

Service Delivery

One of the first requests for training the Village got was, surprisingly enough, from Napa State Hospital. Karen Strand, a nurse and team leader, Gail Green, a member and consumer advocate, and I traveled across the state to conduct a day long training for their “traditional” staff. Karen and I, as traditionally trained professional staff were expected to be able to connect with them. Note that our goals at the time were to help them to be comprehensive integrated, and client centered. Recovery had yet to become a prevalent model at that point.

We had seen a number of charts contrasting the traditional medical model and the progressive rehabilitation model and created this chart based on the real life changes we’d had to make to fit our practice into the Village’s culture and values. You’ll notice that some of the items, like supported employment and housing, are relatively standard rehabilitation practices, while other items, like personal service coordination, medication collaboration, and collaborative written memory, are quite idiosyncratic. However, since Karen and I had never been trained in, or really exposed to, any rehabilitation practices they were all new to us and all of them required us to transform ourselves.

Transforming Staff / Client Relationships

(1994)

The original vision of the Village Integrated Service Agency was to create a mental health delivery system that was both comprehensive and integrated while keeping the clients central to the decision making process. Two overriding problems and solutions have emerged over time.

1. A truly comprehensive list of services consists of hundreds of services, a prohibitive amount. We found it impossible to predict all the varied service needs and utilization patterns from a clinical or historical analysis of our members. The solution was to have the members’ needs generate a highly individualized and forever changing list of services. Staff had to become flexible generalists, and budget resources needed to be controlled by those most familiar with the members’ needs.
2. Merely collecting a spectrum of service providers in one program, while certainly helpful, does not produce integrated services. More often the result is a maze of turf battles and hierarchical power conflicts. What is needed to create a truly cohesive team and program is an integrating philosophy and value system.

We adopted the psychosocial rehabilitation-recovery philosophy, arguably the philosophy most suited to our present social realities and mental health laws. We needed to make adaptations in every clinical treatment technique and strategy. Fortunately, our staff has been very open in re-evaluating our traditional training

3. and practices and in developing new ones. Though clearly still in process, we have made considerable progress in the entire range of techniques.

What follows is a compilation of this range with accompanying definitions. We continue to challenge and explore in order to help create a new, more humane system. The overall effect of our adaptations and integration is that visitors to our program are always struck by the unity of philosophy and values expressed by our staff. We believe we are helping to create a system that is both comprehensive and integrated while calling for a transformation in traditional patient-expert relationships.

Village Integrated Service Agency Technique and Strategies

Traditional Model	Integrated Services Model
1. Milieu Therapy	1. Recovery Community
2. Case Management Brokered or Clinical Model	2. Personal Service Coordination Strengths Model
3. Treatment Planning	3. Personal Goal Setting
4. Individual and Group Therapy	4. In-Vivo Adult-to-Adult Interactions
5. Medication Compliance	5. Medication Collaboration
6. Socialization and Day Treatment	6. Community Recreation and Social Coaching

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| 7. Prevocational and Vocational Counseling with Vocational Rehabilitation Referral | 7. Supportive Employment Choose / Get / Keep |
| 8. Substance Abuse Treatment Referral | 8. Integrated Substance Abuse Treatment |
| 9. Conservatorship and Payee | 9. Supportive Money Management |
| 10. Residential Treatment | 10. Supportive Housing |
| 11. Emergency and Inpatient Treatment | 11. Community Restabilization |
| 12. History Taking and Charting | 12. Collaborative Written Memory |

Definitions

Recovery Community

A recovery community is a group of people working together in a variety of roles towards healing, growth, and recovery. The focus is on developing roles besides those defined by illnesses, emotional traumas, and past treatment experiences. People are encouraged to try new things and take risks while receiving extensive support. The focus is also on actually doing together in the larger community what is needed, learning, and growing together, rather than just talking about it in an isolated room.

Personal Service Coordination

Personal service coordination is the ongoing collaborative relationship between a person being served and staff which is focused on the person's goals and strengths. Staff serve as "life coaches" walking side by side with the person to help clarify goals, overcome obstacles, explore alternatives and take necessary risks for growth and change.

Personal Goal Setting

Personal goal setting is the process of identifying, developing and pursuing goals desired by the individual. The problem solving process is utilized to identify the

small steps needed and the responsibilities of everyone involved. Personal goal setting provides for affirmation of and learning from each step, whether overall goal is accomplished or not. It is used as the centerpiece to dictate the use of staff time and the type of services required.

In-Vivo Adult-to-Adult Interactions

In-vivo adult-to adult interactions are the individual relationships between staff and an individual where the majority of exchange happens in the community and focuses on a person's goals. Both people explore a variety of roles with each other, moving away from the "helping professional to dependent patient" interactions. Depending on staff skills, psychotherapeutic elements of healing, "corrective emotional experiences," empathy, support and emotional skill development, etc. are embedded in these relationships rather than separated into a more restricted "clinical" context.

Community Recreation

Community recreation is the engagement in social and recreational events with people in the natural setting of the community in a non-segregated way. Staff provide before, during, and post event coaching of people as needed regarding skills required. The goal is normal recreation in normal settings at normal times with persons of the individual's choice.

Supportive Employment

Supportive employment provides for a wide array of support measures made available as needed to help the member choose, get and keep a job. The process emphasizes the right of people with mental illnesses regardless of the severity of their illness to try work of their choice in the community without having to go through prescribed, graduated steps in order to prove or earn this right.

Integrated Substance Abuse Treatment

Integrated substance abuse treatment is a four stage model (engagement, persuasion, active treatment, and relapse prevention) for working towards sobriety and a variety of quality of life goals along the way. It is applicable to every person who abuses substances regardless of the level of denial or their desire for sobriety.

Supportive Money Management

Supportive money management is a voluntary and/or involuntary program of working with people to 1) ensure that social security income is used first to purchase shelter, food and clothing, and 2) train people in the skills and decisions necessary to manage their own money. Assistance may include payee status, progressive money management, monthly budget assistance, loan programs, savings and bank accounts, and interim funding programs.

Supportive Housing

Supportive housing is based on people living in integrated setting of their choice as staff provide varied and adjustable support and services to the person as needed. The amount of need drives the level of support, not the type of residence.

Community Restabilization

Community restabilization helps people overcome serious crisis in their lives in the community by finding meaning in their pain and suffering in order to learn what changes are needed to recover, return to their lives, and not recreate their crisis. Hospitalization and other involuntary treatment are used as little as possible. People are expected to be as responsible for their own crisis and solutions as much as possible, with as little danger and indignity as possible.

Collaborative Written Memory

Collaborative written memory is a process of writing and recording treatment records by the service provider and person together for the primary purposes of 1) recording trials of problem solving and their results, especially regarding medication and crisis restabilization, and 2) recording progressive personal goal setting, planning and quality of life results.

As I read this handout after many years, I still found it very specific and very challenging. For all the staff who keep saying, "We already do recovery. We're just calling it something else." and to all the administrators who just want to change their sign on the door claiming to be doing recovery to keep the money flowing, this chart and definitions alone could provide plenty of confrontation.

Incidentally, this was the first time I'd ever really presented alongside one of my patients, Gail, as a true colleague. I suspect, in retrospect, that she had more impact on our audience than either Karen

or I. Making things more complicated my family was along on the trip sightseeing with us and Gail had recently injured her right arm, had it in a cast, and needed extra physical assistance to get along including having her meat cut at dinner. I learned a lot about “multiple roles” that trip. Here’s a letter I read to her on her retirement years later that sums up her impact on me and my gratitude for having known her:

Farewell to Gail:

You will always be a lady of firsts to me.

You were the first person I knew to progress from years in a state hospital to self sufficiency and a full life...and you did most of it while your medications were working very poorly. I got to see what the path of recovery looked like by watching you.

You were the first person I did a full scale medication collaboration with. We learned about Clozaril together, consulted with experts together, and most importantly I supported your choice to take the medication even though I wouldn’t have chosen to take it. Yes, it helped the lesson for me that you turned out to be right and I was wrong.

You were the first person I had multiple roles with. I was at the same time your doctor, your coworker in the homeless program, and gave presentations alongside you. You even got me one of my first lecturing jobs on a panel of homeless staff at a psychiatric conference.

You are the first person with schizophrenia my kids got to know when you traveled around San Francisco with us and you still form their vision of what their dad does. Yours was the first member’s wedding I went to.

You were the first member to leave me by graduating from the Village. I learned it could work out OK.

Looking back, it’s striking how different we are. We have different races, sexual orientations, political parties, clothes, cars, feelings about guns, favorite sports teams and taste in movies. And yet we’re able to connect even when we haven’t been doctor and patient for a long time.

Your path is yours and mine is mine, but I’m sure glad they crossed when they did.

See you around...I hope.

Mark

