It's one thing to create a nice vision of recovery and ideas about how to apply it. It's something else to create a comprehensive, successful recovery based program. One of the earliest visitors to the Village, the mental health director in San Diego said that the Village served a unique purpose of making the vision concrete; something real that could be experienced and understood in a very hands on way.

Over the years we've hosted numerous visitors to the Village form all over the world. Some come for short visits, some for half day mini-immersions, and some for our popular three day full immersion trainings. All leave with a deeper understanding, a sense of "getting it" that's impossible for me to convey in my workshops and lectures or in this book, but I keep trying anyway.

An Overview of the Village

(2008)

The Village Integrated Service Agency in Long Beach, California has received a growing amount of attention and commendation as a model mental health program with a number of innovative approaches that may be valuable in effecting widespread system change. At the Village, we have had visitors from all over the state, country, and even the world. Our staff and members have been asked to give numerous presentations, trainings and consultations. This paper is designed to give an overview of the program to make it easier to understand what we are about so that others can find applications and relevance to their own service delivery systems. (We definitely do not see ourselves as a "cookie-cutter" program to be replicated everywhere, but rather as an inspiration to help others form their own visions).

History

Works of art created by people such as prisoners, mentally ill people, and graffiti artists who are outside of the art establishment are often referred to as "outsider art." In a similar way, the Village is "outsider mental health." It did not grow out of an internal urge for self-reform and innovation by the public mental health system, but rather out of the anger and frustration of families and consumers, too long seen as "outsiders." In 1987, a group of concerned parents, consumers, business people and a few professionals approached the Lieutenant Governor of California with their numerous complaints about the mental health system. Wisely, the Lieutenant Governor pointed out that no one was intentionally trying to design a poor mental health system. He offered to support them in forming a task force to study various systems and make recommendations for creating a better mental health system.

The task force diligently began its research. They were very impressed with the Program of Assertive Community Treatment (PACT) program in Wisconsin and various rehabilitation programs back east. Perhaps because of the business community's input, they felt their new system design should have capitated funding and a focus on quality of life outcomes. Two years later, after much study and 14 statewide community hearings, the task force's recommendations were incorporated into a bipartisan legislative bill, AB 3777, which was passed in 1989. AB 3777 provided funding for three years, directly

out of the state general funds, for three Integrated Service Agency (ISA) demonstration projects in three different settings -- countywide, urban and rural.

The contract to demonstrate the urban Integrated Service Agency model was awarded to the Mental Health Association in Los Angeles County (MHA/LA) in July 1989 after a highly competitive proposal process with about 20 agencies submitting proposals statewide. MHA/LA, known for its mental health advocacy and involvement in system reform, broke its usual policy against competing with other qualified service providers because of the major impact the ISA demonstration projects could have on statewide system change.

The three ISA projects, the urban in Long Beach, the countywide in Ventura county and the rural in Stanislaus County, were set up to demonstrate the best mental health services possible, not necessarily the most cost efficient. (Only the Village still remains as a model.) As much as possible, funding and administrative barriers were removed. As the contractor, the California Department of Mental Health provided impressive direction that was supportive and empowering. The capitated funding was simplified into a simulated single stream funding with few regulations and bureaucratic entanglements.

The Village ISA and the Stanislaus ISA were set up as closed systems with 120 members who were all admitted at the beginning of the project and who were replaced only through attrition. A matched set of 120 people who continued to receive existing, traditional services was compared to Village members for the first three years of the project by ICF Lewin, an independent evaluator. The members in both the experimental group and the comparison group were screened to ensure that they were disabled by a severe and persistent mental illness approximating the disability criteria used by SSI qualifications and that they represented a cross section of this target population in terms of ethnicity, age and gender.

For its annual operating budget, each ISA received capitated funding at an initial rate of $15,000 per member per year, with subsequent Cost Of Living Allowances (COLAs), to cover all mental health costs (not including housing or physical medical care). Interestingly, the decision to capitate the funding for the ISAs was not motivated by the managed care movement. It was made so that the members' needs would drive the level and type of services they received rather than the agency's need to collect funding by delivering a required number of units of service.

Funding for the Village ISA was extended several times by the state Legislature, and in 1996 special legislation was passed that made its funding a permanent part of Los Angeles County Department of Mental Health's (LAC/DMH) budget. Based on the Village's first years of success, the LAC/DMH has expanded the ISA approach throughout the county for its "high utilizers." The first expansion was the assignment of 12 new "high utilizing" members at the Village in 1993. Following our success, LAC/DMH used realignment to move monies that had previously been funding state hospital beds to fund 1500 "high utilizing" members assigned to 14 different PARTNERS programs started up by a variety of non-profit, for-profit and county-operated organization around the county.

The Village wanted to avoid the fate of many other model programs, appearing suddenly, demonstrating something wonderful, and then disappearing without a trace. To become incorporated as an ongoing

part of the mental health system we sacrificed some of the purity of the model and some of the intensity of our services.

Starting in 1997, we converted to a partially capitated program with multiple funding sources each with large paperwork and administrative burdens and each with biases against individualized, quality of life based services. Incorporating enough MediCal billing to pay for the majority of our services has been extremely expensive and time consuming and constantly exerts an eroding effect on our culture and values. Incorporating a Department of Vocational Rehabilitation (DR) contract and several HUD contracts (Shelter Plus, PATH, and Safe Haven) has added to our administrative burdens as well. (See Figure 1)

We doubled our size to 276 members to increase our economy of scale by increasing our caseloads and creating larger teams. We began admitting new members based entirely on county cost saving criteria rather than any humanistic needs and pioneered a two-tiered capitated system with 138 "moderate utilizers" at $4,950 per year and 138 "high utilizers" at $16,190 per year. Overall, we lowered our average cost per member to about $10,000.

Despite these burdens, some necessary and some unnecessary, we feel that we have preserved our core values and services and outcomes while proving that the ISA approach can be practical, using current resources and conditions.

Beginning in 1998, the California state legislature passed a series of bills (AB34, 1034, and 2034) expanding the integrated services approach to homeless and jail diversion populations as a step towards creating an entire integrated system of care. The Village took on an additional 150 homeless and jail diversion members as one of the first few programs statewide pioneering this effort. There were substantial new challenges in working with this population including increased forensic advocacy, substance abuse issues, more difficult benefit assistance and increased focus on housing as well as concerns about safety and community acceptance. However, we have found for the most part, that over time these members have blended in with our older members and with only modest adaptations we have been able to serve them with in the same culture and program design.

MHA/LA and the Village took the lead on training other AB34 programs around the state and collecting real time quality of life outcomes. The 1999-2003 statewide report that documented a 67% reduction in hospital days, a 67% reduction in homeless days, a 72% reduction in incarceration days and an increase from 5% to 19% in employment including a 20% increase in full time employment demonstrated the program's widespread success and saved it from budget cuts.

In 2000 the Village expanded our homeless and jail diversion services opening up a new Transitional Age Youth team fro 50 members between the age of18 and 25. A substantial number of these youths have already had extensive contact with mental health services and/or are aged out of the foster care and dependency court system. This group has been a major challenge for us and despite a number of innovative attempts to adapt the ISA model including creating a TAY group house, using a mentoring

model, substantial housing subsidies, school to career preparation, and creating a TAY Academy, we do not yet feel a sense of mastery.

In 2003 we underwent a major program redesign motivated by three factors. First, the LAC/DMH "decapitated" the contract. They were having difficulty monitoring the capitated features of the contract, especially responsibility for "unauthorized" hospitalizations. They were also responding to substantial budget cuts outside the AB34 program with cost shifting. Two unfortunate outcomes of this change were the loss of continuity of care with the hospital for our members and an elimination of the financial incentive/reward for avoiding hospitalizations for us.

Second, we had grown uncomfortably large. The repeated expansions put us at 476 ongoing members, plus the Homeless Assistance Program's daily census of 50 to 100 members. We had multiple interlocking teams, some case management teams and some specialty teams, and were increasingly creating procedures and internal bureaucracy to make decisions that had relied on personal relationships before. Metaphorically, the Village had become a city and we were struggling to maintain intimacy. We responded by creating several "neighborhood" teams that are about 125 members each, about the size the Village began that include both case management and some specialty services (like financial planning, employment, and community integration). We also created a "downtown" that is primarily specialty services that interact with the community (like housing development, job development, substance abuse support, and the career center including supportive education).

Third, our system had very little flow and, as a result, ongoing long waiting lists. We decided that developing successful approaches to the "flow problem" was likely to be essential to developing an integrated system of care, regardless of funding level, and took it upon ourselves to try several experiments. Nothing has been more difficult emotionally for both our members and staff than transitioning from services and relationships of indefinite duration to creating flow and graduation from the Village.

We created the Fast Track team to take 50 members right off the street or out of jail with very limited if any wait, intensively engage them providing full ISA services, but time limited to one year (with some flexibility). After one year some members are transitioned to the long term neighborhood teams, some to lower levels of service, and some leave the public mental health system entirely. The hand drawn sign on the wall "Remember Fast Track is time limited! So get a job, an apartment, and have a dream come true…before you hit the road" captures the sense of pressure to progress on both staff and members.

We created a Mainstreet program to work with both members and staff encouraging, persuading, and preparing long term members to leave the Village to use community resources and lower levels of care instead. Peer support, graduation ceremonies, and WRAP plans were emphasized. Unfortunately, our community resources were inadequate and there was nowhere welcoming for people to move on to. We responded in 2005 by creating the Wellness Center, a consumer run program that relies on peer support, self help and creating natural community supports and roles outside the mental health system as well as a Nurse Practitioner for ongoing medications and crisis response.

These programs, along with substantial internal culture change emphasizing recovery have created a modest flow of graduates and our waiting list is gone.

Over the years our Homeless Assistance Program has expanded substantially. In addition to operating a low demand, "no wrong door" drop in center with lockers, showers, clothes, laundry, mailboxes, and telephones, we have outreach workers who connect to people while they are still on the street, in jail, or in hospitals or other mental institutions. Our Outreach and Engagement team combined with our Fast Track and Safe Haven teams together provide a range effective welcoming, triage, "housing first," and intensive case management services to help a variety of "rejected" people begin their recoveries.

The Village has also emerged as a major training program. We have given dozens of presentations ranging from major professional conferences to local consultations. We have had hundreds of visitors to our program from at least 15 states and 20 foreign countries. Our multiple-day immersion training experience has been the most successful. We have had an ongoing exchange with Japan for a number of years that has led to substantial program development there. We have connections to several nearby major universities and have been an active clinical training site for nurses, social workers, and psychiatrists.

We have maintained close relationships with our two major constituency groups, consumers and their families. Our members have participated in consumer conferences and advocacy nationwide. In 1998 we hosted the annual nationwide consumers' Alternatives Conference of the National Empowerment Center. We have participated actively in AMI on multiple levels and an entire issue of the Journal of CAMI was devoted to us in 1993.

In 1998, the National Mental Health Association made us one of six models to be used by communities nationwide for planning mental health services in their Partners in Care program. Also in 1998, SAMSHA designated us as a model of exemplary practice eligible for federal funding for implementation in local communities. In 2003, after visiting the Village, the President's New Freedom Commission on Mental Health cited the AB34 program as a model of creating comprehensive state mental health plans to coordinate services.

Building on the AB34 success MHA/LA (now renamed the National Mental Health Association of Greater Los Angeles – NMHAoGLA) and the Village had a major role in multiple aspects of the creation, promotion, passage, and implementation of Proposition 63, the Mental Health Services Act, passed by the voters of California in 2004. We are devoting substantial resources to the transformation of our mental health system into the recovery based, consumer and family centered system visualized in the President's Commission report.

Program Design

While many of the elements of the Village program were specified in the original legislation and included in the original proposed work plan, Village staff and members have always been encouraged to

experiment with new ideas and methods. Considerable resources were spent on staff training, and the Village has become a "living laboratory" which is able to test new practices leading to positive outcomes. Now, nine years later, we have built a solid foundation based on our clear consensus about principles, values and practices and we continue to try to improve our quality by exploring new ideas and innovations.

The three basic elements of the Village's initial program design were (1) collaborative case management teams, (2) psychosocial rehabilitation and (3) capitated funding.

(1) Collaborative Case Management Teams.

Our primary focus is to create a collaborative relationship between members and staff that encourages members to choose, pursue, and achieve quality of life goals (which may differ substantially from the staff's goals) in the areas of finances, housing, employment, social, education, legal, substance abuse and medical care.

The original three 40 member teams have been through a number of reincarnations while retaining much of their original spirit. We presently have three large collaborative case management "neighborhood" teams, the TAY team, and the Fast Track team. The teams each have a director, some specialists, like the psychiatrist, money manager/payee, and employment counselor, and a group of personal service coordinators (PSCs) who may be professionals or paraprofessionals and includes substantial numbers of consumer staff. (See Figure 2) We do not use the term case manager because people are not cases and do not want to be managed. Although a given PSC has lead responsibility for 15 to 20 members, the entire team works with everyone in a collaborative, non-hierarchical style. The team is predominantly community based; the staff spends 60 percent of their time outside of the Village building.

Team staff members, regardless of professional background, are expected to collaborate with members in forming their Recovery Plans which outline their action plan to achieve their chosen quality of life goals. Unlike the traditional clinic atmosphere where professionals create a treatment plan for their clients which often revolves around office-bound therapy sessions, the Village staff accompany and support members as they live their lives in the community. This philosophical shift has been difficult at times for staff trained in clinical expertise. Examples include the social worker who wondered why he had worked so hard to get his degree as he stood patiently with a member who couldn't decide whether to buy apples or oranges at the market, or the nurse who grew frustrated waiting in line at the Social Security Administration where she was treated as badly as the member she was accompanying.

Over time, all of the staff have become very comfortable doing what is needed, whatever that is. We value the combination of professional and non-professional staff and our flexibility to hire team members with a wide variety of life skills and experiences. We feel our teams successfully and collaboratively combine the "clear eye" and common sense of the non-professionals with the education and expertise of the professionals. We have created teams that are both multidisciplinary, with a

wealth of professional expertise, and multiexperiential, able to create healing relationships with a wide range of members.

As a psychiatrist I am not the team leader for administrative or hierarchical functions. As physicians, we take lead responsibility on the team for members' medical conditions, psychiatric medications and hospitalizations. We are fully integrated team members that participate in team meetings and planning around a member's quality of life goals. We strive toward the same collaborative relationship with our members even when it comes to their medication choices. Since the loss of capitation we are rarely actually the treating physician in the hospitals any more. PSCs regularly see their members in the hospital, as do we at times, trying to use the hospital in a focused way to support community based life. We want the hospital to be one element of a member's life and services, instead of being the center of it. Whenever possible, the team creates community based alternatives to hospitalizations tailored to each individual's immediate needs.

The Village operates a 24-hour, seven days a week emergency beeper system and acts as our own after-hours emergency outreach team when needed. We also regularly coordinate with the Long Beach police's Mental Evaluation Team (MET).

Staff remains in contact with their members to provide continuity of care, supporting them when they are experiencing relapses and when they are taking risky steps forward toward their quality of life goals.

(2) Psychosocial rehabilitation.

The collaborative case management teams are integrated into a comprehensive psychosocial rehabilitation program, and they have incorporated psychosocial rehabilitation principles and values into all their work. The emphasis is on creating a high risk/high support environment that promotes hope and the recovery process. This is achieved by establishing collaborative, adult-to-adult interactions between members and staff, by providing supportive services in whatever setting the member chooses, by encouraging members to try new things and by helping members gain empowerment by not being afraid to fail. For example, our experience has shown that a member who has failed two, three or four times at employment can make it on his fifth, sixth or seventh try. We strongly emphasize strengths and abilities and de-emphasize illness and disabilities.

Psychosocial rehabilitation has gradually transitioned into recovery. Our entire program is a recovery based culture. (See Figure 3) In addition, the PSCs are practically supported by a variety of rehabilitation specialists.

Our housing department is consumer run and works hard to create and maintain relationships with quite a number of affordable housing landlords in our community. They match members with landlords and housing options, create individualized support plans alongside the PSCs, and offer on-call response to landlords to reduce crisis and evictions. They also handle the administration of several HUD programs including Shelter Plus to help members obtain and maintain housing subsidies.

There are community integration/outreach specialists who work with members to create a "menu" of social activities that range from workouts at the YMCA to movies at the mall, from watching professional hockey to playing volleyball, from poetry readings at a local coffee house to reggae dancing at a night club. (See figure 9.) The emphasis is on learning by doing rather than classroom-style skills training, on community integration rather than internal structured programming. Members also play a key role as paid “life coaches” reaching out to other more isolated members to encourage them to come along on an activity or offering special support to them during a time of crisis.

There is a full-time substance abuse/recovery specialist who supports members and their PSCs as they work on recovery using a four stage (engagement, persuasion, active treatment and relapse prevention) model incorporating harm reduction and motivational interviewing techniques. He liaisons with Dual Recovery Anonymous meetings at several different locations in the community. He also works to increase access for Village members in community substance abuse treatment programs which have not routinely accepted people with mental illness into their programs. In 2005, we opened Thunder Road, our own 12 bed dual-diagnosis residential treatment program.

Employment is a cornerstone of the Village and its psychosocial rehabilitation orientation. All members are encouraged to work and are supported on the job by their PSC as well as by the Village employment staff. The Village has job developers who help members create opportunities for competitive jobs in the community. The job developers work with our three work site supervisors and our supported education Career Center, including collocated support services at Long Beach City College, to create a full “menu” of job opportunities and supported work and learning experiences open to all members.

The Village runs a cafe/deli, mini mart, maintenance unit, and clerical unit that are staffed by members. Each member holding a job in one of the Village businesses maintains daily, regular work hours. These jobs are limited to nine months, are paid at least minimum wage, and are intended as preparation for competitive community employment. As with the social program, the entire employment menu is available to all members by their choice without having to complete any prerequisite steps or prescribed "gradual" path.

The Village’s financial planning/payee system helps members manage their Social Security benefits so that they have food, clothing and shelter. This three-phase system doesn’t just manage funds for the members but teaches members to manage their own funds, creating budgets, gradually increasing members’ financial responsibilities, and opening up bank accounts in the community with them. There are also classes available to teach specific skills as members work to become their own payee. Money management operates in coordination with the Village bank which handles the cash. These financial services have been crucial in helping members end their homelessness and avoid some of the worst complications of their substance abuse as well as build more complete lives for themselves in the community.

One of the most important features of our psychosocial rehabilitation/recovery culture is the widespread inclusion of consumers in almost all aspects of the Village. Consumer representatives attend Village management meetings and serve on the Village advisory board which is made up of one-

fourth consumers, one-fourth family members, one-fourth mental health professionals and one-fourth community members. Members also serve on the Village's grievance and total quality management committees.

Members work side by side with Village staff not only on their own recovery goals, but also to improve the Village as a recovery community and to help their peers in a variety of both paid and unpaid roles. There is a respite care and life coach system where members and other people in the community are given special training and then hired by the case management teams to provide additional help.

Members are allowed free access throughout the building. We eat together, work together, socialize together, and use the same restrooms. Safety is maintained by a community watch system and paraprofessional security, rather than by segregating off members and watching over them with armed, uniformed guards. Boundaries between staff and members are intentionally and massively blurred.

Several members and a number of program graduates and other consumers are employed as full time Village staff in fully integrated jobs, in the Wellness Center as peer supporters, and with Project Return: The Next Step, a countywide consumer-run self-help program. Project Return maintains its own entirely member run center, clubs, and activities available to Village members.

Cultural relevance has been approached, not by establishing special programs, but by hiring a culturally diverse staff and using community resources to meet each individual's unique needs.

(3) Capitated Funding

The Village ISA was initially funded on a case rate basis to create quality of life outcomes, not to create units of service. Unfortunately, this funding scheme has only really survived in our memories and our culture. At present, our services must include sufficient "billable services" to maximize our MediCal match under the rehabilitation option. We've tried to avoid distorting our program and we continue to choose to allocate funds very differently than standard, more traditional systems of care. We spend our funding on creating social and employment opportunities for members, smaller case management case loads, increased psychiatrist availability, substance abuse treatment and money management/payee services rather than on hospitalization, other institutional care, structured day treatment, partial hospitalization, or psychotherapy.

The decision-making for these "managed care" decisions has been decentralized from fiscal administration to the service team level. Each team has its own budget with which to purchase outside services or meet member's practical needs. Both financial and clinical decisions are made by the team who is familiar with the needs of the members it serves. We call this system "designed care" where services are designed around actual needs and projected benefit in contrast to "regulated care" where services are administratively authorized based on pre-set regulations. Our teams have acted in a very cost conscious and fiscally responsible manner while actively including members in the decision-making process.

Since we were "decapitated" we have lost a lot of our ability to purchase and coordinate outside services including hospitalization, but we have retained the team budgets and a substantial legacy of "designed care." (See Figure 4)

Accomplishments:

(1) Integrating and sustaining care. A substantial number of the original Village members are still connected to the Village. We have an ongoing dropout rate of only about 5% per year. The teams rarely lose or forcibly discharge members. The attrition has been largely by member choice, primarily because the member left the Long Beach area, although it is at times due to prolonged imprisonment or death.

The Village offers a clear, single point of responsibility for everyone it serves. There is 24-hour a day coverage, seven days a week. The universal application of the psychosocial rehabilitation/recovery philosophy promotes integration of the various program elements included in our "designed care" approach. Fragmentation of care, so frequently the result of a "spectrum of services" model, has been virtually eliminated.

(2) Focusing on quality of life outcome accountability. The Village has consistently allocated resources and provided services to attain quality of life goals. All of its "clinical" services are driven by quality of life outcomes and its overriding goal is community integration rather than treatment of illness.

From the very beginning, the independent evaluator, who compared the quality of life outcomes of our members with those in the control group over the first three years, was most impressed with our employment result. Those results were comparable to the best results in the literature, especially for a randomly selected group. Results in virtually all other quality of life areas were also positive, but difficult to demonstrate statistically. (See Figure 5 for the highlights of the Lewin three-year evaluation.) Our success across the whole range of quality of life areas is unmatched in the literature.

The Village has continued to work on improving our outcome measurement system. Although flawed, we now have an unparalleled longitudinal data set with costs, services and outcomes. In 1997 we began facilitating and participating in a multi-center outcome "report card" with the Los Angeles Partners Programs. (A sample report card is in Figure 6.) Since 1999 we have collected the quality of life outcome data for the entire statewide AB34 program. We are presently field testing, validating, and widely promoting our "Milestones of Recovery," a recovery based outcome measurement tool. (See Figure 7)

(3) Creating a comprehensive mental health program entirely within the psychosocial rehabilitation/recovery model. We have been able to create a true "one stop shop" by offering all services within our recovery based culture. We have successfully integrated effective services of all kinds. We have maintained a high level of ethics, safety, staff and member satisfaction by sticking to our empowerment, reduced boundaries, high acceptance and respect, inclusive values.

(4) Decentralizing financial responsibility and decision-making. For over a decade our case management teams, rather than fiscal administration, made the decisions about hospitalization and other outside

purchased services. Each team had a budget and carefully tracked its expenses. By decentralizing financial decision-making to the team level where treatment decisions are made, the Village gave financial responsibility to the staff who know the members and their needs the best.

Even now, our "designed care" approach places the emphasis for expenditures on creative ways to help the members meet their individual needs rather than on constructing programs.

(5) Budgeting that reflects values and goals. Psychosocial rehabilitation and community integration are at the center of the Village's philosophy and its integrated services. The Village budget reflects these values and goals by allocating more resources to employment and community support activities and less to clinical treatment and hospital services. (See Figure 8 for the funding breakdown in the first few years when all expenses were tracked and capitated. Current data is not available for comparison.)

Even since the introduction of MediCal, with its medical emphasis, we have managed to maintain our recovery focus. Rehabilitation and recovery activities do not have to wait and see what money is left over for their funding.

(6) Collaborating with "treatment resistant" members. Everyone at the Village tries to find ways to be helpful to members regardless of the choices they make. There are no requirements, like participating in particular programs, complying with medication recommendations, or abstaining from drugs and alcohol. There is no "readiness" requirement members have to meet before they can receive any services. As staff, we try to see the world from each member's point of view while emphasizing social realities. The services are member driven, starting wherever a member is at any given time. Because we've agreed to work on the members' goals and to promote their visions of recovery, the vast majority of power struggles (along with the resulting violence and suicidal behavior) have been eliminated.

Over the years we have successfully worked with target groups of difficult members – high utilizers, homeless and jail diversion, transitional age youth, institutionalized people. At this point we believe our recovery based integrated services model can be used effectively with all types of people.

(7) Reducing dependence on hospitalization. Our targeted usage of hospital care was one of the most significant improvements we made according to the independent evaluator. Overall, we spent 7 percent of the budget on hospitals and on other 24-hour institutional care as compared to a Los Angeles County Department of Mental Health baseline of 42 percent. The Village's average length of stay in the hospital was about 7 days. This has been a program accomplishment that became possible when hospital funds were given to the teams to spend as they chose if they could avoid hospitalizations that has deteriorated since the financial tools were removed.

Reducing dependence on hospitalizations was also an emotional accomplishment for members, staff, families and our community. After recognizing the cost of relying on hospitals as a safety net for responsibility and caretaking, we chose to increase our own respective responsibilities and caretaking and grew in self-confidence and reliance as a result.

(8) Integrating substance abuse treatment. The level of substance abuse by members continues to be very difficult to measure, and it is the variable most associated with all other negative outcomes and high cost. However, we have been able to integrate substance abuse treatment into all aspects of our program. Our staff is technically and emotionally comfortable with our approach. A large number of our serious abusers are in recovery, and the vast majority are slowly progressing in that direction. Many of the worst complications of substance abuse have been substantially reduced and individuals' quality of life has improved. We found that we have been able to give increased services to people when they have increased problems even if substance abuse is contributing to their problems.

(9) Creating some flow and graduation. We have struggled to adapt our long held values of "no fail" - relationships of indefinite duration, accepting people wherever they are at, avoiding time limited services – to encourage members to move on, whether it be to do more for yourself, or to create a life in the community with friendships, natural supports, and fun, or to leave the Village "nest" like a bird learning to fly and graduate.

We have about 50 graduates from both our long term teams and Fast Track over the past few years, many of whom are now at the Wellness Center. This flow has opened up the Village to new members and eliminated the waiting list. We don't have to ration our openings nearly as strictly any more.

Discussion:

As we transitioned from protected model program environmental to "real world" conditions there have been serious administrative and clinical challenges. Our program now includes large proportions of difficult subgroups of people including long term state hospitalized, homeless, repeatedly incarcerated, disengaged, and conserved people. Nonetheless, we have averaged a 95 percent community tenure among our members.

We have successfully addressed many of the concerns associated with our initial visions that (1) an entire mental health system can be constructed on a rehabilitation/recovery framework, and (2) staff can make individualized, fiscally responsible, resource allocation decisions for their members without outside regulation.

Staff does need to make substantial emotional and self-identity changes to be effective rehabilitation/recovery workers. We accomplished this originally as a 1 - 2 year long experiential, group process. In contrast, now new staff are immersed in the program, inculcated with the model, and emotionally supported with the inevitable issues of boundaries, risk, power, caretaking, lack of order, and emotional intensity. The vast majority thrive within 3 – 6 months. We have numerous converts among our social work, nursing and psychiatrist trainees as well.

Employment continues to be a strong focus of the Village's culture. Because of the strong financial disincentives in both SSI and Section 8 subsidies (together taking $5.00 out of every $6.00 a member makes) we have had to promote work almost entirely for its recovery, self-identity, and "role in life" benefits rather than for its financial benefits. Although many of our members are relatively new, already about 10 percent of members have successfully completed our ten-month work-training

program and another 10 percent have held a competitive job for over three months. We have had difficulty in Long Beach's depressed business climate getting substantial employer support for "identified mentally ill" jobs and have been forced to use almost entirely a supported, fully competitive approach. This does have the positive aspect of keeping expectation high, but makes for long, frustrating job searches. Overall, for a group traditionally considered permanently disabled and not appropriate for employment services our members are making steady strides towards reintegration into the job market.

We continue to have members at a range of social integration outcomes (see Figure 9). For the members who spend a great deal of time at the Village, we view ourselves as providing a sense of belonging in a community ("It's like Cheers, you come in and everyone knows your name.") and meaningful roles. We do not view ourselves as providing asylum or protection from the "natural consequences" of members' actions. The process of moving out centers around our members finding welcoming, meaningful niches in the larger community. We often remain in the role of an "occasional community" for members to return to for holidays or special occasions or just to visit in an analogous way to visiting our families after we have our own homes. This model accommodates those members who need some ongoing service or connection but want to "exit" the limitations of the mental health system.

We try not to provide anything at the Village that our members can find in the community. The obverse is also true: We must provide services and a welcoming community when Long Beach doesn't. We built our internal community out of the same elements a normal community is built – work and social relationships, government, budgets, celebrations, rituals, and shared experiences – not out of "therapeutic" elements like day treatment or therapy groups. We're building a community for people, not for patients.

The outside community is not a fixed environment either. Sometimes we work to help our members live more successfully in our community and sometimes we work to help our community to be a better place for our members to live in. We've partnered with our local YMCA and a community art workshop. We sponsor block parties, health fairs, and cleanup efforts. We help build and manage housing. We catalyzed the formation of dual diagnosis anonymous groups and helped train the police's Mental Evaluation Team. Our Village community is an active part of Long Beach's community, not an asylum apart from it. We are facing new challenges as our local community is rapidly gentrifying and our members are not part of the city's vision for a more financially prosperous future.

Despite numerous fears and warnings, our own included, we have not seen negative effects from too much hope, empowerment or expectations. "Failures" have not lead to demoralization or giving up as much as leading to alterations in support, or better yet, changes in self-destructive patterns, like substance abuse or not taking helpful medications, in order to achieve more the next time. As with "normal" people, goals often change, but the believing in yourself that hope brings lasts. Our members continue to achieve things we "know are impossible," including moving on without us, which keeps us vigilant to make sure we're not artificially limiting them.

We have found that our experiences resonate strongly with those in the recovery movement. Many of our members are actively engaged in a developmental recovery process from the serious losses and trauma of their mental illnesses. We have developed a four stage model of recovery (analogous to grief stages) including hope, empowerment, self-responsibility, and having meaningful roles in life. Supporting the risk taking essential to recovery can bring up serious emotional issues especially with family members (who have often been traumatized), but fortunately not with our administration (who we've yet to seriously traumatize or bankrupt). Recovery is a courageous process.

Since the passage of Proposition 63, the Mental health Services Act, our involvement in system change efforts, have accelerated dramatically within LAC/DMH and throughout the entire state of California. We have contributed substantially in a number of areas including outcomes and quality assurance, recovery oriented program and system design, leadership and personal transformation, personnel policies, charting, and culture transformation.

We have continued to innovatively expand "the best we can do" including improved services for dual diagnosis treatment, housing, employment, health care, education, transitional age youth, flow and graduation. We look forward to new challenges as they emerge.

Conclusion:

The Village has become a popular model for system change. The initial advantages of adequate funding and few bureaucratic regulations allowed us to create a "clean" program built upon our values and the members' needs without being distracted by destructive irrelevancies. Also, by being able to create a new program from scratch, we did not have any old patterns to undo. The positive outcomes achieved by members and staff have strengthened our vision and commitment. We have adapted to changes in funding, membership, and in our neighborhood. We continue to pursue new challenges and create innovative approaches. We hope our work at the Village will be useful for others.

Figure 1

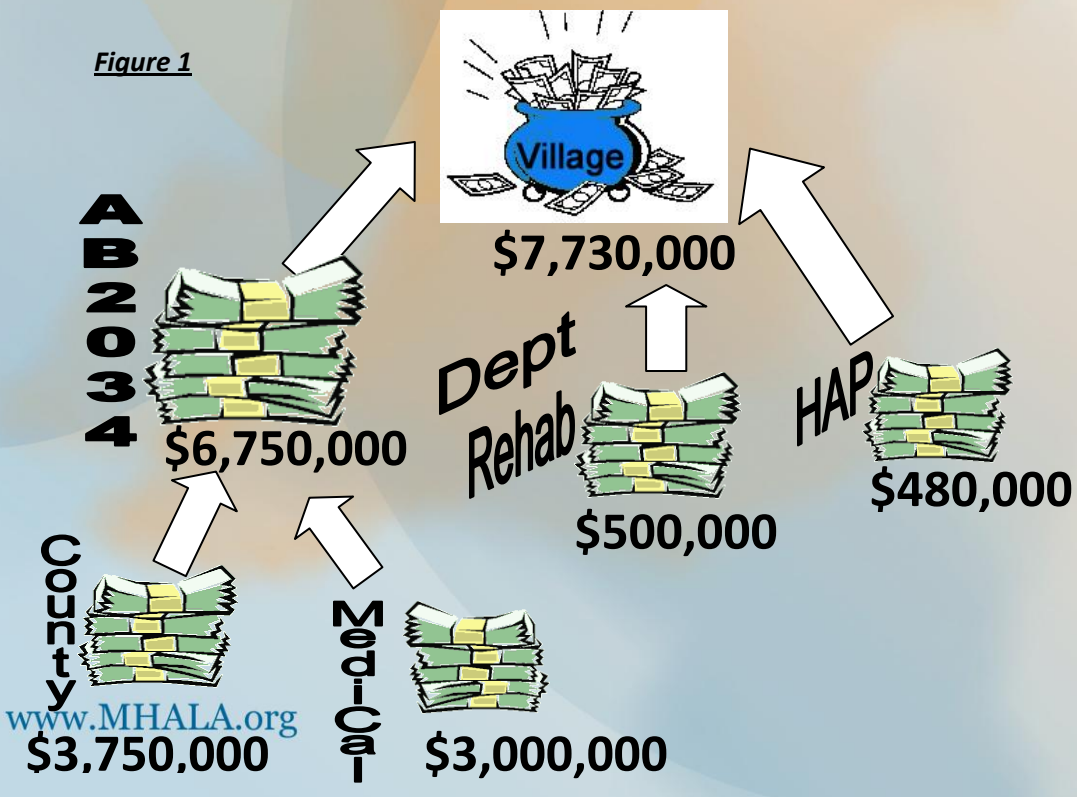


Figure 2

Village Program Structure - 2005

- **Approximately 475-500 members**
- **Homeless Assistance Program**
  -50 temporary case management slots
  -No limit to number of people served through HAP
- **4 Service Coordination Teams**
  -3 Neighborhoods of 125-140 members each
  -1 Transitional Age Youth (TAY) team of 50 members
- **Employment Department** (serves all members)
- **Housing Department** (serves all members)
- **Medical Administrator** (serves all members)

Service Coordination Teams	Employment Department
1 Director	1 Employment Coordinator
1 Assistant Director	4 Work Site Supervisors
1 Psychiatrist	3 Job Developers
1 Financial Planner	1 Day Labor Job Developer
1 Community Integration Specialist	1 Administrative Assistant for Day Labor
1 Employment Specialist	3 Neighborhood Employment Specialists
9 Personal Service Coordinators • 1 RN or LPT • Licensed & Unlicensed	

Figure 3

COMPARISON OF TWO MODELS SERVING ADULTS WITH PSYCHIATRIC DISABILITIES

	Traditional / Medical Model		Psychosocial Rehabilitation/Recovery Model
1.	Disabilities define treatment	1.	Abilities define services
2.	Low expectations	2.	High expectations
3.	Institutional settings	3.	Natural settings
4.	Focus on intrapsychic functioning	4.	Focus on functional behavior
5.	Help to minimize stress	5.	Help to take risks
6.	Medicate until symptoms are controlled	6.	Medicate minimally - Symptoms okay
7.	Practitioner makes decisions / Prescribes treatment	7.	Member and staff collaborate to identify strengths and develop actions
8.	Dependence and caretaker approach	8.	Self-help, interdependence, support systems approach

9. Expert to patient	9. Adult to adult
10. Illness / symptom focus	10. Wellness / health focus

Figure 4

COMPARISON OF MANAGED CARE MODELS

Standard	***Village***
Mental health benefits integrated into medical care	Mental health benefits " carved out" from medical plan
Broad pool of potential consumers	Defined target group of seriously mentally ill
Gatekeeping to mental health service from generalist M.D.	Gatekeeping by DMH approval, often self-referred
Services primarily given to broad population, very little serious M.I.	Services only for SMI, perhaps restricted to target populations like "high users," homeless, jail diversion or aging out foster care
Medical model focus on symptom relief and treating illness	PSR model focus on helping people recover and integrate into community
Menu of services predetermined- mostly traditional MH services	Menu of services extremely flexible based on an individual's needs
Services usually time-limited	Services though growth oriented, usually of indefinite duration
Providers are a combination of program staff and contracted services- may be badly fragmented	Providers almost exclusively program staff – strongly integrated
Case managers have relationships to providers, act to restrict and regulate service delivery and increase "red tape" "red tape"	Case managers have highly personal relationships with consumers, act to access and regulate service delivery and decrease
Clinical and financial needs negotiated between case manager and consumer Attempt to provide array or spectrum of services delivered according to predetermined set of regulations centered around "medical necessity "- -	Clinical and financial needs negotiated between case manager and consumer Attempt to provide integrated, comprehensive services delivered based

"regulated care"	on ongoing assessment of client needs/wants - - "designed care"
Accountability for providing services authorized	Accountability for consumer quality of life outcomes
Clinical staff must obtain approval and authorization for service decisions	Clinical staff empowered to make service decisions and accept responsibility for consequences
Consumers and families use grievance process and appeal to impact program decisions	Consumers and families directly involved in program development

Figure 5

INDEPENDENT EVALUATOR'S FINDINGS:

MAJOR HIGHLIGHTS (1990-1994)

- Village members had significantly fewer hospital days than the comparison members. Village members also had significantly lower costs for inpatient care.

- At the Village, 72.6% of members tried paid employment over a three-year period, compared to 14.6% of the comparison group.

- The percentage of Village members living in group and institutional settings declined from 15.8% at baseline to 10.8% after three years. Among the comparison members, the percentage remained fairly constant from 23.7% at baseline to 23.2% after 3 years.

- Village members reported more solitary leisure activities and more activities with others during the week before the interview than did comparison members. Village members reported significantly more support at each of the three annual interviews.

- Families of Village members reported significantly less burden and less stress from burden than did family members of the comparison group. Families of Village members also were much more positive about the member's hopes for the future than families of the comparison group.

- Members at the Village were significantly more satisfied with mental health services than members in the comparison group.

In Chandler, D., Meisel, J., Hu, T., McGowen, M., & Madison, K. Client Outcomes in a Three-Year Controlled Study of an Integrated Service Agency Model. *Psychiatric Services*, December, 1996, **47**, No. 12, pp. 1337-1343.

Figure 6

MHA Village Report Card

Report Period: 12/1/05 - 12/31/05

	Team West		VILLAGE TOTAL	
FULL ENROLLMENT/CNT	**114**		**477**	
ACTUAL ENROLLMENT	**114**	**100.0**	**477**	**100.0**
Male	66	57.9	252	52.8
Female	48	42.1	225	47.2
ETHNICITY	**114**	**100.0**	**477**	**100.0**
Caucasian	57	50.0	234	49.1
African American	36	31.6	166	34.8
Hispanic	11	9.6	47	9.9
Native American	3	2.6	6	1.3
Asian/Pacific Islander	2	1.8	7	1.5
Other	5	4.4	17	3.6
ACUTE HOSPITALIZATION	**7**	**6.1**	**18**	**3.8**
Number of New Episodes	10	***	20	***
Number of Days	87	***	216	***
LIVING ARRANGEMENTS	**114**	**100.0**	**477**	**100.0**
Homeless/Emer. Shelter	5	4.4	38	8.0
Prison/Jail	3	2.6	11	2.3
State Hospital	1	0.9	2	0.4
Number of Members	1	0.9	2	0.4

Number of Days	31	***	62	***
IMD	3	2.6	7	1.5
Less Than 6 Months	0	0.0	3	0.6
More Than 6 Months	3	2.6	4	0.8
In Residential Program	0	0.0	5	1.0
In Drug && Alcohol Facility	6	5.3	28	5.9
SNF	1	0.9	3	0.6
In Board and Care Facility	18	15.8	52	10.9
Living With Family	11	9.6	34	7.1
Living Independently	64	56.1	291	61.0
Other	2	1.8	6	1.3
IN SCHOOL	**7**	**6.1**	**45**	**9.4**
Trade School	6	5.3	15	3.1
High School/GED	1	0.9	2	0.4
College	0	0.0	28	5.9
WORK EXPERIENCE	**8**	**7.0**	**80**	**16.8**
Working In Communtiy	6	5.3	52	10.9
< 20 hours per week	1	0.9	16	3.4
>= 20 hours per week	5	4.4	36	7.5
Working In Agency	2	1.8	28	5.9
Paid	2	1.8	28	5.9
Volunteer	0	0.0	0	0.0
ON CONSERVATORSHIP	**11**	**9.6**	**29**	**6.1**
ON PROBATION	**10**	**8.8**	**24**	**5.0**
ON PAROLE	**1**	**0.9**	**8**	**1.7**

INCARCERATED (JAIL DAYS)	**6 (127)**	**5.3**	**24 (543)**	**5.0**
WITH SUBSTANCE ISSUE	**36 (110)**	**32.7**	**141 (450)**	**31.3**
AVERAGE ASII SCORE	**3.9**	**25.9**	**4.5**	**29.8**
MONTHLY INCOME	**114**	**100.0**	**477**	**100.0**
Less than $500	17	14.9	96	20.1
Between $500 && $1000	85	74.6	315	66.0
More than $1000	12	10.5	66	13.8

Figure 7

MILESTONES OF RECOVERY SCALE

1. "Extreme risk" – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.

2. "High risk/not engaged"- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. "High risk/engaged" – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.

4. "Poorly coping/not engaged" – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

5. "Poorly coping/engaged" – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.

6. "Coping/rehabilitating" – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing "non-disabled" roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be "testing the employment or education waters," but this group also includes individuals who have "retired." That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.

7. "Early Recovery" – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.

8. "Advanced Recovery" – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbors.

Figure 8

SERVICE EXPENDITURE PATTERNS:

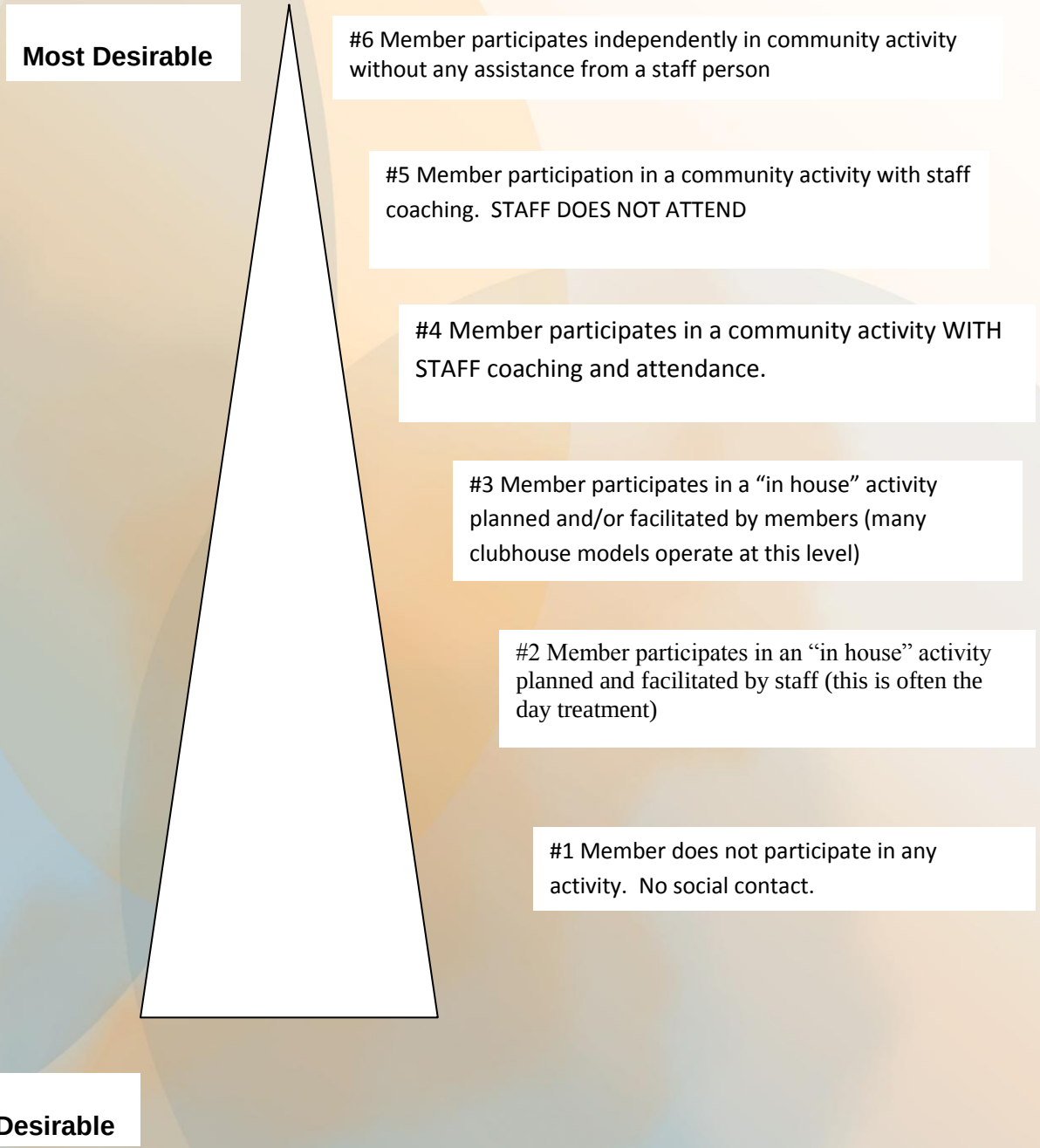
VILLAGE vs. COMPARISON GROUP (1990-1994)

	Village	Comparison
Type of Service	**Percent of Total**	Percent of Total
Case Management	40.6	10.1
Day Treatment	0.2	1.0
Medications	11.2	10.2
Residential	0.3	2.1
Socialization	11.6	1.2
Outpatient Therapy	4.7	23.2
Vocational	25.1	1.3
Acute Hospital	5.1	27.9
Long Term Care	1.3	23.1

- The three largest areas of expenditure for the Village members were in case management, employment services and socialization services. The three greatest areas of expenditure for the control group were acute hospitalization, outpatient therapy, and long-term care.

In Lewin-VHI, Inc., with Meisel, J., & Chandler, D. The Integrated Service Agency Model: A Summary Report to the California Department of Mental Health, June, 1995

Figure 9


Most Desirable
#6 Member participates independently in community activity without any assistance from a staff person
#5 Member participation in a community activity with staff coaching. STAFF DOES NOT ATTEND
#4 Member participates in a community activity WITH STAFF coaching and attendance.
#3 Member participates in a "in house" activity planned and/or facilitated by members (many clubhouse models operate at this level)
#2 Member participates in an "in house" activity planned and facilitated by staff (this is often the day treatment)
#1 Member does not participate in any activity. No social contact.
Least Desirable

The Village has become a very special place over the years, a second home for me and many other people. Though many people have come and gone and many changes have taken place, the senior leadership and the culture have remained fundamentally intact. We're very proud of, and still somewhat shocked by, what we've accomplished. It's been a magical ride.

For those of you seeking to "replicate the Village," three things should've been clear from this overview:

First, the Village has a totally unique birth, parentage, and upbringing that can never be replicated. Although you can potentially learn a great deal from our example, we're not an example of the process of how to create a new program or transform an old one.

Second, the Village is constantly evolving. As we like to put it we're in "perpetual white water." Even if you tried to replicate the Village the way it is now, by the time you finished, we would've changed. The Village is a moving target.

Third, MHA/LA, the Village's parent agency is far more than a provider of mental health services. We are part of a national organization whose mission is to "ensure that all people with mental illness assume their full and rightful place in the community." We approach that by advocating for quality care and the protection of rights for people with mental illness and for children with emotional problems, innovating by designing and demonstrating service and housing models for people with mental illness, replicating effective models through our training and consultation, and educating about mental illness to increase public awareness, improve access to care and end discrimination. The choices we make and the Village's overall culture is profoundly affected by MHA's larger mission. We are not just a mental health program. We're also an army of advocates, a living laboratory creating innovation, and an active training center. You probably won't be trying to replicate all that.

On the other hand, we are real people, not legends. We have our foibles and missteps. We've learned a lot of things the hard way. The rest of this chapter may give you some idea how we built the Village.