The Village, though widely admired, is often considered too expensive to be the standard of care everywhere. (Only New York State has enough money to do that if they ever chose to.) Successful efforts were made to apply the model wherever money was available to be diverted, for example with high-utilizers of services, institutionalized patients, jailed and homeless populations. The AB2034 programs spread this statewide presaging the MHSA's Full Service Partnerships. But all of these programs have highly restrictive admissions criteria and aren't available to most people. Even with our repeated expansions the Village always filled up and had a waiting list.

One of the main goals of the redesign in 2003 was to promote graduation and flow. Unfortunately, we rapidly became dissatisfied by the "lower level of services" available in our community. Not only were they in short supply and hard to access, they were far from recovery oriented. We realized we'd have to invent an inexpensive recovery oriented lower level of care, a "Village-lite" if recovery was going to be the basis for an entire transformed system design.

There were already a few Wellness Centers in California that we built on, but in typical MHA fashion we wanted our Wellness Center to be a living laboratory, a source of innovation, advocacy and replication. This paper was an internal document I wrote to our staff trying to help them focus on what I felt were the new issues to focus on.

Wellness Center Ideas

(2004)

The Village and other Integrated Service Agencies have proven our ability to engage with and transform the lives of many people with severe mental illnesses previously thought hopeless. It is a very intensive and costly process averaging about $15,000/year per person. When this cost is continued over many years, because these programs make an indefinite length, "no fail" commitment to the people we work with, the available resources become exhausted, the programs are filled, and the list of people needing help continues to grow.

Last year the Village began several experimental programs to try to deal with the "flow problem". Main Street was created to assist people to graduate from the Village to make room for more people. An entirely voluntary program, it focused on cultural change in the staff and members pursuing graduation, psychological growth to leave the Village, and community resource development to support community integration.

Considerable progress has been made but the availability of community psychiatrists and medications have emerged as a major obstacle. The vast majority of our graduating members need an ongoing supply of medications that they can access without sacrificing self-responsibility. Some graduating members at times also need accessible crisis assistance and collaboration without sacrificing their lives and freedom. Neither has been reliably available. A good deal of the problem is economic. Most of our graduates have only MediCal or are uninsured. The psychiatric services, public or private, available to

them are basically very brief, infrequent medication refill appointments, no psychiatrist availability between appointments and a reliance on the hospital as a safety net. Those members with MediCare, HMO's or insurance have generally favored better.

This low level of service doesn't meet the needs of most of our graduates and has handicapped the entire graduation process. Neither staff nor members feel comfortable graduating with such limited psychiatric support available outside the Village in the community.

MHA's present strategy is to attempt to create a financially viable Wellness Center to support graduating members indefinitely. The principle building blocks for the proposed Wellness Center are:

1) Consumer Run: Although the Wellness Center includes professionals, including a psychiatrist, it will be consumer run. It is hoped that the administration of the program with professionals working to support consumer goals will model the individual clinical interactions between the professions and the members. We would expect some situations both administratively and clinically in which professionals would have increased responsibility but the "default" setting for both levels is self-help and self-responsibility.

2) Network Support: The fundamental support relationship will not be a case-manager-client relationship. Instead support will be mutual, with both give and take, with members supporting each other. The primarily consumer staff will have expertise in developing WRAP plans, and identifying community based network and supports, not in taking care of people.

3) Safety Net: The program is intended to be its own safety net. While the Urgent Care Center, Emergency Rooms, Hospitals and even returning to the Village exist; the vast majority of crisis should be handled within the Wellness Center itself. Some staff will have the flexibility to temporarily take some responsibility for members in crisis rather then leaving them entirely to self-responsibility if they are occasionally too impaired to be self-directed. The emphasis in all crisis management will be on teaching skills to enable the next crisis to be self-directed.

4) Team Medication Services: In place of the normal system of rapid psychiatrist med refills without crisis accessibility, the Wellness Center will use a nurse practitioner-psychiatrist team to expand medication services. Both will do assessments together and "know" the members. The nurse practitioner will focus on routine refills, "Wellness Checks" and documentation. The psychiatrist will focus more on crises and transitions.

5) Getting Even Better: Patricia Deegan wrote "Some people with mental illnesses get well, and then they just keep getting even better." The primary action of the Wellness Center is not managing crises, providing ongoing medication and documentation, or achieving stability, although these are the most urgent reasons for its creation, it's most costly and heavily reimbursed functions, and its clearest social mandate. The primary action is ongoing growth and recovery for the members "getting even better."

This includes education, employment, wellness strategies, advocacy, self-help, community integration, family, romance and deeper psychological healing and spiritual growth.

The Wellness Center has had a tumultuous couple of years. Before it really had time to fully explore those issues and discover new ones it was adopted by LA County's DHM as it's new model; the solution to its budget problems and its overwhelming caseloads. They're in the process of replicating it widely even before it's really had a chance to mature. Meanwhile our Wellness Center wasn't sufficiently funded by DMH and had to cut back services while being touted as the new model.

I still think that the Wellness Center has a chance to evolve into something far more than "Village-lite." The issues I identified in this piece still need work. At some point I would like to see a chart that like the old "Traditional model vs. Recovery Model" charts would contrast "Village Model vs. Wellness Center Model." Hopefully they'll be given enough money and freedom to truly innovate and develop.