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Peer Support Within Clubhouse: A Grounded Theory Study

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Abstract Peer support facilitates recovery. However, little is known about the role of peer support within the Clubhouse model. This article reports on Clubhouse members' experiences of peer support and the outcomes they identify from engaging in this phenomenon. Grounded theory guided the study design involving 17 semi-structured interviews conducted with 10 Clubhouse members. Constant comparison and open coding were undertaken to identify underlying concepts within transcripts. A conceptual model of peer support was derived from Clubhouse members' experience. Four levels of peer support emerged: Social inclusion and belonging; shared achievement through doing; interdependency; and at the deepest level, intimacy. Peer support within Clubhouse is a multi-layered construct in terms of depth and nature of relationships. Clubhouse appears to contribute a unique *tier* within the layered construct of peer support. This tier is based on the sharing of achievement through working together on shared tasks within the work-ordered day Clubhouse structure.

Keywords Peer support · Recovery · Mental health · Clubhouse

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Introduction

Over one hundred longitudinal studies conducted within the last century provide robust evidence that good long-term outcomes ranging from mild functional improvement to complete recovery happens for around two-thirds of people with severe mental illnesses (Warner 2004). Additionally, published testimonies from those with the lived experience of mental health recovery have provided much of the rich, qualitative data needed for the research community to begin engaging in efforts to operationally define the concept or construct of recovery and to explore what facilitates or indeed hinders the recovery journey (Davidson et al. 2005). Peer support has been recognised and evidenced as a key facilitator of mental health recovery over the last two decades (Corrigan et al. 2005). It has been defined as the notion of reciprocity in giving and receiving support based on the key principles of respect, responsibility and shared experience (Mead et al. 2001). This shared experience provides peers with the understanding of what benefits and motivates the other.

Peer support offers an abundance of positive outcomes evident in consumer testimonies and research. Peer support enables the assumption of roles lost due to mental illness (Davidson et al. 1999; Deegan 1993). It provides hope in one's recovery and leads to greater life satisfaction through extension of social network and interconnectedness (Herman et al. 2005). Peer interactions promote interdependence, enhance ability to cope and improve management of mental health symptoms and day-to-day living (Hardiman 2004; Kennedy and Humphreys 1994). Sense of community and the deeper connection of friendship, arise from belonging to peer support groups (Boydell et al. 2002; Hardiman 2004).

There is great variation in the evidence for consumer-centred services and programs in relation to peer support. Consumer-centred services and programs are those that focus upon the needs and goals of consumers as defined by each individual (Mowbray et al. 2009). However, there are a diverse range of service and program types that could be labeled consumer-centred and only some have examined the role that peer support plays within them. Mutual-help groups, also known as self-help groups, provide mutual aid to consumers by sharing their problems, and together, working through their recovery. These structured groups usually take place at regular weekly times where issues experienced are discussed. Peer support within this context has been given significant attention in the literature (Corrigan et al. 2002; Corrigan, et al. 2005; Davidson et al. 1999; Galanter 1988).

Consumer-run drop-in centres are a second type of service context that has been examined in relation to peer support. Consumer-run drop-in centres provide a safe and supportive environment where social and recreational activities are provided (Mowbray et al. 2009). They also foster an environment where consumers can share their experiences and provide others with assistance with their daily needs. Consumer-run drop-in centres have only preliminary evidence exploring the outcomes of peer support (Davidson et al. 1999; Hardiman 2004; Kaufman 1995).

The Clubhouse program is another type of consumer-centred program which is more routinised in its structure. While peer support is mentioned within Clubhouse literature, there has been no formal examination of the role that peer support plays within a Clubhouse context. A Clubhouse is an intentional community based upon the human need to be needed. Members, rather than patients or clients, attend the Clubhouse. With a strengths rather than deficits orientation, members' recovery occurs through active and needed engagement in the Clubhouse, rather than through traditional therapy groups. It is through this active and needed engagement in the work of the Clubhouse that members achieve or regain the skills and confidence needed to return to vocationally productive and socially satisfying lives (Beard et al. 1982). There are over 300 Clubhouse programs operating in over 29 countries and a growing number of Australian Clubhouses (Norman 2006).

The work-ordered day is a core structure of all Clubhouses. It involves a nine to five work day schedule where members and staff work side by side on the tasks and roles needed for the effective running and development of their Clubhouse (Beard et al. 1982). Work typically ranges from reception, administrative, clerical and financial roles to restaurant and cafe management and building maintenance roles. The work-ordered day provides members with the opportunity to be active and needed contributors within the community whilst working towards independent recovery goals (Rosenfield and Neese-Todd 1993).

The importance of peer support is emphasised within core documentation of the Clubhouse model. Internationally developed Clubhouse Standards which act as a 'bill of rights' for members, focus upon membership and peer to peer relationships (International Centre for Clubhouse Development 2006). Standards focus upon the role of membership in creating belonging and a sense of community within members' lives. Other standards concentrate on enhancement of member to member relationships (International Centre for Clubhouse Development 2006). The second of Four Guaranteed Rights of Clubhouse membership (Beard et al. 1982) is 'a right to meaningful relationships'.

Peer support is a prominent theme within Clubhouse literature (Hallberg 1995; International Centre for Clubhouse Development 2006; Jackson 1992; Vorspan 1995). Sense of belonging, peer interactions, positive outcomes of membership and Clubhouse relationships are discussed within members' published testimonies (Jackson 1992; Vorspan 1995). However, there is no formal examination of the role peer support plays within a Clubhouse context.

Understanding the principles and practice of the Clubhouse model informed the development of this study's research question. The aim of the current study was to develop a theoretical understanding of peer support within the Clubhouse context, using a grounded theory approach.

Methods

Study Approach

Grounded theory generates a framework to summarise and understand a phenomenon using the voice and multiples realities of, and therefore meanings constructed by participants as they live through their unique experiences (Grbich 2007). This approach is most suitable for research where there is little prior knowledge. Since peer support within the Clubhouse context lacks exploration, a grounded theory approach was utilised (Glaser and Strauss 1967).

Sampling and Recruitment

Ethical approval was obtained from the University of Sydney Human Research Ethics Committee. Written permission for recruitment and implementation of the study was obtained from the Director of the Pioneer Clubhouse. Participants were recruited through advertisements in the Clubhouse newsletter, announcements at Clubhouse meetings and posters displayed throughout the Clubhouse.

Maximum variation purposive sampling method was used to select a range of participants in terms of gender, age and stage of recovery (Polgar and Thomas 2008). This was done to identify common themes emerging from a diverse sample of members. Sampling continued until saturation of themes was reached. Potential participants were excluded from the study if they were registered under the Protected Estates Act (New South Wales Consolidated Acts 1983) and/or Guardianship Act 1987 (New South Wales Consolidated Acts 1987), or were experiencing episodes of acute illness at the time of the study.

Participants

Ten members attending Pioneer Clubhouse in Sydney, Australia, were recruited. Participants ranged in age from 30 to 63 ($m = 43.8$). Sixty percent of participants were female. All had one or more of the following psychiatric diagnoses: bipolar disorder (40%), schizophrenia (30%), anxiety disorder (10%), schizoaffective disorder (10%), alcohol or substance abuse (10%), and depression (10%). Participants had been members of the Clubhouse from 1.5 to 11 years (see Table 1).

Data Collection

Prior to data collection, the primary researcher attended the Clubhouse on a regular basis to initiate entry into the field. This provided the opportunity to build rapport with members and staff and gain greater insight into the peer networks operating within Clubhouse.

Data collection involved semi-structured, individual, in-depth interviews to explore participants' experiences of peer support. After the eighth interview, the initial interview guide was reviewed and expanded upon taking into consideration new and emerged concepts introduced by participants.

Interviews spanned a 6 week period and took place at the Clubhouse. Written informed consent was obtained prior to participation in audio-taped interviews. Seventeen interviews were conducted in total. Initially individual interviews were undertaken with seven participants. Following this, close examination of the transcripts led to the expansion of the interview guide to incorporate themes raised by participants. Three new participants were interviewed individually with the revised guide. The original seven participants were then re-interviewed. At this point, no new concepts emerged hence identifying data saturation and thus no further interviews were required. Each interview took between 20 min and 1.5 h.

Data Analysis

In keeping with grounded theory principles, the constant comparison method (Strauss and Corbin 1990) was used throughout the interviewing process. Interviews were transcribed verbatim and member checking was used to confirm accuracy of transcripts and allow participants to edit responses. No participant requested any changes to be made. Analysis then involved a cyclical, iterative approach and occurred in three distinct stages (Grbich 2007), as outlined below.

First, transcripts were scanned and sorted into excerpts which were analysed by two of the authors of this paper prior to the next interview. Open coding was used to identify emerging themes (Glaser and Strauss 1967). Excerpts were labelled with initial codes. A second interview guide expanding upon the initial guide was developed subsequent to the seventh interview according to the codes and concepts introduced by participants. For instance, friendship, and the role work plays in fostering peer relationships emerged as new areas relating to peer support from the participants perspective. This ongoing, iterative process continued until data saturation was reached

Table 1 Participant demographics

	Age	Gender	Clubhouse membership (years)	Diagnosis
Participant 1	63	Female	10	Bipolar disorder
Participant 2	44	Female	11	Schizophrenia,
Participant 3	56	Female	1.5	Bipolar disorder
Participant 4	61	Male	9	Depression, alcohol and substance abuse
Participant 5	30	Male	3	Schizophrenia
Participant 6	31	Male	2	Anxiety disorder
Participant 7	41	Female	4	Schizoaffective
Participant 8	41	Male	2	Bipolar disorder
Participant 9	35	Female	10	Schizophrenia
Participant 10	36	Female	6	Bipolar disorder

subsequent to the fourteenth interview with no new or emerging concepts yielded.

Second, excerpts of 9 of the 17 transcripts (53%) were purposefully selected. The three authors independently and selectively coded excerpts into clusters of like concepts (Strauss and Corbin 1990). This involved identifying meaningful words or phrases and developing categories based on these clusters of codes. This provided the initial categories for coding.

Third, consensus coding was used to synthesise the three independent sets of categories using the wording of participants when possible (Grbich 2007). This process involved tallying, collating and expanding categories until all authors reached consensus on the cluster of categories and codes. Consensus was achieved when each category could be conceptualised using a clear, definitive, interpretive summary to describe the category that was consistent with views expressed by all participants.

Fourth, axial coding was undertaken to identify and describe the variations in peer support experiences or degrees of peer support spoken of by the participants and how these levels of peer interactions were characterised in terms of commonalities and differences with other experiences of interactions. Conceptual diagrams were developed and compared in order to characterise each peer support experience. Each 'experience' or level of peer support was given a clear and discrete description including how each experience differed in terms of depth of interaction and relationship to the other levels.

Results

The Clubhouse Model of Peer Support

As analysis of themes continued, a clear concept of distinct levels of layers of peer support began to emerge. Subsequent data confirmed this. These layers included: (1) *Social inclusion and belonging;* (2) *Shared achievement through doing;* (3) *Interdependency; and* (4) *Intimacy*. The *Clubhouse Model of Peer Support* was developed depicting these layers (see Fig. 1). Each layer represents a greater depth in the nature of support. At the most simple level, peer support is about belonging to a community as a member of Clubhouse. At its deepest level, peer support involves genuinely caring and looking out for the wellbeing of each other.

A related change in role within each level of peer support was also identified. One's role in peer support at the more 'superficial' level is that of *Clubhouse member*. This is followed by a *unit member*, then a *respected peer*, and finally at its most profound level, a *valued friend.*

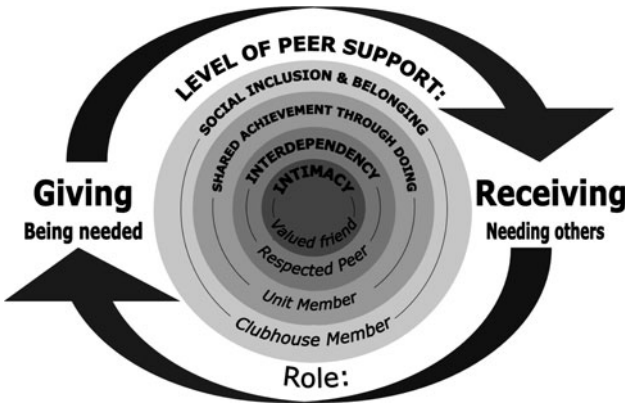

Fig. 1 Clubhouse model of peer support

Positive Outcomes of Peer Support

Level 1: Social Inclusion and Belonging

The role of *Clubhouse member* encapsulates the experience of belonging through membership of the Clubhouse. Participants discussed physically belonging to a community of people and having a place to be welcomed and meet peers. The following quote is illustrative of this view: "You're coming to a place where there are people and you're not alone. Not like staying at home where you're by yourself and you have no one to talk to" (Participant 6).

This level involves giving and receiving in its most basic form, giving of one's time and presence in the community. It involves being surrounded by others and providing company to others. Participants spoke of the reassurance of knowing there was a place that would be welcoming and familiar: "You're … the first person they see and smiling at them. That makes them feel better to know that someone's here" (Participant 1).

Sense of community and belonging created through membership of Clubhouse provides greater social network and decreases social isolation. Participants spoke of the decrease in social isolation and stigmatisation: "It's a great feeling you have between one another. It's that sense of community and I think that sense of community is really important especially when you've got a mental illness when you might have been marginalised" (Participant 7).

Level 2: Shared Achievement Through Doing

Clubhouse member transitions to the more involved role of *unit member*. At this level, giving and receiving is practical and hands-on. Rather than merely belonging to one's community, a member becomes an active participant in giving and receiving through physically doing collaborative tasks with peers. These tasks have a shared focus that requires peer collaboration for successful completion.

Participants emphasised the importance and uniqueness of the work-ordered day in building relationships:

> The difference is the work-ordered day and that wasn't there at the drop-in centre … If people are typing or doing the Pioneer Post they … work and make relationships at the same time which I think is very important …. Whereas at a drop-in centre, there is no structure (Participant 10).
>
> You can just sit down next to anybody and do a task and before you know it, you know them … it's easier for me to be in a work environment and make friends than be in a 'sitting down, doing nothing' environment (Participant 7).

From achieving together, satisfaction and self-confidence increased:

> When I came here I didn't know anything about reception, I didn't know anything about the RAM [Restaurant and Maintenance] unit … [Peer] was very supportive of me on reception. I was really shy … That sort of brought me back into things. I'm a bit more confident now (Participant 5).

The new role of valued contributor to one's peer community transpired within this level. Participants articulated a shift in self-perception from 'sick person' to a 'productive, contributor' with skills and knowledge to be celebrated and shared:

> My roles are receptionist, editing, helper. I see myself as a contributor by coming to Clubhouse … I contribute to the functioning of the house and to other members. We give and we receive … It all gives me a sense of purpose, self-esteem and you feel like you're not just a vegetable. You're actually doing something worthwhile (Participant 1).

Participants conveyed a heightened ability to tolerate limitations or challenging behaviours of peers and to accept different opinions. They also discussed other's acceptance of their limitations:

> I love to help out. I love it but I couldn't do it there [in a previous employment position] because I was too slow. Here I can do it because I'm good at it and they don't care about slowness (Participant 3).

Participation in the work-ordered day gave members the opportunity to observe the practical skills and abilities of peers. They were then able to learn and acquire these skills directly from peers: "It means being helped along the way and it means helping along the way. Showing other members how to cook, how to … bake, clean and being shown new skills by other members [which] are helpful to me" (Participant 9).

The work-ordered day also gave members the opportunity to teach their skills or impart their knowledge to others. Participants discussed the opportunity for leadership roles and the increased self-confidence and self-worth that came with this role.

Level 3: Interdependency

The level of interdependency epitomises members' giving and receiving of personal experience and knowledge. Whilst at Level 2, the sharing relates to practical skills or 'doing', at this deeper level, peers discussed the significance of having others with whom to share personal experiences, knowledge and advice: "It is about discussing issues. Giving advice and providing advice from experience and finding a common ground" (Participant 8).

The exchanging of personal experience and knowledge offered the opportunity for participants to recognise the "similarities between [their] own story and other peoples" (Participant 5). Sharing of knowledge amongst peers also enhanced participants understanding of their own illness.

> Sharing your experience helps your look at your own illness and see that you're not the only one who's had depression or mania or got schizophrenia. You feel as though you're okay because there are other people who are experiencing that too … you can help each other through the bad times because you know where each other is coming from (Participant 10).

Members are offered alternative ways of dealing with their issues from those who have experienced similar situations. This adds to their knowledge of symptom and illness management:

> We do have the same issues with our illness or some of the same issues, side effects of the mental illness and all kinds of things to do with mental illness. And if you didn't meet with other members then you wouldn't get to talk about side effects so it's really helpful to have friends who are going through the same thing (Participant 7).

Shared knowledge at this level extended beyond mental illness into more general daily living needs such as navigating government departments and managing finances: "I have helped other people with the things that have happened to me throughout the years. If I've been given advice, I give advice … in housing matters, in alcohol-related matters, Centrelink matters and … immigration" (Participant 9).

The ease of seeking help from peers was emphasised by participants:

> I feel more at ease talking about the problems I have with people I know are in the same boat. They'll listen to me and I'll listen to them. There's no single person who hasn't got a hassle so everybody knows what's going on and can jump in when needed (Participant 2).

Finally, participants emphasised the benefit of mutual understanding where one is not judged and does not need to explain behaviour: "If you're down, you don't need to explain that you're not feeling well. You can just talk about it and people understand. There is no need to explain yourself … people don't expect explanations" (Participant 8).

Within the level of interdependency, peer support involves the sharing of personal experience and knowledge. A much greater level of openness and trust is required at this level. The final, intimate level of peer support goes one step further.

Level 4: Intimacy

Intimacy is the deepest level of peer support. It involves emotionally and intimately depending upon and looking out for one another. Rather than purely advising and sharing personal experiences in relation to others' practical and instrumental needs, this level of support involves a deep caring for the emotional wellbeing of another: "If somebody doesn't turn up for a while you can miss them. You think I hope he's okay, I haven't seen him in a while. Or you know that one of your dear friends …. is having an operation and you wonder how he is doing and you miss him. You don't really realise how much you depend on someone until they're not here" (Participant 6).

Intimate peer support sees relationships extend to taking the responsibility for the wellbeing of others.

Intimacy gives rise to the role of *valued friend*, where the void of not having anyone to share one's life with is filled. Participant 2 described the sense of genuine care received from peers at Clubhouse as: "People give a damn because otherwise, they wouldn't be sticking around you".

The need for each other at this level equates to sharing of love between friends. Being needed by others validates members' self-worth and self-value:

> I'm very proud of it. It's very important to be needed … my friend needs me … and I give him as much support as I can. It makes me feel good about myself. It makes me feel loved. It gives me a sense of pride to know that someone needs you and somebody loves you … I give them lots of hugs and tell them that I love them too (Participant 6).

Intimacy in peer support requires the ability to trust and be trusted. Trust required at this level of peer support is built from working together with other members in the work-ordered day and the sharing of experiences that came from this as described by participants:

> Around the work-ordered day, you get to know people. After a while, you know who you can trust … They take a while to trust you but once they do trust you, they trust you. With a drop-in centre, I couldn't imagine that you'd get the same amount of trust with people. They're just dropping in, saying hello and having a cup of tea and going (Participant 9).

Knowing one another intimately leads to increased honesty and insight. Participants spoke of the acute insight friends had of their needs and the ability friends had to identify when they were experiencing difficulties:

> When I feel anxious I don't want to talk about myself and she said to me 'how is such and such going?' And I said, 'okay' and then immediately asked her a question to take the focus off me. She said, 'you come out with a question towards me, most people talk about themselves if you ask them a question'. She knew that I was deflecting and I felt good about that because she knew things weren't great (Participant 7).

Friendships have provided Clubhouse members with social networks outside of Clubhouse operation. Participants emphasised how the peer support received within Clubhouse transcends the operation of the Clubhouse's nine to five day:

> Because of Clubhouse I have that extended network after hours … And I'm lucky that I've got friends … Seeing everyone on the weekend is very different because they're still your friends and you can talk to them about things. They'll be there for you (Participant 5).

Sharing of intimate moments with one another not previously experienced even with relatives, was described by participants as of utmost importance. Participants felt fortunate and honoured to gain such a sense of closeness and importance to another member:

> I think unknowingly it has helped me to express myself, like putting my arms around her … there is a certain closeness and even though I can't describe, it is a beautiful feeling … so very comforting and intimate. We both feel good together. I don't have that intimacy with other relationships that I have. I feel privileged (Participant 6).

Negative Outcomes of Peer Support

A few negative outcomes of peer support were identified by participants. None of these negative outcomes were

discussed more than twice throughout the interviews of all participants. It is noteworthy to add that for most negative outcomes of peer support mentioned, participants counteracted these with positive outcomes arising from each challenging experience. Participants discussed the difficulty experienced with dealing with challenging behaviours of other members that arise from differences in stage of recovery: "You've got to be tolerant of that sort of behaviour. And sometimes it's harder to take than others. You've just got to be patient" (Participant 2).

Other participants commented on the need to balance relationships between people with mental illness and people without mental illness: "It's quite nice to be away with people that don't have a mental illness. I think you've got to have a balance … I think it's good to have other people in your life as well" (Participant 5).

One participant spoke of the peer pressure she felt to work: "I don't feel pressure to work but I feel as though I should. Or maybe everybody else is helping out and I should do something" (Participant 7).

Being too involved in the wellbeing of others concerned participants. They described feeling responsible for other's wellbeing however sometimes not knowing where the boundary between caring and interfering or dependency lies: "At the same time I wonder if I give too much in the way that I might not be doing that person any good and am I making him too dependent on me. I wonder at what point do I draw the line?" (Participant 6).

In summary, potentially negative aspects include need for tolerance, diversity of friendships, pressures to engage and sense of responsibility for the other. It might be argued that these equate to the challenges inherent within the general nature of relationship forming and are not specific to relationships between peers with mental illness.

Conclusion

Peer support within Clubhouse encompasses levels of peer support; varying degrees of peer interaction and quality of support with additional benefits to offer. With each level of support, come different roles moving from *Clubhouse member* at its most superficial level, to that of *valued friend* at its deepest level.

Positive outcomes of peer support have been demonstrated within mutual-help and consumer-centred services and programs (Boydell et al. 2002; Corrigan 2006; Frese and Walker Davis 1997; Hardiman 2004; Humphreys and Rappaport 1994; Solomon 2004; Verhaeghe et al. 2008). This study adds to previous knowledge by demonstrating the powerful role that peer support plays in another type of consumer-centred program, specifically a Clubhouse context. Analysis revealed four distinct layers of peer support operating within a Clubhouse. These layers are: (1) *Social inclusion and belonging;* (2) *Shared achievement through doing;* (3) *Interdependency; and* (4) *Intimacy.* The *Clubhouse Model of Peer Support* developed from findings in this study encompasses a multi-layered structure of peer support, a concept not previously identified in the broader peer support literature (see Fig. 1). Whilst Levels 1, 3 and 4 reflect themes with other peer support literature, it appears that Level 2 *(Shared achievement through doing),* appears to be an additional peer support opportunity that the work-ordered day structure of a Clubhouse provides.

The development of associated roles with each level of peer support is also a novel concept to the construct of peer support. With each level of peer support, the following transitions in role development are seen, *Clubhouse member* to *unit member*, then *respected peer* and finally, *valued friend.*

Negative outcomes of peer support were also explored in this study, a facet of peer support under-examined within broader peer support literature (Boydell et al. 2002). These identified risks appear to parallel those risks that are inherent to the development of close human relationships; necessary risks that all need to take in order to not be alone.

The current study illuminates the significant role consumers play in the recovery of their peers due to shared experiences, 'expert' knowledge and the care and empathy they have for one another. Staffed mental health programs might benefit from recognising the value of this potentially under-utilised resource. Findings suggest that priority should be given to maximising opportunity for peer support to occur. The levels of peer support identified within the *Clubhouse Model of Peer Support* present program developers the challenge of considering aspects of service delivery that foster each level: social inclusion and belonging, shared achievement through doing, interdependency and intimacy. With each level there are additional benefits for the giver and receiver.

Finally, the work-ordered day, a unique component of the Clubhouse model has emerged as a valuable structure that creates an opportunity for shared achievement through doing. This shared achievement appears to have played a significant role in Clubhouse members' development of trusting relationships and this has enabled their transition into deeper levels of peer support. Clubhouses should celebrate the role of the work-ordered day and other staffed mental health programs might consider in what capacity this element of shared achievement could be included in their service delivery.

While this study was conducted in one Clubhouse program, it is reasonable to assume some level of generalisation could be made to other accredited Clubhouse programs operating in accordance with International Clubhouse Standards (International Centre for Clubhouse

Development 2006). Findings can be generalised beyond Clubhouse programs. Comparative studies between Clubhouse and other models of mental health service delivery, particularly other professionally-staffed programs, would assist in identifying best practice in maximising opportunities for peer support. Comparative studies would enable further exploration of whether, *shared achievement through doing* is unique to the Clubhouse model's work-ordered day or appears within other contexts.

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References

Beard, J. H., Propst, R. N., & Malmud, T. J. (1982). The Fountain House model of psychiatric rehabilitation. *Psychosocial Rehabilitation Journal, 5*, 47–53.

Boydell, K. M., Gladstone, B. M., & Crawford, E. S. (2002). The dialectic of friendship for people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*(2), 123–131.

Corrigan, P. W. (2006). Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services, 57*(10), 1493–1496.

Corrigan, P. W., Calabrese, J. D., Diwan, S. E., Keogh, C. B., Keck, L., & Mussey, C. (2002). Some recovery processes in mutual-help groups for persons with mental illness; I: Qualitative analysis of program materials and testimonies. *Community Mental Health Journal, 38*(4), 287–301.

Corrigan, P. W., Slopen, N., Gracia, G., Phelan, S. M., Keogh, C. B., & Keck, L. (2005). Some recovery processes in mutual-help groups for persons with mental illness; II: Qualitative analysis of participant interviews. *Community Mental Health Journal, 41*(6), 721–735.

Davidson, L., Chinman, M. L., Kloos, B., Weingarten, R., Stayner, D. A., & Kraemer Tebes, J. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice, 6*(2), 165–187.

Davidson, L., Sells, D., Sangster, S., & O'Connell, M. (2005). Qualitative studies of recovery: What can we learn from the person? In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 147–180). Washington, DC: American Psychological Association.

Deegan, P. E. (1993). Recovering our sense of value after being labelled mentally ill. *Journal of Psychosocial Nursing, 31*, 7–11.

Frese, F. J., & Walker Davis, W. (1997). The consumer-survivor movement, recovery and consumer professionals. *Professional Psychology: Research and Practice, 28*(3), 243–245.

Galanter, M. (1988). Zealous self-help groups as adjustment to psychiatric treatment: A study of Recovery. *Inc. American Journal of Psychiatry, 145*(10), 1248–1253.

Glaser, B. G., & Strauss, A. L. (1967). *Discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine DeGruyter.

Grbich, C. (2007). *Qualitative data analysis*. London: SAGE Publications, Inc.

Hallberg, P. (1995). *The right to meaningful relationships: The essence of the Clubhouse*. Paper presented at the 10th International Clubhouse Seminar, Toronto, Canada.

Hardiman, E. R. (2004). Networks of caring: A qualitative study of social support in consumer-run mental health agencies. *Qualitative Social Work, 3*(4), 431–448.

Herman, S. E., Onaga, E., Pernice-Duca, F., Oh, S. M., & Ferguson, C. (2005). Sense of community in Clubhouse programs: Member and staff concepts. *American Journal of Community Psychology, 36*(3/4), 343–356.

Humphreys, K., & Rappaport, J. (1994). Researching self-help/mutual aid groups and organizations: Many roads, one journey. *Applied & Preventive Psychology, 3*(4), 217–231.

International Centre for Clubhouse Development. (2006). International Standards for Clubhouse programs. Retrieved 15th May, 2008, from http://www.iccd.org/docs/standards.pdf.

Jackson, R. (1992). How work works. *Psychosocial Rehabilitation Journal, 16*, 63–67.

Kaufman, C. L. (1995). The self-help employment center: Some outcomes from the first year. *Psychosocial Rehabilitation Journal, 18*, 145–162.

Kennedy, M., & Humphreys, K. (1994). Understanding worldview transformation in mutual help groups. *Prevention in Human Services, 11*, 181–189.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal, 25*(2), 134–141.

Mowbray, C. T., Woodward, A. T., Holter, M. C., MacFarlane, P., & Bybee, D. (2009). Characteristics of users of consumer-run drop-in centers versus Clubhouses. *Journal of Behavioral Health Services & Research, 36*(3), 361–371.

New South Wales Consolidated Acts. (1983). Protected Estates Act 1983. Retrieved 4th December 2008, 2008, from http://www.austlii.edu.au/au/legis/nsw/consol_act/pea1983200/.

New South Wales Consolidated Acts (1987). Guardianship Act 1987. Retrieved 4th December, 2008, from http://www.austlii.edu.au/au/legis/nsw/consol_act/ga1987136/.

Norman, C. (2006). The Fountain House movement: An alternative rehabilitation model for people with mental health problems, members' descriptions of what works. *Scandinavian Journal of Caring Sciences, 20*, 184–192.

Polgar, S., & Thomas, S. A. (2008). *Introduction to research in the health sciences* (5th ed.). Edinburgh: Churchill Livingstone.

Rosenfield, S., & Neese-Todd, S. (1993). Elements of a psychosocial Clubhouse program associated with a satisfying quality of life. *Hospital & Community Psychiatry, 44*(1), 76–78.

Solomon, P. (2004). Peer support/Peer provided services underlying processes, benefits and critical incidents. *Psychiatric Rehabilitation Journal, 27*(4), 392–401.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: SAGE Publications.

Verhaeghe, M., Bracke, P., & Bruynooghe, K. (2008). Stigmatization and self-esteem of persons in recovery from mental illness: The role of peer support. *International Journal of Social Psychiatry, 54*(3), 206–218.

Vorspan, R. (1995). *Clubhouse relationships need work!* Paper presented at the 10th International Clubhouse Seminar Toronto, Canada.

Warner, R. (2004). *Recovery from schizophrenia: Psychiatry and political economy* (3rd ed.). Hove, UK: Brunner-Routledge.