The Village attained a national reputation and efforts were made to spread the Village by SAMHSA and NMHA, but we struggled. Our view that, “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” made defining replication difficult. It became tempting to try to clearly define our practices to insure “fidelity to our model” in other programs. This paper is an internal paper urging us to do just that to compete with clubhouses and ACT programs that had recently been “manualized” to promote replication.

We didn’t act on my recommendations partly because they seemed so contrary to our values and partly because none of us wanted to sit down and write a manual of the Village. The list of practices in this paper, however, has had an ongoing life reincarnated as David Pilon’s “Dirty Dozen” that we include in our immersion trainings.

Spreading the Village

(1999)

Some programs are born to model and some grow into it. The Village was clearly born into it. The various “Fathers of the AB3777 bill” visualized a whole series of integrated service agencies (ISA’s) that would, by example, transform California’s mental health system. Alas, since we are the only program to survive intact we’ve had to become a supermodel.

On the surface of it, we’ve succeeded marvelously: backed by Mental Health Association in Los Angeles County’s (MHALA) substantial advocacy abilities, we’ve attained numerous major awards, have given dozens of presentations, have had hundreds of visitors come for immersion trainings, and been designated by SAMSA and the National MHA as a program to be replicated. Yet when we’re asked where else has replicated the Village, we hesitate, unsure if, in fact, anyone has.

We can perhaps point to some programs (especially those with our ex-staff working there) that have replicated “some” of the Village, but nowhere has our comprehensive program. Indeed, the goal of most visitors is to do “some” of the Village. It may be that it isn’t really possible to have a truly holistic program without being truly comprehensive. Only a comprehensive program can really be “no fail”, “we do whatever is needed”, “one stop shopping”. When the Village is forced to use outside resources to supplement our services serious problems arise and the culture is diluted.

Beyond a failure to be truly comprehensive, we usually criticize other programs for not having the “right values” in their culture. We describe them as too “traditional” or “medical model”, too concerned with agency finances or risk management. They just don’t have our spirit. This begins to sound pompous of us and they object that of course they believe in their members and care about them and want them to recover, just like we do.

I think there may be a crucial difference between believing in something and practicing one’s beliefs. Numerous people believe in prayer or going to church, or keeping the Sabbath or saying the Rosary or

even meditating, but how many actually practice these beliefs? Beliefs don't necessarily translate into action, and they certainly don't necessarily translate into social action. It's a very rare Thich Nhat Hanh who created social Buddhism in Vietnam and rescued hundreds of boat people, or Mother Theresa who embodied Christian charity to minister to orphans. What may be unique about the Village is it's translation of beliefs into social practice. Now I'm verging on extreme pompousness.

Here's my list of our successful social practices based on our beliefs.

(1) We do have integrated services. We work together (and get upset when it's not smooth) and don't avoid any part of our member's lives. The Village is truly a "one-stop shop''.

(2) We really do have continuity of care. We're available 24/7 and we connect to our members wherever they are (even Louisiana and Texas).

(3) We really are "no fail". We don't try to transfer difficult members or manipulate them into signing out of our program or withdraw them on technicalities. We stay committed to them and they stay committed to us. Less than 5% leave per year and almost none are "lost to follow up".

(4) Our staff really does leave the office. A lot. Actually every single day. We are community based.

(5) We practice empowerment. I made a list once and it included: We give members access to their charts, the entire building, and our vehicles. We share the café and bathroom as equals. The members make their own goals and chose what programs and even medicines they take. They chose where to live, what's on our social calendar, and what supports they want. They can switch staff and even teams they're working with during open enrollment without needing a reason. They're part of the advisory board. Certainly there's always room for improvement, but we do pretty well.

(6) We are "the dual diagnosis system". Every staff is involved in substance abuse treatment issues every day. We don't refer them to a specialty staff or clinic or expect someone else to do it for us. (This is not to say we don't use residential treatment programs when needed.)

(7) Our staff does interact with the members on a real emotional level rather than behind psychotherapeutic or professional barriers. Open displays of emotion are actively encouraged, regular parts of our interactions with members. We grieve with our members and we rejoice with them.

(8) We hire our members and other people with serious mental illnesses. Lots of them. And not just for training positions, but also as full staff equal to any of us.

(9) Our members do have a variety of non-patient roles. They're not always receiving services as patients, clients, cases, students or even consumers. There are other roles for them to have in our community.

(10) We really do maintain a quality of life instead of a symptom reduction focus. We measure quality of life outcomes. We make goals around them and actively work on them. It's far more common for our staff to know who needs an apartment or a job, than who hears too many voices or who has too much paranoia.

(11) Our budget reflects our values. We actually pay for a lot of employment, community integration, life coaches, accessible psychiatrists, etc. And we actually don't pay a lot for hospitalizations, locked treatment, therapy, day treatment, etc. We put our money where our mouth is.

(12) Our program really is individualized. There are no two members getting the same services or having the same goals. Everyone is different.

This list probably needs some refinement and revision, but it seems to me we are at the point where we can say that these practices would make a program a "replication" of the Village. And if these practices aren't there it isn't one. By being specific, behavioral, and overt about how we practice our beliefs we can probably more effectively advocate and catalyze the spread of our practices. It's time to move beyond the global "there needs to be more programs like the Village" that we see monthly in the media, and move beyond mental health administrators making value statements. Although we can't make a workbook or a blueprint for replicating our success we can create a concrete auditing and advocacy tool. Other "super-model" programs (e.g. Fountainhouse and PACT) have relatively recently taken this approach to promoting the spread of their values and programs, and I think it's time for us to do so to.

Since the President's New Freedom Commission Report recommended a recovery based transformation of the mental health system, we've been able to couch our system transformation efforts as promoting recovery using the Village as an example of a recovery based program rather than promoting replication of the Village itself. That shift has enabled us to shed some of our pompousness and in increase our impact. Nonetheless, with the rise of manualized Evidence Based Practices being touted as a scientific path to transformation, we are again feeling the pressure to manualized the Village and promote Integrated Service Agencies as an Evidence Based Program. We'll see if we can get any staff to sit down and write a manual this time around.