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Relationship Between Educational Leisure Motivation and Recovery From Mental Illness Among Members of Clubhouse International

Dianna Rene Pearce
Walden University

Walden University

COLLEGE OF EDUCATION

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Dianna Pearce

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Dr. Nancy Walters, Committee Member, Education Faculty
Dr. Patricia Anderson, University Reviewer, Education Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Walden University
2016

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Individuals with serious mental illness (SMI) exhibit low motivation to participate in educational leisure activities at Clubhouses accredited by Clubhouse International (CI). This correlational study examined the relationship between each of 4 motives, intellectual, social, competence-mastery, and stimulus-avoidance, to engage in leisure activities, and the perception of recovery from SMI. Knowles's theory of andragogy supported the concept of informal self-directed learning, which occurs with leisure activities. Literature indicates that participating in leisure activities such as those offered at Clubhouses aids in the recovery from SMI. Quantitative data were collected from a convenience sample of 75 individuals at 4 CI clubhouses using 2 Likert-scale instruments, the Leisure Motivational Scale (LMS) and the Recovery Assessment Scale – Domains and Stages (RAS-DS). Pearson correlation coefficients indicated significant moderate positive correlations between each of 4 motives, intellectual, social, competence-mastery, and stimulus-avoidance, to engage in leisure activities, and the perception of recovery from SMI. These findings were used to design a professional development program on motivation to teach the staff at a Clubhouse about how to engage members in leisure activities. The study has the potential to inspire positive social change by motivating members to improve their quality of life, learn social and work skills, develop friendships and a support system, reengage with society, and to become employed.

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Dedication

This study is dedicated in loving memory of my father who held onto the hope for me until I was able to hold it for myself.

Acknowledgments

I would like to thank my chair Dr. Marianne Borja for her guidance, and encouragement. In particular, for the many after hours and weekend support she gave me in brainstorming the many twists and turns the process entailed. She was always there for me.

Table of Contents

List of Tables

Section 1: The Problem

Introduction

Mental illness is a medical condition that interferes with how a person functions and relates to others. It can affect an individual's moods, thinking and feelings. In addition, it can cause a disruption of everyday coping skills (National Alliance on Mental Illness [NAMI], 2013). The ability to interact with other individuals and the competence needed to complete daily tasks are diminished (NAMI, 2013). In 2011, a county in Southern California reported 21,040 hospitalizations and 16,297 emergency room visits for individuals with self-inflicted injuries and those whose primary diagnoses were mood and personality disorders, and schizophrenia, (County of XXXX). These statistics do not include mental disorders related to drugs or alcohol.

In addition, individuals with serious mental illness (SMI) lose occupational performance (Gregitis, Glacken, Julian, & Underwood, 2010), which can result in the inability to work in competitive employment. A staff worker at a CI Clubhouse, V. Rodriguez, stated that individuals with (SMI) need to be motivated to engage in leisure activities (personal communication, December 5, 2014). Rodriguez explained that "individuals with SMI, whether through institutionalization, or their very symptoms of SMI, lose the ability to know or ask what the next task they are to accomplish" (personal communication, December 5, 2014). A study by Nimrod (2014) suggested that people with depression realize that participating in leisure activities will allow them to cope better with their mental illness. However, their symptoms make them less able to

participate on their own without encouragement (Nimrod, Kleiber, & Berdychevsky, 2014).

This project study examined leisure motivation and recovery from SMI. The purpose was to determine if there are positive relationships between the motivation to engage in leisure activities (which include the intellectual, social, competence-mastery, and stimulus-avoidance motives, and the perception of recovery) from SMI among 75 individuals at four Clubhouses. This study was expected to add to the knowledge base of Clubhouses and helped focus on the impact that leisure motivation has on directing persons with SMI toward recovery. This section covers the following: the problem, rationale, methodology, study results, implications, and proposed project.

Definition of the Problem

Individuals with SMI are often found confined to their homes and cut off from interacting with family, friends, and society (Sheppard, 2008). Some individuals with SMI carry a social disability that creates stress. Stress limits coping skills, in turn negatively affects individuals' quality of life (Borge, Martinsen, Ruud, Watne, & Frilis, 1999). Lysaker et al. (1993) stated that individuals with psychosis have trouble understanding the behavior of others and can fail to understand how their own behaviors affect others. Because many people who suffer from SMI do not work, their lives are less structured. They have time that could be used in leisure activities to promote balance and meaning in their lives (Lloyd, King, Lampe, & McDougall, 2001; Lloyd, King, McCarthy & Scanlan, 2007). The problem is that many people with SMI are not motivated to participate in leisure activities which limits their exposure to needed resources that can

help recovery (V. Rodriguez, personal communication, January 21, 2013). Beard and Regheb (1983) stated that there are no external forces that compel individuals to participate in leisure activities. However, Beard and Regheb identified four motives, (a) intellectual, (b) social, (c) competence-mastery, (d) and stimulus-avoidance that identify reasons why individuals may engage in leisure activities (p. 222).

Participating in leisure activities provides educational learning opportunities in an informal setting. Participation in informal leisure activities at community-based clubhouses provides the opportunity to learn specific skills in addition to developing attitudes and coping strategies that are perceived to promote wellbeing. This type of informal educational setting gives a "sense of belonging and acceptance, the growth of hope and confidence, and the recognition that others share similar problems" (MacKean & Abbott-Chapman, 2011, p. 228). However, many individuals with SMI have low motivation to participate in leisure activities (Lloyd et al., 2007).

Leisure activities, which are comprised of activities outside of mandated work, are freely chosen by the individual. *Leisure* is defined as an individual and emotional experience that concentrates on the individual's psychological condition instead of on a specific activity (Gunter, 1987). Spending time devoted to leisure activities gives those with and without SMI the feeling of personal achievement and self-improvement, and fosters one's physical well-being (Argyle, 1996; Ussher, McCusker, Morrow & Donaghy, 2000). Many people with SMI refrain from participating in leisure activities due to a lack of social skills and self-confidence (Lloyd et al., 2001). A staff member at a CI Clubhouse stated that "some of the members at the Clubhouse will walk directly to the

café when they arrive in the morning. They will sit and do nothing unless we motivate them to participate in the leisure activities available at the Clubhouse" (J. Baker, personal communication, October 15, 2013).

The local setting was (CI) accredited Clubhouses in the southwestern part of the United States. The Clubhouses operate on a work-ordered day (WOD). The WOD is the organized framework of structured day-to-day educational leisure activities within the clubhouse. The structure in the clubhouse is similar to the structure found in the workplace. Unit meetings are held in the morning and afternoon and daily tasks are divided up among members. Tasks support the running of the Clubhouse, such as the clerical, café, and kitchen responsibilities An important feature of the clubhouse is that staff and members work together in all the WOD activities (Clubhouse International, 2015).Leisure activities are used to help members develop self-esteem, confidence, and social support systems. A staff worker stated, "Most of the leisure activities at the Clubhouse are informal educational learning activities involving intellectual, vocational, and social skills. Informal classes in nutrition and employment readiness are also conducted during the 'WOD" (V. Rodriguez, personal communication, Dec 03, 2014). There is no charge to belong to a Clubhouse, and individuals who join are members for life (J. Baker, personal communication, June 19, 2013).

Members of the Clubhouse must be at least 18 years of age who have been diagnosed with SMI (Aquila, Santos, Malamud, & McCrory, 1999). SMI includes, but is not limited to, schizophrenia, depression, bipolar disorder, obsessive compulsion disorder (OCD), and posttraumatic stress disorder (PTSD; J. Baker, personal communication, June

19, 2013). The mission of the Clubhouse is to support adults with mental health disorders by providing opportunities for work, education, wellness, housing, and friendship.

The local average active membership is 65, with an average of 25 members attending daily. Basic Clubhouse WOD operating hours are from 8:00 A.M. to 4:00 P.M. Monday thru Friday. A member can be involved with data processing, creation of the daily newscast, newsletters, fund raising, or meal preparation. General Educational Development Certificate (GED), technical training, and university degrees are supported for all members. All activities at the Clubhouse, as membership itself, are voluntary and fall under the definition of leisure activities. Although the Clubhouse does not provide job-specific training, the WOD concept involves computer education, and other educational job skills that transfer to the job market (S. Hendenkamp, personal communication November 10, 2012).

The gap in practice exists between the educational leisure activities at Clubhouses and members' motivation to engage in them, which may assist with members' recovery from SMI. The purpose of the study was to determine if there was a positive relationship between the motivation to engage in educational leisure activities and members' perception of recovery from SMI. Data from the study was expected to provide the evidence to justify the development of a motivational workshop for staff that would encourage members to engage in leisure activities.

NAMI (2013) defined recovery as a process wherein a person has learned about her or his personal diagnosis and the treatment available, has created a support system of family and or peers, and can take action to successfully manage the diagnosed condition

by helping others. Recovery also includes a restoration of hope, self-identity, meaning in life, and personal accountability (Andresen, Oades, & Cuputi, 2003). From an anecdotal perspective, J. Baker (personal communication, June 11, 2013) explained that when members come to the CI Clubhouse, for the first time, or after they experience an extended absence, they need to relearn many of the social and vocational skills needed to engage in the larger community. These skills include personal living skills, interpersonal skills, communication skills, leadership skills, and computer skills.

Rationale

Evidence of the Problem at the Local Level

Recovery from SMI is a complex, ongoing process that evolves over time and does not guarantee the disappearance of symptoms. According to Watson (2012), mental health policy now focuses on recovery, whereas since the mid-1970s, recovery was not the considered the primary goal of treatment. Watson stated, “These changes are partially the result of sociological research conducted during the age of institutional treatment and the early stages of community-based care” (p. 290). The main focus of Clubhouses is on recovery.

Many individuals with SMI live in a vicious cycle of symptoms and psychosocial dysfunction, and lack self-confidence to perform work (Di Masso, Avi-Itzhak, & Richard-Obler, 2001; Masterboom, 1992). Varying degrees of motivation exist in this population to engage in leisure activities. For example, many members tend to sit around, doing nothing, and do not engage in leisure activities with those who take charge and lead many of the leisure activities of the WOD. J. Baker a staff worker at a clubhouse stated,

"This is a common occurrence, in that some members lack the incentive, desire, or confidence to participate in leisure activities, while other members are highly motivated and engage in all areas that the Clubhouse has to offer" (personal communication, June 3, 2014).

A program coordinator from another Clubhouse witnessed people engaged in leisure activities of the WOD, and noticed how being engaged gave them a chance to step outside of themselves and focus on the activity instead of continuously focusing on their symptoms (T, Bayless, personal communication, March 9, 2015). C. Nunez, a staff worker, stated that most of the members do not have paid employment and unless they are active members, do not have any structure built into their lives. By attending the Clubhouse active members improve over time, focus on obtaining employment, gain employment, and successfully reenter the competitive job market (personal communication, September 6, 2016).

The Clubhouse is short-staffed on purpose. Members are an integral part of the functioning of the Clubhouse. The Clubhouse will not run unless members are present and work alongside the staff. J. Baker, a staff worker stated," There are members who enter the Clubhouse each morning and walk directly to the café. Unless encouraged and asked to join the unit meetings, these individuals tend to stay in the cafe and do nothing all day (personal conversation, June 3, 2014).The symptoms of depression can cause a lack of motivation because the ability to enjoy activities is diminished (Nimrod, Kleiber, & Berdychevsky, 2014). By encouraging members to become involved in the WOD

process, members are motivating members to create structure in their lives" (J. Baker, personal conversation, June 3, 2014).

Evidence of the Problem from the Professional Literature

The literature showed that people with chronic SMI lose social skills (Pernice-Duca, Case, & Conrad-Garrisi, 2012). Moore, Viglione, and Rosenfarb (2013) stated that "Even when a patient's symptoms relatively are controlled well by pharmacotherapy, deficits in daily and social functioning continues to interfere with independent and productive living" (p. 253). Many individuals with SMI, including schizophrenia, depression, or other types of mental illness, have a problem with social interaction (Markowitz, Angell, & Greenberg, 2011). In particular, individuals with schizophrenia are unable to read the facial expressions, nonverbal cues, and body language of others; and they tend to have a reduced ability to communicate (Moore et al., 2013; Reichenberg, 2010).

Many people with SMI lack the self-confidence that is needed to engage in leisure activities because of the problems with psychosocial functioning (Lloyd et al., 2007). This problem is evident at the Clubhouse among new members and members who are returning from a long hiatus due to a relapse. It takes time for returning members to reengage in the WOD.

Schonebaum and Boyd (2012) stated that the outcome of the WOD is job readiness. This outcome is accomplished through the opportunity of members to develop interpersonal skills, strong support networks, and coping skills with job stress (Schonebaum, & Boyd, 2012). J. Baker explained that when members return to the

Clubhouse after an extended absence, they need to relearn many of the social and vocational skills they previously learned at the Clubhouse. These skills include personal living skills, interpersonal skills, leadership skills, and computer skills (personal communication, June 3, 2014).

The loss of occupation for an individual with SMI can cause a disruption in daily routines and behaviors that are needed for successful employment, including work attitudes, and values (Yau, Chan, Chan, & Chui, 2005; Prusti, & Branholm, 2000). A Clubhouse member and a participant in a study by Carolan, Onaga, Pernice-Duca, and Jimenez (2011) stated, "Structure is important. …instead of having too much free time on my hands it keeps me engaged and accomplishing and succeeding….it's a good structure program, and I think it helped" (p. 128). Another participant from the same study stated, "Helping others helps me not to think about my problems. I feel like I have a purpose and can help others. It feels nice to do that when you are usually the one who needs help from others" (Carolan et al., 2011, p. 128). Participation in programs can help adults with SMI to move from being passive recipients of social services to providing support to others (Propst, 1997).

According to Suto (1998), leisure is measurable in targeting the outcomes of clients' occupational performance. However, Lloyd et al. (2007) stated that even though leisure activities are instrumental in recovery, people with SMI tend to withdraw from leisure activities, and do not take advantage of the social and interpersonal skills individuals can acquire through participation. One problem is that individuals with SMI cannot decide which activities they want to participate in (Lloyd et al., 2001).

The Clubhouse function is also to address unemployment. Important to the success of member employment is the support they receive from the leisure activities of the WOD (Schonebaum & Boyd, 2012). In addition, members can be involved in volunteer work until they are ready to accept paid employment (Schonebaum & Boyd, 2012). Wilczynska-Kwiatek and Bargiel-Matusiewicz (2008) stated that unemployment is connected with low self-esteem, depression, risk of suicide, and alcohol-related diseases. Participation in the WOD, prior to being competitively employed, had a major impact on average employment length for ICCD Clubhouse members (Schonebaum & Boyd, 2012). Lloyd et al. (2007) stated that members who attended an ICCD Clubhouse "possess characteristics that contribute to higher self-reported levels of recovery and to relatively low stimulus avoidance motivation" (p. 39). There are very few empirical studies to date (Fitzgerald, 2013, Lloyd, 2007) on the effect of Clubhouses on recovery; most are qualitative.

Some patients with SMI are reluctant to engage in leisure activities and there is not an abundance of information on the leisure motivation of individuals and their recovery from SMI at Clubhouses. The purpose of the study was to determine if there are positive relationships between the motivation to engage in leisure activities, which include the intellectual, social, competence-mastery, and stimulus-avoidance motives, and perception of recovery from SMI in individuals at four Clubhouses. This study added to the knowledge base of Clubhouses and helped focus on the impact that leisure motivation has on directing persons with SMI toward recovery.

Definitions

Active membership: Active membership has several definitions. The Clubhouse defined active membership as a member who attends at least once every 3 months (ICCD, 2013). This study, defined an active member as an individual attending a Clubhouse for at least three months and a minimum of 5 hours per week. Though membership does not require a member to attend a specific number of days a week (N. Zumarraga, personal communication, June 18, 2013), this is the accepted definition at the Clubhouses under study.

Clubhouse member: A member is an individual 18 years or older with a verified mental health diagnosis (J. Baker, personal communication, January 21, 2014).

CI Clubhouse accredited: "A Clubhouse is accredited if it meets the CI International Standards and goes through the accreditation process. There are 36 standards that have been agreed upon internationally and provide the basis to assess Clubhouse quality" (J. Baker, personal communication, January 21, 2014).

CI Modeled Clubhouses: "Any non-accredited Clubhouse that states they are modeled after the CI Clubhouse Work-Ordered-Day. The non-accredited Clubhouses pick and choose from the 36 standards of the CI accredited Clubhouses, thus redefining the Work-Ordered-Day, which can affect the quality of the program (V. Rodriguez, personal communication, December 2014).

Competence-mastery motive: The competence-mastery motive is a subcomponent of the Leisure Motivational Scale (LMS) Instrument and assesses the extent participants

are willing to engage in leisure activities to accomplish, master, challenge, and participate (Beard & Regheb, 1983).

Intellectual motive: The intellectual component is a subcomponent of the LMS Instrument and involves mental activities that include learning, exploring, discovery, and creating (Beard & Regheb, 1983).

*Leisure activity***:** Leisure activity is participation in freely elected actions that are pleasurable and provide a sense of accomplishment and value (Gunter, 1987). Leisure activities found at Clubhouses include skills training, and vocational services (Pernice-Duca et al., 2012). For the purpose of this study leisure activities at the Clubhouse include experiences such as learning computer applications, including Microsoft's, Word, Excel, Access, Publisher, and video software. In addition, nonformal and informal educational leisure activities in nutrition, yoga, employment job readiness, production of monthly newsletter and daily newscast; résumé building; meal planning; and budgeting are part of the WOD (V. Rodriguez, personal communications, Dec 3, 2014).

*Leisure motivation***:** Leisure motivation can be defined as the involvement in leisure activity that is motivated from a personal need or reason (Crandall, 1980).

*Leisure Motivational Scale (LMS)***:** LMS is a self-reporting, 48-item Likert-scale developed by Jacob Beard and Mounir Ragheb. The instrument measures the "psychological and sociological reasons for participation in leisure activities" (Beard & Ragheb, 1983, p. 219). The LMS is composed of four subscales, which are intellectual, social, competency-mastery and stimulus avoidance.

Quality of life: Quality is defined as how individuals determine their goodness of life. Quality of life is determined by looking at the many aspects of life including satisfaction with work, personal relationships, and how individuals emotionally react to life events (Dienes, Suh, Lucas, & Smith, 1999).

Recovery: Recovery is considered as a unique journey. The individuals in recovery have learned about their diagnosis and the treatment available, have created a support system of family and or peers and are able to take action to manage successfully their condition by helping others (NAMI, 2013a).

Recovery Assessment Scale Domains and Stages (RAS-DS): The RAS-DS is a self-reporting 38-item Likert scale adapted from the Recovery Assessment Scale (RAS) instrument by Hancock, Scanlan, Bundy, and Honey in 2014. The RAS-DS measures mental illness recovery. The author suggested that questions in the RAS-DS are related to the underlying construct of recovery. The instrument measures functional, personal, social, and clinical aspects of recovery (Hancock et al., 2004).

SMI: SMI is defined by the Center for Mental Health Services (CMHS) in the Federal Register. "… adults with a SMI are persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM-III-R1 and …that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities…" The definition states that "adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illness" (Department of Health and Human Services, 1999, p. 1).

Social motive: The social motive is a subcomponent of the LMS instrument and assesses the participant's need to socialize for interpersonal relationships and the esteem of others (Beard & Regheb, 1983).

Social isolation: Social isolation is the lack of meaningful interaction with another human being. The isolation is not considered voluntary and can lead to loneliness and despair that can affect an individual's mental and physical health (Pantell et al., 2013).

Stimulus-avoidance motive: The stimulus avoidance motive is a subcomponent of the LMS instrument and assesses the participant's motivation to avoid or get away from over invigorating experiences in life (Beard & Regheb, 1983).

Work-Ordered-Day (WOD): The Work-Ordered-Day (WOD) relates to the tasks undertaken and accomplished daily at the Clubhouse. These tasks or activities aid members in developing vocational and socialization skills, and improving self-esteem and self-reliance, which are the very basis of the recovery process (ICCD, 2013b). Staff and members work side-by-side, and work is centered within the Clubhouse community. No work is done for any other business or outside agency (ICCD, 2013a). The work-ordered-day sends the message that members are valued, capable, and needed (Gregitis et al., 2010).

Significance of the Problem

A study of the relationships between leisure motivations and recovery at Clubhouses could help identify how Clubhouses can provide better services. Based on the results of the data analysis, a professional development training program was developed

for staff at CI Clubhouses. Emphasis was placed on the different motivating factors to engage in leisure activities.

Most studies concerning leisure activities and recovery have been qualitative. This empirical study builds on the current body of knowledge. Empirical data should be generated for various reasons. Empirical evidence from this study showed there are positive relationships between leisure activities and recovery from SMI. Before this study, only Lloyd et al. (2007) had addressed the relationship between leisure activities and recovery at Clubhouses. Results from Lloyd's study were significant (r = .35): There was a moderate positive correlation between the motivation to engage in leisure activities and recovery. The outcome of this study confirmed a moderate positive relationship between leisure motivation and recovery. Thus a project was created to develop a professional development program for staff at Clubhouses to help motivate members. This project could help members with mental illness to progress in recovery.

People can recover from mental illness and live productive lives (United States Department of Health and Human Services, 2012. According to Sheppard (2008), a consequence of nonparticipation in non-coercive social and restorative programs is social isolation. Members of clubhouses experience a decrease in hospitalization and incarceration rates; Clubhouse attendance helps members move from shelters and group homes into independent housing.

Carpentier and White (2002) found that individuals who are a part of a cohesive social network are more likely to seek psychiatric services and to attend future follow-up appointments. A staff worker stated that members of the Clubhouse have the advantage

of obtaining the resources needed for quality housing, psychiatric, and medical care. The more knowledge staff has about leisure motivation and recovery, the more effective staff could be in helping members in the recovery process. The more that is known about how to engage individuals in leisure activities, the more assistance those individuals with SMI in recovery can receive. In addition, the more that is known about recovery, the more society can combat the stigma that affects those individuals with SMI and create social change (V. Rodriguez, personal communication, January 21, 2013).

Guiding/Research Question

The research questions are derived from Knowles's theory of andragogy. One of the assumptions or principles of Knowles theory (1980) states that adults are intrinsically motivated to learn.

The purpose of the study was to determine if there are positive relationships between the motivation to engage in leisure activities, which includes the intellectual, social, competence-mastery, and stimulus-avoidance motives, and the perception of recovery from SMI in individuals at four Clubhouses. The following four research questions and hypotheses were addressed:

RQ1: Is there a positive relationship between the intellectual motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*H*O1: There is no positive relationship between the intellectual motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

*H*A1: There is a positive relationship between the intellectual motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

RQ2: Is there positive relationship between the social motive to engage in leisure activities and the perception of recovery from SMI in individuals at four Clubhouses?

*H*O2: There is no positive relationship between the social motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

*H*A2: There is a positive relationship between the social motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

RQ3: Is there a positive relationship between the competence-mastery motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*H*O3: There is no positive relationship between the competence-mastery motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

*H*A3: There is a positive relationship between competence-mastery motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

RQ4: Is there a positive relationship between the stimulus-avoidance motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*H*O4: There is no positive relationship between the stimulus-avoidance motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

*H*A4: There is a positive relationship between the stimulus-avoidance motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

Review of the Literature

The literature review was completed using the following databases: ERIC, Thoreau, PsycInfo, Sage Journals, PubMed, Psych Abstract, and Science Direct. Additional research was carried out using the website for CI Clubhouses. The following keywords were used: *mental health, ICCD Clubhouses, CI Clubhouses, recovery, social isolation, deinstitutionalization, psychosocial, leisure motivation* and *leisure satisfaction*.

Statistics and information were gleaned from several government agencies under the umbrella of the United States Department of Health and Human Services, for example, National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, and reports from the Surgeon General's office. In addition, literature was extracted from the XXXX County Health and Human Services Agency and non-profits, such as NAMI). There was a limited amount of studies available. Thus I had to rely on a number of studies over 5 years old.

The literature review was organized by the following subheadings: theoretical framework, mental illness, stigma, recovery, history of CI Clubhouses, the organization of CI Clubhouses, leisure activities, and motivation to engage in leisure activities.

Theoretical Framework: Knowles' Adult Learning Theory

Andragogy (adult learning) by Knowles (1980), is a theory of assumptions based on six assumptions about adult learners. Four assumptions indicate: (a) adults are self-directed learners; (b) adults accumulate unique life experiences and knowledge to the learning experience; (c) adults are goal oriented; and (d) adults are relevancy oriented. These assumptions were developed first; and the last two assumptions; (e) adults are internally rather than externally motivated to learn; and (f) adults need to understand why it is essential to learn something, followed several years later (Knowles, 1984).

Knowles (1980) believed that the climate of the classroom must suit adults, physically and psychologically. Adults should feel "accepted, respected, and supported" and the environment should include a "spirit of mutuality between teachers and students as joint inquirers" (p. 47). In addition, it is important for adult learners to be involved in what they need to learn, what and how they are going to learn, and how they will evaluate what they have learned (Merriam, Caffarella, & Baumagartner, 2007). Wlodkowski (2008) contended that the first and third assumptions by Knowles (1980) best help explain adult motivation to learn. Wlodkowski (2008) argued that these two assumptions reflect the individualistic and pragmatic culture found in the social norms in United States. In addition, adults are more motivated to learn what is of use to them far more than what information has intellectual value for them (Wlodkowski, 2008). Aslansian

(2002) stated that research supports Knowles (1980) second assumption that that gaining knowledge about how to do something is the most common type of education adults tend to seek.

Adults move toward self-directedness at different rates within the different dimensions of their lives; however, there may be times, when an adult learner may move into a temporary dependent learning situation (Knowles, 1980). During a crisis situation, Knowles suggested that the adult learner may need to fall back into a directed learning situation. Knowles (1989) declared that with age comes more knowledge and range of experiences with which adults use to define themselves.

Clubhouses use the WOD to apply the six assumptions of Knowles into the member's learning experience. The staff's role is to facilitate the transition of individuals with SMI from temporary directed, to self-directed learning tasks as well as to foster the member's internal motivation to learn and participate in leisure activities. Members with SMI are encouraged to bring their existing knowledge and experience into each leisure activity and to apply it to new learning experiences.

The staff provides meaningful learning experiences, identifies the readiness of the member with SMI, and ties the member's learning experience and readiness to the member's goals. In addition, staff works with members to identify the relevance in participation of leisure activities and how these activities can improve member's lives. Staff provides support to members exhibiting symptoms of mental illness by assisting members in learning how to participate in leisure activates, rather than spending their time passively observing others who are engaged in activities. The staff provides a

respectful and comfortable learning environment for each member on the path to recovery from SMI.

SMI

Mental illness affects one-in-four Americans every year (National Institute on Mental Health [NIMH], 2013). Mental illness affects every day coping skills by disrupting one's thinking or moods, and the ability to deal with other individuals and daily tasks is diminished (NAMI, 2013). Structured programs, such as the Clubhouse, which allow individuals with SMI to apply structured leisure activities to their recovery, are worldwide.

In a pivotal study, Faris and Dunham (1939) showed that individuals suffering from schizophrenia are more likely to come from poorer urban neighborhoods, with weak social ties. Less than one-third of adults with SMS receive medical attention for treatable conditions (Manderscheid, Druss, & Freeman, 2007). This lack of treatment results in a shorter lifespan by 25 years (Manderscheid et al., 2007). In a study by Laursen, (2013) individuals with schizophrenia and bipolar had a shortening of life span by 12 to 20 years. The Mayo Clinic (2014) stated that those diagnosed with bipolar disorder have a greater chance of having heart disease and obesity issues; thus, reducing their life expectancy. Individuals with bipolar had a slightly longer lifespan over people with schizophrenia (Laursen, 2011).

Laursen and Nordentoft (2011) stated that those individuals with schizophrenia have a greater chance of being undertreated for heart disease. In addition, the medication prescribed for schizophrenia can cause weight gain, lipid changes, and fluctuations in

glucose levels, and long term use can lead to a shortened life span (Rummel-Klugeet al., 2010; Weinmann, Read, & Aderhold, 2009). Lifestyle choices like smoking, poor diet, and the lack of exercise add to the higher mortality rate with individuals with bipolar and schizophrenia. Kelly et al. (2011) stated that 55% of those individuals with schizophrenia smoke cigarettes daily.

SMI includes schizophrenia, bipolar, major depression, panic attacks, post-traumatic stress disorder, obsessive-compulsive disorder, and borderline personality disorder; SMI can erode the very coping skills needed to function in the everyday world (NAMI, 2014a). Individuals of all races, nationalities, ages, and socioeconomic groups are affected by SMI. NAMI (2014) stated that SMI is not a result of weakness, poor character, or low intelligence, and an individual's lack of recovery is not based on lack of willpower. The onset of SMI is usually during adolescence and young adulthood, 15-25 years of age (NAMI, 2014a). Without treatment, the consequences of SMI include unemployment, homelessness, suicide, incarceration, substance abuse, and unemployment to name a few (NAMI, 2014a).

Stigma of Mental Illness

Bathje and Proyer (2011) stated that the most powerful of stigmas is the stigma from mental illness, and there is a relationship between this stigma and the avoidance of treatment. According to Bathje and Proyer (2011), there are two types of stigmas in mental health, public stigma and self-stigma. Public stigma involves the public response to people who seek services for mental health issues. Public stigma can be displayed as fear and stereotypical labels, such as people with mental illness are dangerous or weak, or

the belief that mental illness cannot be controlled. The internalization of public stigma is self-stigma. It is for this reason that many people with mental illness do not seek treatment. The public label of a mental health diagnosis is too hard to accept (Bathje & Proyer, 2011). Accepting the fact that a mental illness is out of an individual's control and the individual is worthy of help is necessary before that individual can accept help for a mental illness (Bathje & Proyer, 2011).

Women are more prone to feeling self-stigma than men, and the stigma affects feelings of inferiority (Girma, Tesfaye, Froeschl, Möller-Leimkühler, Dehning, & Müller, 2013). Girma et al. (2013) stated that individuals with mental illness with higher educational levels were found to be less affected with self-stigma. In addition, the lower the side-effects from medication, the lower the feelings of self-stigma. Knifton (2012) stated that stigma provides a barrier to family and community-support that is needed for those with SMI to flourish. This stigma contributes to barriers in employment, medical care, shelter, and relationships (Mizock, 2012). When individuals with SMI are also overweight, they experience a double stigma. Combating stigma is crucial for recovery from mental illness. There is a direct relationship between how individuals with SMI feel about themselves and think about themselves, which in turn affects individuals' recovery success (Markowitz, Greenberg, & Angell, 2011).

Recovery from SMI

The history of recovery from mental illness dates back to the 1800s with a former patient Jean-Baptiste Pussin at the Bicêtre Hospital in France. According to Rudnick (2012), Pussin went on to work as ward supervisor for the incurably insane at the same

hospital after his release. Pusin and his wife developed new ways of treatment for the mentally ill. These new ways of treatment were considered revolutionary in that they forbade cruelty, emphasized kindness, and focused on the value of work. Shackles were removed, and the customary beating of patients ended. Pussin was able to convince head doctor, Philippe Pinel, that these new developments had remarkable effects. Instead of the accepted method of bleeding, purging, and scorching patients, Pinel created a new model of talk therapy that dealt with primary individual and societal motives for patient's problems (Henderson & Bekhuis, 2014). Pussin followed Pinel to Salpetrière hospital to transform that hospital to follow more humane practices. Many former patients were employed as staff at the hospital. Philippe Pinel indicated that to consider mental illness as an illness without recovery, is not based on facts. Pinel stated that he saw a 93% recovery rate for those individuals who sought treatment within a year of the first onset of difficulties (Rudnick, 2012). The high success rates of recovery that were recorded at the time are in doubt. What is not in doubt, however, is that recovery did happen. Of course, toward the end of the century, treatment for the mentally ill took a turn back to ill-treatment and a lack of belief in recovery

United States Department of Health and Human Services (HHS) (2012) recognized the need for a working definition of recovery for policy makers to providers. The working definition is a compilation from mental health recipients to workers in the field. SAMHSA declared, "Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012, p.1 para.). SAMHSA identified a number of guiding

principles to recovery that included hope and the fact that it is person-driven, holistic in nature, and occurs via many pathways. Support for recovery comes from peers, allies, family, and community systems and is socially founded and motivated (SAMHSA, 2012).

Davidson, Tondora, and Ridgway (2010) asserted that they consider people who are fighting against their illness to be in recovery. In combating SMI, it is also important to accept the parts of the illness the individual cannot change. Drake and Whitley (2014) argued that case management, skills training, and medications are traditional clinical approaches and should not be labeled as recovery-oriented because they do not use identified core aspects of the recovery process.

Calabrese and Corrigan (2005) found that individuals living with schizophrenia in developing countries, as opposed to those living in the United States, have a 30% better chance of recovery than those living in first-world countries. These authors contended that the difference in recovery is based upon culture, precisely that populations in developing nations place a higher value on family ties; whereas, industrialized countries, such as the U.S., de-emphasizes the importance of extended family members and social relationships. The authors further challenged that the U.S. places value on autonomy, which can have an adverse impact on individuals with mental illness (Calabrese & Corrigan 2005). Pernice-Duca et al. (2012) maintained that it is for this particular reason Clubhouses or drop-in centers are so important to those with SMI. These types of organizations offer an alternate source of support.

Chein, Leung, Yeung, and Wong (2013) identified five tactics for psychosocial interventions. They included cognitive behavioral therapy with family intervention, the use of training programs for the development of social skills, psycho-education, and assertive community treatment (ACT) programs. Chein et al stated that clinical research indicates that a community-based psychosocial approach to treating schizophrenia shows long-term improvement. Tew et al. (2012) acknowledged that although there have been adequate studies that identify the social factors that stimulate recovery; there is a lack of studies that have shown how these social factors influence recovery. The specific interventions needed for recovery are still in question. Tew et al. argued that even though relationships are essential to recovery, individuals' needs for relationships vary from person-to-person and that standardized methodologies of social inclusion may not meet the needs of all people.

To support recovery, Tew et al. (2012) indicated that the symptoms of depression can cause an absence of motivation because the ability to enjoy activities is diminished (Nimrod, Kleiber, & Berdychevsky, 2014). There needs to be a shift from individualized treatment to treatment that includes families, friends, and social systems and maintains the importance of individuals' identity and connectedness to their community instead of hospitalization. Di Masso (2001) asserted that members of CI Clubhouses, who attended on a regular basis, saw a sharp decline in hospitalizations. Danzer and Wilkus-Stone (2015) argued that the hospitalization experience for those with SMI tend to cause disengagement from the professional help needed for recovery. Schön (2010) stated that there is a gender difference in regards to how recovery takes place. For women,

hospitalizations tend to increase feelings of disempowerment. Women recover and become empowered by engaging in emotionally supported relationships and finding a whole identity. Schön (2010) argued that men found hospitalizations a positive experience by teaching them coping tools. Men begin recovery through medication, and with education that teaches them ways in which they can manage their illness.

Ikebuchi (2007) stated that although there have been an increase in the number of articles published on social functioning; the cognitive and social functioning measures used have garnered only limited conclusions. In addition, there have been inconsistent results as to construct validity in many publications. These results have led to difficulty in choosing the right measurement tools for answering specific research questions regarding recovery (Jaeger et al., 2013).

History of CI Clubhouses

The CI Clubhouse is an international psychosocial rehabilitation model of mental illness treatment modeled after Fountain House in New York City, which began operation in 1948 (Casstevens, 2012). Fountain House was the brainchild of six men discharged from the Rockland Psychiatric Center in New York State. Their desire was to build a community of support to help them move from being patients in a facility to members of their community and to develop life skills (Sheppard, 2008). The clinical view at this time and up into the 1980s was that there was no cure for individuals suffering from bipolar disorder or schizophrenia. At that time, considering that individuals with such a diagnosis could ever be productive members in society was unthinkable and cruel (Propst, 1997).

After the National Institute of Mental Health (NIMH) was created by congress in the late 1970s, the institute granted Fountain House a multi-year grant to create a training design to replicate the Fountain House (Propst, 1997). Over 100 new Clubhouses opened within the next 10 years (Propst, 1997). Since then, there are over 339 CI accredited Clubhouses worldwide, with over 220 in the United States (Sheppard, 2008). Other CI Clubhouses can be found in such countries as China, Kazakhstan, Ireland, South Korea, Argentina, Italy, Sweden, and Uganda (McKay, Johnsen, & Stein, 2012).

The international standards for CI Clubhouse accreditation were established in 1994 (Floyd, 2010). Accreditation is dependent on complying with 36 international traditions that set the standard for a psychosocial restorative environment (Casstevens, 2011, Floyd, 2010). The CI described a clubhouse as "a restorative environment for people who have had their lives drastically disrupted, and need the support of others who believe that recovery from mental illness is possible for all" (Clubhouse International, 2014, para. 1).

The Organization of CI Clubhouse

Beard and Regheb (1982) described Fountain House Clubhouse, the first and model for all CI Clubhouses to follow, as an intentionally designed and created community that fosters social skills and support, skills that are necessary for productive lives. In addition, Beard et al. stated that interested members are encouraged to assist in research and educational programs as part of the WOD. So important is this WOD concept that HHS (2013) has included the CI Clubhouse on its National Registry of Evidence Based Practices and Programs. The National Consensus on Recovery from

Mental Illness indicates that recovery from mental illness comes from the components of social support networks and interpersonal relationships (HHS, 2010).

A major structural component of the clubhouse is that it purposefully is understaffed. Schonebaum and Boyd (2012) contended that under staffing creates an environment of dependence on members for the Clubhouse's operation. When members know they are needed and participate in the activities necessary to run the club, the members' self-confidence and self-esteem improve (Schonebaum & Boyd, 2012). In addition, Clubhouses focus on interpersonal collaboration in running the clubhouse, which helps members improve their interpersonal skills and social networking (Carolan et al., 2011). This process is done by emphasizing positive coping skills and emulating a different way of interacting positively with other members and staff, placing less emphasis on members' illnesses, more emphasis on their talents and skills, and helping them to improve the quality of members' lives (Carolan et al, 2011). Carolan et al. (2011) stated that meaningful tasks employed by the Clubhouse, through the structure of the WOD, attracted members to return to the Clubhouse on an ongoing basis. In doing so, the members shifted from being passive recipients of support to giving active support to others.

The average number of U.S. members using each Clubhouse per day is 45, with an average active membership of 145 for each Clubhouse (Mckay et al., 2012). According to Mckay et al. (2012), the ICCD identified an active member as any individual attending one time per three months. Males make up 56.64% of the membership. Clubhouse members diagnosed 44.6% with schizophrenia, 17.96% with

bipolar, and up to 59.57%, with depression. Members identified themselves as, 21.69% African American, 5.50% Hispanic, 3.92% Asian, 1.69% American Indian or Alaskan Natives, 1.4 % Native Hawaiian, 6.22% unknown, and 21.69% Caucasian (Mckay et al., 2012).

Researchers in China discovered that individuals with schizophrenia attending Clubhouses in China reported significant improvement in symptoms and quality of life after 6 months of attendance (Tsang, Ng, & Yip, 2010). Schonebaum and Boyd stated, "Members develop confidence and self-esteem because they truly are needed" (p. 392). Members can choose to volunteer in several areas of interest while they are unemployed, and gain access to immediate employment when they are ready (Schonebaum and Boyd, 2012).

Members and staff together make decisions for the work-ordered day, and the importance of productive strengths-based work is emphasized. Strength-based work is client-lead and focuses on the individuals' strengths and how these strengths could help the individual in the future. The staff-to-member ratio is kept very low so that member participation is necessary for the successful running of the Clubhouse (Casstevens, 2012).The WOD described the framework of the day-to-day movement within a Clubhouse. It is highly structured with meetings, programs and activities scheduled on a daily, weekly, and monthly basis. All of these activities fall under the definition of leisure activities because they are freely elected activities that are gratifying, and stimulate a sense of accomplishment and importance (Gunter, 1987).

Uniquely different from community drop-in centers and day-treatment programs, the Clubhouse supports a three-tiered approach to competitive employment for individuals with SMI, including; (a) temporary employment, which lasts from six to nine months; (b) supportive employment; and (c) independent employment (Gregitis et al., 2010). In addition, there are many volunteering opportunities, which play a big part in the Clubhouse concept (J. Baker, personal communication, July 20, 2013). As a part of the reaccreditation process, which occurs every 3 years, the CI policy requires that each Clubhouse collect data regarding the effectiveness of their programs (Gregitis et al., 2010).

Schonebaum and Boyd (2012) indicated that the WOD participation may have a positive impact on subsequent job success independent of an individual's inherent ability to work. Accordingly, McKay et al. (2005) concluded, "Individuals with longer memberships tended to work longer and had higher job earnings" (p. 255). McKay et al. explained that the Clubhouse model is designed for members to overcome the barriers to full community participation, such as self-stigma, dependency, and the lack of interpersonal skills caused by past isolation. Jung and Kim (2012) stated that the perception of stigma is lower in those individuals who attended an ICCD Clubhouse than those individuals who receive services from a rehabilitation skills training model.

In addition to working with adults, Fountain House and Genesis house in Massachusetts, provide a transitional program for young individuals from 18 to 25. At the Genesis House, the goal of employment is paramount among all its members, and members have testified as to the Clubhouse supporting their goals (McKay et al., 2012).

Helping members find employment is an important objective of the Clubhouse. Di Masso et al. (2001) contended that the more frequently members attend a Clubhouse, the more importance they place on work. In addition, Di Masso et al. maintained that attending the Clubhouse readies members to return to work by teaching members acceptable office behavior. SAMHSA (2013) stated that the Clubhouse model is beneficial to individuals with SMI. HHS identified three areas that they found improved through the use of Clubhouses. These areas included employment, quality of life, and perceived recovery from SMI.

Carolan et al. (2011) proposed a social process recovery model. The model indicates that individuals with SMI experience stigma and isolation. Clubhouse participation increased social network and support, which aided in recovery (Carolan et al., 2011). In addition, Carolan et al. stated that CI Clubhouse members say that they have experienced personal growth through attendance at a Clubhouse. Members believe their quality of life has improved. The CI environment gave members an opportunity to experience a positive frame of mind. The Clubhouse atmosphere provided members opportunities to try out choices and to experience consequences. Members could assess their choices and change their behaviors. The opportunity to engage in skill development allowed for improvements in the area of self-efficacy. In an older study, Herman, Onaga, Pernice-Duca, Oh, and Ferguson (2005) stated that core aspects of the Clubhouse as identified by members include tasks and roles at the Clubhouse, social connections and recovery. V Rodriguez stated, “During the WOD members engage in leisure activities

that teach them vocational and socialization skills" (personal communication, June 5, 2014).

Educational Leisure Activities at Clubhouses

Three kinds of venues exist where learning occurs, including (a) formal institutional, which takes place in a formal institutional setting; (b) nonformal, which takes place in many locations including a community center; and (c) informal (Merriam, et al., 2007). Nonformal learning usually takes place with a facilitator, has a curriculum, and is short-term and voluntary. Merriam et al. contended that it is difficult for adults to recognize informal learning because it is unstructured and spontaneous. Informal learning is rooted in daily activities and can be hard to identify, due to its informal nature.

Merriam et al. (2007) identified three frameworks for informal learning, including self-directed learning, which is intentional learning; incidental learning, and described as an "accidental by-product of doing something else" (p. 36), and socialization or tacit learning, which is neither conscious nor intentional. Longworth (2003) stated that the individuals involved in the leisure activities may not recognize that the activities in which they are participating is adding to their knowledge base.

Knowles (1975) proposed that self-directed learning has a linear quality. Knowles suggested six steps to self-directed learning. Formulating learning goals and evaluating learning outcomes are steps three and six. These two steps are part of the Clubhouse WOD structure. V. Rodriguez stated, "Informal educational leisure activities are embedded into the WOD. Every six months new goals are established in the Clubhouse and a review of learning outcomes takes place between staff and members" (personal

communication, November 12, 2014). MacKean and Abbott-Chapman (2011) recognized community-based organizations as a medium for informal learning. In addition, the ABA defined informal learning as "unstructured non-institutionalized learning activities that are related to work, family, community, or leisure" (p. 228).

The symptoms of depression can cause amotivation because the ability to enjoy activities is diminished (Nimrod, Kleiber, & Berdychevsky, 2014). Iwasaki et al. (2014) stated that leisure activity performs an important function in the recovery from SMI. Iwasaki, Coyle, Shank, Messina, and Porter (2013) indicated that leisure is an activity that is engaged in by free choice; therefore, it should have some meaning to individuals, or they would not pursue it. The motivation behind leisure is, therefore, important.

Leisure activity is prominent in the recovery process in that it stimulates meaning making, and the reduction of boredom in those with SMI (Iwasaki et al., 2014). Blank, Leichtfried, Schobersberger, and Mölle (2014) contended that for some individuals, the absence of work itself causes harm to both physiological and psychological health. It is, therefore, important how people control their free time and what they do with their free time.

There is a correlation between the perception of living an active life and recovery. Leisure activity is a primary coping tool for stress, and the fact that an individual with SMI engages in leisure activities is a predictor of recovery (Iwasaki et al., 2014). Tjörnstrand, Bejerholm, and Eklund (2015) supported Iwasaki theory. They suggested that participation in leisure activities at a mental health day program setting was

perceived by participants as aiding in recovery. Participants felt that they were participating in life more, in spite of their symptoms.

Nimrod et al. (2012) stated that leisure activities can produce both positive and negative results. Results of the activity depend on the individual. It is important to tailor the right activity to the right individual. Yoga, for one individual, may produce a relaxed state, but for another, may bring up intrusive thoughts and cause anxiety (Nimrod et al., 2012). Nimrod et al. (2012) further stated that the use of leisure activities in individuals with major depression, may lower stress and improve or offer relief from symptoms. The individuals' attention shifts away from the reason for their stress, and a relaxed state ensues. Tjörnstrand et al. (2015) indicated that self-mastery through leisure activities was considered a key factor to recovery.

Iwasaki et al. (2014) stated that the role of leisure activity and stress reduction exist in cultural diverse populations. When leisure activities are positive, the activity can contribute to improving the quality of life for individuals with SMI. In addition, it is important to focus on the feelings and meanings the person with SMI gains from leisure activity. When results are positive, the person is more likely to repeat the activity at a later date (Iwasaki et al., 2013). However, Nimrod et al. (2012) asserted that leisure activity presents a challenge in those with depression, due to the very symptoms of the disease, lack of interest and enjoyment in activities, and an overall feeling of unworthiness.

Motivation to Engage in Leisure Activities

Research surrounding why adults are motivated to learn or engage in learning activities was initiated by Houle (1961, 1988). Houle contended that adult learnings can be broken down into three learning orientations: goal orientated learners, activity oriented learners, and learning-oriented participants. These three orientations are the foundation of later works that strive to understand questions surrounding the reasons adults may or may not engage in adult learning activities (Houle, 1961, 1988). Tough (1971) built upon the works of Houle, and contended that 90% of adult learning involves independent learning or self-directed learning. Houde (2006) states that motivation plays an important part in all six assumptions of Knowles theory of andragogy (adult learning). In Beard and Regheb's (1983) study, undergraduate students chose from 45 needs to participate in 10 different leisure activities. Beard and Regheb (1983) identified 10 motivators for engaging in leisure activities. Among these motivators were self-actualization, companionship intellectual aestheticism, self-esteem, and self-control. Beard and Regheb (1983) studied students and non-students and asked participants to identify the reasons for participation in leisure activities. A broad range of leisure activities were used in the study. According to Beard et al. reasons for participation in leisure activity include four components; (a) intellectual; (b) social competence; (c) competence-mastery; and (d) stimulus avoidance. The intellectual component involves mental activities such as learning, exploring, discovery (Lloyd et al., 2007).

The social competence component measures the participants need to socialize for interpersonal relationships (Lloyd et al., 2007). The competence-mastery component determines the degree participants are willing to engage in leisure activities to

accomplish, become skilled at, challenge, and compete (Lloyd et al., 2007). The stimulus avoidance component assesses the participant's motivation for relaxation and to avoid or get away from over stimulating life experiences (Lloyd et al., 2007).

Yu (2006) stated that human behaviors are maintained, directed and initiated by motivation. Yu dimensionalized five intrinsic motivational categories for participation in physical leisure activities among young adults. The two top categories included health and body image. Relief from stress is a reason for participation as is a relief from stressful emotions, including anxiety, nervousness, and upset feelings. The other three categories included self-efficacy, social needs, and enjoyment. Respondents mentioned that they enjoyed the self-control and self-competence they felt during the activity. Participation allowed for interaction with others, meeting new people, and having fun. Chiu (2009) stated that the more persons believe in their ability to participate in the activity, the more they involve themselves in the activity. Chiu stated, "Leisure motivation has a direct casual influence on leisure participation" (p. 10).

Beard and Regheb (1983) studied college students involved in intermural basketball and developed an instrument to measure participant's leisure needs. These researchers stated that the present day Leisure Motivation Scale (LSM) developed by Beard and Ragheb builds on the past studies of researchers Iso-Ahola and Allen, and others.

Chen and Pang (2012) stated that the Leisure Motivation Scale (LMS) scale has been employed in many different types of environments to understand leisure motivation. Kay and Mannell (1990) studied Italian and Chinese participants from a recreational

organization in Toronto using the LMS. Results for the Italians were similar to Beard and Regheb (1983). However, two additional components were added due to cultural diversity of the Chinese. Chen and Pang contended that Western cultures tend to look at social situations as competitive where eastern societies view social situations as collective in nature.

Lounsbury and Polik (1990) adapted the LSM study to measure participant's need for a vacation. Ryan and Glendon (1998) used a shortened version of the LMS in a study of 1,127 British vacationers. A pilot study using the full versions of the LMS was completed prior to the questionnaire using the shortened version. Participants were asked to identify motivational factors for taking a vacation and if participants last holiday met these factors. Ryan and Glendon used a shorter version on the LMS scale and concluded the integrity of the original four factors remained. Ryan and Glendon concluded that all of the components significantly relate to holiday satisfaction. Another study by Starzyk, Reddon, and Friel (2000) explored leisure motivation among young offenders and high school students. Starzyk et al. (2000) stated correlations were statistically significant between 19 of the 20 factors from the Personality Research Form (PRF-E).

A study by Lloyd et al. (2007) showed a correlation between leisure motivation and recovery, $r = .35$ (n = 44. $p = 0.019$. Participating in the study were 44 Clubhouse members from two Clubhouses in Australia. Two instruments, the LMS and the Recovery Assessment Scale (RAS) (Beard & Ragheb, 1983; Corrigan, Salzer, Ralph, Sangster, & Keck, 2004) were used to measure the association between members' motivation to engage in leisure activities and their perception of recovery. I expanded on the study by

Lloyd et al. and enlarged the study to include Clubhouse members from 4 Clubhouses and enlarged the participant pool to 75. In doing so, Clubhouses and other programs may adapt leisure activities to meet positive outcomes for those with SMI. In addition, this study looked for a positive association between leisure motivation and recovery.

Implications

Findings measured positive relationships between motivation to engage in leisure activities, which includes the intellectual, social, competence-mastery, and stimulus-avoidance motives, and perception of recovery from SMI. By understanding the relationships between leisure motivation and recovery, community support systems, such as Clubhouses, and occupational programs, researchers could help design better programs to reintegrate individuals back into their communities. In addition, by identifying leisure motivation and the activities that motivate a person with SMI to engage in leisure time activities, recovery could take place. Through leisure activities, members with SMI can affect social change by improving their quality of life, by learning social and work skills, and by developing friendships and a support system, which could empower members to reengage with society, and, for many, to become employed.

As a result of this study, a professional development/training curriculum with training materials was proposed. The project involves the creation of a motivational workshop that can be used at Clubhouses at the local level, as well as Clubhouses and drop-in centers worldwide. In addition, having evidence from this study could help to support the idea that spending public funds for SMI recovery is beneficial to the public

good. Empirical evidence could help persuade government officials to support legislation for additional monies for Clubhouses and other mental health facilities.

Summary

Mental illness affects a quarter of the American population and causes a disruption of everyday coping skills by disrupting an individual's thinking or moods (NAMI, 2013). Social isolation is a common condition for those with SMI and reflects negatively on individuals' quality of life. Improved quality of life can be accomplished through the many leisure activities incorporated into the WOD of the Clubhouse. Through this study, I investigated if there is a positive correlation between members' motivation to participate in WOD leisure activities and their perceptions of recovery from SMI.

Section 2: The Methodology

Introduction

The purpose of the study was to determine the relationships between motivation to engage in leisure activities including the intellectual, social, competence-mastery, and stimulus-avoidance motives and self-reported perception of recovery from SMI among 75 individuals at four Clubhouses in the southwestern part of the United States. Participation in activities that provide meaning and purpose may facilitate recovery from mental illness. Section 2 covers the following: a description of the research design and approach, setting and sample, instrumentation and materials, data collection and analysis, assumptions, limitations, scope, and delimitations of the study.

Research Design and Approach

Several quantitative research designs exist. A survey was not appropriate because this study did not describe a trend or participant's opinions on various subjects. In addition, a traditional approach to quantitative research, the experimental design, was not appropriate because I was not looking for a cause and effect between the two variables (Creswell, 2012).

A quantitative correlational design was most suitable for this study because the research investigated whether two variables influence each other. There are two types of correlational designs, the explanatory and the prediction designs. Of these two, the explanatory design (also called relational research [Creswell, 2012] was the more applicable. The explanatory design was appropriate for this study because I sought to explain the relationship between variables and how they covaried. In addition, several

factors that identify an explanatory design are present. The study took place at one point in time; all participants were treated as one single group; each variable produced a score, and a correlational statistical score was obtained in the data analysis. Finally, I drew conclusions from the statistical test results.

A qualitative study could have been used for this study; however, I felt that an empirical design would be more meaningful. Qualitative research analyzes words and images taken from the transcripts of participants' interviews. Words and images are then grouped into codes or themes to reveal the meaning of the data (Creswell, 2012). From my review of the literature, I found excellent narrative and exploratory studies on Clubhouses, but there was a lack of statistical evidence on recovery there from SMI. An empirical correlational study between members' perceptions of motivation to engage in leisure activities and members' perception of recovery was expected to give mental health practitioners solid evidence. In addition, it was expected to help those in education when developing educational programs for those with SMI.

Setting and Sample

Approximately 100,000 people living with mental illness access Clubhouse services annually (2012 ICCD Directory & Resource Guide). As of 2012, there were 341 accredited Clubhouses in 32 countries. Convenience sampling was used for this study. Convenience sampling uses participants from a population who are willing and available to be studied (Creswell, 2012). The Clubhouses selected for the study were located in the southwestern part of the United States. This region was chosen for this study because I live in southern California, near one of the accredited Clubhouses. There are seven

Clubhouses spread across the southwestern part of the United States. In total, I approached five Clubhouses to participate. I chose these Clubhouses because logistically they were easiest for me to access. Clubhouse directors from four Clubhouses agreed to participate. The average daily attendance at each U.S. Clubhouse is 45 (Mckay et al., 2012), making the potential population approximately 180 persons.

The director of each Clubhouse who agreed to the study set up a time and date for me to come in and present the study to the members of the Clubhouse. After the study was explained to the members, a time and location for completing the questionnaires were given and members were invited to participate. A total of 79 members took the surveys. 75 members completed the surveys, and 4 members declined to participate and returned the surveys without answering any questions.

The null hypothesis is only rejected if there is strong evidence against the hypothesis. A Type I error is committed if the null hypothesis is rejected when it is, in fact, true. The probability of a Type 1 error, given the null hypothesis is true, is called the significance level of the test or α. This level is commonly set low and was set at .05 for the purposes of this study. A Type II error is committed by not rejecting the null hypothesis when it is, in fact, false. The power of the test is the probability of correctly rejecting the null hypothesis when it is false. The power of the test depends on the choice of alpha, the sample size and the value of the parameter. It is the common choice for the power to be set at .80 (Triola, 2012). The medium effect size of .30 was used for this study because statistician J. Lani, Lloyd et al. (2007) used medium effect size in a similar study (personal communication January 15, 2014).

The power analysis formula by Cohen (1992) was used to determine sample size. Based on a power of .80, an alpha of .05, a medium effect size of .30, and a statistical method of product moment correlation with a one-sided test, a sample size of 68 was required (p. 158). Cohen stated, "The tabled sample sizes provide close approximations for a one-sided test at .05α (e.g., the sample sizes tables under α=.10 may be used for one-sided tests at α = .05" (p. 156).

All active members in the four Clubhouses were eligible and invited to participate in the study. An active member is defined by Clubhouse International as a male or female, 18 years, or older, with a diagnosed mental illness, who attends at least once every 3 months (ICCD, 2013). All participants who were active members at one of the four Clubhouses were targeted for the study.

Instrumentations and Materials

I employed two instruments to collect the data, including the Leisure Motivation Scale (LMS) and the Recovery Assessment Scale – Domains & Stages (RAS-DS). Copies of the instruments are in Appendices B and C. Permissions to use the LMS, and RAS-DS instruments are in Appendices D and E. In addition, participants provided answers to four demographic questions: marital status, age, sex, and length of membership at the Clubhouse. A copy of the demographic questionnaire is in Appendix F.

The LMS was first published in 1983 by Beard and Regheb, and revised by Idyll Arbor in 1989, by adding an additional observation sheet to the instrument, with permission from the authors. The observation sheet was not used in this study. The LMS,

which measures a person's motivation to engage in leisure activities, is divided into four subscales. The LMS instrument examines four motives of leisure motivation, which are intellectual, social, competency-mastery and stimulus avoidance. These are the independent variables for the study. The LMS instrument uses a 5-point Likert scale from "1"-*never true*, to "5"-*always true*, and it consists of 48 statements. The data from the Likert scale were treated as interval data. Although the Likert scale can measure both ordinal and interval data in educational research, in this study it was treated as interval data (Creswell, 2012). Scores for each of the subscales, intellectual, social, competence-mastery, and stimulus-avoidance were derived by adding up the scores from each question on the subscale of the questionnaire. Questions 1–12 relate to the intellectual. Questions 13–24, the social, Questions 25–36 the competence-mastery, and Questions 37–48 the stimulus avoidance. A score for each of the four subscales could be as low as 12 or as high as 60. A high score for each subscale suggested that the participant is very motivated to participate in leisure activities.

Beggs and Elkins (2010) stated that the Cronbach alpha coefficient for each of the subscales in the LMS indicated a strong measure of reliability. Beggs and Elkins reported alpha coefficients for the intellectual motive at 0.91, the social motive at 0.87, competence-mastery at 0.91, and the stimulus-avoidance motive, 0.84. According to T. Blaschko, the sub-scores of the LMS were found to have strong validity and reliability (T. Blaskchko, personal communication, March 24, 2015). In addition, the LMS manual stated that the 48 questions, or full-scale instrument, “has strong content validity and strong internal consistency” (Arbor, nd, p.1)

The Recovery Assessment Scale (RAS-DS) is a revised version of the Recovery Assessment Scale (RAS) by Corrigan, Salzer, Ralph, Sangster, and Keck. The instrument was revised by Nicola Hancock and The University of Sydney in 2011, with permission of the authors. The RAS-DS measures the concept of recovery from SMI, which is the dependent variable in this study. The RAS-DS measures a person's perception of recovery from SMI. The RAS-DS uses a 4-point Likert scale and consists of 38 statements. The participant made one of four choices from "1"-*untrue* to "4"-*completely true*. The data from the Likert scale were treated as interval data. Although the Likert scale can measure both ordinal and interval data in educational research, in this study it was treated as interval data (Creswell, 2012). The total score was determined by adding up the score from each question of a participant's questionnaire. The score of the RAS-DS could be as low as 38 or as high as 152. High scores for the RAS-DS suggested that the participants viewed themselves in recovery from SMI. Rasch analysis of the RAS-DS revealed high internal reliability and validity. The Cronbach's alpha for the total score is .96, which indicates strong reliability (Hancock, Scanlan, Honey, Bundy, & O'Shea, 2014).

Participants completed the instruments at one of the four Clubhouses, while I was on onsite at the Clubhouse. Copies of the full-versions of the instruments are provided in Appendices B and C. Raw data collected will be kept in a locked file cabinet at the researcher's home for a period of five years.

Data Collection and Analysis

Permission for this study was obtained by the Institutional Review Board at Walden University (approval number 10-05-15-0228048). In addition, consent was obtained from the directors of each Clubhouse under study. The director of each Clubhouse was contacted via email and telephone, the main methods by which the study were explained, and permission for the study was received from participating Directors (see Appendix G). Letters of cooperation were obtained from the directors from each Clubhouse and appear in Appendix H. In addition, cover letters explaining the instruments used in the study, and the IRB Consent Form for adults over 18 were emailed to the director of each clubhouse, as it was the director who made the final decision to accept the study. The IRB consent forms were sent to the directors for their review. This allowed the directors to be informed in the event of any questions participants might ask the directors.

The director of each Clubhouse set up a time and date for the researcher to come in and present the study to the members of the Clubhouse. Members were invited to ask questions during the initial meeting. After I explained the study to the members, a time and location for completing the questionnaires was given. The directors at each site provided a private and public place for their members to complete the questionnaires. In addition, any additional questions or concerns that the participants had were addressed at the time. When a member agreed to participate in the study, the participant was given a consent form for their keeping. This consent form was on paper. Any questions the participants had about the consent form were answered at that time. After which, I

explained how to fill out the questionnaire. The questionnaire was in hard copy. The participants then completed the questionnaire in one of the rooms provided. When the questionnaires were completed, the participants gave the questionnaire to me. I provided a lock box for the questionnaires for safe transfer to my home. The locked box is now at my residence, where it will reside for a period of 5 years. After which, all raw data will be destroyed.

Data from the questionnaires were entered into an Excel spreadsheet. The Excel file was imported into an SPSS file. SPSS software was used to calculate the Pearson correlation coefficient (*r*) score and the p values, also known by its full name, the Pearson Product Moment Correlation or PPMS. The test measures how well the independent and dependent variables are related. The Pearson correlation coefficient is utilized when the number of independent variables under study is one, and when the data are linearly related. The scores for each subscale of the LMS were correlated with the total score on the RMS-DS. According to Triola (2012) r measures the strength of a linear relationship between the two scales. The p score tells if there is significant evidence of a linear correlation. A one-tailed correlation test was used because the alternative hypotheses are directional.

I discussed using the Pearson correlation test with the author of the RAS-DS instrument and with the holder of the LMS license by phone and or/email (T. Blaschko, March 23, 2015; N. Hancock, personal communication, March 24, 2015). Both agreed that using the scores of the four subscales from the LMS and the total score of the RAS-DS instrument was a valid use of the instruments.

Data Analysis Results

Descriptive Data

A total of 75 participants completed the study. All participants completed two questionnaires, the LMS questionnaire and the RAS-DS. The LMS questionnaire consisted of 48 questions with a 5- point Likert Scale from "1"- never true, to "5"- always true. The questions from the LMS questionnaire were divided into four subscales; Intellectual, Social, Competency-Mastery, and Stimulus Avoidance. There were 12 questions in each subscale. A total score for each of the four subscales could be as low as 12 or as high as 60. A high score for each subscale suggested that the participant was very motivated to participate in leisure activities. The range, mean, and standard deviation for the Intellectual, Social Competency-Mastery, and Stimulus avoidance subscales of the LMS were 47.55 (48, 9.16), 45.88 (48, 11.48), 44.23 (57, 11.85), 39.92 (48, 11.61 (Table 1).

The RAS_DS consisted of 38 questions with a 4-point Likert scale“1"-*untrue* to “4”-*completely true*. The total score of the RAS-DS could be as low as 38 or as high as 152. High scores for the RAS-DS suggested that the participants viewed themselves in recovery from SMI. The, range, mean, and standard deviation for the RAS-DS was 83.00, 124.27, 19.83 (Table 1).

Table 1

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Intellectual	75	48.00	12.00	60.00	47.55	9.16
Social	75	48.00	12.00	60.00	45.88	11.50
Competence-Mastery	75	48.00	12.00	60.00	44.63	10.91
Stimulus-Avoidance	75	48.00	12.00	60.00	39.92	11.61
RAS_DS	75	83.00	69.00	152.00	124.27	19.83

Research Questions

RQ1: Is there a positive relationship between the intellectual motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*H*O1: There is no positive relationship between the intellectual motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

*H*A1: There is a positive relationship between the intellectual motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

A Pearson correlation coefficient, one-tail test, was calculated for the relationship between the participants' intellectual motive to engage in leisure activities and the participant's perception of recovery from SMI. A moderate positive correlation was

found ($r(73) = .526$, $p < .001$), indicating a significant linear relationship between the two variables. The null hypothesis is rejected and alternative hypothesis is accepted.

There is a moderate positive relationship between the intellectual motive to engage in leisure activities and the participant's perception of recovery from SMI at four Clubhouses. As the scores for the intellectual motive to engage in leisure activities increased so did the scores for the participant's perception of recovery from SMI (Table 2).

Table 2

Correlation between the Intellectual Motive and Recovery from SMI

		Intellectual	RAS-DS
Pearson Correlation		1	526**
Intellectual	Sig. (1-tailed)		.000
	N	75	75
Pearson Correlation		.526**	1
RAS-DS	Sig. (1-tailed)	.000	
	N	. 75	75

RQ2: Is there a positive relationship between the social motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*HO*2: There is no positive relationship between the social motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

HA2: There is a positive relationship between the social motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

A Pearson correlation coefficient, one tail test, was calculated for the relationship between the participants' social motive to engage in leisure activities and recovery from SMI. A moderate positive correlation was found ($r(73) = .424$, $p < .001$), indicating a significant linear relationship between the two variables. The null hypothesis is rejected and alternative hypothesis is accepted. There is a moderate positive relationship between the social motive to engage in leisure activities and recovery from SMI at four Clubhouses. As the scores for the social motive to engage in leisure activities increased so did the scores for the participant's perception of recovery from SMI (Table 3).

Table 3

Correlation between the Social Motive and Recovery from SMI

		Social	RAS-DS
Social	Pearson Correlation	1	.424**
	Sig. (1-tailed)		.000
	N	75	75
RAS-DS	Pearson Correlation	.424**	1
	Sig. (1-tailed)	.000	
	N	75	75

RQ3: Is there a positive relationship between the competence-mastery motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*H*O3: There is no positive relationship between the competence-mastery motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

*H*A3: There is a positive relationship between competence-mastery motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses.

A Pearson correlation coefficient, one tail test, was calculated for the relationship between the participants' competence-mastery motive to engage in leisure activities and recovery from SMI. A moderate positive correlation was found ($r(73) = .469$ $p < .001$), indicating a significant linear relationship between the two variables. The null hypothesis is rejected and alternative hypothesis is accepted.

There is a moderate positive relationship between the competence-mastery motive to engage in leisure activities and recovery from SMI at four Clubhouses. As the scores for the competence-mastery motive to engage in leisure activities increased so did the scores for the participant's perception of recovery from SMI (Table 4).

Table 4

Correlation between the Competence-Mastery Motive and Recovery from SMI

		Competence-Mastery	RAS-DS
Competence-Mastery	Pearson Correlation	1	.469**
	Sig. (1-tailed)		.000
	N	75	75
RAS-DS	Pearson Correlation	.469**	1
	Sig. (1-tailed)	.000	
	N	. 75	75

RQ4: Is there a positive relationship between the stimulus-avoidance motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*H*O4: There is no positive relationship between the stimulus-avoidance motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

*H*A4: There is a positive relationship between stimulus-avoidance motive to engage in leisure activities, and the perception of recovery from SMI in individuals at four Clubhouses?

A Pearson correlation coefficient, one tail test, was calculated for the relationship between the participants' stimulus-avoidance motive to engage in leisure activities and recovery from SMI. A moderate positive correlation was found ($r(73) = .341$ $p < .001$), indicating a significant linear relationship between the two variables. The null hypothesis is rejected and alternative hypothesis is accepted.

There is a moderate positive relationship between the stimulus-avoidance motive to engage in leisure activities and recovery from SMI at four Clubhouses. As the scores for the stimulus-avoidance motive to engage in leisure activities increased so did the scores for the participant's perception of recovery from SMI (Table 5).

Table 5

Correlation between the Stimulus-Avoidance Motive and Recovery from SMI

		Stimulus-Avoidance	RAS-DS
Stimulus-Avoidance	Pearson Correlation	1	.341**
	Sig. (1-tailed)		000
	N	75	75
RAS-DS	Pearson Correlation	.341**	1
	Sig. (1-tailed)	.000	
	N	75	75

Based upon the results of the data analysis a professional development training program will be developed for staff at CI Clubhouses. Emphasis will be placed on the different motivating factors to engage in leisure activities.

Assumptions, Limitations, Scope, and Delimitations

Results cannot be generalized to the general population of Clubhouses because the study used convenience sampling. However, because of the similarities of accreditation standards and operating procedures, results show a trend.

I made three critical assumptions during data collection; that all participants would be able to read and understand the directions and questions presented; that participants would answer the questions without any prodding, influence, or suggestions from another participant, member, or staff; and that participant would answer the questionnaire honestly. A potential limitation of the study was that a convenience sample was used, and therefore, information cannot be generalized to a larger population. Another limitation was that I had no way of knowing if the participants' answers were true and reflected the honest feelings of the participant. Respondents may not have felt encouraged to provide accurate, honest answers.

There are over 200 accredited CI Clubhouses in the United States; however, the scope of this study only included four Clubhouses. The four Clubhouses are located in the southwestern part of the United States.

Protection of Human Subjects

To respect vulnerable populations, the Institutional Review Board (IRB) at Walden University reviewed the ethical standards of this research prior to beginning this

study (10-05-15-0228048). I completed The National Institutes of Health (NIH) Office of Extramural Research training course “Protecting Human Research Participants”.

I did not have access to any confidential information such as educational or medical records concerning participants. I worked at one of the clubhouses as a warmline supervisor before the study commenced. I knew several of the individuals who chose to participate in the study; however, I held no position of power or authority over the members of the Clubhouse. The questionnaires contained no materials or topics, considered offensive, or degrading. The very issue of recovery may seem sensitive to participants; however, participants had advanced knowledge that this was the subject of the study and could choose not to participate. The topic of the RAS-DS questionnaires involves one’s self-assessment of their recovery. Questions are very general, for example, “I can handle it if I get sick again.” If the participant was to become stressed for any reason while taking the questionnaires, they had immediate access to Clubhouse staff and community resources. Participants did not become stressed while completing the questionnaire. Participants were able to terminate their participation in the study at any time as required by Federal law, and the IRB. Four participants made the choice not fill out the questionnaire after reading it over.

Each Clubhouse provided a public or private area reserved for completing the consent form and questionnaire. Participants were able to ask any questions they may have had about the study and completed the questionnaires. Participants were not subject to pressure from the Clubhouse staff, public, family, or other members while taking the questionnaires. To gain access to the Clubhouse, one needed to sign in at the reception

desk. Non-members were not allowed to walk around the Clubhouse unescorted. Only members had access to the Clubhouse unescorted.

Participating in the study incurred no economic or social loss. Participants were under no obligation to finish the questionnaires, could freely opt out of the study at any point, and did not incur any discrimination by the director, me, or staff for choosing not to be involved in the study. Participants did not incur any monetary, social, or prestige by involvement in the study. There was no risk of a major adverse effect on participants of the study, other than the inherent risk one takes in engaging in life activities. Participants were seated at a table with the consent form, questionnaire, and pen or pencil. I announced at the group meeting that there were several benefits of the study. One benefit of the study was for me, as this study is part of the requirement for graduation and EdD Degree. The results of the study showed there are positive relationships between participation in leisure activities, and recovery. The more we add to the body of knowledge concerning what motivates people in recovery, the more we can assist those with SMI towards recovery. Another benefit for participants is the design of a professional development program on motivation that can educate staff in stimulating members toward recovery.

Participants had complete confidentiality. The questionnaire given to participants did not ask for any identifying information. The questionnaire answers are locked in a file cabinet at my home, and only I have access to the information. The consent forms given to participants and read by participants before they participated in the study informed members of their rights.

Conclusion

In Section 2 the research methodology used for this study was discussed in depth. Included were the quantitative design, the setting, and the selected instruments. Addressed was the data collection and analysis as well as the assumptions, limitations, and delimitations, protection of the participants and safeguards put in place for participants' security. After approval by the IRB approval at the University level, the study was conducted on-site at four CI Clubhouses in the southwestern part of the United States. Section 3 will describe the professional development training program that was developed based on the results of the study. Emphasis will be placed on the different motivating factors to engage in leisure activities. Also included is a description of the goals, the rationale for the project, literature review, and the implementation of the project.

Section 3: The Project

Introduction

As a result of study findings that indicate significant correlations between four motivating factors to engage in leisure activities and recovery, a professional development training program was developed on the topic of motivation for staff at clubhouses. The program will be available to all full-and part-time staff at the Clubhouse. The goal of the program is to expand staff's ability to create a learning environment that motivates members to engage in educational leisure activities. The program will provide realistic and practical strategies to increase the staff's resources and body of knowledge. Staff will reexamine the importance of motivation; they will be exposed to the theories of adult motivation and the importance of incorporating adult learning theories into the formal learning environment for individuals with SMI. Participants also will be introduced to four motivating factors and explore how staff can identify which factor or factors motivate an individual. The goal was to develop a professional development program that could help staff explore ways to motivate members more efficiently to participate in leisure activities and thus promote recovery from SMI. Specifically, staff will engage in activities, presentations, and discussions to identify what motivational methods are being used at the Clubhouse and what additional motivational methods could be used to engage members at their local Clubhouses. Adult learning and motivational theories will be used to help staff members to explore and change their frames of references and perspectives (i.e., beliefs, value judgments, and feelings) relative to what motivates members with SMI. Staff will engage in role-playing exercises to improve

motivational interviewing skills that are used to help identify the needs of members. In addition, staff will explore ways to tap into members' desires to enact a positive change in their lives by participating in leisure activities.

Rationale

Data analysis of the results showed a correlation between engaging in leisure activities and clients' perception of recovery at Clubhouses. Clubhouse staff members are aware that many members must be motivated to engage in leisure activities. This project genre was chosen to give staff members the opportunity to explore theoretical and practical ways to motivate their local clubhouse members. A 3-day professional development workshop will provide staff an opportunity to discuss common and unique motivational factors used at Clubhouses. Four factors of motivation will be considered intellectual, social, competency-mastery, and stimulus-avoidance helping staff to match a motivating factor to individual members. Role-playing exercises on motivational interviewing will provide training for staff to better identify which factor motivates members and how to communicate this factor to them.

Along with learning about the Mezirow's (1981) transformational learning theory, staff will be exposed to, and interact with, individuals from different backgrounds. These individuals may help them discover any cultural biases that may be limiting their ability to motivate individuals from culturally diverse backgrounds.

Maslow's (1943) hierarchy of needs theory will be presented to help staff understand how motivation to engage in leisure activities is related to the physiological needs of individuals with SMI. Clubhouses vary in required educational backgrounds for

listed positions. The position of peer support may only require a lived experience and a high school diploma or general education development (GED) credential. A generalist position may or may not require a bachelor's degree in a human service related field. Yet, staff is expected to train members in a multitude of subjects and vocational skills. A professional development program helps staff better understand motivation, implement adult learning theories, and improve their job skills to aid members in their recovery and reengagement into society.

Review of the Literature

The following databases were used to identify articles for the literature review: ERIC, Thoreau, PsycINFO, Sage Journals, Education Research Complete, PubMed, PsycARTICLES, and PsycAbstract. The following keywords were used: *professional development, motivation, staff, in-service training, training, adult learning, employment training, transformative learning, transformational learning, and Maslow*. The literature review is organized according to the following subheadings: theoretical framework – transformational learning, professional development, and workshop on motivation.

Theoretical Framework: Transformational Learning

Transformational or transformative learning is a theory introduced by Mezirow in 1978 and involves how adults interpret their life experiences. Mezirow (2000) defined learning as "the process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one's experience in order to guide future action" (p. 5). Hodge (2014) stated that the theory distinguishes between the learning of schemes and perspectives. Schemes relate to knowledge and beliefs, and perspectives relate to the

unconscious of thought, feeling, and will. Hoggan (2016) stated that not only is it a good, sound, and useful theory, it comes from one of the writers. Mezirow's background was in Foundations of Education before he entered into adult education (Rose, 2015). Literature reviews from diverse fields from agriculture to health care referred to this theory (Taylor & Snyder, 2012). Transformational learning is adept in formal, nonformal and informal styles of education (Nohl, 2015).

Mezirow (2000) identified 10 stages to the transformational learning process, beginning with a disorienting dilemma. The start of the dilemma can be non-determining and identified when something unusual enters a person's life (Nohl, 2015). Transformational learning can also take place in the classroom. Theatrical events can be created by workshop facilitators to invoke the transformational process (Pernell-Arnold et al., 2012). The second and third stages of the transformational learning process relate to with the learners' "self-examination with feelings of fear, anger, guilt, or shame, and critical assessment of assumptions" (Mezirow, 2000, p. 22). Self-examination and critical assessment can be a tough period for the learner. The learner can confront assumptions that they now see as limiting, and it is a time filled with subjective reframing (Heorhiadi, La Venture & Conbere, 2014).

In the next two stages of Mezirow's (2000) theory are "recognizing that the discontent felt during the transformation process is shared with others, and exploration of options for new roles, relationships, and actions" (Mezirow, 2000, p. 22). Learners during these phases have the opportunity to display their new practices with peer's to gauge their reactions and give appraisals (Nohl, 2015). The following four stages are "planning a

course of action, acquiring knowledge and skills for implementing one's plans, provisional trying of new roles, building competence and self-confidence in new roles and relationships," allow learners to turn learned habits into a new focused experience through a shift in the individual's perspective (Mezirow, 2000, p. 22).

What follows next is the last stage, "a reintegration into one's life by conditions dictated by one's new perspective" (Mezirow, 2000, p. 22). This stage is where the transformation process ends. At this stage, individuals will find social communities or relationship with other peers that support learners to cement their new perspective and meaning schemes (Nohl, 2015).

Academic theorists stress that transformative learning focuses on an individual personal transformation not simply upon acquiring new knowledge (Maiese, 2015). The transformative change is a holistic difference within the individual, which results in a change in how they experience the world and their meaning schemes (York & Kasl, 2006). A holistic conversion shows the importance of understanding the intellectual aspect of that change as well as the emotional and social (Clark, 1993). The process involves the learner to experience a period of disorientation, followed by critical self-review of their beliefs, and a behavioral change in the actions of their new mean schemes. Martin and Griffiths (2014) declared, "Transformative Learning is emancipatory in that it frees individuals to make their own interpretations of the world rather than (often unconsciously) acting on the purposes, beliefs, judgments, and feelings of others" (p. 939).

Transformational learning was the framework I chose for this project. Clubhouse staff is aware that many members need to be motivated to take part in clubhouse activities. The dilemma for staff is understanding how to motivate members. Christie (2015) stated that if presented the motivation and information required to test and change beliefs, learners will have the opportunity to develop into individuals adept for the evolving world. Transformational learning results in changes in motivation (Hoggan, 2016). The more people understand themselves, the more similarity exists between their behaviors and their authentic self. Learners need to become aware of how they take their mental schemes for granted; after which they can challenge change before they are able to change and expand them, if they desire (Eriksen, 2015). However, Christie (2015) warned that the learner must be convinced that transformation is necessary for change to take place.

Some Clubhouse staff come from backgrounds in sociology. Others have only been taught the clinical model of SMI and were only introduced to the recovery model on the job. Though many have started the transformational learning process, they carry a number of false assumptions concerning SMI. A three-day professional workshop can help guide these staff through a wide range of transformative stages of learning, including self-examination and critical assessment of their perspectives on SMI. The workshop will give them the social environment to explore and test new perspectives and give them the tools to reintegrate new ideas into the Clubhouse setting.

Professional Development

Anthony and Weide (2014) asserted that professional development (PD) training programs are the lifeblood of the success of a company. Due to the upsurge in global competition and advances in technology, employers realize that continuous employee education is the chief driver to the bottom-line of a business (Beausaert, Segers, & Gijselaers, 2011). Rao (2014) agreed that in a changing environment, for organizations to maintain a competitive work force, organizational managers must commit the resources to do so. It is by the attainment of knowledge through PD training that people are given the tools to improve performance on the job. Bryson (2014) contended that today practitioners are expected to be lifelong learners to develop in their profession. A PD training program is important because real-world and simulated learning are not enough to develop the skills needed in the workplace. Long-time workers need mentoring, support, and PD training as much as newer employees to the profession (Bryson, 2014).

Huber (2011) identified patterns and traits found in successful PD training programs worldwide. Patterns and characteristics showed participants to be from a homogeneous group; training is comprehensive and extensive, goals and objectives are explicit, approaches to learning should be all inclusive to include motivation and reflection, and the focus should include personal development. In addition, a quality PD training is one in which learners are involved (Anthony & Weide, 2014). PDs are successful when employees learn during activities and can retain and use what they learned after returning to the workplace (Sankey & Machin, 2014).

PD training has a direct impact on workplace efficiency and morale. When the quality of training is diminished, there is a decline in productivity and employee motivation (Sankey & Machin, 2014). In addition, when training is reduced, employers see a reduction in work productivity. Poor professional development trainings cause individuals to take longer at their assigned tasks, to show signs of increased stress, and to increase employee turnover (Anthony & Weide, 2014).

Successful PD training considers the needs and abilities of the learners (Huber, 2012). Individuals are discriminating in what they learn. Adult learners tend to lean toward problem-oriented rather than theme-centered learning. As such, workers look at learning as a way to develop tools that can be applied in task situations (Huber, 2012). Adults learn at a higher rate when they can see practical applications to what they are being taught than they do not see a connection between their learning and real-world application (Huber, 2012).It is also important to use a variety of learning methods for the adult learners to accept new information. Cordingley (2015) contended that an effective PD training or workshop includes sustained collaboration among peers. Continued motivational and transformative learning support may be expected because staff will be working together on a daily basis. In addition, learning from observing their peer and focusing on refining their skills occurs from peer support, and will be encouraged during group discussions and exercises (Cordingley, 2015).

Workshop on Motivation and Engagement

More money is spent on adult education than on elementary through post-secondary school combined. A diverse field of adult education has been created to catch

the adult learner, a learner who views learning as a passionately personal pursuit. To date, thousands of books exist and an expansive number of articles have been written on adult learning and its theories (Merriam et al, 2007). Beginning methods focused on adult education as a change in behavior, Merriam added, and even newer theories are based on this notion.

Motivation is an essential human process, energy, or inside force one cannot see, but whose result is realized in the accomplished goals. Wlodkowski (2008) contended that "motivation is basic to survival" (p. 2). Motivation can be perceived when thought and imagination are used to pursue our goals (Wlodkowski, 2008). Actions utilized by learners to accomplish their goals may come from unconscious thought (Markman, Maddox, & Baldwin, 2005). Renninger and Bachrach (2015) contended that activities that trigger interest are often unexpected, fleeting. Many times participants are not even aware that their interests have been sparked.

Amotivation may stem from an individual not seeing a connection between engaging in an activity and its outcome; therefore, the individual will not participate in the activity (Jung, 2013).The symptoms of depression can cause amotivation because the ability to enjoy activities is diminished (Nimrod, Kleiber, & Berdychevsky, 2014). A negative side effect of schizophrenia is the lack of motivation to engage in beneficial activities, even with extrinsic motivators added (Blanchard et al., 2011). This lack of motivation could be due to the fact that those individuals with schizophrenia have reduced anticipatory gratification (Horan et al., 2016). Extrinsic motives are activated by

tangible incentives such as money, grades, social status; whereas intrinsic motives are biologically driven by emotions or the unconscious (Brantrschen et al., 2014).

Intrinsic motivation is employed when individuals are involved in the learning process, though researchers are not unsure how that is accomplished. Intrinsic motivation for the individual learner has to do with the activity and the different motivational factors of other group members (Anthony & Weide, 2014). The use of intrinsic motivation can come from the personal satisfaction an individual receives by engaging in the activity and is found to be influenced directly by intellectual stimulation (Bolkan, Goodboy, & Griffin, 2011, Bolkan, 2015). When a learning activity and assessment is developed, it is important to know the audience and the type of motivation, intrinsic, or extrinsic, that will motivate and trigger students to learn at an increased rate (Bates, 2015).

The framework of intrinsic motivation originated from Maslow's Hierarchy of Need Theory (1943), and Maslow believed there was an explicit link between motivation and individual development (Browning, 2014). Moffett et al. (2014) argued that Maslow's theory is an explanatory concept and that humans are driven by unfulfilled desires. Maslow (1943) described five basic needs, which include physical, safety, social, esteem, and self-actualization needs. The bottom needs such as food, shelter, security, must be fulfilled before an individual will be motivated to attend to the higher needs on the ladder (Čížek, 2012). Learners need their lower needs such as shelter, food, and security, taken care of before they can learn (Wlodkowski, 2008).

A successful workshop on motivation and engagement will include inspirational motivation. Inspirational motivation is achieved when facilitators inspire and energize learners to achieve their goals, and when facilitators communicate high expectations of learners (Beauchamp, Barline, & Morton, 2015). Learners can monitor and control their motivation to learn. However, the learners must perceive that the required tasks performed during a learning activity are aligned with their personal goals. If a conflict exists, the learners' ability to motivate themselves to learn is diminished (Paulinoa &Lopes da Silval (2011). In addition, the learners must feel confident in themselves and feel in control of their learning by being active participants in the learning process (Blalock, 2015). Workshops that incorporate role play exercises and group activities will allow learners to actively participate in the learning process.

Project Description

Potential Resources and Existing Supports

The director and the board of directors had agreed to the training. There was not a rental fee for the room as this is the staff's Clubhouse. The Clubhouse Board room is reserved for the training. The room is equipped with a computer, tele-prompter, large viewing screen, and flip chart, with flip chart stand. All other materials, paper, pens, markers, and copies for handouts, necessary for the workshop already exist at the Clubhouse. Staff will be seated in ergonomic chairs around one large table. A smaller table will be set up in the corner, with water and an assortment of snacks and refreshed throughout the day.

Staff will be mandated to attend the training. Staff will be paid their regular hourly salary, while participating in the training. Clubhouses have a reciprocal agreement in shifting, or borrowing staff from one Clubhouse to another when extra staff is needed. The training will occur during the staff's regular working hours; therefore the Clubhouse will not incur any additional labor costs. The Clubhouse will prepare the lunch for free to the staff during the training. Providing a free breakfast and lunch to the staff will incur a loss to the Clubhouse of $3.00 per employee per day. The standard cost for breakfast or lunch is $1.50. The Clubhouse director will deduct $3.00 for each staff member per day from the Clubhouse budget under the category of special events. Working in the kitchen and serving members and staff on a daily basis is voluntary and part of the WOD; as such, there will be no additional labor costs for the lunch.

Potential Barriers and Potential Solutions

The workshop will be onsite at the local Clubhouse. The only perceived potential barrier will be for the Clubhouse director to arrange for qualified staff from other Clubhouses to fill in for Clubhouse 1 staff's responsibilities for the 3 days the staff members are in training. By scheduling the workshop 6 months in advance, it is possible to borrow staff members from other Clubhouses in the area. Clubhouses have a reciprocal agreement to exchange staff members when needed on special occasions. Each Clubhouse has a shuttle van. The van will be used to transport borrowed staff members. The staff members on loan will include travel time into the 8- hour day. No extra overtime hours will be incurred. The local Clubhouse director will, therefore, be without staff members for approximately 30 minutes in the morning and afternoon. Being short

staff members will give an occasion for members to step up and engage more in the WOD.

Proposal of Implementation and Timetable

The Clubhouse 1 will conduct the 3-day professional development training for winter, 2017. The exact date will be set by mid-summer. After the exact date has been set, emails will be sent to all clubhouse staff members announcing the training date. The date will be set well in advance so that staff members will be able to coordinate any time off needed around the training. Day 1 of the 3-day workshop will begin on a Wednesday and will continue for the next two days, Thursday and Friday. The training will begin promptly at 8:00 a.m. and end at 4:00 p.m. These are the hours that the Clubhouse is open for business. The Clubhouse Board Room will be the main area utilized. Training will be mandatory for staff. Lunch will be catered by the members of the Clubhouse for staff members who will have access to the cafe during the morning and afternoon break. Hour-by-hour details for the three full-day training are provided in Appendix A. In addition, there is an instructional plan, which includes the purpose, goals, and objectives, for the three full-day workshop, a syllabus, learning activity handouts, and evaluations

Role and Responsibilities of Student and Others Involved

I will be on site for the entire 3-day workshop. I have created and will implement the PD training, including the evaluation process. The majority of the facilitating is my responsibility. Several guest facilitators from the recovery program of the local university will participate in the workshop. Each day of the workshop, a guest facilitator will take responsibility for a learning segment, which will include a presentation and one or more

exercises related to the presentation. However, I will be responsible for the evaluation process for these guest facilitated learning segments. The members of the Clubhouse from Unit 1, which includes the kitchen and café, will be responsible for providing breakfast and lunch for the staff. Unit 1 prepares breakfast and lunch on a daily basis, and staff members regularly eat said meals. Including staff for the three-day event will not cause an undue burden on the WOD. The staff is responsible for attending all learning segments and being fully engaged in the learning process, keeping an open non-judgmental attitude mind. The director of the Clubhouse is invited to take part in the workshop but is under no obligation to attend or participate.

Project Evaluation

An important part of PD training is the evaluation process as stakeholders are concerned about the effectiveness of adult education. Scholars realize how beneficial evaluations are for teachers and students in the professional development training area, and are appealing the educational community to incorporate assessments in the learning process (Conley-Tyler et al., 2016). Evaluations are necessary to assess the changes in staff's knowledge, skills, and behavior. In addition, evaluations are needed to identify any program changes that are needed. However, at this time there is a lack of reliable assessment tools for facilitators tasked to create and deliver PD trainings (Main, Pendergast, & Virtue, 2015). The overarching goal of the project is for participants to gain the knowledge of motivational and adult learning theories and build skills that can be put into practice in everyday work situations at the local Clubhouse. By successfully

meeting the learning objectives, staff will be able to increase staff and member motivation at the Clubhouse.

This project employed a behavior outcome-based evaluation in the PD training evaluation. A behavior outcome-based evaluation focuses on what the participant has learned, not what was taught, and the difference the program made in the life of the learner. The desired outcome for the participant is increased knowledge, betterment of skills, and a change in beliefs and attitudes (Lixun, 2011). My project fits the parameters of a behavior outcome goals evaluation as it followed Tyler's linear program planning model with expected outcomes or learning objectives clearly stated at the beginning of each learning segment. An evaluation at the end of each learning segment was developed. The evaluation measured how effective each segment was in meeting the established learning objectives.

The overall goal of the evaluation is to assert that the learning objects from each learning segment were met by participants. Formative and summative evaluations were used. Formative and summative evaluations focus on what occurred during the training, what participants perceived of their learning process and reflections concerning their experiences (Clardy, 2001). At the end of each learning segment for Day 1, and Day 2, formative evaluations will be completed by participants. The formative evaluation collects information on participants after a lesson has been completed. Data are evaluated in an effort to assess how thoroughly the student assimilated the material. After which, the teacher or facilitator can plan or change the next sequence of a component to be studied (Hosp, 2012).

The evaluation will contain mixed methods of quantitative and qualitative data. Quantitative data will be collected using a Likert scale from "1"-strongly disagree, to "5"-strongly agree, and consist of seven statements. The data from the Likert scale will be treated as interval data. Three qualitative questions will be asked. At the end of Day 3, participants will complete a summative evaluation. A summative evaluation assesses the program and indicates if learning goals and objects are achieved (Costel et al., 2016). The summative questionnaire will contain eight quantitative and three qualitative questions. A list of the formative and summative evaluations is located in Appendix A.

Description of Key Stakeholders

The Clubhouse Director and Board of Directors, staff members, and members of the Clubhouse, all have a vested interest and as such are stakeholders of the project, as do several additional facilitators that are recruited from the local university that offers a vocational program in recovery. Including instructors that specialize in recovery from the local university will ensure that staff is exposed to updated knowledge, skills, and attitudes required in the recovery environment, and acquire a balance between theory and practice. Facilitators of recovery are stakeholders because they have a vested interest in providing the highest level of education to those in the recovery field.

I am also a stakeholder. My role will be as the main facilitator and overseer of the development training and I am also vested in the program. I will be responsible for designing the training content, facilitating, and the creation and review of the evaluations. I will be on-site all 3 days to coordinate and assure that the training runs smoothly. An outside consultant will be available to review the program to eliminate any bias.

Implications Including Social Change

The project is a three-day Professional Development Training program that will offer full- and part-time staff, working at the Clubhouse the opportunity to learn and practice motivational techniques, theories, and ways to motivate Clubhouse members. Exercises and role play activities will take place to teach staff members how to interact with all participants, to stimulate self-evaluations of their assumptions, and to explore new roles and creative thought. The outline for three-day professional development training is located in Appendix A.

Local Community and Local Stakeholders

The project creates a trickle-down theory in practice for staff members and members at the local clubhouse. As staff members' knowledge and skills improve, so does the transfer of learning to the members of the Clubhouse. When staff members are able to motivate Clubhouse members to engage in leisure activities, the Clubhouse member's perception of recovery increases. As members recover, they have the ability to become contributing members of society, either by teaching other members in the Clubhouse, by volunteering in the community, or working part-time to full-time jobs.

Positive social change is evident as individuals, instead of hiding and isolating in their homes, become vibrant members of the Clubhouse, learning new skills and giving back to the local community. As members become visible to the public, change in the perception of mental illness may take place. Positive social change may occur, both in the Clubhouse and in our local community. When individuals, who have resisted treatment in the past, see peers with mental illness living full lives, despite reoccurring symptoms,

they may become more open to receiving services. Local businesses employing Clubhouse members through the Clubhouse temporary employment program (TEP) may soon realize they have tapped into a market of responsible, eager employees. These are individuals that are ready and able to perform and take on the responsibilities required of them.

Far-Reaching Social Change

Each time an individual recovers from SMI, the public and private stigma surrounding mental health issues lessens. Stigma is an obstacle to the social integrity of individuals with SMI (Jung & Kim, 2012). Stigma also negatively impacts those individuals in need from seeking treatment (Brown & Bruce, 2016). As the public discovers the reality of recovery, and public and private stigma lessens, more people with mental health issues may reach out for treatment. With the lessening of public and private stigma towards mental illness, a positive social change within the country will be noticeable. With the publics' reduced fear of individuals with mental illness, the tolerance for diverse behavior can increase. Life becomes safer for people with SMI. Positive social change is seen within the health care community and the judicial system as workers become comfortable interacting with individuals experiencing symptoms. Empathy and compassion for those with mental health issues increase.

Conclusion

The staff is aware of motivational problems within the Clubhouse setting. The data collection and analysis directed the development and creation of the PD program regarding motivation. The PD program was designed for full and part time staff working

at a local accredited CI Clubhouse; however, the program is appropriate for a larger audience of staff working at model recovery clubhouses based on the work-ordered-day. The workshop is scheduled for winter 2017 and involves the transformational learning of staff and the identification of the four factors of motivation; intellectual, social, competence-mastery, and stimulus-avoidance.

Staff employees who participate in professional development may see an increase in job motivation, and enhanced work performance. In addition, staff may find they have increased their transferable knowledge, and practical skills to aid members of the Clubhouse. See Appendix A for the project PowerPoint, syllabus, outline of events, exercise scenarios, handouts, and formative and summative evaluations of the program are located in.

Section 4 constitutes a self-reflection on the project, including its limitations, barriers, implementation, and recommendations for alternative approaches. It also constitutes critical self-assessment of myself as a scholar, what I learned during the process, and its practical applications. Leadership for change is discussed as are the implications, applications, and future research.

Section 4: Reflections and Conclusions

Introduction

This quantitative, correlational, project study was used to determine if there were positive relationships between the motivation to engage in leisure activities and the perception of recovery from SMI in individuals at four Clubhouses in the southwestern part of the US. Results of the study indicated that among the 75 participants, there was a moderate positive relationship between engaging in leisure activities and recovery.

As a result, a 3-day professional development workshop was developed. The overarching project goal was to develop a workshop that would help staff explore better ways of motivating members to participate in leisure activities at CI Clubhouses. Specifically, staff will have the opportunity to engage in activities, presentations, and discussions to identify the motivational methods used at the different Clubhouses and to recognize additional motivational methods that can be employed to engage members. Adult learning and motivational theories will be introduced. As a result, staff members will have the opportunity to explore and change their meaning structures and meaning perspectives (i.e., beliefs, value judgments and feelings) toward what motivates members with SMI. Engaging Clubhouse staff in role-playing exercises during the training is expected to improve their motivational interviewing skills and to identify members' needs. In addition, staff can explore ways to tap into a member's desire to improve his or her life by participating in leisure activities.

Project Strengths and Limitations

The project focused on the problem at the local level: the lack of motivation of members to engage in leisure activities. Teaching staff about motivation and how to transfer that learning to the Clubhouse setting will help members on their road to recovery. The project director gives staff members the opportunity to interact with their peers during exercises and discussions. The staff members will explore new roles and attitudes in a safe, confidential, learning environment, bond with other staff members, and increase staff morale. Guest facilitators from the university will gain insight into the motivational challenges that surround Clubhouse members. Facilitators will add this newly gained information to their body of knowledge when improving and designing more recovery programs for their University. The limitation is the time staff would need to be away from their scheduled duties with Clubhouse members.

Recommendations for Alternative Approaches

Information garnered from the literature, the study, and from project preparation shows that motivation to engage in leisure activities at the Clubhouse is a problem for members with serious mental health issues. I would recommend that Clubhouse staff training be available at the national level to staff from accredited and model CI Clubhouses. Developing an online course that will be available to staff at the national level would eliminate the necessity for staff to have to be away from the clubhouse for an extended time. The program could be broken down in small 15 to 30 minute segments so staff could fit training into their daily regimen. Staff could also repeat segments that they are having difficulty mastering, or repeat segments as a review to hone their skills

Scholarship, Project Development, and Leadership

Scholarship

During the proposal stage, I learned how to organize my thoughts, from seeing a local problem in my head, to putting it down on paper, using a scholarly voice. It was not until I started my literature review that I began to discover the gaps that existed in the field of recovery from SMI and the challenge I had undertaken. As I progressed through both literature reviews, I increased my skills in database searching. At times, I became frustrated and overwhelmed when I knew what I wanted to find, and I knew the answer in my head, but I needed a peer reviewed article to support my beliefs and was not able to find such an article. Many times my search led me into a different direction. These new directions opened up a wealth of knowledge, ideas, and thoughts I could never have imagined. I found my own beliefs and assumptions challenged at times, with many an "ah-ha" moment of exhilaration. I found this experience completely different from past research and narratives I produced for nonformal and informal classes in adult education. I developed skills in synthesizing information from a large number of peer reviewed articles to support my local problem and project study. My ability of critical analysis and examination improved immensely, and I found myself using these skills on a daily basis unintentionally.

Project Development and Evaluation

While developing my project, I learned that looking at the evaluation portion of the project in the very beginning can help direct the development of the project. This is accomplished by asking, what is to be learned and how will I know this objective will be

met. I became acquainted with Tyler's linear program planning model, which I found to be simple, direct, and effective, without limiting or obscuring my creative thought patterns that I rely on in developing programs. The model also changed my perspective from what do I want to teach the students, to what do the students want to learn. What do they need to take back to the work environment?

Leadership and Change

Leading by example and effective communication are topics cited as the top two qualities in leadership (Tremaine, 2016). Leadership is not innate and is internally formed. The ability to lead is achieved through activity that is uncomfortable and by shifts that are vague and internal. These changes take time to happen. When change does happen, meaningful answers and authenticity start to develop (Fusco, O'Riordan & Palmer, 2016).

Effective listening is one of the most important components of my job. To accurately assess and evaluate individuals with mental health issues, I must listen without judgment, understand the learner's needs, and appropriately motivate learners toward activities that will develop the individual's skills toward recovery. Part of active listening is motivational interviewing, asking open-ended questions, and responding with reflective and summarizing statements. Though I use these skills on the job, I found myself further developing these skills, while participating in the many IRB hours I attended. I was dealing with a marginalized population; therefore I had additional rules and regulations required by the IRB before being granted approval for the study. Standards and procedures were not written down, so a lot of experimentation had to be

explored and enacted to qualify for the study. This issue was a very painful process at times as I felt very restricted. I had to do creative thinking *outside the box* to make the study doable. I found this process comparable to the recovery environment. Many Clubhouses are government supported, and newer regulations demanded at the county level conflict with the recovery model. I found it necessary to use creativity to walk the line between Clubhouse needs and what the county requires.

As I progressed in my doctoral dissertation, I found myself applying much of what I was learning from the literature review to my everyday tasks at work. When my study began to focus on motivation, I found I became more observant of Clubhouse members and their motivation levels. I observed, I began to question, and gave more critical thought to my actions and the reactions of others.

Analysis of Self as Scholar

Though I have decades of teaching behind me, I never considered myself a scholar, but the doctoral process caused me to develop into one. I am a lifelong learner. I became a teacher in informal education of adults at the age of 15, when I became a ski instructor. As a Tour Guide and Tour Manager for international tour companies, I traveled and taught adults about many locations in the world. When I was not traveling, I was immersed in researching the history, geology, culture, and statistics of the areas where I was working. In the mid-90s I returned to school and studied computers. Working in the technology field was fast paced and always changing. I found myself teaching reluctant adults in a Call Center how to move from dummy computers to PC's, and later on teaching a variety of proprietary and off-the-shelf software applications.

Fifty percent of my time was learning new software, staying one step ahead of those learners I was teaching.

When I returned to school to update my education and eventually pursue my doctorate, I also changed professions and entered the mental health field. Though I was working with a different population; I found many similarities. When adults confront a new subject, whether it is academic, computers, or basic vocational skills, it invokes fear, anxiety, and insecurities. Having experienced this fear, I can establish a connection of empathy as a trainer. Using an empathic approach, I can create an environment of excitement, creativity, and hope for the adult learner.

Becoming a scholar, especially at my age, has inspired others to return to school and pursue their dreams. Countless times, I have heard women say, “I always wanted to finish my degree, but I figured I was too old.” To which I have answered, “So it takes two, four, or six years to finish, it is only time and we only live once. Do you want to look back in 20 years and regret not trying to grasp your dreams?" These are the same words I said to myself back in 2008, and I will continue to say to others who touch my life.

A**nalysis of Self as Practitioner**

As a teacher of adults, the most rewarding moment is when I see that *ah-ha* moment on the face of the learner. In working with individuals with mental health issues, I get to experience that moment in many different arenas. Many times it happens when they discover who they used to be or when they realize they can still pursue the dreams they had before being diagnosed. Their symptoms may still surround them, but it no longer defines them.

After those self-defining moments, I get to experience the joy that learning a new task brings, and see the thirst for knowledge they possess.

As a scholar, it is now my responsibility to use my research skills and knowledge to find new ways of reaching and motivating those individuals with serious mental health issues towards recovery. It is equally important that I impart the knowledge and expertise I have learned to Clubhouse staff. The Staff members spend their days partnering with members, and helping members reintegrate into society. New practices and strategies are imperative if we are to help members along their own personal and unique path to recovery. As a practitioner, I cannot think of a more rewarding and worthwhile focus.

I was amazed by the energetic and heartfelt reaction I received from the Clubhouse directors who participated in the study, and by the personal and positive encouragement that I received from the authors of the instruments used in the study. I realized early on that this study was going to add much needed empirical knowledge in the support of Clubhouses.

Analysis of Self as Project Developer

I learned that I have a natural talent and ability that I can draw on in the PD development process. I enjoy the creativity and imagination that come into play during the process. My history as a program developer has been a solo experience, without any formal planning model to follow. I found the four questions from Tyler's linear program planning model enlightening and straight forward. The first two questions have always been in the forefront of my mind during program development; identifying the purpose of the program and what types of events will achieve the purpose. The last two questions were not developed into my programs as well as they could; organizing the events in

effective manner and determining when the purposes have been met. Using these simple four questions helped me to develop this program and those I will develop in the future.

Reflection on the Importance of the Work

Knowing Clubhouse staff as I do, I can only see staff attending the workshop with the best of intentions. Working with those with SMI is selfless work. Working in the field of recovery is not a career that one enters for financial success. For many, it is a career they enter knowing the financial hardships they will face, but realizing that it is a career that changes lives. A career individuals enter if they believe positive social change is important and necessary in society. In many cases, staff members have seen their lives changed through recovery and are driven to give back and help others.

Giving staff the opportunity to learn new skills and gain knowledge that they can apply back at the Clubhouse will touch countless lives for the better. Motivating staff members to motivate Clubhouse members will result in Clubhouse members re-engaging into society, finding work, returning to school, parenting, and being able to live life to member's fullest potential.

Implications, Applications, and Directions for Future Research

The findings from my study support the findings from a previous study that indicated a correlation between the motivation to engage in leisure activities and recovery at CI Clubhouses. My study expanded the number of Clubhouses and almost doubled the number of participants from the previous study. Although my study and the previous study used convenience samples, some of the results may apply to other CI Clubhouses because all CI Clubhouses use the same 38 standards for their work ordered day.

The results of this study and project added to the body of knowledge of recovery and impact positive social change at the individual, organizational, and societal level. Individuals at the Clubhouse will receive benefits from the staffs' increased knowledge from the professional development training. Increasing members' motivation to engage in leisure activities at the Clubhouse will help their perceived recovery. Increasing members' social skills may improve the way they relate to their family members and friends, resulting in the potential for a fuller life. The Clubhouse organization will have another piece of evidence that CI Clubhouses are making a difference in members' lives and making an impact in the local community. The governing county that funds many of the Clubhouses will have additional empirical data that supports the Clubhouse concept as valid, useful, and worthwhile.

For future research, I would support strongly the stakeholders of model and non-accredited Clubhouses to repeat the study with a randomized sample and to compare their results to previous studies. I would also support motivational training for certified and model Clubhouse staff. To date, at the local level, training that is required is centered on the disclosure of personal information, cultural competency, fraud, and other subjects that do not teach staff how to interact, motivate, and work with their members. Training at the CI Clubhouse center on the workings of the Clubhouse and the 38 standards, yet still misses the very essence of how to motivate staff to motivate members.

Conclusion

When I first started my dissertation, I was told that it was important to choose a subject about which I felt passionate. As I look back, I understand how important those

words of advice were for me. The dissertation process and my development as a scholar were long, challenging, at times painful, and fraught with anxiety: a walk in the dark with just a faint spark of light very far in the distance. The literature reviews were demanding, yet thought provoking. I became frustrated as I discovered the limited number of peer-reviewed articles on the subject of recovery from SMI, especially empirical studies. If I had not been passionate about the topic of recovery, I do not believe I would be where I am today. The passion of believing in the recovery model gave me the power to overcome the many challenges I faced during this process.

The academic knowledge, and skills, and critical analyses I acquired during the dissertation help me every day, while I am interacting with those individuals with mental health issues and their family members. Using a scholarly voice, I am able to combat the public and private stigma that surrounds mental health issues.

Armed with the results of my study, I add to the body of knowledge regarding recovery. In addition, I was able to prepare a Professional Development Training project that I can use with the staff at clubhouses. I will be able to add small sections of the workshop at weekly staff meetings. In addition, by breaking down the different segments, I am able to instruct family members of those individuals with mental health issues with practical skills they can use in their interpersonal relationships.

Social change cannot help but happen as increasing numbers of people with serious mental health issues recover. It is said in the recovery community that an important sign of recovery is when an individual is able to give back to society. As a

scholar and one in recovery, I now have more to give and will bring more power to social change.

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Appendix A: The Project

Training Syllabus

How to Motivate Yourself and Others in the Clubhouse Environment

The wicked leader is he whom the people revile.
The good leader is he whom the people revere.
The great leader is he of whom the people say, "We did it ourselves.
Leo Tzu (over 2500 years ago)

Winter 2017
(XXX) Clubhouse
Wednesday, Thursday and Friday 8:00 a.m. to 4:00 a.m.

Facilitator: Dianna Pearce Email dianna.pearce@waldenu.edu Phone760 715-7996

I. Rationale:

Research shows a correlation between engaging in leisure activities and members' perception of recovery at Clubhouses. This training will give staff the opportunity to explore theoretical and practical ways to motivate their local clubhouse members.

II. Learning Objectives and Goals:

The goal for the participants is to help them explore ways of better motivating members in the participation of leisure activities to help promote recovery from SMI.

Aim

This course is designed for staff to be given a safe environment to challenge their beliefs and assumptions towards motivation and how to motivate Clubhouse members. Staff will learn and practice motivational interviewing to identify which of the four motivation factors will motivate individual members towards engaging in leisure activities at the Clubhouse.

Specific Learning Outcomes:

By the end of this course, students will:

1) identify motivational problems involving members of the Clubhouse and staff behaviors towards motivation
2) engage in a self-critical examination to explore their individual and collective beliefs and assumptions towards motivation
3) explore new methods of approaching motivation towards Clubhouse members with SMI
4) demonstrate a basic knowledge and understanding of Transformative learning theory, and Maslow's Hierarchy of Needs Theory
5) apply new theories in their work with members of the Clubhouse
6) identify the importance and difference between intrinsic, extrinsic, and amotivation
7) incorporate transformative learning from theory into practice

8) identify the four different motivating factors of Clubhouse members through motivational interviewing.
9) leave the workshop with a different perspective towards motivation, and be able to apply these new assumptions and beliefs in the Clubhouse setting
10) exhibit an understanding of the importance of body language as they interact with members

III. Training Format and Procedures:

The training will be conducted in safe and comfortable learning environment. Seating will be in ergonomic chairs situated around the large boardroom in the Clubhouse. All training will be in the boardroom unless participants elect to use the computer room to look up information they feel would add to the learning experience. Role plays exercises will also be conducted in the training room. The café area will be reserved exclusively for staff during the lunch hour from 12:00 to 1:00. Lunch will be catered by Clubhouse members. The café will be open and available to staff during the morning and afternoon breaks.

The staff is expected to follow the basic rules of the clubhouse; dress and behave in a professional manner. All cell phones and other media devices will be turned off during the training sessions. The staff is expected to attend all trainings, and participate in all discussions, and exercises with an active and open mind, and being respectful of others. Confidentiality is expected regarding any personal information or comments that are made inside the training room referring to Clubhouse staff and members.

Facilitators will present PowerPoint slides, and informal lectures on motivational and adult learning theories. During this time, students will have the time to ask questions for clarification. At the end of the lectures, there will be a time for questions, discussions, and role play exercises.

At the end of each session, staff will be asked to complete an evaluation questionnaire. The staff is requested and will be given time and reflect on each segments events and acknowledge if the learning objectives and goals have been achieved. Staff will be asked for any additional comments that may help in planning the next day's activities or future courses.

IV. My Assumptions

It is my wish that staff feels free to impart any knowledge and experience they may have that pertains to the subject under review. During brainstorming exercises, I request that staff try and abandon any self-judgements and be spontaneous in contributing new ideas and concepts. During role plays and exercises, please assume that there is no single "right" or "wrong" answer and to use the variety of skills they already possess.

VIII. Inclusivity Statement

It is understood that each facilitator and staffer participating the training represents a diversity of experiences and perspectives. The training is committed to delivering an

environment for learning that respects diversity. We ask all those participating in the training to:

- share their unique experiences, values and beliefs
- be receptive to the opinions of others
- respect the uniqueness of others
- welcome the opportunity to learn from each other
- appreciate each other's beliefs and talk in a considerate manner
- remember to keep what is said in the classroom in the classroom

Workshop Lesson Plan

Day 1
Learning Objective: After completing this section, participants will be able to: identify motivational problems involving members of the Clubhouse and the staff's behaviors towards amotivation; embark on a self-critical examination by participants will explore the staff's individual and collective beliefs and assumptions towards motivation; explore new methods of inspiring motivation towards Clubhouse members; create GHAG and SMART goals. become familiar with Motivational Framework for Culturally Responsive Teaching.

Day 1 "A look at Motivation"

Topic or Activity	Hours	Presenter	Description of Segments	Materials Required
Breakfast and Welcome	8:00–9:00	Facilitator	Breakfast, Workshop Introduction and Learning Objectives. Discussion of the Rules of the Workshop Address any staffs concerns.	Catered Breakfast,
Discussion on Motivation Vocabulary Challenge	9:00–9:20 9:20–9:30	Facilitator	Discussion Identify Problems in your clubhouse with motivation. Opening Exercise Group Exploration	PowerPoint Slides Computer, tele-prompter White board and markers paper and pens Flip chart with

Group Brain Storming Breakout Session Group Discussion	9:30–9:37 9:37–9:55 9:55–10:02		3-Way Discussion. Come back to group and discuss findings	paper, Black felt marker. Masking Tape
Evaluation	10:0210:07		Evaluation	Evaluation
Break	10:07–10:27			Access to café and restrooms
Presentation and Discussion	10:27–11:00	Guest Facilitator	Rules from "The Energy Bus"	PowerPoint Slides Computer, tele-prompter
Role Play Exercise	11:00–11:30	Facilitator	One-on-One Exercise. 5 Ways to love your Passengers.	Paper and pens
One-on-One exercise	11:30–11:55		One-on-One Exercise. Examining Limiting Beliefs	Paper and pens
Evaluation	11:5512:00		Evaluation	Evaluation
Lunch	12:00–1:00			Catered Lunch
Presentation (20 minutes) One on One (20 minutes) Group Discussion (10 minutes)	1:00–1:20 1:20–1:50 1:50–2:00		Challenging your Beliefs through GHAGs Goals. One-on-one. Group Discussion on GHAGs.	PowerPoint Slides Computer, tele-prompter Flip Chart and paper. White board and markers Paper and Pens
Break	2:00–2:20			Access to café and restrooms
Presentation And group activity (20 minutes)	2:20–2:40		SMART Goals	PowerPoint Slides Flip Chart and paper,

Exercise	2:40 – 2:55		Staff creates own SMART Goals	White board and markers Paper and Pens
Evaluation	2:55-3:00		Evaluation	Evaluation
Group Discussion	3:00-3:30		Discuss Motivational Framework for Culturally Responsive Teaching	
Group Discussion Wrap up	3:30–4:00		Review of the Day, and Questions	White board and markers

Day 2
Learning Objective: After completing this section, participants will; have a basic understand of Transformative learning theory, and Maslow's Hierarchy of Needs Theory; learn how to apply the theories in their work with members of the Clubhouse; understand the importance and difference between intrinsic, extrinsic, and amotivation motivation; gain an understanding of Servant Leadership, and the Situational Leadership Model.

Day 2 A look at Motivational and Adult Learning Theories: Theories and practice.

Topic or Activity	Hours	Presenter	Description of Segments	Materials Needed
Breakfast and Review of Day 1 Presentation and Questions.	8:00–8:30	Facilitator	Breakfast, Review and Clarification Day 1. Presentation Day 2 learning goals concerns.	Catered Breakfast,
Presentation	8:30–9:00	Facilitator	Presentation on Maslow's Hierarchy of Needs Theory.	PowerPoint Slides Computer, tele-prompter Flip Chart with paper White board and markers Evaluation
Exercise and Group	9:00–9:25	Facilitator	Exercise matching needs to the correct	Paper and Pens

Discussion			level in the pyramid	Handout
Evaluation	9:259:30		Evaluation	Evaluation
Group Discussion	9:30–10:00	Facilitator	Group Discussion on Hope	Flip Chart and paper, marker White board and markers
Break	10:00–10:20			Access to café and restrooms
Presentation & Discussion (20 Minutes) Exercises on One-on-One (30 Minutes) Exercise One-on-One Group Discussion	10:20–10:50 10:50–11:40 11:15–11:45 11:45–11:55	Guest Facilitator	Presentation Transformative Learning Theory Applying the 10 stages Exercise Assumptions Group Discussion	PowerPoint Slides Computer, tele-prompter White Board Flip Chart with paper and marker
Evaluation	11:5512:00		Evaluation	Evaluation
Lunch	12:00–1:00			
Presentation (20 minutes)	1:00–1:30	Guest Facilitator	Servant Leadership	PowerPoint Slides Computer, tele-prompter White Board Evaluation
Presentation (30 minutes)	1:30–2:00	Guest Facilitator	Situational Leadership II (SLII) Model	PowerPoint Slides Computer, tele-prompter White Board
Break	2:002:20			
Exercise One-on-One	2:20–2:40	Facilitator	Exercise SLII Model	

Group Exercise	2:403:00		Exercise SLII Model	
Evaluation	3:003:05		Evaluation	Evaluation
Review, Questions and Wrap up (40 minutes)	3:05–4:00		Group Discussion	White Board Flip chart with paper

Day 3
Learning Objective: After completing this Workshop, the staff will; have incorporated Transformative learning from theory to practice; be able to will identify the four different motivating factors of Clubhouse members through motivational interviewing, understand the importance of body language; leave the workshop with a different perspective towards motivation, and be able to apply these new assumptions and beliefs in the Clubhouse setting.

Day 3

Topic or Activity	Hours	Presenter	Description of Segments	Materials Needed
Breakfast and review of Day Presentation and Questions.	8:00–8:30	Facilitator	Breakfast, Review and Clarification Day 1.	Catered Breakfast,
Presentation (30 Minutes)	8:30–8:50	Facilitator	Presentation on 4 Factors of Motivation	PowerPoint Slides White Board, Flip Chart Pen and Paper
Exercises	8:50–9:05		Exercise- Matching Motivational factors to Descriptions (Handout)	
Discussion	9:05–9:15		Discussion of Exercise	
Discussion	9:15-9:25		Discussion on Intellectual Factor	
Discussion	9:25–9:30		Exercise on Social	

			Factor Presentation	
Discussion	9:30–9:45		Discussion on Competent–Mastery Factor	
Discussion	9:45-9:55		Discussion on 4 Factors of Motivation	
Evaluation	9:55 – 10:00		Evaluation	Evaluation
Break	10:00–10:20			Access to café and restrooms
Exercise	10:20–11:00		Exercise on Work Ordered Day and 4 Motivating Factors	
Discussion on Motivational Interviewing	11:00–11:10	Facilitator	Discussion on motivational interviewing-	PowerPoint Slides Computer, tele-prompter White Board Paper and Pens
Exercise 3-Way	11:10–11:25		Exercises using Open Ended Questions	Paper and Pens
Discussion	11:25–11:27		Discussion on Reflective Statements	PowerPoint Slides Computer, tele-prompter, White Board
Exercise 3-Way	11:27–11:40		Exercises using Reflective Statements	
Discussion	11:40–11:42		Discussion on Summarizing Statement	PowerPoint Slides
Exercise 3-Way	11:42–11:55		Exercises using-Summarizing Statements	PowerPoint Slides Computer, tele-prompter White Board Evaluation

Evaluation	11:55–12:00		Evaluation	Evaluation
Lunch	12:00–1:00			
Discussion	1:00–1:20	Facilitator	Discussion on Body language	PowerPoint Slides Computer, tele-prompter White Board Evaluation
Exercise using Body Language	1:20–1:40		Exercise-Presenting with body language	
Exercises using MI and Body language	1:40–1:55		Exercise IM interviewing with Body Language	Paper and Pens Evaluation
Evaluation	1:52–2:00		Evaluation	Evaluation
Break	2:00–2:20			
Group Discussion (20 minutes	2:20–2:50	Guest Facilitator	Social Change	PowerPoint Slides Computer, tele-prompter White Board
Group Discussion	2:50–3:20	Facilitator	Discussion, What will you do differently with what you have learned	Flip chart with paper, markers, White Board Evaluation
Review, Questions and Wrap up (40 minutes	3:30–4:00		Review of day, 3, questions, and evaluation	Evaluation

Four Factors Exercise 1 Handout

Please fill in the motivating factor (intelligence, social, competent-mastery, and stimulus-avoidance) that matches the description.

Description	**Motivating Factor**
To stop thinking- “get out of my head”	
Meet new and different people	
Expand interest	
Competition	
Decrease isolation by networking with others	

See stimulation	
To become comfortable with others	
To reduce my symptoms	
To get and stay in shape	
Meet new and different people	
To have more meaning in my life	
To feel a sense of belonging	
To slow down	
To influence others	
To rest	
Use ones imagination	
Learn about one's self	
To feel a sense of belonging	
To reduce stress	
Improve skills	
Become unique and original	
Discover life and the world around me	
Enjoy time with others and create friendships	
Feeling of achievement	
To help others	
To be more active	
To learn and satisfy ones curiosity	
To calm down	
Define and assess my abilities	

Maslow Matching Exercise Handout

Match the Members Need to the Hierarchy Level

A member is hungry _____
A member is ill _____
A member just lost his parents _____
A member is having problems with the police _____
A member is not following through on his task in the kitchen _____
A member is afraid. His medication is causing mood swings. _____
A member is not able to perform sexually _____
A member is homeless _____
A member is having problems in his math class _____
A member is having problems with self confidence _____
A member is not understand how to search online, after being shown 3 times _____
A member is afraid of his roommate _____
A member is not able to keep up with his child support payments _____
A member is not keeping his room clean in his Independent Living House _____
A member has not slept in 3 days _____
A member is having problems with others gossiping about him _____
A member just received his GED _____
A member just got married _____

Levels
Number 5 Self-Actualization
Number 4 Esteem Needs
Number 3 Belonging
Number 2 Safety
Number1 Physiological

Professional Development 3-Day Workshop on Motivation
Exercises

Day 1

9:20 – 9:30
Exercise - 1 Vocabulary Challenge
The purpose of this exercise is to get staff focused and ready to learn.

The phrase, “I believe that all roads lead toward recovery “is written on the white board”.

- Staff calls out words that can be created from the phrase.
- Facilitator writes the words on the whiteboard.

Rules: Words must be in English and at least 3 letters long.
Example: cover, very, berry, dairy, read, record
Allotted time for exercise 10 minutes

9:30-9:37
Exercise 2 - Brainstorming Motivational Issues
The purpose of the exercise is for staff to brainstorm and discuss motivational issues at the Clubhouse. Both large and small groups will be utilized in this exercise.

- The staff will present motivational issues seen at the Clubhouse to the facilitator.
- The facilitator will them write down the issues presented on a large white board.
- The issues presented will then be ranked in order of staff's perception of importance by a simple vote.
- Issues in order of importance will be then be transferred onto a large white paper and taped to the wall in the training room.

Allotted time-7 minutes

9:37-9:55

- *Staff will break up into groups of 3s*
- Staff will discuss the top 5 issues and possible solutions
- A note taker will in each group of will write down the solutions brought up in their group.

Allotted time-20 minutes

9:55-10:02

- Staff will report back to the large group.
- The note taker from each group will report their finding.
- Findings will be written onto the flip chart andthen taped to the wall in the training room.

Allotted time-15 minutes
Total time for exercise sequence-52 minutes

11:00 -11:30
Exercise 3 - Ways to "Love your Passengers"
The purpose of this exercise is to recognize how "challenging" members might respond to the 5 ways of love

From the book The Energy Bus, rule 8 states Love Your Passengers
There are Fives ways To Love your Passengers:

- ✓ make time for then,
- ✓ listen to them,
- ✓ recognize them,
- ✓ serve them,

- ✓ bring out the best in them.

- Staff will break up into groups of 2s and discuss how to use the 5 ways to love your passengers in real life scenarios.
  Scenario: Member does not want to interact and join in the activities on a Monday morning.

- 1st person: Think of a person that you find difficult to work with at the Clubhouse. It is not important to identity the member. Become that person.
- 2nd person plays the staff member and employs the 5 ways of love using questions. Stay away from "yes" or "no" questions.
- 1st and 2nd person discuss the scenario, and how it made you feel.- discuss any ah-ha moments. Reveal the identity of the member and discuss additional thoughts that come up.

Remember to stay out of judgment.
Repeat the exercise by reversing roles.
Total time for exercise - 30 minutes

11:30 – 11:55
Exercise 4 - Examining your Driver's Seat
The purpose of this exercise is to identify and examine self-limiting beliefs

- Staff will break up into groups of 2s.
- Think about something in your life that you really want to do but don't think you can.
- 1st person brings up something that they really want to do, but don't think they can do.
- 2nd person helps address how the barriers can be broken down
- *Example*- Going back to school.
- List some limiting beliefs or "why nots"
  - Can't afford it
  - Don't have the time
  - Can't pass entrance exam
- Discuss with partner how these beliefs can be changed
  - Student Loans, Scholarships
  - Online classes, where you can take classes during the weekend or at night.
  - Take preparation classes, go to a school that does not require an exam
- After the 1st person is a finished, reverse role.
- Repeat three times

Total time for exercise - 30 minutes

1:20 – 1:50
Exercise 5 - Big Hairy Audacious Goals

The purpose of this exercise is to learn how to create GHAG's and break them down into smaller workable goals and objectives.

- Staff will break up into groups of 3
- Have each person identify a GHAG of their own.
- 1st person identifies a GHAC. It does not have to be something that you feel is possible to obtain, just something you would like to obtain.
- 2nd person is the note taker.
- With the support of the 2nd and 3rd person, break down the GHAG into smaller goals and objectives needed to obtain that goal.
- Repeat the process so each person has an opportunity.

Total time for exercise- 30 minutes

2:40 – 2:55

Exercise 6 - *Smart Goals*

The purpose of the exercise is for staff to be practiced at creating SMART goals.

- Staff will break into groups of 2's.
- Each person with create 3 SMART goals and write then on paper that is provided.
- Each goal will be discussed after it is written down. Each partner will check that each of the SMART requirements are fulfilled.

Time allotted - 20 minutes

Day 2

9:00 – 9:25

Exercise 7 - Maslow's Matching Exercise - Handout

The purpose of the exercise is for staff to able to identify the different levels.

- Have staff complete the handout Maslow matching exercise
- Staff will have 10 minutes to complete the handout

After completing the handouts, staff will return to the main out and discuss the results. …..Notice that some of the issues can be difficult to put in just one level.

Staff may discuss members at the clubhouse and where they lie in the Pyramid if time allows.

Remind members of confidentiality.

Handout included in Appendix A

10:50 – 11:40

Exercise 8 - Transformative Learning

The purpose of this exercise is to learn to apply the 10 stages of transformative learning into your life

Break into groups of 3s

Discuss the 10 stages of TL. Ask yourselves and discuss with others in your group:

- Do you think you have had a dilemma?
- What do you think you can do during this workshop to analysis your beliefs and assumptions?
- Have you seen other staff engage in TL?
- What new roles or actions do you think you could try?
- What type of plan would you like to develop?
- What type of skills would you like to develop?
- What does it take for you self-confidence to improve?
- How do you think you can apply your new knowledge and skill in the Clubhouse? - What would it look like?

Allotted time - 30 minutes

2:20 – 2:40

Exercise 9 - Situational Leadership II

The purpose of this exercise is to become familiar with the 4 stages of the learner and the 4 types of leadership and which apploys to which.

1St person will identify a task of the Work Ordered Day
Break down the task into the 4 stages D-1 – D4
The 2nd person will identify the Leadership style that is to be used; directing, coaching, supporting, or delegating and possible responses that could be employed.
Reverse roles
Allotted time – 20 minutes

Day 3

Exercise 11 - Four Factors Exercise

8:50 – 9:05

The purpose of this exercise is for staff to be able to identify the correct motivating factor to the descriptors of that factor.

- Staff will be given a handout of the four different descriptors in a mixed order.
- Group will break up into pairs.
- They will fill in the proper motivating factor.
- Group will convene to go over the answers.

Time allotted - 20minutes
Handout Included in Appendix A
Allotted time – 15 minutes
11:10 – 11:25

Exercise 12 - Motivational Interviewing - *Open-Ended Questions*

The purpose of this exercise is for staff to become comfortable using Open-ended questions in conversations with members.

- Have staff break into groups of three.
- One plays the staff, One the Member, and One is the observer Once the role play is completed, shift positions and continue the exercise until each person gets a chance to play all three parts,
- The one playing the member is given a slip of paper with their scenario on it.
- The staff person starts asking questions to get the member talking and opening up about what is bothering him at the moment.
- The observer will take notes and review after the exercise is finished with the other members of the group.
- Each Observer will give a little synopsis of the role play to the larger group.

Scenarios-
Member has changed medications and is very sleepy and sluggish. Doesn't want to participate in the WOD.
Member is staying at a shelter, and his debit card was stolen. He hasn't had anything to eat since lunch yesterday.
Member's roommate just tried to commit suicide.
Time allotted – 15 minutes
11:27 – 11:40

Exercise 13 - Motivational Interviewing - *Reflective Statements*
The purpose of this exercise is for staff to become comfortable using reflective statements in conversations with members.

- Have staff break into groups of three.
- One plays the staff, One the Member, and One is the observer Once the role play is completed, shift positions and continue the exercise until each person gets a chance to play all three parts,
- The one playing the member is given a slip of paper with their scenario on it.
- The staff person starts asking questions to get the member talking and opening up about what is bothering him at the moment.
- The observer will take notes and review after the exercise is finished with the other members of the group.
- Return to the larger group when finished
- Each Observer will give a little synopsis of the role play to the larger group.

Scenarios-
1. Member has moved and feels very lonely without his old roommates.
2. Member is staying at a shelter, and is very stressed out. He is starting to hear voices.
3. Member's just got out of the hospital after a manic episode. He is afraid of having to go back into the hospital again.
Allotted time – 13 minutes

11:42– 11:55

Exercise 14 - Motivational Interviewing - Summary Statements
The purpose of this exercise is for staff to become comfortable using summarizing statements in conversations with members.

- Have staff break into groups of three.
- One plays the staff, One the Member, and One is the observer Once the role play is completed, shift positions and continue the exercise until each person gets a chance to play all three parts,
- The one playing the member is given a slip of paper with their scenario on it.
- The staff person starts asking questions to get the member talking and opening up about what is bothering him at the moment.
- The observer will take notes and review after the exercise is finished with the other members of the group.
- Each Observer will give a little synopsis of the role play to the larger group.

Scenarios-
1. Member talks about his family and the lack of support he is receiving. He has decided that he might need to stay away from them for the time being and build a different support system.
2. Member talked about his last trip to the hospital and his fears of having to go back again.
3. Member's just found out that he has cancer. He doesn't know what he is going to do.
Allotted time – 13 minutes

1:20 – 1:40
Exercising 15 - Body Language
The purpose of this exercise is to learn how to give presentations while standing using body language that is comfortable to your audience.

- In a standing position the 1st staff member will give a presentation of the Clubhouse or something else they are very familiar with.
- 2nd and 3rd person will observer and take notes of body position, palms, facial expressions, and belly button forward.
- After the presentation, 2nd and 3rd person will discuss their evaluation of the presentation.
- Staff will rotate and another staff will give a presentation.
- Rotate again until all have a chance.

Allotted time 20 minutes

1:40-1:55
Exercise 16 - Interviewing with MI and Body Language
The purpose of this exercise is to learn how to converse with members using body language that is comfortable to your audience.

- While seated, Staffer will interview 2nd person with MI techniques.
- The observer and take notes of body position, palms, facial expressions, and belly button.
- After the presentation, observer will discuss their evaluation of the interview.
- Staff will rotate and another staff will give a presentation.
- Rotate again until all have a chance.

Allotted time – 15 minutes

Formative Evaluation

Day 1 Name_____ Date_____
Name of Session_____
Thank you for attending this segment of today's workshop. Your evaluation of the program is important. Please take the time to reflect and answer the following questions. Your ideas and feedback help us to evaluate the program and make changes to future workshops.
Please circle the answer that most closely states how you felt about the segment.

I was satisfied with the facilitator's presentation.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

The goals and learning objectives were clearly understood and achieved.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

The information presented was clearly delivered and easy to understand.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

The material was useful and applicable for my job

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

The presentation added to my knowledge base

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I feel I apply what I learned from this session at the Clubhouse

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I would like to have more training in this area

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Please give an example of what you learned in this segment and how you can apply it during your work day?

_____
_____
_____
_____

What did you learn in this segment that changed your beliefs about motivation?

_____
_____
_____
_____

What material would you like to see added to this segment of the workshop?

_____
_____
_____
_____

Summative Evaluation

Name_____ Date_____

Thank you for attending the 3-day workshop on Motivation. Your evaluation of the program is important. Please take the time to reflect and answer the following questions. Your ideas and feedback help us to evaluate the program and make changes to future workshops.

Please circle the answer that most closely states how you felt about the segment.

I was satisfied with the overall workshop.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Subjects and theories presented were easy to understand and useful to me.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

The environment was comfortable and conducive to learning.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I was given ample time to ask questions and have them answered during the workshop

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I was able to challenge my beliefs and assumptions in a non-judgmental environment.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

The workshop added to my knowledge base, and gave me was useful, and practical tools that I can take back to my work environment.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I would recommend this training to others who work in the Clubhouse environment.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

As a result of this workshop I believe I can better motivate the members of my Clubhouse.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Please give an example of what you learned in this workshop that will help you in motivating members of the Clubhouse

_____
_____
_____
_____

What was your most memorable ah-ha moment during the workshop?

_____
_____
_____
_____

What would you like see added, deleted or changed in future workshop?

_____
_____
_____
_____

PowerPoint

binder.zip

Please click on the icon above to open the PowerPoint presentation.

Appendix B

Leisure Motivation Scale

LEISURE MOTIVATION SCALE (LMS)

PURPOSE: The purpose of this scale is to help the patient and the therapist work together to find out in part, why the patient chooses to engage in leisure activities.

DIRECTIONS: Listed below are 48 statements. Each one begins with the phrase: "One of my reasons for engaging in leisure activities is…" To the left of each statement is a line to indicate how true that statement is. A "1" means that the statement is never true, "2" means that it is seldom true, "3" means that it is sometimes true, "4" means that is often true, and "5" means that it is always true. Write down the number that best fits your situation.

DEFINITION: "Leisure Activities" are those things that you do that are not part of your work and are not part of your basic grooming needs.

1 NEVER TRUE	2 SELDOM TRUE	3 SOMEWHAT TRUE	4 OFTEN TRUE	5 ALWAYS TRUE

One of my reasons for engaging in leisure activities is…

____1. to expand my interest
____2 . to see stimulation
____3. to make things more meaningful to me
____4. to learn about things around me
____5. to satisfy my curiosity
____6 to explore my knowledge.

____7. to learn about myself
____8. to expand my knowledge
____9. to discover new things
____10 to be creative
____11. to be original
____12. to use my imagination

____13. to be with others
____14. to build friendships with others
____15. to interact with others
____16. to develop close friendships
____17. to meet new and different people
____18. to help others

____19. so others will think well of me for doing it

____20. to reveal my thoughts, feeling, or physical skills to Others
____21. to influence others
____22. to be socially competent and skillful
____23. to gain a feeling of belonging
____24. to gain other's respect

___25. to get a feeling of achievement
___26. to see what my abilities are
___27. to challenge my abilities
___28.becuase I enjoy mastering things
___29. to be good in doing them
___30. to improve skill and ability in doing them

___31. to compete against others
___32. to be active
___33. to develop physical skills and abilities
___34. to keep in shape physically
___35. to use my physical abilities
___36. to develop my physical fitness

___37. to be in a calm atmosphere
___38. to be active
___39. to develop physical skills and abilities
___40. to slow down
___41. because I sometimes like to be alone
___42. to relax mentally

___43. to avoid the hustle and bustle of daily activities
___44. to rest

___45. to relieve stress and tension
___46. to do something simple and easy
___47. to unstructure my time
___48. to get away from the responsibilities of my everyday life

Appendix C

Recovery Assessment Scale - Domains and Stages

Recovery Assessment Scale – Domains and Stages (RAS-DS)

Instructions: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and circle the number to the right that best describes you at the moment. Circle only one number for each statement and do not skip any items.

FUNCTIONAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
It is important to have fun	1	2	3	4
It is important to have healthy habits	1	2	3	4
I do things that are meaningful to me	1	2	3	4
I continue to have new interests	1	2	3	4
I do things that are valuable and helpful to others	1	2	3	4
I do things that give a me a feeling of great pleasure	1	2	3	4
PERSONAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I can handle it if I get sick again	1	2	3	4
I can help myself become better	1	2	3	4
I have the desire to succeed	1	2	3	4
I have goals in life that I want to reach	1	2	3	4
I believe that I can reach my current personal goals	1	2	3	4
I can handle what happens in my life	1	2	3	4
I life myself	1	2	3	4
I have a purpose in life	1	2	3	4
If people really knew me they would like me	1	2	3	4
If I keep trying I will continue to get better	1	2	3	4
I have an idea of who I want to become	1	2	3	4
Something good will eventually happen	1	2	3	4

I am the person most responsible for my own improvement	1	2	3	4
I am hopeful about my own future	1	2	3	4
I know when to ask for help	1	2	3	4

Recovery Assessment Scale – Domains and Stages (RAS-DS – Research Version 2).

PERSONAL RECOVERY (continued)				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I ask for help, when I need it	1	2	3	4
I know what helps me get better	1	2	3	4
I can learn from my mistakes	1	2	3	4
CLINICAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I can identify the early warning signs of becoming sick	1	2	3	4
I have my own plan for how to stay or become well	1	2	3	4
There are things that I can do that help me deal with unwanted symptoms	1	2	3	4
I know that there are mental health services that help me	1	2	3	4
Although my symptoms may get worse, I know I can handle it	1	2	3	4
My symptoms interfere less and less with my life	1	2	3	4
My symptoms seem to be a problem for shorter periods of time each time they occur	1	2	3	4
SOCIAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I have people that I can count on	1	2	3	4
Even when I don’t believe in myself, other people do	1	2	3	4
It is important to have a variety of friends	1	2	3	4
I have friends who have also experience mental illness	1	2	3	4
I have friends without mental illness	1	2	3	4

I have friends that can depend on me	1	2	3	4
I feel OK about my family situation	1	2	3	4

Recovery Assessment Scale – Domains and Stages (RAS-DS – Research Version 2).

Appendix D

Permission for Leisure Motivation Scale (LMS) Instrument Use

Agreement

Idyll Arbor, Inc. ("Company") and DIANA R PEARL ("Student") agree as follows:

1. Idyll Arbor, Inc. will provide Student with a copy of Leisure Motivation Scale (LMS) ("Assessment") and Manual. (If more than one tool is to be used, please write in the name of all applicable tools.)

2. Student agrees to use the entire testing tools as it is presented. No re-ordering of the test statements or partial use of the statements is allowed without prior written agreement from Idyll Arbor, Inc. SEE ATTACHMENT RE SUMMARY DEP 12/4/14

3. Student may make up to 150 copies of the Assessment as needed for research. Any unused copies left over after Student's research must be destroyed.

4. If Student's research requires that s/he re-type the Assessment, Company gives him/her license to do so, as long as no more than 0 copies of each are made.

5. The Student agrees to retain the original wording and order of all the statements in the testing tool.

6. If the Assessment is to be translated into a different language, the follow apply:

   a. the student and his/her university advisor agree that the translation protocol provided by Idyll Arbor (shown below) will be completed as it is written. Any deviations in the protocol must first be approved by Idyll Arbor in writing.

   b. The Student will provide Idyll Arbor with an electronic version of his/her translated tool as a PDF file.

   c. The Student will provide Idyll Arbor with a copy of the translated testing tool. Idyll Arbor will retain all rights in the testing tool translation.

Translating Testing Tools into Different Languages

The translation of a standardized testing tool must stay true to the words and meaning of the original test. There is a standard, three-step protocol used when translating testing tools. The first step is for an individual who is fluent in both the language of the test and the language the test is to be translated into to translate the test. The second step is to have a second translator who is also competent in both languages and who has no knowledge of the test, has never seen the original translation of the test, and has had no discussions about the test, translate the work of the first translator back to the original language of the test. The third step is to have a third person compare the first test (pretranslation) to the last test (posttranslation) to compare and contrast any differences in grammar, intent, or content. If the posttranslation test is basically the same as the pretranslation test, then the translation into the second language is considered to be a true translation.

7. The length of this license runs from 1/15 through 12/15

8. If Student needs more than 1 copies each of the Assessment or an extension beyond 12/15, s/he must submit a request, in writing, to Company at least 60 days prior.

9. If Student includes a copy of the Assessment in his/her paper, the Student is required to over mark the Assessment with "*Sample, Do Not Copy*" in at least 20 point type. This over mark

1

DRP 12/4/14

Summary of Student's Research.

The purpose of this study is to explore the correlation between leisure motivation and recovery of individuals with serious mental illness (SMI). Participation in activities that provide meaning and purpose may facilitate recovery from mental illness. Specifically the study will examine the association between motivation to take part in leisure activities and self reported perception of recover in members of ICCD Clubhouses in Southern California.

This will be a quantitative study of the relationship between Leisure Motivation and Recovery of those attending certified ICCD Clubhouses or Clubhouses modeled on ICCD standards. One group of people with SMI is being studied along with several variables that are not manipulated by the researcher. Convenience sampling will be used for this study. Convenience sampling uses participants from a population that are willing and available to be studied. 4 Southern California ICCD Clubhouses sites were selected for this study because the researcher lives in San Diego, CA. The active attendance at the ICCD Clubhouses is 45 persons. This makes a population of 180 persons. Using the Cohen Primer of medium groups a sample size of 86 is targeted. I plan on visiting each of the 4 sites personally and administrating the surveys. I will be making 45 copies of the Assessment for each of the 4 clubhouses participating in the study.

Permission for this study will be obtained by the Institutional Review Board at Walden University. In addition, permission will be obtained from the Executive Directors of each Clubhouse under study. The Executive Director of each Clubhouse will be contacted via email and telephone. The study will be explained and permission for the study will be obtained from participating Executive Directors. Consent from each participant will be acquired before they take part in the study. After each participant has given written consent for the study they will be given a copy of the instrument to fill out. I will collect surveys when they are completed.

I am at the proposal stage of my dissertation. A copy of your approval needs to be submitted during the proposal stage. I am looking at starting the study towards the first part of next year, 2015.

I can send you a copy of my proposal when it is completed if you wish.

Thank you,

Dianna R. Pearce MS.

Doctoral candidate (ABD)

Walden University

DRP
12/2/14

Agreement Question 2

I will only be using the first page of the Instrument, the 48 questions. The second page does not apply to my study.

NOTE: No copies of any of Idyll Arbor's testing tools may be made until Idyll Arbor, Inc. returns a signed contract that contains the signature of the student, the signature of the student's university supervisor, and the signature of one of Idyll Arbor's executive staff.

Date: 9/26/14

DRP
Student Signature

Donna R Prange
Student printed name

3119 45th ST
San Diego CA 92105
Student's Address:

Date: 9/29/14

Marianne E. Borja Ed. D. RD
Signature of University Advisor

Marianne E. Borja Ed, RD
Advisor printed name

Walden University
Name of University

100 Washington Avenue South Suite 900
Minneapolis MN 55401
Address of University

Date: 9 Dec 14

Thomas M. Blaschko, Idyll Arbor, Inc. President
39129 264th Ave. SE, Enumclaw, WA 98022 USA

Please print off a copy of this contract with the appropriate information filled in and mail back to Tom Blaschko, Idyll Arbor, Inc., 39129 264th Ave. SE, Enumclaw, WA 98022, USA.

Appendix E

Permission for Recovery Assessment Scale- Domains and Scales (RAS-DS)

Instrument Use

---------- Forwarded message ----------
From: **Nicola Hancock** <nicola.hancock@sydney.edu.au>
Date: Tue, Sep 9, 2014 at 3:26 PM
Subject: RE: Permission and copy of revised RAS instrument
To: Dianna Pearce <dianna.pearce@waldenu.edu>

Hi Dianna

Thanks for your email. I'm thrilled to hear you are doing a study with Clubhouse – and very happy to share the instrument (now called RAS-DS) with you.

A lot of work has happened since the American OT Journal publication.

You can access the RAS-DS at http://ses.library.usyd.edu.au/handle/2123/9317

I will attach the manual (although this is due to be updated sometime soon). It is designed to be user-friendly/accessible for staff working in the MH sector.

I have just submitted a paper for publication called something like Recovery Assessment Scale – Domains & Stages (RAS-DS): Feasibility and measurement.

I'm happy to forward a copy of it to you but obviously this would need to stay with you and not be forwarded or passed around at this stage. The feasibility data and psychometric strength of the RAS-DS looks great.... around 400 consumer data sets.

I look forward to hearing more about your study!

Kind Regards

Nicola

NICOLA HANCOCK, PhD | Lecturer
Occupational Therapy | Faculty of Health Sciences
THE UNIVERSITY OF SYDNEY
T +61 2 9351 9379 | F +61 2 9351 9197

Appendix F

Demographic Information

Demographic Information (Please place an X for appropriate choice)

Marital Status

Married_____ Single_____

Age

18-30_____ 31-50_____ 51 and above_____

Sex

Male_____ Female_____

Length of time as a member of the Clubhouse

Less than 1 year_____ 1 to 5 years_____ Over 5 years_____

Appendix G

Sample Email and Phone Correspondence to Clubhouse Directors

Dear _____

My name is Dianna R. Pearce, and I am a doctoral student Higher Education and Adult Learning (HEAL) through the Richard W. Riley College of Education at Walden University. I am interested in undertaking a correlational study on the relationship between leisure motivation and recovery at Clubhouses. I am inviting four Clubhouses in southern California to participate in the study, and I would like to know if you would be willing to take part. The study will be approved thru the Institutional Review Board (IRB) at Walden University before the start of the study. All requirements for a study using protected populations will be insured.

The study will use the Recovery Assessment Scale – Domains and Stages (RAS-DS) and the Leisure Motivation Scale (LMS) test instruments and will be completed onsite at the different CI accredited and/or model Clubhouse locations. Offsite completion of the study may take place upon request of the participant. All active members in your clubhouse are invited to participate in the study. The questionnaires will be anonymous. The questionnaires will take about 20 to 25 minutes. All information will be kept confidential.

I will contact you in a week or two to discuss your participation.
I would be most appreciative if you would allow me to include your clubhouse in my study. I will follow up with you by email or phone in a week or two to discuss more about the study.

Thank you,

Dianna R. Pearce MS.
Doctoral Candidate
Walden University

Text of Telephone Conversation with Clubhouse Directors:

Hello _____

I am following up on the email I sent you on _____.

I would like to know if you would be willing to allow your active Clubhouse members to take part in a study that I am doing on the association between Leisure motivation and recovery. As I stated in my email, this study will have IRB approval through Walden University. The questionnaires will take about 25 to 30 minutes, and will be completely anonymous, and results will be kept confidential.

If you are interested, I will send you more information on each of the questionnaires included in the study and a formal consent form for you to sign.

Do you have any questions?

Thank you,

Appendix H

Sample Letter of Cooperation

Community Research Partner Name

Contact Information

Dear Researcher Name,

Based on my review of your research proposal, I give permission for you to conduct the study, Relationship between Leisure Motivation and Recovery from Mental Illness among Members of Community Recovery Clubhouses: within at _____. As part of this study, I authorize you to do data collection and results dissemination activities. Individuals' participation will be voluntary and at their own discretion.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden

Authorization Official

Contact Information