The Evolution of a Therapeutic Village for Persons with Serious Mental Illness

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Project Transition began in 1982 as an effort to help one person with serious and mental illness (SMI) get his life back - more accurately, to find a way for life to have a more favorable meaning to him in the wake of many psychiatric hospitalizations. At the time, long-term hospital care for persons with SMI was the norm; however. But, often, discharged patients were still symptomatic and vulnerable to psychiatric and addictive relapse. They (and their family members) were demoralized. Additionally, many of these patients seemed unable - without significant support - to generate essential relationships, belonging, membership in social networks, and to participate in work, school, and play.

Our challenge was evident: How do we reverse this vicious cycle and help a person get more from treatment and to manage recurring symptoms, acute episodes, and the threat of relapse? At the same time, since certain capacities seemed to be missing, it was important to help the person access human nourishment - daily positive relationships, a sense of belonging, and societal role functioning - within a stress buffered community. The therapeutic village had to provide these before he or she could self-generate them. Over time, these "additives" became generated by the person and through relationships, rather than exclusively by the program.

We began, not by setting up a program, but by renting one apartment to help this young man and a fellow patient who joined him. Both had been recently discharged from a nearby psychiatric hospital where we practiced. Our goal was to provide caring companionship for them, to assure continued treatment, and to help them live better lives.

Over the next five years, our census grew to twenty-one half with Borderline Personality Disorder (BPD) and the other half with more traditional diagnoses. We developed activities and therapies in response to the group's, interests, and needs. We viewed this collective effort as a community organized around the intentions of acceptance, healing, and growth.

Our program was located at several apartment complexes, where Project Transition's clients (whom we refer to as members) lived as roommates in apartments scattered within each complex. Our commitment was to integrate a spectrum of psychiatric treatments with programs of growth and development. At the same time, we focused on promoting healthy relationships and recovery in a non-hospital, normalized environment.

We identified our niche population as the group of people who were failed by traditional treatment programs. Our work led us to develop guidelines for the long-term recovery of persons with SMI. We have found that a diverse mix of factors - age, race, gender, education, socioeconomic background, and diagnosis - embody essential, dynamic components of a therapeutic village.

We now work with approximately 21 members at each of our autonomous programs, allowing us to maintain the necessary intimacy of small size. The refinement of our model continues.

Affirmation of a Belief

Persons disabled for years with the symptoms of SMI can learn to get on with a better life in a "normal" life setting, one in which they are naturally a part of the wider community. This minimizes stigma, generates hope and maximizes the transfer (portability) of acquired skills and other adaptive gains as the person moves on from Project Transition.

Since we selected the setting of an open apartment complex, we first had to address the issue of safety, coupled with high societal expectations of member behavior. Our members had persistent psychiatric symptoms and a pronounced vulnerability to episodes of acuity. With prior hospital admissions averaging 15 per person (a range of 1-60), one half of our members had no subsequent hospitalizations while they were with us by the time they graduated from Project Transition (median length of stay: nine months). Those who were hospitalized while at Project Transition had a length of stay (LOS) per hospitalization of nine days, significantly less than the months (and, in some instances, years) that characterized previous patterns of hospitalization. Persons with Borderline Personality Disorder were at particular risk for repeated, brief re-hospitalizations, both prior to and during their stay at Project Transition. Fifteen percent of our members with BPD accounted for 60% of PT member hospitalizations. It is interesting to note that these hospitalizations typically occurred early on, as well as in the later phases of stay. This supports our belief that both the early and late phases are characterized by significant change, transition, and loss - core vulnerability factors for many persons with BPD and other diagnoses. Persons with the more traditional diagnoses were rarely hospitalized (17%); most were hospitalized on one occasion only. One suicide occurred at Project Transition in twenty-five years. These findings suggest that seriously ill persons with SMI can cope with an open, "normal" living situation, if there is a sufficient "human environment" of fellow members and staff with an ability to effectively respond to acute episodes of suicidality, violence, psychosis, and drug and alcohol relapse.

Many people benefited from our program; fewer others did not. Statistically significant favorable outcomes occurred across several rated areas, including reduction and stabilization of illness, self-management of persistent symptoms, self-management of acute recurrences and their treatments, independent living after graduation, and employability.

Our data revealed that favorable outcomes were linked to length of stay: graduated persons with LOS greater than one year showed outcome results that were significantly superior than for the subgroup for whom the LOS was shorter (i.e., the lower the LOS under one year, the lower the outcome measures). This supports our contention that successful recovery is a long-term undertaking. Significant goals are attainable, but only given sufficient time. Our view is that persons with SMI often need to develop new skills and coping strategies, not simply get better medications. Moreover, they need to belong to social networks during this restoration - and beyond - to sustain their gains and recovery.

Design of the Therapeutic Village
Each of Us Needs a Village

We chose an open environment in an apartment complex - a low supervision, high responsibility setting. Many of our members, when admitted, were considered "unworkable" in traditional settings, and were still quite dominated by symptoms of illness accompanied by low functioning. More recently we have added a subgroup of persons with BPD who were very high functioning, and yet unable to get on with a safe and satisfying life. The open context that we chose set the bar high for coping and functioning, which promoted higher levels of personal and

social responsibility than would have been thought possible. The safety net that we established through active involvement, 24 hour beeper access, relationship, and community building defined a human rather than an institutional environment. At Project Transition, there are no restraints, locks, takedowns, or hovering supervision. This unusual arrangement allows members to live in a normal and attractive setting - the difference is that we provide it at the start, before they are "ready." In this respect, it can be said that we start at the end.

Essential ingredients in the experience of Therapeutic Village are validation, time, relationships, belonging, learning, practicing, and graduation as opposed to discharge.

One Stop Shopping

We bring the treatment, skill development, and crisis interventions to our members where they are living. They do not have to go elsewhere. This offsets the problems in which the person with SMI "falls between the cracks" of a service system characterized by separate providers. The work of our therapeutic communities is strengthened not only by scheduled meetings and activities, but also by the constant informal daily interactions that members and staff share throughout the day and evening. By keeping the size of the member community to approximately 21, each program's staff team gets to know the members intimately.

Over the years, we have seen weaknesses in the traditional vendor model, principally multiple providers and sites, poor coordination and communication, service and communication discontinuity, and relational transience. Our approach is to have a closely-knit staff team provide "everything" at the apartment complex. The Medical Director is frequently on-site to respond to complex psychiatric and medication issues. Doctorate psychologists see members twice weekly in individual sessions and twice weekly in group sessions. Psychiatric Rehabilitation Counselors, aka life-skills coaches and case managers, provide supportive supervision and serve as "faculty" for the day and evening curriculum of habilitation, rehabilitation and wellness activities. Nearly twenty of our staff have completed intensive training in Dialectical Behavior Therapy; each program features dialectical skills workshops twice weekly. We also provide a 24/7 crisis pager service for emergent situations and proactive strategies. Family members are provided with an individualized orientation, progress updates, educational and support programs. Addiction Counselors provide individual and group counseling (augmented by participation in NA/AA) to members who struggle with substance abuse in addition to other psychiatric problems (two-thirds of our population). Each program has a Wellness Specialist to focus on physical well-being and quality of life enhancement.

"One Size Does Not Fit All"

These efforts of inclusion and integration reflect our belief that there are many paths to recovery. Whichever path is chosen, new needs and challenges emerge which frequently require new responses. A person, not ready for vocational or school preparedness at one point, may be ready later on. Someone else may only be ready to start there and later learn to practice self management of symptoms and relapse prevention. This led us to coin an adage, "Recovery has three R's, not one":

1. Reduction of symptoms/stabilization of illness and learning its self management,
2. Restoration of a life of new meaning and purpose (the psychiatric and addiction recovery vision), and
3. Reintegration into family and community - the concept of human bridge.

We have been able to address these areas with the awareness that a better quality of life is rarely the province of a single ideology or of programmatic rigidity. Nor is it a highly linear process. At Project Transition, our staff and members alike are enriched by being part of a system that responds to the creativity and needs of the group as a whole, as well as by its diversity.

"You Can Take it With You"

When a member feels better, is less dominated by illness and disability, has established a sufficient degree of self-control, and is functioning and living more fully, the question becomes: How does one successfully leave Project Transition? Historically, this has been a vexing area. Too frequently, persons with SMI rarely leave a program where they have been successful without a high likelihood of relapse. We designed specific initiatives to help the person (and family members) build equivalent social networks prior to full graduation from the program. The effort of getting ready to leave includes, yet also transcends, getting a place to live and finding a job. We help our members belong to adaptive social networks beyond Project Transition before fully leaving. We also extend multiple opportunities to remain meaningfully connected to our staff and members for the months or even years that this transition may require. For example, the person who is getting ready to move on from the program might choose to continue to see his or her Project Transition doctor for medication management and/or attend a Project Transition community meal and/or fun activities and/or a skill development workshop, and so on. A carefully orchestrated program of reintegration often requires this porous boundary of membership. Our belief is that flexibility, ongoing relational supports, and "practice rehearsals" and their teachable moments are all highly relevant to successful outcome over the long haul. At Project Transition, each member has "Life Membership," even after the programmatic and economic relationship is over. This practice has affirmed that each of us needs a village for healing growth, and wholeness.

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