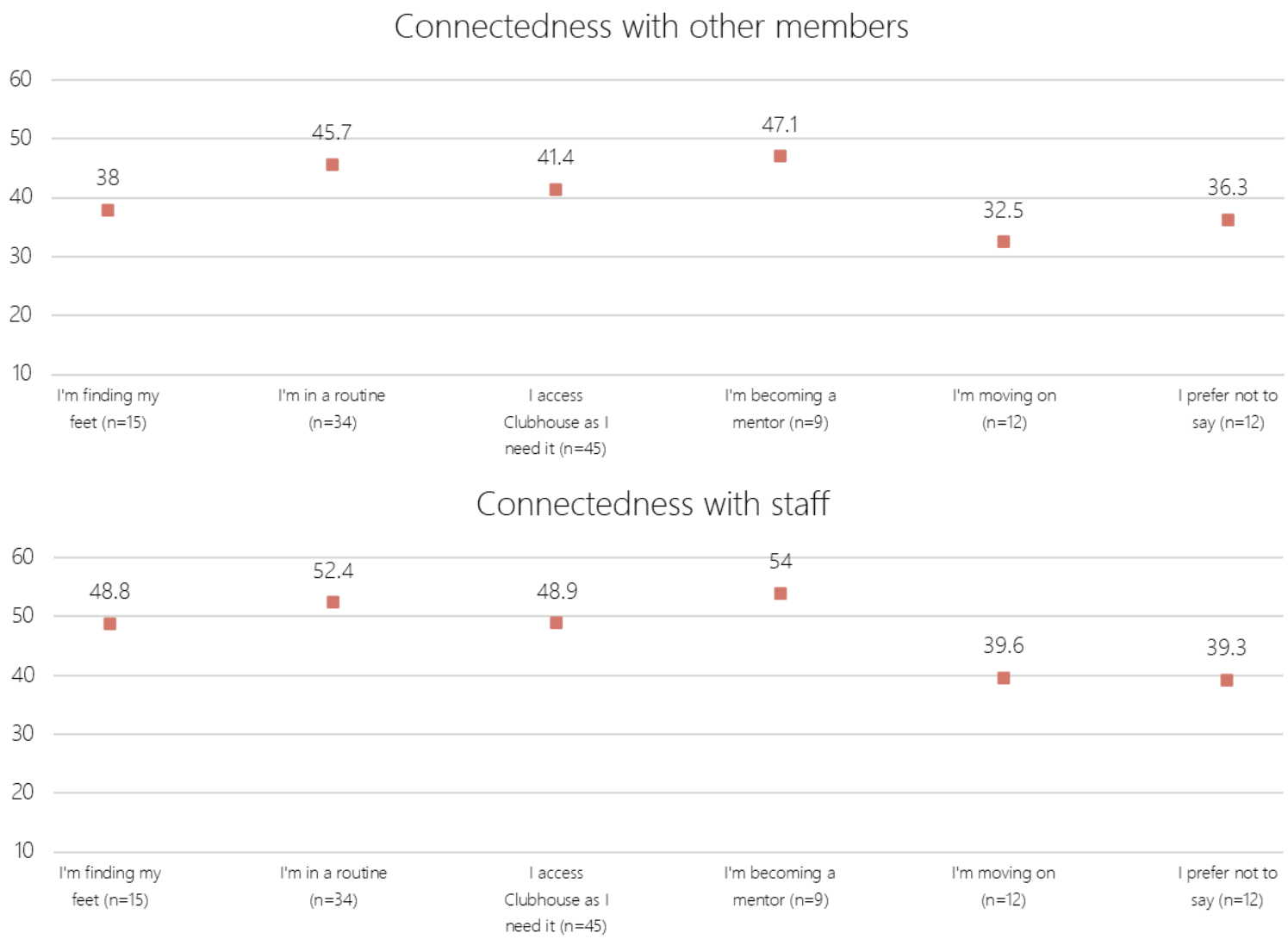
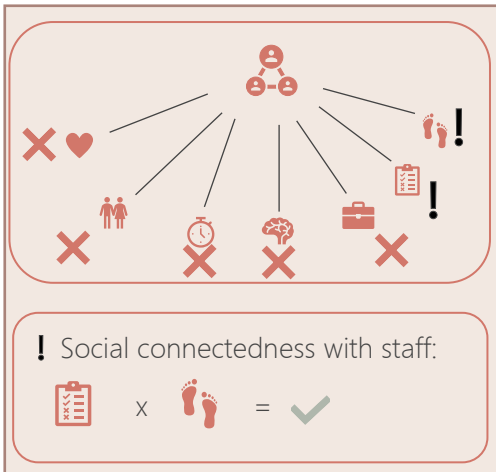


Figure 23. Social connectedness with other members and staff by stages of the Stepping Stone Journey.

Similarly, there were different levels of social connectedness with staff across the stages of the Stepping Stone Journey (Figure 23). Members who were 'in a routine' or 'becoming a mentor' scored above 50 out of 60, indicating higher connectedness. Those who were 'moving on' and 'prefer not to say' continued to score below 40, which are statistically significantly lower connectedness scores compared to other stages (p=0.01).

Recent research has indicated that perceived affiliation with the Clubhouse predicts better recovery outcomes[xiii]. People at particular stages of the Stepping Stone Journey, specifically "I'm in a routine" and "I'm becoming a mentor", appear to be more connected to people at the Clubhouse, and this may in part explain higher progress (RAS) scores in these groups.

"Even just last year I was more task-focused and so now in the last year, it's been more social, getting more involved…for some people it's good to come here for a coffee and a chat, for some people it's good to do stuff"- 46-year-old male, member for 16 years



What predicts social connectedness?

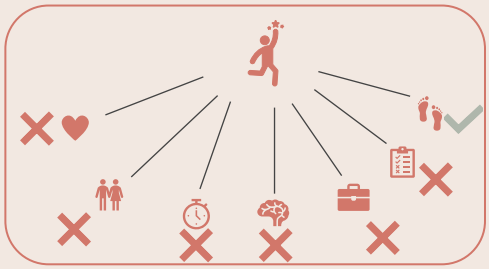
We conducted a predictors analysis for social connectedness outcomes (see p.21 for details). No predictors or any of their interaction terms were statistically significant for connectedness with other members. No sole predictors nor any interaction terms were statistically significant for connectedness with staff, except:

- identifying as 'I'm in a routine' AND attending Clubhouse less than one wanted to predicted lower social connectedness (p=0.04)

Quality of Life across the stages of the Stepping Stone Journey

Quality of life was previously defined and discussed on pp. 63-65; please refer back to these pages for further scoring information. All groups had a quality of life satisfaction score above 4, except those who 'prefer not to say' who were significantly lower in satisfaction than the other stages of the Stepping Stone Journey (mean±SD: 3.0±1.2; Figure 24). It is promising to see that members report similar quality of life scores across the different stages of the Stepping Stone Journey, showing that members are getting what they need from the service. However, the group who 'prefer not to say' where they are at on their Stepping Stone Journey need further investigation to explore why their quality of life is meaningfully lower than others.

Figure 24. Quality of life scores by stages of the Stepping Stone Journey.



What predicts quality of life?

We conducted a predictors analysis for quality of life outcomes (see p.21 for details). No predictors or any of their interaction terms were statistically significant, except:

- identifying as 'accessing Clubhouse as I need it' predicted better quality of life (p=0.03)
- identifying as 'prefer not to say' predicted worse quality of life (p=0.02)

Other longer-term outcomes by stages of the Stepping Stone Journey

Hospitalisations did not statistically differ by stages of the Stepping Stone Journey (p=0.21), with hospitalisation rates ranging from 0-30% across the six groups: 25% (n=2) for those 'finding their feet', 33% (n=10) for those 'in a routine', 6% (n=2) for those 'accessing Clubhouse as they need it', 0% (n=0) for those 'becoming a mentor', 9% (n=1) for those 'moving on', and 33% (n=3) for those who 'prefer not to say'.

Employment did not significantly differ by stage of the Stepping Stone Journey (p=0.22). For employment, those 'finding their feet' were primarily unemployed (38.4%), those 'in a routine' are primarily doing work-ordered day (38.2%) or are unemployed (26.2%), those 'accessing Clubhouse as they need it' are primarily in some form of employment (37.8%), those becoming a mentor are primarily volunteers (33.3%) or doing work-ordered day (44.4%), those members who are 'moving on' are primarily independently employed (25%) or retired (25%), and those who 'prefer not to say' are primarily in some form of employment (25%) or volunteering (25%).

Education did not significantly differ by stage of the Stepping Stone Journey (p=0.28), those members at the stage of 'becoming a mentor' had no one seeking further formal education, whereas those members 'finding their feet' and 'in a routine' had 33% and 27%, respectively looking for further education. The stages with the highest proportion of members wanting further education were those 'accessing Clubhouse as they need it' (38.1%), 'moving on' (41.7%) and 'prefer not to say' (40%). Detailed means and standard deviations for all outcomes are shown in Appendix Table A3.

NB: Caution should be exercised in interpreting the outcomes by stages of the Stepping Sone Journey. The robustness of analysing outcomes by stages of the Stepping Stone Journey is compromised due to the following factors that impact the reliability of cross-comparisons.

The concept of "stages of the Stepping Stone Journey" did not emerge until midway through the evaluation, which meant we did not measure it until Wave 2. This timing constraint meant that not everyone in our evaluation sample would have had the chance to identify with a "stage of the Stepping Journey" if they had had only completed a survey in Wave 1. This also meant that we had less opportunity to accumulate sufficient participant numbers for each group.

Additionally, our methodology was not statistically powered to conduct thorough analyses of the short-, medium- and long-term outcomes across these different stages of the Stepping Stone Journey. Ideally, a minimum sample size of 90 per group would have been required to detect significant differences at sufficient power between the stages of the Journey.

What do members and staff think could be improved about Stepping Stone?

Short answer: Members and staff found it difficult to think of improvements that they wanted to see at Stepping Stone. But when prompted further or given other opportunities to contribute, the suggested improvements focused on:

- Getting the staff and member balance right
- Strategies to relieve overwhelm for staff and members
- More structured training, especially at the onboarding stage

During the one-on-one interviews and focus groups, we asked members and staff to identify things they thought could be improved at Stepping Stone. Many members expressed not feeling like anything needed to change, or that **if they wanted something to change there were already channels available to them to voice their concerns**. A lot of members felt that they could go to a staff member to be heard. This was encouraging to hear.

*"If there are things you don't like or you think are being done wrong, **you just bring it up and you're listened to**. If its valid, things are actioned from it." – male, member for 1 year.*

For the members and staff who suggested improvements, the main issues were:

- Needing more staff and/or more members to complete work-ordered day tasks
- Wanting somewhere quiet to go when things get overwhelming or chaotic
- Receiving more specific onboarding and skills training

For staff there were additional issues related to:

- Streamlining communication channels

More staff, more members (in balance)

Some members expressed that over time they felt some staff were not available as often for spontaneous support. Staff feel that changes in different funding streams have diversified the way that staff can and are required to work so this has somewhat shifted the services that are prioritised. Staff noted the tension between the way the Clubhouse International model is delivered according to the standards (see Appendix A) and some of their funding requirements. Many staff expressed there was a need for more staff without an increase in membership as their current workloads were feeling overwhelming. Staff believed that a better balance in the staff: member ratio would mean:

- Staff can "focus on one hat for at least a day". *"You wear lots of different hats and there is no time between functions to transition or debrief or write notes."* Although the nature of the

Clubhouse model means that all staff are required to be generalists, a lot of staff noted that there were natural strengths in their team that they could lean into more.
- Being available to members to connect and provide spontaneous support
- Staff are able to respond, rather than react. A lot of staff talked about the unplanned crises that come up regularly in Clubhouse and that these were hard to manage because of their already full workload. They said, *"everything feels urgent"* and there isn't always a clear protocol for how to handle a situation or who to escalate the situation to.
- Members can have more meaningful tasks for WOD and give members stability (e.g., having the same anchor for a whole day in the units)

"In an ideal world you world have another 5 staff members and then you could be working lighter, and like have more time and attention for the members" - staff, 11 months

We acknowledge that since we collected this data, Stepping Stone have hired new staff members and the membership numbers have increased. However, this means it is especially important to consider the other improvements noted (e.g., A quiet place; Onboarding/training protocols; Streamlined Communication) so that existing concerns are not exacerbated by a busier Clubhouse.

A quiet place for members and staff

We heard both members and staff say that the Clubhouse can get quite chaotic and loud. For some, the overload of sensory stimulation was their biggest challenge at the Clubhouse. They expressed that the lively environment was "both a wonderful thing and can be overstimulating"; "invigorating, and also overwhelming." Some staff noted if they had just had a really challenging support or had to deal with something unexpected, there was nowhere for them to go that was quiet and private, even feeling like if they went outside they would still come across someone who needed their time; "I love being around members but there are times when we all need quiet space."

Training and onboarding for members and staff

Some staff felt that at times they were thrown "in the deep end" at work. While Stepping Stone is not intended as a clinical treatment facility, there are sometimes mental health incidents that arise that staff do not always feel equipped to handle. Staff felt that both members and staff would feel better supported with protocols in place to help staff make decisions when these incidents come up. They want to know who they can go to in the moment and what boundaries exist for managing incidents. In addition, after the incident they want thorough debriefs to be an integral part of incident management. These debriefs would be to:

- identify why and how the incident happened in the first place without blame
- understand how each person involved needs to be supported

- decide what to do in the future if it happens again
- plan how to communicate this learning to everyone on the team

Staff identified areas that they felt skills training would improve Stepping Stone:

- a more structured onboarding procedure that goes through each service and unit systematically
- trauma-informed practice education
- mental health first aid
- suicide prevention training
- specific therapies or coaching strategies (e.g. solution-focused therapy)
- training to support members with finding and maintaining housing

Members identified areas that they felt skills training would improve Stepping Stone:

- upskilling member capacity for more meaningful tasks in WOD
- a more in-depth orientation process that includes the next steps after Orientation
- mental health education training such as peer group study or sharing emotional management tips

Streamlined Communication for staff

This theme came through especially strong in the staff focus groups. There were lots of post-it notes referencing improving communication to support a better workplace and better impact for members.

Less on the coordination board	More streamlined and concise communication	More opportunity for staff catch ups	So many streams that things get lost in translation or missed

Staff noted that there were several digital channels as well as ad hoc conversations with management staff that would alert them to support coordination changes, upcoming events or training, and general information provision. They also expressed that this was, at times, communicated last-minute. While it was acknowledged that sometimes coordination of tasks needed to be changed last minute, the regularity of the last-minute changes had become common and often meant they found it difficult to prepare appropriately. Staff also noted that because the communication channels are digital (e.g. WhatsApp) and changing regularly they were constantly checking their mobile phones and that this reduced their ability to be present with members.

KEY FINDINGS

WHO comes to Stepping Stone?

In one year…

- 187 people came to do a Tour of the Clubhouse
- 72% of those who did a Tour became a Stepping Stone member (11 people per month)
- Members waited on average 105 (±43) days to return to the Clubhouse after joining.

People who chose to become a Stepping Stone member were…

- More likely to be male (63%), aged 48 years on average, and most commonly diagnosed with Schizophrenia (20%).
- People who became a member in the past year were younger and less likely to be diagnosed with Schizophrenia when compared with All Members.

HOW is Stepping Stone delivered and accessed by members?

- Only 20% of the overall income for Stepping Stone was recurrent.
- Members told us there were different stages of the Stepping Stone Journey. These were 'finding my feet', 'in a routine of coming to the Clubhouse', 'out in the community and accessing the services as needed', 'becoming a mentor', and 'moving on'.
- Outreach was the most commonly experienced service for new (88%) and existing (97%) members.
- Members engaged with Stepping Stone services differently based on:
    - whether they are new or existing members,
    - their stage of the Stepping Stone Journey,
    - where they live (e.g., proximity to the Clubhouse).
- Members said Stepping Stone is somewhere they can progress at their own pace, a place where they are accepted and valued, and not known for their diagnosis.

WHAT is the impact of Stepping Stone on its members?

- Existing members scored higher than new members across all progress domains, social connectedness and quality of life.
- There was a much higher proportion of new members (41%) accessing hospital for their mental illness in the past 6 months than existing members (16%).
- Over 3-6 months, new members experienced a meaningful reduction in hospitalisations and a meaningful increase in functional progress.
- There were two stages of the Stepping Stone Journey that experienced different outcomes, 'I'm moving on' and 'I prefer not to say' who reported lower satisfaction with Stepping Stone and lower impact outcomes than other stages.
- In the members' words…

"It just changed literally my whole world"; "You can just be yourself and I guess that's now resonating into other aspects of my life"; "It's transformed me, and even though I've come back I'm still nowhere near as sick as I was, and I still haven't needed hospital."

So what's next?

Recommendations

This evaluation project has created a deep understanding of the experiences, engagement and outcomes of members and staff at Stepping Stone. The aims of this evaluation project were to:

- Capture the impact of Stepping Stone on members' physical and mental health and wellbeing, social participation, and civic participation.
- Communicate the impact of Stepping Stone on members to funding bodies, current and prospective members and other people interested in understanding Stepping Stone.
- Use the evidence generated in this evaluation to suggest improvements for Clubhouse.
- Build capacity within Stepping Stone so that evaluation becomes part of Clubhouse thinking and practice.

In order to achieve these aims we need to act on the findings of this evaluation project. That is what we focus on here in the Recommendations section. In this section, we make recommendations based on the evidence, for issues that were identified across multiple sources of data (i.e., surveys and interviews) or from multiple stakeholders' perspectives (members and staff). We acknowledge that some of these issues are long-running, already-known issues at Clubhouse and that some have started to be addressed since this Evaluation Project commenced in August 2022. However, we still feel it is important to highlight these to reflect the voices of the members and staff.

To help Stepping Stone take action, we have also categorised the Recommendations based on:

- Effort or cost for implementation of recommendation (high vs. low)
- Potential impact of recommendation (high vs. low)

We appreciate that these indicators are not binary extremes (i.e., high vs. low) but rather a gradient (as shown in Figure 26). The binary approach we have taken is to simplify interpretation and help Stepping Stone create priority lists of actions. Stepping Stone will need to check our assumptions for required resources for implementation based on their existing resources and forecasted budgets.

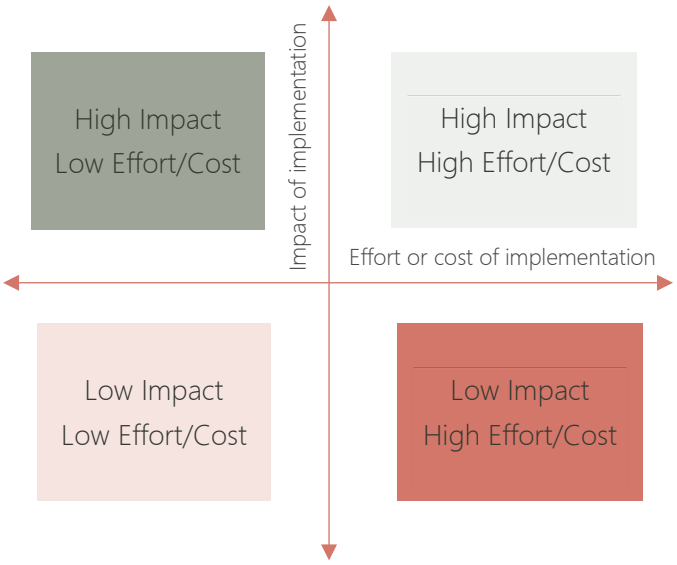


Figure 26. Continuum of relationship between potential impact of recommendations and effort/cost.

Recommendations for Stepping Stone

We appreciate that Stepping Stone already has great mechanisms for members to be involved in refining how the Clubhouse operates. However, there are some key learnings from both members and staff in this Evaluation Project that could be acted upon to further improve Stepping Stone.

Recommendation	Details	Potential Impact	Effort/ Cost
1.1 Advocate for funding that fits	Educate funders on how the Clubhouse Model operates and how funding mechanisms and required reporting is best suited to support this Model. Use the evidence from this Project to demonstrate the impacts of Stepping Stone on members to advocate for recurrent funding.	high	high
1.2 Onboard new members	Acknowledge that new members need clear expectations and structure to engage early on. Explain at Orientation that some new members feel overwhelmed and that they can engage at the Clubhouse when they are ready, but in the meantime members and staff will prioritise Outreach. Consider organising the details of those first few engagements (e.g., which staff will greet them, which WOD unit will they engage with).	high	low
1.3 Prioritise Outreach	Continue to prioritise Outreach for all members and systemically track members which ones are due for contact. This service helps new members to feel connected to Clubhouse when they are not attending and supports existing members when their circumstances shift.	high	low
1.4 Create a dedicated quiet space	Discuss at a house meeting that a space in the Clubhouse becomes a dedicated quiet space. Stepping Stone should agree on the rules together, but we propose: it can be accessed by members and staff at any time, the door can be closed, there is no music, and there is no talking.	high	low

Recommendation	Details	Potential Impact	Effort/ Cost
1.5 Continue to re-build employment and education	New and existing members both have a desire for more employment opportunities. Continue to re-build the employment and education unit within Stepping Stone. Broaden the types of Transitional Employment positions available (admin/office roles), systematically discuss employment goals with all members, use members as case studies to break down myths about Transitional Employment and celebrate members' employment milestones.	high	high
1.6 Strengthen the focus on housing	Supporting access to safe housing is a core part of the Clubhouse Model. Members need better support for this, and staff need more training in how to offer accommodation support. Use relationships with partners to educate staff on options for members obtaining or retaining safe housing. Systematically discuss housing goals with all members.	high	high
1.7 Refine staff schedules and communication	Create more space in staff's daily schedules to transition between roles, or create schedules where staff remain in one role across a whole day or half-day. Consolidate the number of channels that staff receive messages about coordination and establish a protocol about how last-minute schedule changes are communicated and expectations for checking channels frequently throughout the day.	high	high
1.8 Build professional development practices for staff	Introduce an off-site professional development day at least once every six months when all staff can be together to debrief on their practices and plan for further skill development. Host trainers to deliver skill training in specific topics identified by staff.	high	high

Recommendations for Monitoring, Evaluation and Learning

This Evaluation Project was the start of a new journey for Stepping Stone. The Stepping Stone community are starting to embrace the role of Monitoring, Evaluation and Learning (MEL) in their practice and starting to understand the role that MEL can play in strengthening the Clubhouse. We acknowledge that this change is at an early stage and that there is understandably some reluctance for staff to fully embrace MEL practice in their already-busy daily activities. We will work with Stepping Stone over the next phase of this project to build capacity for MEL, help embed MEL practices and support the implementation of the following recommendations.

Recommendation	Details	Potential Impact	Effort/ Cost
2.1 Embed Orientation Survey	Retain the Orientation Survey for all new members at Orientation (or within 2-weeks). Work with staff and members to understand the value this survey holds and that most members are comfortable completing the survey (particularly if it is interview-administered). The items in the Orientation Survey will be refined following this project.	high	low
2.2 Add key outcomes from the evaluation survey to the annual member surveys	Discuss at a house meeting the idea of adding key outcome measures used within this evaluation to the existing Annual Member Survey. These additional questions would enable ongoing evaluation of the impacts of Stepping Stone. Host an annual House Meeting dedicated to reporting the findings of these surveys to celebrate progress and discuss implications.	high	high
2.3 Refine the constructs being measured	Amend the tool used in this project to measure 'social connectedness' to a tool that captures 'belonging and inclusion', and consider adding a tool that captures 'social re-integration into community'. We heard from members that belonging and acceptance was a key part of their progress journey, more so than social networks and friendships. Analyses could then be added to confirm this as a mechanism for better progress.	high	low

Recommendation	Details	Potential Impact	Effort/ Cost
2.4 Amend KPI on 'Returners'	Change the KPI in the Stepping Stone Operational Plan from % of members returning within 2-months to 5-months (based on the mean (SD) return time for new members).	low	low
2.5 Track the reach of Stepping Stone	Regularly track and report on the relationship between number of Tours, Orientations, and Returners to understand which promotional efforts throughout the year are yielding Tours and potentially to ramp up Outreach at times when Returners are lower. Also explore the Non-members who do a Tour but do not return- these people chose to not engage in the current Evaluation Project.	high	low
2.6 Refine data collection	Continue to refine the Salesforce forms and database to streamline data capture, not only at Orientation but throughout a member's Stepping Stone Journey. Implement a 'data validation sprint' every quarter to check on missing data for all members and backfill data where possible. Collect more specific descriptions of member's diagnoses at Orientation to enable members to be classified according to severity for funding eligibility.	low	low

Appendix A. International Standards for Clubhouse Programs.

The International Standards for Clubhouse Programs, consensually agreed upon by the worldwide Clubhouse community, define the Clubhouse Model of rehabilitation. The principles expressed in these Standards are at the heart of the Clubhouse community's success in helping people with mental illness to achieve social, financial, educational and vocational goals. The Standards also serve as a "bill of rights" for members and a code of ethics for staff, board and administrators. The Standards insist that a Clubhouse is a place that offers respect and opportunity to its members.

The Standards provide the basis for assessing Clubhouse quality, through the Clubhouse International Accreditation process. Every two years the worldwide Clubhouse community reviews these Standards, and amends them as deemed necessary. The process is coordinated by the Clubhouse International Standards Review Committee, made up of members and staff of Accredited Clubhouses from around the world.

MEMBERSHIP

1. Membership is voluntary and without time limits.

2. The Clubhouse has control over its acceptance of new members. Membership is open to anyone with a history of mental illness, unless that person poses a significant and current threat to the general safety of the Clubhouse community.

3. Members choose the way they utilize the Clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.

4. All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.

5. Members at their choice are involved in the writing of all records reflecting their participation in the Clubhouse. All such records are to be signed by both member and staff.

6. Members have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a significant and current threat to the Clubhouse community.

7. The Clubhouse provides an effective reach out system to members who are not attending, becoming isolated in the community or hospitalized.

RELATIONSHIPS

8. All Clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed.

9. Clubhouse staff are sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement.

10. Clubhouse staff have generalist roles. All staff share employment, housing, evening and weekend, holiday and unit responsibilities. Clubhouse staff do not divide their time between Clubhouse and other major work responsibilities that conflict with the unique nature of member/staff relationships.

11. Responsibility for the operation of the Clubhouse lies with the members and staff and ultimately with the Clubhouse director. Central to this responsibility is the engagement of members and staff in all aspects of Clubhouse operation.

SPACE

12. The Clubhouse has its own identity, including its own name, mailing address, email and telephone number.

13. The Clubhouse is located in its own physical space. It is separate from any mental health centre or institutional settings, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.

14. All Clubhouse space is member and staff accessible. There are no staff only or member only spaces.

WORK-ORDERED DAY

15. The work-ordered day engages members and staff together, side-by-side, in the running of the Clubhouse. The Clubhouse focuses on strengths, talents and abilities; therefore, the work-ordered day must not include medication clinics, day treatment or therapy programs within the Clubhouse.

16. The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems.

17. The Clubhouse is open at least five days a week. The work-ordered day parallels typical working hours.

18. The Clubhouse is organized into one or more work units, each of which has sufficient staff, members, and meaningful work to sustain a full and engaging work-ordered day. Unit meetings are held to foster relationships as well as to organize and plan the work of the day.

19. All work in the Clubhouse is designed to help members regain self-worth, purpose, and confidence; it is not intended to be job specific training.

20. Members have the opportunity to participate in all the work of the Clubhouse, including administration, research, enrolment and orientation, reach out, hiring, training and evaluation of staff, public relations, advocacy and evaluation of Clubhouse effectiveness.

EMPLOYMENT

21. The Clubhouse enables its members to return to paid work through Transitional Employment, Supported Employment and Independent Employment; therefore, the Clubhouse does not provide employment to members through in-house businesses, segregated Clubhouse enterprises or sheltered workshops.

Transitional Employment

22. The Clubhouse offers its own Transitional Employment program, which provides as a right of membership opportunities for members to work on job placements in the labour market. As a defining characteristic of a Clubhouse Transitional Employment program, the Clubhouse guarantees coverage on all placements during member absences. In addition, the Transitional Employment program meets the following basic criteria.

a. The desire to work is the single most important factor determining placement opportunity.

b. Placement opportunities will continue to be available regardless of the level of success in previous placements.

c. Members work at the employer's place of business.

d. Members are paid the prevailing wage rate, but at least minimum wage, directly by the employer.

e. Transitional Employment placements are drawn from a wide variety of job opportunities.

f. Transitional Employment placements are part-time and time-limited, generally 12 to 20 hours per week and from six to nine months in duration.

g. Selection and training of members on Transitional Employment is the responsibility of the Clubhouse, not the employer.

h. Clubhouse members and staff prepare reports on TE placements for all appropriate agencies dealing with members' benefits.

i. Transitional Employment placements are managed by Clubhouse staff and members and not by TE specialists.

j. There are no TE placements within the Clubhouse. Transitional Employment placements at an auspice agency must be off site from the Clubhouse and meet all of the above criteria.

Supported and Independent Employment

23. The Clubhouse offers its own Supported and Independent Employment Programs to assist members to secure, sustain, and better their employment. As a defining characteristic of Clubhouse Supported Employment, the Clubhouse maintains a relationship with the working member and the employer. Members and staff in partnership determine the type, frequency, and location of desired supports.

24. Members who are working independently continue to have available all Clubhouse supports and opportunities as well as participation in evening and weekend programs.

EDUCATION

25. The Clubhouse assists members to reach their vocational and educational goals by helping them take advantage of educational opportunities in the community. When the Clubhouse also provides an in-house education program, it significantly utilizes the teaching and tutoring skills of members.

FUNCTIONS OF THE HOUSE

26. The Clubhouse is located in an area where access to local transportation can be assured, both in terms of getting to and from the program and accessing TE opportunities. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.

27. Community support services are provided by members and staff of the Clubhouse. Community support activities are centred in the work unit structure of the Clubhouse. They include helping with entitlements, housing, and advocacy, promoting healthy lifestyles, as well as assistance in accessing quality medical, psychological, pharmacological and substance abuse services in the community.

28. The Clubhouse provides assistance designed to help members improve their physical health and wellness, in partnership with community-based resources and healthcare providers. If the Clubhouse also provides in-house wellness activities, they are scheduled to be consistent with a vibrant, side-by-side work-ordered day; and significantly utilize the teaching skills and expertise of members.

29. The Clubhouse is committed to securing a range of choices of safe, decent and affordable housing including independent living opportunities for all members. The Clubhouse has access to opportunities that meet these criteria, or if unavailable, the Clubhouse develops its own housing program. Clubhouse housing programs meet the following basic criteria.

a. Members and staff manage the program together.

b. Members who live there do so by choice.

c. Members choose the location of their housing and their roommates.

d. Policies and procedures are developed in a manner consistent with the rest of the Clubhouse culture.

e. The level of support increases or decreases in response to the changing needs of the member.

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

30. On a regular basis the Clubhouse conducts an objective evaluation of its effectiveness, including Clubhouse International Accreditation.

31. The Clubhouse director, members, staff and other appropriate persons participate in a comprehensive two- or three-week training program in the Clubhouse Model at a certified training base.

32. The Clubhouse has recreational and social programs during evenings and on weekends. Holidays are celebrated on the actual day they are observed.

FUNDING, GOVERNANCE AND ADMINISTRATION

33. The Clubhouse has an independent board of directors, or if it is affiliated with a sponsoring agency, has a separate advisory board comprised of individuals uniquely positioned to provide financial, legal, legislative, employment development, consumer and community support and advocacy for the Clubhouse.

34. The Clubhouse develops and maintains its own budget, approved by the board or supported by an advisory board, which provides input and recommendations prior to the beginning of the fiscal year and routinely monitors it during the year.

35. Staff salaries are competitive with comparable positions in the mental health field.

36. The Clubhouse has the support of appropriate mental health authorities and all necessary licenses and accreditations. The Clubhouse collaborates with people and organizations that can increase its effectiveness in the broader community.

37. The Clubhouse holds open forums and has procedures which enable members and staff to actively participate in decision making, generally by consensus, regarding governance, policy making, and the future direction and development of the Clubhouse

Table A1. Means and standard deviations of outcome scores for existing and new members cross-sectionally and longitudinally.

	Cross-sectional samples			Longitudinal sample			Longitudinal sample		
	Existing (n=157) mean (SD)	New (n=75) mean (SD)	p-value difference b/w groups	New members at Orientation (n=28) mean (SD)	New members at follow-up (n=28) mean (SD)	p-value difference within group	Existing members at Intake (n=71) mean (SD)	Existing members at follow-up (n=71) mean (SD)	p-value difference within group
Recovery Assessment Scale (RAS-DS)									
Personal Progress	73.3% (±14.2)	71.6% (±16.0)	0.11	70.5% (±16.4)	70.3% (±18.5)	0.93	76.3% (±13.6)	77.2% (±16.0)	0.55
Functional Progress	78.0% (±14.2)	74.0% (±16.3)	**0.01**	74.4% (±18.2)	77.8% (±20.6)	0.37	79.3% (±13.6)	80.2% (±14.2)	0.47
Symptom Management Progress	69.5% (±17.0)	65.2% (±19.5)	**0.03**	67.6% (±18.6)	60.1% (±22.7)	0.14	72.5% (±16.5)	71.5% (±18.6)	0.75
Social Progress	74.3% (±17.0	70.0% (±17.6)	**0.01**	70.1% (±15.4)	69.0% (±18.5)	0.70	67.6% (±18.6)	67.6% (±18.6)	0.93
Client Interaction Scale (CIS)									
Connectedness with other members	38.1 (±16.8)	32.2 (±20.1)	**0.03**	35.5 (±18.3)	38.1 (±13.2)	0.36	40.4 (±14.9)	41.2 (±13.0)	0.53
Connectedness with staff	44.5 (±17.3)	38.1 (±20.8)	**0.02**	41.4 (±19.1)	45.9 (±13.5)	0.10	46.8 (±15.9)	48.9 (±11.9)	0.11
Manchester Short Assessment of Quality of Life (MANSA)									
Quality of life	4.6 (±1.2)	4.1 (±0.9)	**0.01**	3.8 (±1.7)	3.8 (±1.3)	0.98	4.5 (±1.0)	4.4 (±1.0)	0.77

	Cross-sectional samples			Longitudinal sample			Longitudinal sample		
	Existing (n=161) n (%)	New (n=76) n (%)	p-value difference b/w groups	New members at Orientation (n=28) n (%)	New members at follow-up (n=28) n (%)	p-value difference within group	Existing members at Intake (n=74) n (%)	Existing members at follow-up (n=74) n (%)	p-value difference within group
Hospitalisations									
Hospitalised	26 (16)	31 (41)	X^2=18.5,	9 (32)	6 (21)	X^2=2.0,	10 (14)	13 (18)	X^2=0.36,
Not hospitalised	131 (81)	41 (54)	**p<0.01**	18 (64)	22 (79)	p=0.37	62 (84)	61 (82)	p=0.83
Prefer not to say	4 (2)	4 (5)		1 (4)	0 (0)		2 (3)	0 (0)	

Table A2. Detailed proportions of employment and educational statuses and aspirations existing and new members at orientation/intake and follow-up.

	Existing member at intake (n=160), %	New member at Orientation (n=74), %	p-value difference bw groups	New member at follow-up (n=28), %	Existing member at follow-up (n=71), %
Current Employment					
Independent employment	15.8	10.6		8.3	16.9
Supported employment	3.3	1.2		0.0	4.5
Transitional employment	5.4	1.2		2.8	6.7
Clubhouse work-ordered day	13.3	0.0		11.1	10.1
Volunteer	15.8	7.1	NA	8.3	20.2
Active job search	4.6	4.7		5.6	3.4
Retired	8.3	4.7		5.6	7.9
Student	7.1	8.2		8.3	2.2
Unemployed	14.6	44.7		44.4	21.3
Prefer not to say	5.0	1.2		0.0	0.0
Other	6.7	16.5		5.6	6.7
Employment Aspiration					
Independent employment	29.5	31.8		23.5	40.5
Supported employment	6.6	17.8		29.4	8.9
Transitional employment	8.2	9.3		20.6	6.3
Clubhouse work-ordered day	7.4	6.5		2.9	6.3
Volunteer	11.5	12.1	NA	2.9	15.2
Active job search	0.0	4.7		2.9	5.1
Retired	17.2	0.9		5.9	10.1
Student	3.3	8.4		5.9	2.5
Unemployed	1.6	2.8		0.0	3.8
Prefer not to say	3.3	1.9		0.0	1.3
Other	11.5	3.7		5.9	0.0

Current Education					
Postgraduate degree	9.9	4.0		4.0	5.4
Graduate certificate/diploma	2.8	4.0		0.0	1.4
Bachelor's degree	23.9	16.0		18.0	18.9
Diploma/Advanced diploma	7.0	9.3		7.0	10.8
Certificate II/III/IV	22.5	24.0	NA	11.0	29.7
Year 12	15.5	14.7		4.0	10.8
Year 11	2.8	5.3		0.0	2.7
Year 10	7.0	9.3		0.0	10.8
Did not finish Year 10	5.6	12.0		0.0	6.8
Prefer not to say	2.8	1.3		18.0	2.7
Education Aspirations					
I don't want further formal education	37.8	25.3		39.0	47.3
Postgraduate degree	31.6	12.0		4.0	5.4
Graduate certificate/diploma	6.1	5.3		0.0	2.7
Bachelor's degree	3.1	13.3	NA	18.0	10.8
Diploma/Advanced diploma	9.2	6.7		7.0	5.4
Certificate II/III/IV	6.1	16.0		11.0	17.6
Finish high school (Year 12)	2.0	4.0		4.0	2.7
Prefer not to say	4.1	16.0		18.0	8.1

Table A3. Means and standard deviations of outcome scores by stages of the Steps journey.

	I'm finding my feet (n=15) mean (SD)	I'm in a routine (n=34) mean (SD)	I'm out in the community and access Clubhouse as I need it (n=45) mean (SD)	I'm becoming a mentor (n=9) mean (SD)	I'm moving on from Clubhouse (n=12) mean (SD)	I prefer not to say (n=12) mean (SD)	p-value difference bw groups
Recovery Assessment Scale (RAS-DS)							
Personal Progress	73.9% (±12.7)	81.8% (±13.2)	76.7% (±14.5)	85.3% (±12.6)	69.7% (±10.9)	63.7% (± 14.8)	**0.01**
Functional Progress	77.8% (±11.3)	83.3% (±14.3)	80.0% (±13.2)	87.0% (±11.7)	80.7% (±16.0)	78.8% (± 17.2)	0.55
Symptom Management Progress	69.0% (±18.1)	73.5% (±17.6)	70.6% (±17.5)	79.0% (±20.5)	69.5% (±16.7)	53.2% (± 19.7)	**0.04**
Social Progress	71.4% (±20.8)	81.6% (±16.5)	76.2% (±14.2)	74.6% (±20.0)	70.8% (±15.9)	61.9% (±21.0)	**0.04**
Client Interaction Scale (CIS)							
Connectedness with other members	38.0 (±7.9)	45.7 (±9.2)	41.4 (±11.4)	47.1 (±6.9)	32.5 (±16.7)	36.3 (±14.1)	**0.04**
Connectedness with staff	48.8 (±9.4)	52.4 (±6.7)	48.9 (±10.9)	54.0 (±5.3)	39.6 (±16.8)	39.3 (±14.7)	**0.01**
Manchester Short Assessment of Quality of Life (MANSA)							
Quality of life	4.3 (±1.3)	4.8 (±0.9)	4.3 (±0.9)	4.4 (±0.9)	4.4 (±0.7)	3.0 (±1.2)	**0.01**
Hospitalisations							
Hospitalised Not hospitalised Prefer not to say	2 (25) 6 (75) 0 (0)	10 (33) 19 (63) 1 (4)	2 (6) 30 (91) 1 (3)	0 (0) 8 (100) 0 (0)	1 (10) 10 (90) 0 (0)	3 (33) 6 (67) 0 (0)	X^2=12.12, p=0.28

	I'm finding my feet (n=15) n (%)	I'm in a routine (n=34) n (%)	I'm out in the community and access Clubhouse as I need it (n=45) n (%)	I'm becoming a mentor (n=9) n (%)	I'm moving on from Clubhouse (n=12) n (%)	I prefer not to say (n=12) n (%)	p-value difference bw groups
Education Aspiration							
I don't want further formal education	6 (40)	7 (58)	23 (51)	9 (100)	7 (58)	4 (33)	
Postgraduate degree	1 (7)	0 (0)	3 (7)	0 (0)	0 (0)	0 (0)	X^2=12.12, p=0.28
Graduate certificate/diploma	0 (0)	1 (8)	3 (7)	0 (0)	1 (8)	2 (17)	
Bachelor's degree	1 (7)	2 (17)	3 (7)	0 (0)	2 (17)	2 (17)	
Diploma/Advanced diploma	1 (7)	1 (8)	4 (9)	0 (0)	1 (8)	1 (8)	
Certificate II/III/IV	2 (13)	1 (8)	4 (9)	0 (0)	1 (8)	1 (8)	
Finish high school (Year 12)	1 (7)	0 (0)	2 (4)	0 (0)	0 (0)	0 (0)	
Prefer not to say	3 (20)	0 (0)	3 (7)	0 (0)	0 (0)	2 (17)	
Current Employment							
Independent employment	1 (7)	4 (12)	12 (27)	0 (0)	3 (25)	2 (17)	
Supported employment	1 (7)	2 (6)	3 (7)	0 (0)	0 (0)	0 (0)	
Transitional employment	0 (0)	4 (12)	2 (4)	0 (0)	0 (0)	1 (8)	
Clubhouse work-ordered day	2 (13)	13 (38)	4 (9)	3 (33)	1 (8)	0 (0)	
Volunteer	1 (7)	0 (0)	7 (16)	4 (44)	1 (8)	3 (25)	X^2=13.09, p=0.22
Active job search	1 (7)	1 (3)	0 (0)	0 (0)	0 (0)	0 (0)	
Retired	2 (13)	1 (3)	5 (11)	1 (11)	3 (25)	0 (0)	
Student	1 (7)	0 (0)	1 (2)	0 (0)	1 (8)	2 (17)	
Unemployed	5 (33)	9 (26)	8 (18)	1 (11)	2 (17)	2 (17)	
Other	1 (7)	0 (0)	3 (7)	0 (0)	1 (8)	2 (17)	

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