

**INTRODUCTION TO MENTAL HEALTH CLUBHOUSES:
HOW THE FOUNTAIN HOUSE CLUBHOUSE BECAME
AN INTERNATIONAL MODEL**

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INTRODUCTION

In June 2010, Fountain House in New York (FHNY) hosted the symposium *Community: Its Role in Psychiatric Recovery*. The symposium was arranged by, among others, Alan Doyle and Kimiko Tanaka at FHNY and researchers from all over the world gave presentations. It was suggested that an anthology be produced on Clubhouses in different welfare contexts, and I was appointed coordinator of the project. I contacted Professor Thomasina Borkman, editor of this *Journal*, concerning the possibility of developing a special issue on mutual aid elements at international clubhouses, and in late 2010 we sent out a notice inviting researchers to submit proposals for the special issue. In this process, the research directory of the International Center for Clubhouse Development (ICCD) was employed. FHNY generously supported the project without interfering in the academic process. Authors of approved proposals were invited to a 3-day research meeting held at the FHNY guest house in June 2011. At that meeting, Borkman and Karlsson led discussions on early paper drafts, and a detailed process schedule was agreed upon. Completed drafts were processed through a standard blind peer review process with two expert reviewers. I managed the peer review process sending papers to reviewers in Europe, Asia, and North America, while Thomasina Borkman evaluated reviewers' assessments and guided the authors through the revision process. By August 2012, final versions of accepted articles were submitted to this *Journal*; there were enough articles for one full issue and

one half of an issue. Professor Thomas Jamieson-Craig, Kings College London, UK had been asked to write a conclusion with an assessment of the special issue's contribution to Clubhouse research which will appear in the one-half issue (Vol. 7(2), July 2013).

Clubhouses are said to be "community centers that give people with mental illness hope and opportunities to reach their full potential" (ICCD, 2011a). According to the *International Center for Clubhouse Development* (ICCD), there are today more than 300 clubhouses on five continents, most of them in the United States (about 200) and Europe (about 75) (ICCD, 2011b). In this special issue, they are examined from the viewpoint of self-help/mutual aid. The clubhouse history starts with a small self-help group for people with mental illness more than 65 years ago. In this group's first newsletter (W.A.N.A. Society Bulletin, 1944) it was concluded that:

The members of W.A.N.A. look back upon their first six months of activity as a period of experimentation in which as individuals they tested their own and their fellow members' capacities for constructive and cooperative work and as a group explored the possibilities of self-help and mutual aid for mental Patients. (p. 2)

Today clubhouses form a huge international organization, but peer support and mutual aid still play significant roles. In these special one and one-half issues we will present primary data from clubhouses in the United States, United Kingdom, Japan, Taiwan, Italy, and Sweden that will broaden the understanding of the prerequisites for self-help mutual aid activities in different welfare contexts. All clubhouses described subscribed to the same Standards, meaning that they (are supposed to) operate in similar ways—even in different welfare contexts.

I will sketch the history of FHNY and briefly introduce the Standards for clubhouses which were developed in 1989, placing them into a self-help/mutual aid perspective.

CLUBHOUSES—SOME HISTORY

The history of clubhouses contains, at least, two important sub-stories. One is the self-help/mutual aid group that developed into a worldwide network still containing vital mutual aid elements. The second is that Fountain House in New York (the first clubhouse) played an important role in developing the theoretical framework of psychiatric rehabilitation (Anthony, Cohen, & Farkas, 1990). Frequently, the clubhouses are compared with today's psychiatric rehabilitation evidence-based programs, for example, Individual Placement and Support (IPS) (Bond, 2004).

The Beginning

Fountain House in New York, the original clubhouse still flourishing today, sprung from a self-help group W.A.N.A. (We Are Not Alone) first formed in the middle 1940s. The systematic documentation of its history is limited, even if there is a rich mouth-to-mouth tradition within and among clubhouses. Steven B. Anderson's (1998) book *We Are Not Alone—Fountain House and the Development of Clubhouse Culture* is one important exemption. Anderson was a staff member of FHNY for more than 25 years and this book is often referred to when clubhouses discuss their own history. He describes the history of clubhouses based on the careful research of hundreds of original documents from the archives of FHNY. I rely most extensively on his book for the brief history provided below. This history has also been vetted by several current knowledgeable senior staff at FHNY.

The group was originally created by Mrs. Elisabeth Schermerhorn and a psychiatrist, Hiram Johnson, who gathered people with mental illness to prepare some patients for a life outside the Rockland State Hospital by increasing their social skills. The head of the psychiatric ward, Russell Blaisdell, had close connections to the newly born Alcoholics Anonymous (AA) movement, and was the first psychiatrist who let an AA group be run within a hospital (Karlsson, forthcoming). While we have no documentation affirming it, it is conceivable that the ideas from the AA group inspired or, at the very least, contributed to the group that later became W.A.N.A.

When patients from the Rockland State Hospital group left the hospital, they decided to continue supporting each other, and created W.A.N.A. in 1944. Initially, the group kept regular Friday evening meetings; they not only wanted to serve the members but also to reach out to (ex)patients at Rockland State Hospital. Their monthly bulletins were brought to the hospital.

In the beginning, W.A.N.A. was loosely organized, and even after an ex-patient, Michael Obolensky, was elected president, and an advisory board of directors was formed (including Schermerhorn, Johnson, two YMCA officials, and other non-patients), the following years were turbulent. The group grew—there are indications that there were more than 100 members in New York and that “branches” were initiated in Utah and elsewhere—but the lack of resources and power conflicts created strife within the group.

In 1948, Schermerhorn, from a wealthy family, together with a friend and the support of Hartley House (a nearby settlement house), managed to buy a brownstone at 412 West 47th Street in Manhattan, in order to reorganize W.A.N.A. and to create a clubhouse for members. A fountain in the patio inspired the name Fountain House. It was decided that Fountain House should be financially led by an outside board of directors and operationally by the Fountain House Fellowship which contained the ex-patients.

Shortly thereafter, the occupational therapy department at Rockland State Hospital contracted out an occupational therapy program to FHNY. This initiative was supported by Schermerhorn and Blaisdell, among others, and focused on simple routine jobs for members. This is probably one of the first steps of FHNY to focus daily work efforts for their members and to fully integrate the mutual aid efforts between members with professional rehabilitation efforts.

Between 1949 and 1955 three different professionals tried to run the clubhouse with little success. The first one, Marguerite Walker, was a psychiatrist who focused on professional counseling and therapy, and did not seem to acknowledge the mutual aid elements. Walker was soon replaced with a social worker, Sara Boddinghouse, who resigned due to power struggles, lack of resources, and an overload of responsibilities. The third executive director, Sidney Robbins, emphasized FHNY as a normal community for people with mental illness that did not have to deal with stigmatization processes outside. However, he argued that staff was needed to lead the activities of the clubhouse, and they should exercise power at the clubhouse. Not surprisingly, this upset the Fellowship, and in 1955 the board requested his resignation. During these years, it appears that there was continuous conflict between the professional directors and the Fellowship (the ex-patients); the Fountain House Foundation Board tried unsuccessfully, time after time, to handle these conflicts.

The Influence of John Beard

In 1955, John Beard, a young social worker, became executive director of FHNY. Based on his experiences in a previous position in a psychiatric ward, he had developed Activity Group Therapy, where he tried to communicate with and get to know people with severe mental illness through doing activities with them that they were familiar with and by doing activities in groups. In his own words:

Numerous similar examples could be cited to demonstrate that the schizophrenic patient will reveal ego strengths that can be utilized in the activity structure of the group. It is our conviction that when these rudimentary capacities of the patient are regarded as insignificant and extraneous only to be dropped and forgotten, then the patient feels himself dropped and forgotten. Only if his responses, limited as they are, can be made an essential part of the group's activity structure, does the patient himself become a meaningful, positive participant. (Beard, Goertzel, & Pearce, 1958, p. 133)

According to Anderson (1998), Beard started his time at the Clubhouse by getting to know members one by one, and soon he organized work activity groups at FHNY for keeping the building in shape and for supporting the secretary of the Fountain House Foundation in her clerical work. Once again, the Fellowship criticized the new regime and this time the board and the staff decided to abolish

the Fellowship as an organization. All members were invited to rejoin FHNY as one single organization, and most people did. Several interviews with seasoned FHNY staff members suggest that the Fellowship at this time was not a self-organized group of peers with mental illness, but rather a small group of trouble makers, and that the decision to abolish the group was necessary in order to save FHNY. Beard reinstated a new mutual aid system that would include all participants.

Over the following years, Beard introduced a new order at FHNY, focusing on working side-by-side. The earlier power struggles among members and between members and staff diminished as he took the lead. Instead of a hierarchical structure, he tried to induce “self-help” through highlighting the importance of collaboration between members and staff in work tasks. In the early 1960s “Transitional Employment” (TE) practices were firmly established and 54 persons occupied transitional employment positions in 1961.

Late in 1957, Beard gave a presentation about his work at FHNY where he addressed “social rehabilitation,” and the same year, Fountain House was registered as a service mark (a label registered with the government—as would a brand name be—to protect the label Fountain House from being used by other service organizations). Discussion began about if and how to spread the Fountain House program. The board rejected national franchising of the program, a decision that made Schermerhorn resign from her post. But the TE program came to the attention of the rehabilitation field, and in 1971 FHNY was identified as one of 13 psychosocial centers in the United States. People at the Clubhouse were ambivalent about the term “psychosocial” but were excited about the opportunities to influence the field and to spread their concept. FHNY received several grants from the Rehabilitation Services Administration (RSA) and the National Institute of Mental Health (NIMH) to develop and to spread the program. Visits were received from other psychosocial centers and from Community Health Care Centers (CMHC). FHNY was soon financed to run a 5-year training program beginning in 1976, and expectations of the program developed by John Beard grew. One of the first persons to attend the training was Kenneth Dudek, who is today the director of FHNY (Anderson, 1998; Propst, 1997).

During these years, FHNY suffered from a dilemma: how could they both broaden inclusiveness and at the same time keep their identity? Beard pointed out that the idea of the training of professionals from other facilities was not to duplicate the program at other places, but rather to show and explain the philosophy of it. Many CMHCs that provided several different services, including partial hospitalization, set up Fountain House-like programs parallel to their usual services. They often ran these programs in the same building (and with the same personnel) as their clinical services. By 1980, 334 representatives had participated in the training program, and 77 “Fountain House Model” programs had been established in the United States (Anderson, 1998).

An International Organization is Formed

In 1980, it was revealed that Beard had terminal lung cancer. In the same year, a Fountain House-inspired program in Pakistan prepared an international seminar around the program, and a new clubhouse opened in Sweden as a result of a Swedish Television reportage on FHNY (Anderson, 1998; Karlsson, 2007). In 1983, one year after Beard's death and Jim Schmidt becoming an acting executive director, a second international Fountain House seminar was held in Stockholm. Few Americans participated in these first two seminars and Schmidt decided to bring together the programs that were inspired by the Fountain House program and those that had been involved by the 5-year training program. A third international seminar was held in New York in 1985, where the term "Clubhouse model" was introduced (rather than Fountain House Model), and a fourth was held in Seattle. At the fifth international seminar, held in St. Louis 1989, the Standards for clubhouses were formulated. The ambition was to define essential elements at clubhouses, and to strengthen the mutual support between the growing numbers of clubhouses. Essential for this was the Clubhouse Expansion Project, a 3-year project aiming at "constructing a framework which transcended the leadership at Fountain House for strengthening and transmitting clubhouse culture" (Anderson, 1998, p. 175). In 1994, this program was turned into the International Center for Clubhouse Development (ICCD), which at that time was located in and legally belonging to FHNY but later became its own organization separated from FHNY. Today, ICCD coordinates the certification processes among clubhouses on the basis of the Standards.

In 1992, Schmidt resigned, and Dudek was appointed the next executive director at FHNY. Dudek emphasized advocacy efforts and also instituted policies at the clubhouse in compliance with the new Standards. Recognizing the importance of research, he hired Cathaleene Macias for a 2.5 million dollar project to compare a clubhouse (Genesis Club in Worcester, Massachusetts) with a PACT program in the same city (Anderson, 1998; Macias, Rodican, Hargreaves, Jones, Barreira, & Wang, 2006).

SOME BASICS

In order to fully understand clubhouses of today, some core elements must be known. First, I will introduce the *Standards*, which in general describe how a clubhouse should be operated. These are of great interest to this special issue since they should be the same all over the world, even if the welfare contexts that clubhouses act within differ. Then, I will describe some *key activities* at clubhouses. Finally, I will say something about the *international network* of clubhouses, and the training and certification processes that are carried out through this. It is obvious that our efforts must be kept on a general level as there are local variations between clubhouses—even within clubhouses.

The Standards

Today, the Standards of clubhouses (ICCD, 2012) describe memberships and relations, space and function, activities and governance of a clubhouse in 36 items. It states that every person with a history of mental illness can be welcomed as a member of the clubhouse and that all members have access to all clubhouse opportunities. Staff and members are engaged in the daily work side-by-side, and there are neither staff only meetings nor member only meetings. Staff, who's salaries should be comparable to others working in the mental health field, are generalists that take part in the daily work, and are "sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement" (ICCD, 2012). It is obvious that Beard's Activity Group Therapy is still influencing the idea about daily work. There are also traces from his redefinition of self-help: members' power should be executed through their work and closeness to staff, not through "political" processes. Sometimes it is stated within clubhouses that they are not "member-governed," but "member-based," as clubhouses are dependent on the work of their members (Jackson, 2001; Karlsson, 2007).

According to the Standards, the clubhouse should be positioned in the community so that it is easy for members to go there (e.g., central, good communications), should be independent from the surrounding society, and should strive to provide not only daily activities but also affordable housing for their members (if needed). The idea of independence can be traced to the situation in the 1970s, when CHMC's created "fountain house"-activities within the same buildings, and in close connection with partial hospitalization.

Activities

The Standards state that the main activities at a clubhouse are: a) the work-ordered day; b) employment; and c) education. The first activity, the work-ordered day, is that which is done inside the clubhouse. In-house activities are work tasks to run the clubhouse and are organized through work units containing staff and members. Each unit has different tasks, and it is said that "Members have the opportunity to participate in all the work of the Clubhouse, including administration, research, enrollment and orientation, outreach, hiring, training and evaluation of staff, public relations, advocacy and evaluation of Clubhouse effectiveness" (ICCD, 2012). Usually each work unit has two meetings daily—one in the morning and one after lunch—where work tasks are divided between members and staff equally, and where absent friends are contacted (all participation is voluntary, but often some members are expected to show up during different days and times).

Usually a member attends a certain work unit (e.g., administration) for a longer period of time, and thereby has the opportunity to learn more advanced tasks. However, the Standards emphasize that all work "is designed to help

members regain self-worth, purpose and confidence; it is not intended to be job specific training” (ICCD, 2012).

The Standards highlight three different types of employment: a) Transitional Employment (TE); b) Supported Employment (SE); and c) Independent Employment (IE). TE is based on an employment position held by the clubhouse, shared by members for limited time periods (usually 6-9 months). The position should be equal to ”real work” and the member holding it works part time (often 15-20 hours per week), and is paid at least minimum wage from the employer. Since the clubhouse is responsible that the work tasks are carried out, the member holding the position is temporarily replaced if he/she is not able to do it. TE can be a good opportunity for a person with mental illness to try to hold a working position for a limited time, with solid support from a clubhouse (ICCD, 2012; Jackson, 2001, Karlsson, 2007; King, Lloyd, & Meehan, 2007).

The clubhouse version of SE and IE occurs when clubhouse members actually holds job positions themselves, but get support from the clubhouse when needed. Positions are not time limited, and the clubhouse does not provide absence coverage. For SE, but not for IE, the clubhouse offers on-site support for members. There are sometimes certain activities (e.g., dinners) for employed members and sometimes they act as role models for members that are not employed yet. Supported Employment at clubhouses should not be conflated with supported employment described by Bond (2004), and often exercised through the Individual and Placement Support (IPS) model, even if there are similarities between them. The IPS model is handled by vocational rehabilitation specialists put together in teams, whereas the clubhouses operate with support from generalist staff and members.

The final activity that is presented in the Standards is education. Members who want to study outside the clubhouse get support from the clubhouse, and sometimes members are also offered to study within the frames for the work-ordered day (ICCD, 2012; Jackson, 2001; McKay, Johnsen, & Stein, 2005).

At clubhouses, staff and members are doing these activities side-by-side. Staffs are not specialists, but should, according to the Standards, be generalists, share responsibilities together with members, and should be “sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement” (ICCD, 2012). The ultimate responsibility should, according to these Standards, be held by the Clubhouse Director.

These relations might be traced to the shift in understanding of self-help that came to be when Beard once handled the Fellowship situation (see above). By having staff and members working side-by-side, member influence is executed in the daily work instead of in certain meetings and procedures. By putting the final responsibility on the Clubhouse Director, however, struggles about power might be avoided. Jackson (2001) views clubhouses as “Collectivist-Democratic

Organizations” (p. 159), and claims, as many others, that many democratic characteristics are found in the Fountain House Model. However, Mowbray et al. (2006) says that “. . . for most part, governance activities, like making rules, hiring and firing staff, deciding on budget issues, allocating funds to meet members’ needs, and so on, are not allocated to members in many clubhouses” (p. 177).

SIMILARITIES AND DIFFERENCES FROM OTHER MENTAL HEALTH CARE ACTIVITIES

Clubhouses focus on work, and similar to IPS, they provide opportunities following the place-then-train-principle. In brief, this means that one does not qualify for work through a work training program, but that one is offered a job position first, and then trained at the actual work place. According to recent research on work rehabilitation for people with mental illness (Crowther, Marshall, Bond, & Huxley, 2001), this strategy appears to be more effective than the traditional train-then-place approach (pre-vocational training) when it comes to obtaining and retaining positions.

A big difference, of importance for this special issue, is that clubhouses offer peer support before, during, and after the member work effort, which is not generally the case in IPS and similar. There have been some comparative studies that relate TE/SE at clubhouses with IPS or similar (Macias et al., 2006), that appears to turn out slightly in favor of the latter, but since these two strategies seem to be the leading ones when it comes to getting people with mental illness back to work, more research needs to be done. It can also be claimed that comparing these different efforts are like comparing apples and oranges, since their aims are quite different.

Different from other (public) social and work rehabilitation efforts for people with mental illness, clubhouses offer a variety of services: peer support; in-house work training (the work ordered day can, in fact, serve as work training for a member even if that is not the main purpose); as well as several different place-then-train opportunities. And members do not qualify for different stages neither through medical/psychiatric status, nor through accomplishments in activities; according to the Standards, it is the member’s right to choose. Nevertheless, the welfare as well as the occupational context differs between countries, and in several localities job opportunities for people with a history of mental illness are hard to find (this is probably also true for IPS). Perhaps this is why clubhouses have turned toward education in recent years; many clubhouses are now developing different educational strategies parallel to TE and SE.

Finally, as mentioned earlier, one difference between clubhouse efforts and traditional psychiatric and psychosocial rehabilitation, is the peer support

opportunities offered at clubhouses. Henry et al. (2001) claim that the mutuality is a unique feature at clubhouses. Sharing similar experiences (having a history of mental illness and being outside the labor market) can generate mutual aid and strengthen, enlighten, and encourage individuals. At clubhouses, no self-help/mutual aid groups are arranged, but members are daily working side-by-side, and are given rich opportunities to interact. It can also be assumed that some members are acting as role models for others, and actually create an environment where mutual aid is created not only by sharing previous experiences, but also ongoing ones. In addition, there is potentially an anti-stigma effect since staff members are working side-by-side with members. Stories where members tell about their experiences and compare themselves to staff make them realize that the differences are not so big after all, that experiences are common.

In this special issue, clubhouses are viewed as hybrid mental health self-help organizations, meaning that they “have partnership models with staff committed to utilizing the self-help/mutual aid approach [...] and/or top level of governance of sympathetic professionals or business people devoted to utilizing the self-help mutual aid philosophy” (Borkman, 2013). FHNY had its origin in ideas about self-help/mutual aid, and John Beard, as he reformed the clubhouse, tried to reinterpret this idea, in order to be valid for all members. Today, the elements of self-help/mutual aid are everywhere evident within clubhouses, even if the words are seldom used.

International Network

Today, clubhouses around the world can be accredited through the ICCD. There is a certain accreditation process that, according to ICCD (2011c), is evaluative as well as consultative. The core idea of the process is that veteran members and staff from one clubhouse evaluate another clubhouse in collaboration with ICCD representatives. Accreditation can be given for 1, 2, or 3 years, and last year 152 clubhouses were accredited (ICCD, 2011c). As a way of international diffusion, ICCD also offers training for clubhouses at certain training bases in Australia, Canada, England, Finland, South Korea, and the United States.

According to the ICCD annual report 2011 (ICCD, 2011b), there are now clubhouses in North America (216), Europe (78), Asia (34), Australasia (10), Africa (2), and South America (1). The oldest existing clubhouse outside the United States is Fountain House in Stockholm (the first clubhouse in each country is entitled to call themselves Fountain House), established in 1980. In 2007, a coalition of European clubhouses, containing 13 partners (clubhouses/clubhouse coalitions), was founded in Stockholm and named European Partners for Clubhouse Development (EPCD). This activity, where the clubhouse model is adjusted to new countries and cultures, makes this international special issue even more exciting.

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