Psych Rights | Law Project for Psychiatric Rights

November 1, 2021

The Honorable Ron Wyden
Chairman, U.S. Senate Committee on Finance
221 Dirksen Senate Office Bldg.
Washington, D.C., 20510

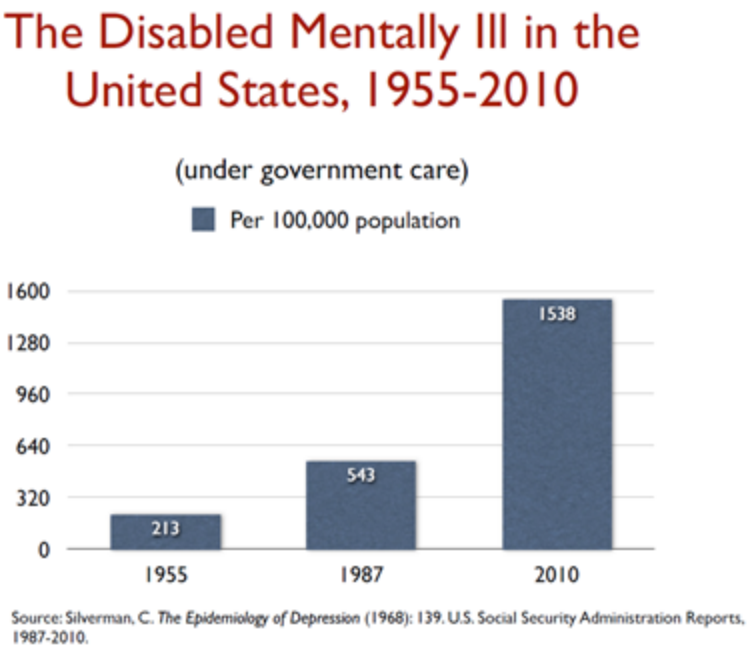
The Honorable Mike Crapo
Ranking Member, U.S. Senate Committee on Finance
239 Dirksen Senate Building
Washington, DC 20510

Re: Unmet Mental Health Needs Request for Information

Dear Senators Wyden & Crapo:

This is in response to your September 21, 2021 letter to Members of the Behavioral Health Care Community and Other Interested Parties, and focuses on your request for information as to "improving reimbursement mechanisms and financing behavioral health care enhancements."

At great expense, our current mental health system's ubiquitous employment of psychiatric drugs, substantially funded through Medicaid, the Children's Health Insurance Program (CHIP), Tricare, and Medicare, is dramatically worsening outcomes and suffering. Since the introduction of the so-called miracle drug Thorazine in the mid-1950's the disability rate of people diagnosed with serious mental illness has increased more than seven-fold.[1]

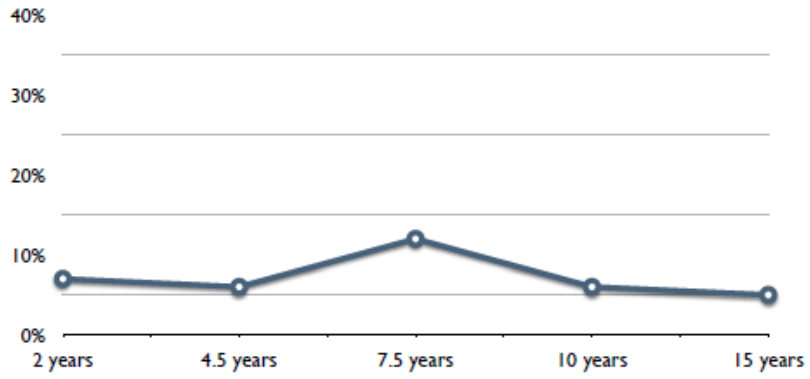


[1] The charts in this letter are from talks given by award winning journalist, Robert Whitaker, author of *Anatomy of an Epidemic* and *Mad in America.*, including his July 16, 2021, talk to the Soteria Network in the UK, "Soteria Past, Present, and Future: The Evidence For This Model of Care," available on YouTube at https://youtu.be/UXe2dgBF70w. This one hour talk is highly recommended.

We now see a recovery rate of only 5% for those people who are maintained on neuroleptics, which is the standard.

Long-term Recovery Rates for Schizophrenia Patients on Antipsychotics

(Martin Harrow's study)



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

This is far worse than anything seen before the advent of the neuroleptics, now marketed as "antipsychotics" in the mid-1950's.

Outcomes in Select Studies from Pre-Antipsychotic Era

(Patients diagnosed as insane, schizophrenic or psychotic)

Study	Time	Good Outcome*
York Retreat	1796-1811	70%
Worcester Asylum	1833-1846	65%
Pennsylvania Hospital	1841-1882	45% to 70%
Warren State Hospital	1946-1950	73%
Delaware Hospital	1948-1950	70%
Boston Psychopathic Hospital	1947-1952	76%
Norway	1948-1952	63%
California FEP study	1956 (no neuroleptics)	88%

* Good outcome = discharge from hospital, or living in community at end of study period

It has been shown that if we try to avoid the use of neuroleptics when people experience their first psychotic break an 80% recovery rate can be achieved. The below chart shows results from the "Open Dialogue" program in Northern Finland in which they avoid the use of neuroleptics if possible.

Open Dialogue in Northern Finland

(Results for First-Episode Patients at Five Years)

Patients (N = 75)	
Schizophrenia (N = 30)	
Other psychotic disorders (N = 45)	
Antipsychotic Use	
Never exposed to antipsychotics	67%
Occasional use during five years	33%
Ongoing use at end of five years	20%
Psychotic Symptoms	
Never relapsed during five years	67%
Asymptomatic at five-year followup	79%
Functional Outcomes at Five Years	
Working or in school	73%
Unemployed	7%
On disability	20%

Source: J. Seikkula. "Five-year experiences of first-episode nonaffective psychosis in open-dialogue approach." Psychotherapy Research 16 (2006): 214-28.

Similar results were achieved during the Soteria-House study in the 1970's conducted by Loren Mosher, MD, who was Chief of Schizophrenia Research at the National Institute of Mental Health (NIMH) at the time.

Soteria-House

Study

First-episode schizophrenia patients treated conventionally in a hospital setting with drugs versus treatment in the Soteria House, which was staffed by non-professionals and involved no immediate use of antipsychotic medications. Results are from 1971-1983 cohorts, with 97 patients treated conventionally and 82 patients treated in Soteria House .

Results

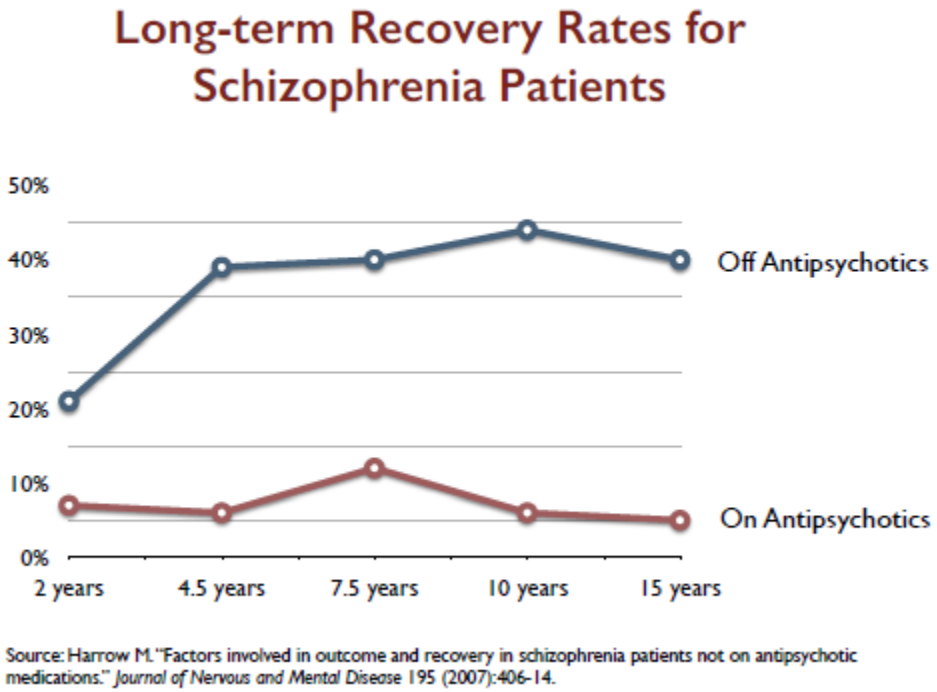
- At end of six weeks, psychopathology reduced comparably in both groups.
- At end of two years:
  - Soteria patients had better psychopathology scores
  - Soteria patients had fewer hospital readmissions
  - Soteria patients had higher occupational levels
  - Soteria patients were more often living independently or with peers

Antipsychotic Use in Soteria Patients

76% did not use antipsychotic drugs during first six weeks
42% did not use any antipsychotic during two-year study
Only 19 % regularly maintained on drugs during follow-up period

J Nerv Ment Dis 1999; 187:142-149
J Nerv Ment Dis 2003; 191: 219-229

What we find is the recovery rate of people who get off of neuroleptics after they have been on them goes from 5% to 40%.



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

While this is 8 times better than staying on them, it is half of what can be achieved by avoiding the use of neuroleptics in the first place. This demonstrates the importance of avoiding the use of neuroleptics if at all possible. In addition to their lives being so much better, allowing 16 times more people to recover not only saves a tremendous amount of treatment expense, it converts people who would otherwise be receiving life-long services and transfer payments from the government into productive, taxpaying citizens. .

In addition to Open Dialogue and Soteria-House programs there are a number of other effective approaches that do not require psychiatric drugs and are extremely cost effective, such as peer respite, The Hearing Voices Network, Intentional Peer Support, Emotional CPR, and other forms of true peer support.[2]

Currently, especially in those states that retain the fee for service approach rather than managed care, it is difficult to impossible to access Medicaid funding to deploy these effective, cost-effective approaches through waivers or otherwise. The Medicaid statute should be amended so that state plan approved services include more flexible community based services/treatments that are effective and states don't have to apply for waivers to fund effective services. Waivers which might not be granted.

[2] It has been found that those with lived experience of psychiatric hospitalization (peers) are able to be very effective because they can relate to patients in ways that people who have not had that shared experience cannot. Sadly, many mental illness programs have adopted what they call peer support, but that has been warped into a "medication compliance" role, which is anathema to true peer support.

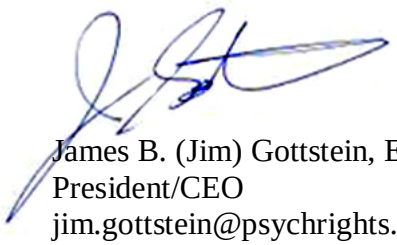
Chapter 9 of *Community Mental Health: A Practical Guide*, by Dr. Loren Mosher and Dr. Lorenzo Burti, lays out the details of an effective community mental health program and I have attached it hereto for your convenience. Published in 1994, it does not include some of the newer approaches described herein, but it is still a valuable and, indeed, practical guide to this day.

The best book to understand the impact of psychiatric drugs in general, not just the neuroleptics, is *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, by Robert Whitaker, from whose work the foregoing is largely drawn.

Finally, the carnage wreaked by psychiatric drugs on poor children and youth, especially defenseless foster children, through Medicaid is immense. They have been removed from their homes because they have been found to be abused or neglected. While some are glad to be removed, for most it is traumatic, which will cause many to act out. Then, the foster placements themselves can be pretty horrific, which will also cause many to act out. Instead of helping these children and youth deal with their feelings, they are told there is something wrong with their brains, they are not responsible for their behavior, and will have to take debilitating drugs for the rest of their diminished lives. These are exactly the wrong messages. Instead, they should be helped to deal with their feelings and helped to be successful. Also attached hereto is Module 8 of the CriticalThinkRx curriculum, "Alternatives to Medication," which documents many such approaches.[3] Medicaid and CHIP should be amended so these types of proven approaches will be provided.

Thank you for your consideration of these thoughts, observations and suggestions. I will be pleased to answer any questions you might have.

Sincerely,



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[3] CriticalThinkRx was developed under a grant from the Attorneys General Consumer and Prescriber Grant Program, funded by the multi-state settlement of consumer fraud claims regarding the marketing of the prescription drug Neurontin®. The full CriticalThinkRx curriculum can be found at http://psychrights.org/education/CriticalThinkRx/AllModulesWithReferences.pdf.

CHAPTER 9

A Community Services Smorgasbord

OUTPATIENT SERVICES

The Heart of the Matter: Mobile Crisis Intervention

WE BELIEVE THE 24-HOUR MOBILE CRISIS intervention team should be the center of every community mental health program. In most situations it will function as the gatekeeper to the system. Systematic research on the use of 24-hour mobile crisis teams has been shown that they reduce hospitalization by at least 50% (Hoult, 1986; Langsley & Kaplan, 1968; Test & Stein, 1978a & b). The experience in South Verona is that fully half of all patients labeled schizophrenic do not need residential care in any given year, principally because in-home crisis intervention is provided.

We expect that a substantial proportion of the work of the emergency services team will be done in the homes of the clients. This requires very good collaborative relationships with gatekeepers of different types: the living group, the general practitioner, the police, and the mental health system staff. A community mental health program that is well embedded in its community will not have great difficulty educating these groups.

Whenever possible the work of the crisis team should take place in the living unit, for the following reasons:

1. Using a battle fatigue or shell shock paradigm, in-home intervention will often prevent evacuation to an unfamiliar setting like hospital or alternative to hospitalization. Hence, the client will be able to remain in relationship to the natural, known support group.
2. It provides externally generated social support in the individual's own territory. Meeting new people on foreign territory is always more difficult than meeting people on one's own ground. As a result, observations made in the home are likely to reflect family reality more accurately than those made in the clinic.
3. Meeting with the in-residence living group (usually, but not always, the family) provides an opportunity for the clinical team to frame the intervention as a healing ritual experience to help alleviate the problem behavior. The usefulness of rituals in facilitating change in social networks has been highlighted by Imber-Black, Roberts, and Whiting (1988) and others (Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1977).
4. The in-home context allows the crisis team to actively unlabel by use of positive reframing of "symptoms" or problem behaviors as normal, or at least understandable, responses to the stresses attendant to the particular situation.
5. By expecting the identified patient to be an ally/helper, maintenance of normal role functioning is promoted from the outset. This process helps preserve personal power and responsibility, goes on in the person's usual social context, and is framed in a normalizing way (see Chapter 8).

Basically, we believe that the in-home intervention paradigm mutes the potentially deleterious side effects of mental health system interventions by minimizing institutionalization and its inevitable decontextualization (even in community-based alternatives) of the individual. The process of repeated decontextualization and associated institutionalization—medicalization of an individual—is critical to the development of a view of that person, by the network and the system, as someone with a "chronic" illness. The disease-in-the-person view also provides the nidus around which the process of stigmatization forms; this process is a major culprit in the development and maintenance of "chronicity."

There are, of course, times when someone must be removed from a situation. Serious continued risk of violence or suicide, despite the family crisis intervention, requires that the situation be defused by removal of the person so disposed. This should be required in only a minority of instances.

We wish to draw readers' attention to the fact that, although for simplicity we label what the mobile team does as *"crisis intervention,"* whenever possible its work should be seen as involving *crisis resolution*. Crisis intervention is too frequently limited to assessment, triage and disposition. Our view is that the crisis team should continue to be involved until resolution occurs or an alternative course of action is clearly indicated.

There will also be situations in which the identified patient has already been taken out of the home and brought to an emergency room or some other intake point without the living group. In these instances it is often difficult to get the person back into the home and regroup the family or other persons in a way that will allow successful negotiation or settlement of the difficulties. However, approaching the problem from a systems perspective, even if it is not possible to send the patient home, will aid in the development of a plan that will facilitate returning there—or at least understanding of why it's not possible to do so. The availability of residential alternatives to hospitalization will allow a minimally decontextualizing response to the crisis; without alternatives, unwarranted institutionalization will take place.

Residential care must be considered when the person has no social network, when the person's social network is worn out physically and psychologically and in need of respite, when there is imminent danger to others, and when there is imminent danger to the self which clinicians judge cannot be successfully handled by a natural social network provided with mental health team support. A final indication for the use of residential care is when the in-home family crisis intervention has not led to a successful return of normal role functioning. Ergo, a situation in which the problem has not resolved or that continues to escalate despite the best ongoing efforts of the crisis intervention team necessitates the use of residential care. This response should be used infrequently.

The configuration of the crisis team will vary considerably across settings because of differences in geography, population density, manpower availability, and local regulations governing personnel use. One configuration used frequently in Italy is a four- or five-person team with two M.D.'s (staff and trainee), a nurse, and a social worker. Trainees from any other disciplines related to mental health may also be added to the team. A team configuration where psychiatric time is hard to find or very expensive and there are no M.D. trainees could be four non-M.D. mental health workers with psychiatric backup and consultation. However, each team should have at least *three* regular staff so as to provide continuity of persons, over time, for the clients.

Incoming calls are routed to the team responsible for the geographic area from which the call is coming. The call is then screened as to whether or not an immediate home visit is indicated. When it is unclear as to what

the best response would be, we advise a home intervention. If a home visit is clearly not indicated, the case can be discussed in the team and a response made in a short period of time. This response can be anything from a call with some information to inviting the putative patient in for an individual or family evaluation.

If a home intervention is thought to be necessary the team *advises the caller of the plan and asks for his or her reaction*. If the plan is acceptable, the caller is asked to assemble the parties relevant to the problem and told that the team will arrive in about 15–20 minutes. If it is a call from police on site, they are asked to stay also.

A minimum of two team members, preferably a *male* and a *female*, should respond to in-home crises. A two-person response provides a feeling of safety and allows on-the-spot team consultation. On arrival the team evaluates the nature of the problem utilizing the interview techniques described in Chapter 6. If several people are present, the circular questioning style popularized by the Milan group (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980) can be utilized to evolve an interactional picture of the problem and possible options for its solution.

Home visits can vary greatly in length; the team should allow at least one and one-half hours in the home but have the flexibility to stay longer if needed. The actual intervention will utilize a variety of techniques previously described, e.g., positive expectations, reframing, support, reassurance, and ritual. The initial evaluation may be followed by daily visits, if necessary, to stabilize the situation. The principle to be kept in mind is that the *intervention should be tailored to the client's and family's needs—not to the needs of the mental health system*.

Ongoing Outpatient Intervention

In our view all line mental health center staff should be members of a crisis team. However, when not involved in crisis work they will carry out a variety of other functions:

Individuals, families and social networks will need to be seen on an ongoing basis, either in their own environments or in the clinic. This caseload is derived from the team's crisis work. We advise that the ongoing interventions with individual clients or families be the responsibility of *at least two members of a team*. Both need not be involved in every session. However, both should be up-to-date on developments. This arrangement will make continuity possible despite illness, vacations, departures, etc.

Specific therapies, such as cognitive-behavioral treatment of depression and behavioral approaches to phobias, can be provided by team members qualified to do so or by center "specialists" (see Chapter 10, p. 178). If a patient is referred to a specialist, the team should retain case responsibility. Specific interventions should be as focused and brief as possible. Group treatment should be highly valued and used to as great an extent as possible. It is in this part of the work that the relational principles and intervention techniques described in Chapters 6 and 7 will be used over and over again.

Case Managers Need to Be Therapeutic

The functions usually ascribed to case managers—case finding, assessment, service planning, linkage, coordination, monitoring, and advocacy—should, we believe, be the responsibility of the mental health center team with which a client makes initial contact. The reasoning behind our position is as follows:

1. Splitting out case management as a special role for one person outside the team complicates the situation unnecessarily and fragments responsibility for the client.
2. The role can be construed in such an activist doing-to way that the client becomes a bystander in the process. The development of competence and greater autonomy by the client via success experiences is very difficult when someone else takes care of everything. Institutional dependence can become case manager dependence.
3. As presently practiced, case managers are almost always individuals, not teams. What happens weekends, nights, and vacations? Clients will have a hard time finding someone they know and who knows them. In such situations, usually brought about by a crisis, a poor decision can be made. In addition to the problem with continuity of persons this engenders, a solo case manager has no peer support group with whom to discuss difficult clinical issues. Use of the generic mental health center team allows all of its members to know something about all the team's clients. Teams should have *no more than* about 20 active cases per member. Hence, a four-person team would have around 80 active cases, a manageable cognitive task for all team members.
4. The words planner, advocate, broker, monitor, and coordinator are not rife with connotations of support, empathy, and understanding. That is, as currently defined, case management does not explicitly acknowledge the importance of a therapeutic relationship to its work. We believe this is a serious omission because case managers will come to see themselves principally as brokers and conduits, lacking a meaningful therapeutic role with clients. However, if their role is defined as therapeutic they can then share the

morale boost a client gets from an accomplishment in which they have been involved. This will, in turn, help prevent burnout (see Chapter 10). Our point is that *no plan should be developed and acted on until a respectful mutual understanding of the problem needing to be addressed, in the context of a positive relationship, has been evolved.*

We also believe that case management can be more relationally focused if the mental health center has a designated concrete resources person(s). Thus, rather than many case managers having to know the ins and outs of all the relevant bureaucracies and the types of programs available, one person should be *very* knowledgeable on these matters and act as a consultant to the case managers and their clients. When relieved of the "doing for" task of identifying these resources, case managers can spend more of their time "doing with" clients, i.e., engaging in consultative activities that involve use of their collaborative relationships.

When mental health center teams are carrying out case management functions, we recommend they see themselves mainly as *consultants* to clients. Their consultative role should begin with a contextually valid empathic understanding of the problem(s) presented. Developing this kind of understanding will probably require team members to be with clients in several of their day-to-day activities. This down-to-earth orientation will also help dehierarchize consultant-client relationships so that they more nearly approximate our recommended partnership orientation. Insofar as these conditions are met, the client will not be made *unduly* dependent, the consultation will be therapeutic, and case management functions will be performed successfully.

COMMUNITY RESIDENTIAL PROGRAMS*

Community residential mental health system programs can be understood and compared by looking at three variables: (1) transitional versus nontransitional; (2) size; and (3) number of staff. For example, the Soteria/Crossing Place alternative to hospitalization we'll describe is transitional, small (six to eight beds), and intensively staffed (1.3 staff per resident). By way of contrast, the halfway house model we espouse shares only transitionalness with the Soteria model, as it is rather large (20–25 beds) and lightly staffed (.3 or .4 staff per resident).

*Portions of the text in this chapter, titled Community Residential Programs/Alternatives to Hospitalization, appeared in Mosher (1989).

Alternatives to Hospitalization

In a properly designed and functioning community mental health *system* community residential treatment facilities should serve the vast majority of disturbed and disturbing individuals in need of intensive interpersonal care who cannot be adequately treated by in-home crisis intervention. Use of these small home-like facilities in conjunction with 24-hour mobile crisis intervention will dramatically reduce the need for psychiatric beds in hospitals (Hoult, 1986; Langsley, Pittman, & Swank, 1969; Mosher, 1982; Stein & Test, 1985). That is, a 100,000 population catchment area will need about ten adult beds on a ward in a general hospital. More than ten beds per 100,000 may be needed in urban areas into which many former long-term state hospital inmates have migrated. This estimate presumes the existence of separate facilities for children and adolescents, geriatric, and addictions cases. We also presume there will be *no* backup state hospital beds. This estimate also presumes that the system will have affordable transitional (halfway, quarterway houses) and nontransitional (group homes, Fair-weather lodges, foster care, apartments, etc.) supported (supervised) and unsupported housing readily available for its clientele's use after the intensive care phase. Without adequate numbers of these facilities, users will get "stuck" at home, in the hospital, in alternatives, or in shelters. This is both clinically unwise and unnecessarily expensive.

In contrast to hospital-based interventions, where various treatments are administered to patients on wards, *residential alternative facilities are themselves the treatment.* That is, the total social environment (place and persons) is the healing intervention. In more traditional language these social environments are conceived of as "therapeutic communities" or "treatment milieus" (Gunderson, Will, & Mosher, 1983).

Research (Braun, Kochansky, Shapiro, Greenberg, Gudeman, Johnson, & Shore, 1981; Kiesler, 1982a,b; Straw, 1982; Stroul, 1987) and clinical experience have shown that approximately 90% of functional psychotics presently treated in hospital, can be equally well or better treated, at less cost, in intensive residential community care. Only patients who are seriously assaultive, uncontrollably overactive, acutely intoxicated, have complicating medical problems, insist on walking or running away, or need special monitoring or diagnostic procedures should be treated in places called hospitals (see Chapter 4).

Seriously disturbed and disturbing persons can be arbitrarily separated into two groups: those who have been recently identified and have not received much residential care (less than three months or so); and those who have been in the mental health system for a long time, usually more than two years, and have had more than three months of residential care

(usually a year or more). For this latter group we prefer the term "veteran" (short for battle-scarred veteran of the mental health wars) to the more commonly used "chronic," as it has no illness association and is nonpejorative.

Community-based residential care is especially important for the first group. First, because these alternative facilities are minimally institutionalizing and maximally normalizing, they provide a means of preventing "institutionalism," a well-known iatrogenic disease (Barton, 1959; Wing & Brown, 1970) that contributes so much to what becomes labeled "chronicity." Second, because of their being relatively inexpensive (averaging about $130 a day), they provide a setting in which an adequate trial of a psychosocial treatment, with minimal or no use of neuroleptics, can be conducted. Low cost is important to a trial of treatment without antipsychotic drugs because the initial episode in residence will likely be longer than is generally allowed presently in hospitals for the treatment of acute psychoses. That is, given the current pressure to shorten hospital lengths of stay for economic (not clinical) reasons, use of neuroleptics becomes almost obligatory. In alternative care settings a three-month average initial length of stay (usually adequate to allow remission to occur) is not economically prohibitive. Thus, these environments allow an attempt to avoid two of today's most recalcitrant mental health problems: "chronicity" and tardive dyskinesia.

The design, implementation, and results of the use of residential alternative care without antipsychotic medication with newly diagnosed psychotic patients has been well researched in random assignment studies (Matthews, Roper, Mosher, & Menn, 1979; Mosher, Menn, & Matthews, 1975; Mosher & Menn, 1978; Mosher, Vallone, & Menn, 1992).

Of relevance to our recommendation of a drug-free psychosocial treatment trial are Soteria study data (Mosher, et al., 1992) from two separate cohorts of clients treated without neuroleptics that indicate that this psychosocial intervention was able to produce reductions in levels of psychopathology at 6 weeks post admission comparable to those found in the neuroleptic treated control group. The power of this milieu intervention to produce short term symptom change in newly diagnosed schizophrenics provides clear scientific support for a seemingly heretical recommendation. Interestingly, there is no random assignment study presently available to definitively support the usefulness of these types of facilities for "veteran" clients. However, there are a number of clinical studies (Kresky-Wolff, Matthews, Kalibat, & Mosher, 1984; Lamb & Lamb, 1984; Weisman, 1985a,b) that consistently demonstrate that these types of social environments can be successfully adapted for use with longer-term clients.

DEFINING THE SOCIAL ENVIRONMENTS

In our work with several types of residential alternatives to hospitalization that treat psychotic clients we have defined six milieu characteristics

TABLE 9.1
Residential Alternatives to Hospitalization: Milieu Characteristics

Quiet
Stable
Predictable
Consistent
Clear
Accepting

(Table 9.1) and ten—five early and five later—milieu functions (Tables 9.2 and 9.3) that are critical to the promotion of recovery from psychosis.

The important characteristics are commonsensical to clinicians who have dealt extensively with psychosis. The environment should be quiet, stable, predictable, consistent, clear, and accepting. The milieu functions that should be emphasized early in the course of a person's stay in this type of environment are: (1) *control of stimulation* so as to prevent the person from being more overwhelmed by incoming stimuli; (2) provision of *respite or asylum*—that is, a place to be away from where the psychosis evolved; (3) *protection or containment* of poorly controlled behaviors engendered by the psychosis; (4) contact with people in touch with, and *supportive* of, the person's immediate experience; (5) early on, *validation* of the person's experience as real, even though it cannot be *consensually* validated. Hallucinations are all too real to the psychotic person. They should be acknowledged and respected as part of his/her experience, and an attempt should be made to understand them and how they are reflected in feelings and behavior. In no instance should they be labeled as "not real" or only "part of the illness." To do so would impede the development of a relationship, since it would affirm yet another disjunction between how the client experiences the world and how it is experienced by representatives of "reality." Bringing subjective experience and objective reality together takes time and

TABLE 9.2
Residential Alternatives to Hospitalization: Early Milieu Functions

1. Control of stimulation
2. Respite or asylum
3. Protection or containment
4. Support
5. Validation

(Results in a quiet, safe, predictable environment)

TABLE 9.3
Residential Alternatives to Hospitalization:
Later Milieu Functions

1. Structure
2. Involvement
3. Socialization
4. Collaboration and negotiation
5. Planning

(Results in an activating, involving, future oriented environment)

can best be done in the context of a positive relationship. This relationship is best facilitated by planting oneself solidly in the client's shoes. This may call for a temporary suspension of one's own objective reality—an oft frightening experience. We encourage this stance because we've so often found it to be helpful. Try it, you might actually come to like it!

The five important functions of these social environments as psychosis is subsiding (Table 9.3) are more complex and require increased participation on the part of the client. By *structure* we mean close ongoing relationships with lots of feedback—*not* a highly organized program of daily activities. While sometimes useful, such prescriptive activities are not usually individualized, flexible, and responsive enough to suit the clientele's needs.

Involvement means setting the expectation that the client will begin to resume participation in her/his life, beginning with personal activities (doing laundry, setting appointments, etc.) and chores necessary for house maintenance (e.g., cooking, cleaning). *Socialization* includes gradually expanding the circle of people with whom the person relates, first within the setting, then outside. *Collaboration and negotiation* denote an interactive process that will begin to identify goals and strategies for achieving them. The result of this process will be a map for the future—a discharge *plan*, if you will.

Obviously many of these functions go on at the same time, and different ones will be more in evidence on different days. They should not be viewed as occurring in a stepwise progression.

The literature also provides differing descriptions of how milieus should be organized to deal with newly identified acutely disordered persons (Table 9.4) and with long-term "veterans" (Table 9.5) of the system. Basically, these descriptions provide more specific approaches that are to be carried out within the overall generic milieu functions listed above. The two types of effective milieus have a number of overlapping characteristics; however, they differ principally with regard to what should be done when. That is,

TABLE 9.4
Effective Milieus for Acute Psychosis

1. Small (6-10 patients)
2. High staff/patient ratio
3. High interaction
4. Real involvement of line staff and patients in decisions
5. Emphasis on autonomy
6. Focus on practical problems (e.g., living arrangements, money)
7. Positive expectations
8. Minimal hierarchy

From Mosher & Gunderson, 1979.

time needs to be allowed for the gross disorganization associated with acute psychosis to begin to recede before focusing on practical problems or decision-making processes. With system veterans this initial reorganization period may be either unnecessary or short and practical problems may be focused on almost immediately. For long-term clients we have found that often the presenting "acute" symptoms are really only a way of accessing help. Once help is assured by being admitted to residential care, these "symptoms" often recede quickly to the background.

If both acute and veteran clients are admitted to the same facility, staff will have to develop the skill necessary to distinguish between their differing needs. Of course, a number of clients will fall in a gray area between the two. Unfortunately, there are no research data and only limited clinical experience to address the issue of whether or not these two populations do better when mixed together or maintained in separate, more homogenous, groups. We believe, but can't prove, that a separate facility for newly identi-

TABLE 9.5
Effective Milieus for Hospitalization Veterans ("Chronic")

1. Clearly defined, specific behaviors requiring change
2. Action (not explanation) oriented, structured program
3. Reasonable, positive, *progressive*, practical expectations with increasing client responsibility
4. Continuation of residential treatment program into in-vivo community settings
5. Continuity of persons
6. Extensive use of groups to facilitate socialization and network-building

From Paul, 1969; Paul & Lentz, 1977.

fied psychotic persons would be the preferred arrangement. The issue will likely be decided on economic grounds; that is, are there enough newly identified clients deemed in need of hospitalization to keep 10 alternative beds (six in a surrogate peer facility and four in homes of surrogate parents) full in a catchment area of 100,000?

IMPLEMENTATION ISSUES

Given the substantial body of research that consistently favors alternative care over hospitalization, it can be legitimately asked why such care is not widely available. We have detailed some of the reasons for this:

> First and foremost, because all alternative care is by definition not given in a hospital it is classified by third-party payers as outpatient treatment. There are limitations on, and disincentives to, outpatient psychiatric care in nearly all health-insurance plans (including Medicare and Medicaid). Alternative care is usually intensive and may involve a residential (but nonhospital) component; outpatient coverage is rarely sufficient to cover professional fees and never covers residential care, because outpatient means nonresidential by definition. . . .
>
> Secondly, since early in our history American physicians, patients, and the public at large have come to expect that serious mental disorders will be dealt with in hospitals. After a century and a half or more, culturally sanctioned expectations are a powerful force and are not easily modified. An attitude of "out of mind, out of sight" is pervasive. Hence, alternatives to psychiatric hospitalization tend to be unacceptable because they run contrary to conventional wisdom.
>
> Thirdly, today's psychiatry prides itself on being scientific. The *Diagnostic and Statistical Manual* ("DSM") is the obsessional person's dream and the medical student's nightmare. Psychiatry's research on brain pathophysiology uses the latest biomedical technology. Its clinical research, especially into drug efficacy, uses highly sophisticated methods. Over the past several decades psychiatry has experienced a rapprochement with the rest of medicine, partly because of its scientific achievements. The growth of psychiatric wards in general hospitals has been part of this process. To ask psychiatry to move many of its therapeutic endeavors out of hospitals would be regarded as a disruption of its new relation with the rest of medicine. Hence, data about the effectiveness of alternatives are not greeted with great enthusiasm by the profession. (Mosher, 1983c, p. 1479)

In addition to the three reasons described above, alternatives to hospitalization have failed to be developed because of a combined training and critical mass problem. That is, those alternatives that exist are mainly in the public/community mental health system. Training in social work, psychology, and psychiatry tends to be focused on preparing students to be private practitioners. Community mental health, along with alternatives to hospitalization, is doubly afflicted; its clientele tends to be unattractive and few potential staff have training relevant to working with them.

This training issue is compounded in the case of residential alternatives to hospital; there are so few of them that it's impossible to provide training sites for more than a handful of students (the critical mass problem). Because there are so few of these facilities, there are not substantial numbers of experienced professionals available to organize, administer, and supervise these programs. This problem could be addressed if professional schools recognized the existence of the phenomenon of alternatives and began to include them in curricula. Over time a cadre of trained persons would be developed to provide the leadership and expertise necessary to implement these programs. We have described elsewhere a model for such community-based training (Burti & Mosher, 1986). Until this image and training issue is addressed it will be difficult to plan, develop, and implement the types of intensive residential community-based care described here.

CLINICAL MODELS

Two models of intensive community residential treatment have been extensively written about: the *surrogate parent model* developed in Southwest Denver (Polak & Kirby, 1976; Polak, Kirby, & Dietchman, 1979) and the Soteria/Crossing Place *surrogate peer model* developed by Mosher and coworkers (Mosher & Menn, 1977; Mosher & Menn, 1978; Mosher & Menn, 1979; Mosher & Menn, 1983; Wendt, Mosher, Matthews, & Menn, 1983). The Polak and Kirby model has not been formally researched in a random assignment study. The Soteria portion of the Soteria/Crossing Place model has been intensively and extensively studied in a random assignment two-year follow-up design. Crossing Place has published a clinical (i.e., nonrandom, no controls) short-term outcome study of its first 150 clients (Kresky-Wolff et al., 1984).

THE SURROGATE PARENT MODEL

The Southwest Denver model was developed in conjunction with the program's use of mobile in-home interventions as their major form of emergency service. They found, logically enough, that a certain percentage of in-home crisis interventions were not successful enough so that they felt safe in leaving all the parties at home. The program's leadership (principally Paul Polak) was moderately hospital phobic, so they devised their surrogate parent program to be used in those instances where someone needed to be temporarily taken out of the home.

The program's design capitalizes on the empty nest syndrome. By means of ads in local papers and word-of-mouth, the CMHC recruited families

whose children had grown up and left home. In this mostly suburban part of Denver many couples had substantial homes with two or more empty bedrooms. Couples who responded to the ad were interviewed by CMHC staff and, if accepted, provided with a modest amount of information about, and training for dealing with, disturbed and disturbing persons. There were no hard and fast selection criteria, but they preferred to use couples with a previous record of some type of community service whose offspring were leading reasonably successful lives (i.e., not drug addicted, in jail, or the mental health system). Each couple was asked to set aside one or two bedrooms for use by CMHC clients. The rooms were paid for whether or not they were occupied.

The program's success (as it is judged by the CMHC and the families) was due to a variety of factors: First, the CMHC's mobile community team promised a 15-minute response time to any crisis that evolved in the surrogate parents' homes. Early in the program's life this availability was tested several times. As the parent couples became more comfortable with their roles, the need to call the backup team became quite rare.

Second, all acutely psychotic patients admitted to one of the homes were treated vigorously with neuroleptics, often via intramuscular "rapid neurolepticization." Hence, they attempted to minimize the occurrence of disruptive behavior through chemical restraint. Whether this type of high-dose neuroleptic treatment was still necessary when the parents became more experienced was never really tested.

Third, the parent couples who stayed with the program were natural healers. They approached their temporary children with a great deal of support, reassurance, and gentle firmness. As they got to know them, the parents began to involve themselves in helping clients with problem-solving. They gradually integrated clients into the family's ongoing life. Although there were no length-of-stay rules, most clients stayed two-to-three weeks and left gradually. Even after they were no longer sleeping in the surrogate parents' home, ex-clients would be invited to visit, to have dinner, or to share in a family event.

Fourth, the parent couples were highly respected by the CMHC staff. They were seen as an integral part of their program. They were identified and highlighted as the persons responsible for the CMHC's ability to use only one bed (on average) in the nearby state hospital—a statistic many people found astounding given a 75,000 person catchment area. Parent couples were sent to professional meetings to speak. They were visited by professionals, officials, and dignitaries of various types. All in all they felt themselves to be important contributors to a groundbreaking, innovative program. The parents became advocates for better community-based care.

Fifth, it provided the couples with a new career to be pursued during their retirement years. In addition, the predictable income from the program allowed many of them to keep and maintain family homes that otherwise might have had to have been sold.

In a sense the program provided preventive mental health care to the parent couples by refilling the empty nest. To us, the Polak and Kirby model is ideal for use in areas with low population density—i.e., semi-rural to rural areas. It is very economical even if the beds are not filled. Current replications provide stipends to the couples of $800-$900 per month per bed. With this model excellent care can be provided in the client's own, or a very nearby, community even in rural areas, thus minimizing disruption of ties with the natural support system. There are many rural areas where the nearest psychiatric impatient care is 100 or more miles away; in this context hospitalization is extremely disruptive for patient, family and network.

Although the surrogate parent model is particularly well suited to rural settings, we believe that urban and suburban community programs should have two or more (i.e., four beds) of these settings available per 100,000 population. Clinically, they would seem to best suited to the treatment of unemancipated psychotic persons, i.e., those in the 16-22-year-old age range with whom in-home family intervention has not been successful. Living in an alternate family environment affords many opportunities for these young people to experience, relate to, and learn from less highly emotionally charged parent figures. When properly planned, these settings can also provide the *client's parents* with an opportunity to share their difficulties with another set of parents, get support and understanding, and perhaps learn new ways of coping with their offspring from the surrogate parents' examples.

Utilizing empty nest parents allows the community program to actually address a problem of many seniors—feeling put out to pasture too soon and unnecessarily. These parents constitute a much underutilized natural resource—the experience, knowledge, and wisdom that accrues to people as they get older. Successful child-rearing capabilities should be a highly prized commodity. Yet, these qualities are rarely explicitly acknowledged and used for the benefit of others except grandchildren. This is an excellent illustration of a principle of good community psychiatry—using already available community resources. These include school and recreational programs, libraries, gyms, *and* personal skills.

SURROGATE PEER MODEL

The model developed by Mosher and coworkers has its roots in the era of moral treatment in psychiatry (Bockoven, 1963), in the psychoanalytic tradition of intensive interpersonal treatment (especially Sullivan, 1931;

Fromm-Reichmann, 1948), therapists who have described growth from psychosis (Perry, 1962), research on community-based treatment for schizophrenia (Fairweather, Sanders, Cressler, & Maynard, 1969) and to some extent in the so-called "antipsychiatry" movement (Laing, 1967). The Soteria project opened its first house in San Jose, California, in the fall of 1971. A replication house, Emanon, opened in another Northern California town in 1974. The original house closed because of lack of funding in October of 1983; the replication closed January 1980 for the same reason.

The basic notion behind the project was that the first treated psychotic episode was a critical intervention point. That is, the project's developers believed that the way the first episode of psychosis is dealt with will likely have great impact on long-term outcome. The project selected young, unmarried, newly diagnosed *DSM-II* schizophrenics because, statistically, the literature clearly indicated that they are the most likely to become disabled (Klorman, Strauss, & Kokes, 1977; Phillips, 1966; Rosen, Klein, & Gittelman-Klein, 1971). Hence, the project took clients with whom a successful intervention might save society a great deal of money over the long run in terms of hospital days, medications, and welfare costs.

An additional reason for taking only newly identified patients was our wish to avoid having to deal with the learned mental patient role that veteran patients have frequently acquired. Neuroleptics were not given for an initial six-week period so that a fair trial of a pure psychosocial intervention could take place. An additional reason for withholding antipsychotic drugs is that no, or minimal, neuroleptic treatment is the only certain way to prevent tardive dyskinesia.

Although the program's individual elements were not new, bringing them under a single roof in a 1915 vintage, six-bedroom house on a busy street in a suburban northern California town was. The program was designed to offer an alternative not only to hospitalization but also to neuroleptic drugs and professional staffing of intensive residential care. The program's psychiatrist, for example, was a consultant who did initial client interviews and staff training but had no ongoing contact with the clients. As the program matured, the psychiatrists came to be seen, and to see themselves, as mostly peripheral to it.

The 11 most important elements of the surrogate peer model we have identified are listed in Table 9.6. They are, for the most part, self-explanatory. However, a comment on the size issue appears warranted. We believe, based on our extensive experience, the Soteria data, the literature on extended families, communes, experimental psychology task groups, group therapy, and the Tavistock model, that for a community to be able to maximize its healing potential no more than eight to ten persons should

TABLE 9.6
Soteria and Crossing Place: Essential Characteristics

1. Small (6 clients), homelike
2. Ideologically uncommitted staff
3. Peer/fraternal relationship orientation
4. Preservation of personal power valued
5. Open social system (easy access and departure)
6. Participants responsible for house maintenance
7. Minimal role differentiation
8. Minimal hierarchy
9. Use of community resources encouraged
10. Postdischarge contacts allowed/encouraged
11. No formal in-house "therapy"

sleep under the same roof. Larger groups require more space than most ordinary houses provide; moreover, the interaction patterns and organizational governance needed are very different. Hence, economy of scale, i.e., facilities of 15 or more beds, is clinically unwise. Ideally, six clients, two staff, and one or two others (e.g., students, volunteers) should sleep in the facility at any one time. Eight clients can be accommodated, but this begins to tax the limits of the size of the social group and stretch staff availability if half or more of the clients are in acute distress. Actually, we believe that a 50-50 mix of disturbed and disturbing persons with nondisturbed persons is about ideal for the functioning of the house as a therapeutic community. This equation of six clients, two or three of whom have been in residence long enough to have reorganized sufficiently to appear relatively undisturbed, and two or three quasi-normal staff (including students) makes for an optimal mix.

There are a number of residential alternatives in existence that have 15 or so client beds (Lamb & Lamb, 1984; Weisman, 1985b). We believe that the home-like atmosphere is so absolutely crucial to the therapeutic functioning of community-based alternatives that we would *not* include such programs as examples of the Soteria/Crossing Place model. It is likely that when the NIMH or state departments of mental health get involved in the development of these facilities they will like the cost-savings of these larger units. However, it seems clear from recent research (Rappaport, Goldman, Thorton, Moltzen, Steener, Hall, Gurevitz, & Attkisson, 1987) that they sacrifice clinical effectiveness when they grow to the size of small hospital units, especially if they are located on hospital grounds. Their non-institutional character is compromised, and with it that compromise the treatment milieu is changed. To reiterate: to be family-like, their critical

and unique characteristic, these facilities should have no more than six, or at most eight, client beds and must be real *community* homes—not institutional appendages.

Minimal role differentiation is a term that is sometimes misunderstood and responded to by comments like "what these clients need are examples of clear roles and boundaries." What we mean is that, for the most part, each line staff member will be able to do anything needed by a particular client. For example, the same staff member may accompany a client to apply for an apartment, go with him to the welfare office to see about SSI benefits, and meet with his family that evening. Only the program director and psychiatric consultants have different, and differentiated, roles. Having staff as generalists makes it easier to use the natural pairings that occur to accomplish particular client goals without having to assign a "special" staff member to the task.

A comment is also in order about the absence of formal in-house therapy. As noted previously, we view the entire facility "package" as providing the therapeutic social environment. Hence, everything that goes on in and out of it can be viewed as therapeutic. However, there are no time-limited in-office therapy sessions—individual, group or family—*in the facility*. We believe that because of this policy client fragmentation and community suspicion about what's going on behind closed doors are prevented and a treatment value hierarchy does not become established. That is, for the environment to be the treatment, the "real" treatment cannot be a one-to-one hour in the office with a therapist. Individual clients may be referred out, as indicated, to receive these types of therapy away from the setting itself. Having said there is no formal in-house therapy, we must go on to say that a great deal of therapeutic interaction takes place in dyads, in groups, and with families in the setting. Much of it is spontaneous, but not infrequently staff will take clients aside to discuss particular issues or behaviors.

Specific therapies can be made available in the house to persons living there as long as these therapies are invited in based on the approval of a majority of the participants and are made available to everyone who wishes to become involved. Hence, art therapy, bibliotherapy, yoga, massage, acupuncture, special diets, etc., have come and gone in the settings depending on the group's wishes and the therapies' availability.

Group meetings are also held. Some, like the house meeting, occur on a regularly scheduled basis. Others, like family meetings, usually occur soon after the client is admitted and on an as-needed basis thereafter. Morning "what are you doing today?" and evening "how was your day?" meetings occur regularly but are not formalized. The Crossing Place brochure describes the social environment that should characterize this type of intensive residential community care:

> The basic therapeutic modality is one-to-one, intensive interpersonal support. Specially selected and trained staff members are with the client for as long as intensive care and supervision are required. The staff members all have experience in crisis-care.
>
> The program's home-like environment is also an important therapeutic element: it minimizes the stress of going into residential care and re-entry into the community because it resembles the client's ordinary environment. Individuals focus on coping with their life-crisis in a real-life setting. In addition, the environment minimizes the potential for severe acting-out by being small, intimate, and rapidly responsive. This setting tends to elicit the best from clients by regarding them as responsible members of a temporary family.
>
> The staff members work closely with the director and psychiatrists to help individual clients formulate goals and plans. The entire staff meets regularly to discuss problems encountered in the helping process. The program director and psychiatrists are available to give individual attention to clients with particularly difficult situations.
>
> The length of stay varies from a few days to several months, depending on individual needs. Discharge is effected when the crisis has subsided and adequate plans have been worked out for important aspects of post-discharge living and treatment.

When we compare Soteria with its successor Crossing Place, we find a number of differences: Soteria House was a carefully designed research project that limited its intake to young, newly diagnosed schizophrenic patients. Crossing Place takes adult clients of all ages, diagnoses, and lengths of illness. Soteria House existed mostly outside the public treatment system in its city. Its clients came from only one entry point and were carefully screened to be sure they met the research criteria before being randomly assigned to Soteria House or to the hospital-treated control group. Because of its restrictive admission criteria (about three or four of 100 functional psychotic patients admitted per month met them), Soteria House was not seen as a real treatment resource within that system.

Crossing Place, on the other hand, is firmly embedded in the Washington, DC public mental health system. It was founded by Woodley House, a long-established private nonprofit agency whose programs include a 22-bed halfway house, a 50-bed supervised apartment program, and a thrift shop with a work support program. Because of contractual arrangements with the District of Columbia mental health system, Crossing Place accepts referrals from a variety of entry points. Its clients are primarily system veterans whose care is paid for by one of these contracts. Although it officially excludes only persons who have medical problems or whose primary prob-

lem is substance abuse, it has little control over the actual referral criteria used by a variety of clinicians.

Thus, in contrast to Soteria House, Crossing Place clientele are a less well-defined, more heterogeneous group. They *may* be less ill, violent, or suicidal (unfortunately it's not possible to know for sure) than those sent to St. Elizabeth's Hospital, the main residential treatment setting for public patients in Washington. Compared with Soteria subjects, Crossing Place clients are older (32 versus 21), are more frequently members of minority groups, and have extensive hospitalization experience (4.5 versus no admissions). Basic subject data comparing the two settings is shown in Table 9.7. Thus, although the characteristics of the Crossing Place client population are not as precisely known as those of the Soteria patients, the former group can be characterized as "veterans" ("chronic") and the latter as newly identified ("acute").

In their presentations to the world, Crossing Place is conventional and Soteria was unconventional. Despite this major difference, the actual in-house interpersonal interactions are similar in their informality, earthiness, honesty, and lack of professional jargon. These similarities arise partially

TABLE 9.7
Patient Demographic Data

	*SOTERIA** (N=75)	*CROSSING PLACE** (N=155)
Age	21	32
Marital status:		
unmarried	80%	96%
Education	13 years	12 years
Employment:		
any prior to admission	73%	47%
Diagnosis	All schizophrenic	62% schizophrenic 26% affective psychosis 17% nonpsychotic
Previous hospitalizations:		
percent of sample	34%	92%
average number	1	4.5
weeks hospitalized previous year	1	8
Initial length of stay	126 days	32 days
Neuroleptic drug Rx during initial admission	24%	96%

*Cohorts I (1971–76) and II (1976–82) combined

from the fact that neither program ascribes the usual patient role to the clientele. Both programs use male-female staff pairs who work 24- or 48-hour shifts.

Soteria's research funding viewed length of stay as a dependent research variable. This allowed it to vary according to the clinical needs of the newly diagnosed patients. The initial lengths of stay averaged just over four months. Crossing Place's contract contains length-of-stay standards (one to two months). Hence, the initial focus of the Crossing Place staff must be: What do the clients need to accomplish so they can resume living in the community as quickly as possible? This focus on personal responsibility is a technique that Woodley House has used successfully for many years. At Soteria, such questions were not ordinarily raised until the acutely psychotic state had subsided—usually four to six weeks after entry. This span exceeds the average length of stay at Crossing Place (32 days).

In part, the shorter average length of stay at Crossing Place is made possible by the almost routine use of neuroleptics to control the most flagrant symptoms of its clientele. At Soteria, neuroleptics were not usually used during the first six weeks of a patient's stay and were sometimes given thereafter. Time constraints also dictate that Crossing Place will have a more formalized social structure than Soteria. That is, when goals are identified rapidly, there must be a well organized social structure to allow them to be pursued expeditiously.

The two Crossing Place consulting psychiatrists evaluate each client on admission and each spends an hour a week with the staff reviewing each client's progress, addressing particularly difficult issues, and helping develop a consensus on initial and revised treatment plans. Soteria had a variety of meetings but averaged one client-staff meeting per week. The role of consulting psychiatrists was more peripheral at Soteria than at Crossing Place. They were not ordinarily involved in treatment planning and no regular treatment meeting was held.

In summary, compared to Soteria, Crossing Place is more organized, structured, and oriented toward practical goals. Expectations of Crossing Place staff members tend to be positive but more limited than those of Soteria staff members. At Crossing Place, psychosis is frequently talked *around* by staff members, while at Soteria the client's experience of acute psychosis was an important subject of interpersonal communication. At Crossing Place, the use of neuroleptics limits psychotic episodes. The immediate social problems of Crossing Place clients (secondary to being system veterans and having come from lower-class minority families) must be addressed quickly: no money, no place to live, no one with whom to talk. Basic survival is often the issue. Among the Soteria clients, because they came from less economically disadvantaged families, these problems were

sometimes present but much less pressing. Basic survival was usually not an issue.

Crossing Place staff members spend a lot of time keeping other parts of the mental health community involved in the process of addressing client needs. Since the clients are known to many other players in the system, just contacting everyone with a role in the life of any given client can be an all-day process. In contrast, Soteria clients, being new to the system, had no such cadre of involved mental health workers. While in residence, Crossing Place clients continue their involvement with other programs. At Soteria, only the project director and house director dealt with the rest of the mental health system. At Crossing Place, all staff members negotiate with the system. The house director supervises this process and administers the house itself. Because of the shorter lengths of stay, the focus on immediate practical problem-solving, and the absence of most clients from the house during the daytime, Crossing Place tends to be less consistently intimate in feeling than Soteria. Still, individual relationships between staff members and clients can be very intimate at Crossing Place, especially with returning clients.

One aspect of the Crossing Place program that deserves special mention is the ex-residents' evening. It is based in part on the Soteria experience, but also grew out of the emphasis at Crossing Place and Woodley House on alumni involvement. An art therapist supervises the session, to which former and current residents are invited. Attendance varies considerably, but the formal time, place, and the nature of the activity make returning much easier for persons who might otherwise not be sure they are "really" welcome. The evening provides social contact, a place to find friends, and a chance to meet new people. Art seems to be an ideal medium around which to focus a meeting of long-term clients. Almost anyone can draw, and the critical comments of others can be easily deflected by saying, "Well, I've never drawn before." Although a large informal social network of clients existed around Soteria, the house never had a formal arrangement with ex-residents. Again, this program difference would appear to be best explained by differences in clientele.

Both Soteria and Crossing Place use non-degreed paraprofessionals as staff. Although some of the staff may, in fact, have college or graduate degrees, they are not required in the application process. These facilities seek staff who are interested, invested, and enthusiastic about the type of work they anticipate doing, independent of credentials. The down side of this practice is that there is often no career ladder available to them. Additional problems with using non-degreed paraprofessional staff are the generally low salaries paid them and a lack of recognition of their value in the professional mental health community. Hence, staff turnover is usually a

consequence of returning to school to get graduate degrees, most frequently MSW's.

Our experience is that the more accurately the reality of the job is described, the less likely it is that a misfit between job and person will occur. Thus, we like to make very explicit exactly what will be expected of staff in ads and job descriptions provided to them. Our view is that the *self-selection process is the primary determinant of the quality of staff*. The requisite values and attitudes predate their employment; the setting only serves to reinforce and expand them.

The job description should contain sufficient substance to allow candidates to easily identify the major activities that will be part of their job. These include:

1. *Client assessment.* Staff are required to evaluate each client's strengths and weaknesses, with an emphasis on expandable areas of strength. The task is to respect and *understand*, in context, what's going on with the client. Psychopathology will be factored in, but in a manner that preserves the focus on health, positive assets, and normalization of functioning. This assessment will also include a future planning element, since in these transitional programs the *process of leaving begins at entry*.
2. *Relationships, "being with."* Staff will be expected to form some modest relationship with most clients. It is expected that they will form close relationships with a minority of clients. The relationships are expected to be peer-oriented, fraternal, nonexploitative, attentive but not intrusive, warm, nurturant, supportive, and responsive. Staff are not expected to like everyone, nor are they expected to have a close relationship with the majority of clients. They are not expected to see themselves as psychotherapists, even with those clients with whom they form close relationships. Quiet, attentive, nondemanding support is highly valued.
3. *Advocacy/empowerment.* Staff will work with clients on *their* goals. If this requires involvement with specialists or others outside the facility, they will be involved as required. Client goals are always primary, even if they require staff to go out of their way. Staff take clients and stay with them, if necessary, to the welfare, vocational, housing, socializing, and recreating systems. Their goal vis-à-vis the clients' goals is to facilitate the process of normalization and integration back into the mainstream of society. They are to view themselves as being clients' employees and should treat them as "the boss" insofar as their requests are at all reasonable. Even seemingly unreasonable requests (if not dangerous to anyone)

should be pursued. Staff are not to see themselves as necessarily knowing what is "best" for the client. A truly unreasonable request will likely be treated as such by the entire social environment. Hence, staff need not make it their responsibility to define this "reality." Also, they need not necessarily try to protect clients from the impact of pursuing their requests (absent real risk of serious harm). Doing so would deprive the client of an in-vivo learning experience.

Basically, staff should be able to put themselves, flexibly and nonjudgmentally, into the client's shoes. This ability will allow them to accept a variety of wishes, needs and goals from the client without a predetermined staff-derived hierarchical scale of importance or "rightness." This is why we try *not* to hire staff with a strong commitment to a particular mental health ideology—psychoanalytic, behaviorist or what-have-you. In our experience adherence to a particular theory inhibits the staff person's ability to be immediately and flexibly responsive.

What follows are three illustrative excerpts of staff-client interactions taken from the Soteria treatment manual (*Treatment at Soteria House: A manual for the practice of interpersonal phenomenology*, 1992, available from LRM). This document attempts to provide management guidelines and case examples of how Soteria staff dealt with various difficult behaviors and states of mind without using seclusion, restraints or medications. Major headings include: aggression, withdrawal, regression, sexuality, relationships, contagion, and leaving.

The first example illustrates the course of a series of interactions around a young woman's firmly held, but not consensually validatable, belief system. It is not uncommon for an individual staff member to spend entire shifts for weeks on end with one resident, often sleeping in the same room with him.

> For a long time it was Monday through Wednesday, which is my shift. I'd spend the whole time with Hope when she wasn't asleep. She went through a long period where she just didn't sleep at all at night, like, you know, we'd watch the sun come up every morning talking. Hope was an all-nighter—one of the most famous all-nighters.
>
> She was consumed by the devil in the beginning, but she wouldn't talk about it as much after a while because she knew that people would try to talk her out of it. Then when she really started to believe that there was something inside her besides the devil, and the closer she would come to figuring out things for herself, she would talk back to you a lot of times, really getting a lot of garbage out. She needed a sounding board. She'd suddenly become more and more rational. She would talk about how she really knew she wasn't the devil, yet inside, she felt so awful. Sometimes I argued with her about it. She would talk about how she was the devil, then together we would find these coincidences that could prove that anybody was the devil or that she wasn't the devil. After a while, when she really became aware that nobody in the house believed that she was the devil, she was sort of pissed off. She really would try hard to prove it. Sometimes I'd get angry at her if she was really carrying on trying to prove she was the devil. I'd tell her about the parts of her that weren't the devil.

The next example is taken from the manual's section on regression:

> I had had three hours of sleep, and even that had been broken sleep. Sleeping with and guarding Sara is not especially conducive to good resting. I was sleeping on the floor by the door so that I would waken if she tried to leave. She awakened at 6 o'clock demanding food. I got up and started to fix her breakfast. She was sitting at the table waiting more impatiently; she then urinated on the bench she was sitting on. I took her to the bathroom, changed her pants and we went back to the kitchen. I fed her at the table. She finished and sat quietly for about two minutes. Then she looked at me with a fearful expression on her face and asked me what day it was. I told her it was Sunday, and she said, "No, I mean what day is it *really*. *You* know what I mean!" I told her that it was Sunday, September 5th. I knew that it was Sara's birthday but for some reason I didn't want to deal with it then. I was tired, I was sad—it was Sara's 16th birthday, "Sweet 16." It was Sara's special day to celebrate, and there sat Sara in Soteria, soiling herself, terrified of dying, of being alone, of being with people, of spiders, of noises, of being loved, of being unloved. Happy Birthday, Sara—it was so goddamned sad.
>
> Anyway, when I told her the date she was stunned. She sat completely still and stared at me. Then came the change—fear, anxiety, joy, little-girl pleasure, sorrow, and pain all flashed over her face in seconds. Then she started to cry, a slow, sad, and painful cry. And then she said, "It's my birthday, say 'Happy Birthday' to me." And I did. Then she got up and came over to me and sat down. She took my hand in both of hers and said, "Hold me!" I held her while she cried for a few minutes. Then she sat up and said, "Give me a present. Give me something. Give me anything. Give me something you don't want anymore. Give me something you hate. Just give me anything of yours and I'll love it forever." I told her that she would be getting birthday presents later in the day—that we hadn't forgotten her.
>
> I was wearing a T-shirt that morning, one that Sara liked. She asked me then if I would wear her shirt and could she wear mine, just for her birthday. No one else in the house was awake—it was early and it was Sara's birthday—so we exchanged shirts.

Regression, while not induced, is allowed and tolerated when it occurs naturally. Staff feel that it is often an important step toward reintegration.

The last excerpt is a marvelous example of the concept of "being with," both physically and psychologically:

While we were talking he kept talking about how his father was Howard Hughes. And at this point he was just laying on the bed and I think I was sitting on the floor next to him. And he was saying he had to find out where his Lear Jet was parked. I asked him why he wanted it and he said he had to get back to Nevada to see his mother. He was saying his back was very sore, so I gave him a back massage. He talked more about his mother. He wanted to see his mother and bring her back here. He'd start crying a little bit. This went on for pretty close to an hour. Afterwards he said his back felt better. He said he could wait to go see his mother but he still wanted to find his Lear Jet. He thought it was parked on the driveway. So we went out to the driveway and it wasn't there. He said it must be at the airport. We came back in the house and we went to his room again. He was talking about things that happened in the war between him and Harly Bird. And then I wanted some coffee so we went over to Spivey's (a nearby restaurant). And I bought him a hamburger. He was telling me all about when he was a kid—the childhood he had and the paper routes and about school. About every two or three minutes he'd stop and laugh and say, "Well, this is silly for me to tell you; you're my father; you already know all this." As we were coming back, he stopped and said, "That was really nice. I knew you were going to take me out to dinner some night, Dad. And now we've done it." When we got back to the house he began telling me the Venutians were going to come down and visit him that night. He says "I can see them coming down now. They're going to be waiting for us." So then we went across the street under the stoplights, because he had to see the sun at the same time he saw Venus, and the sun was just coming up the other side. And he had to be between them for the Venutians to find him. So we were waiting there for maybe a half hour or 45 minutes, and he figured, well, they weren't going to come today, after all. It was getting light and Venus was disappearing from the sky, and they hadn't shown up yet, so he figured they weren't going to come. We came back to his room and it was maybe 5:30 or 6 in the morning by this time. He was talking about this belt that Harly Bird had given him that allowed him to go through space and time and it was a seat belt for the Lear Jet. Somewhere thereabouts he fell asleep, and I fell asleep too.

We hope these examples convey the flavor of the very unusual ways of dealing with madness that evolved at Soteria House. These descriptions should be compared with Dr. Holly Wilson's account of the treatment process on the ward where comparison group clients were sent (Chapter 4, pp. 41–42).

Systematic research comparison of the Soteria and Crossing Place treatment milieus has taken place. Moos' Community Oriented Program Environment Scale (COPES) (Moos, 1974, 1975), a 100-item true-false measure of participants' perceptions of their social environment, was administered at regular intervals to staff and clients in both programs. This measure has both "real" (i.e., "How do you see it?") and ideal (i.e., "How would you like it to be?") forms.

Although staff and client real and ideal data were collected, only staff

real data are reported here (see Figure 9.1). According to these data, Crossing Place staff members, as compared with Soteria staff members, see their environment as three standard deviations higher in practical orientation and two standard deviations higher on order and organization and staff control. Both programs are one or more standard deviations lower than norms derived from other community-based programs on autonomy, prac-

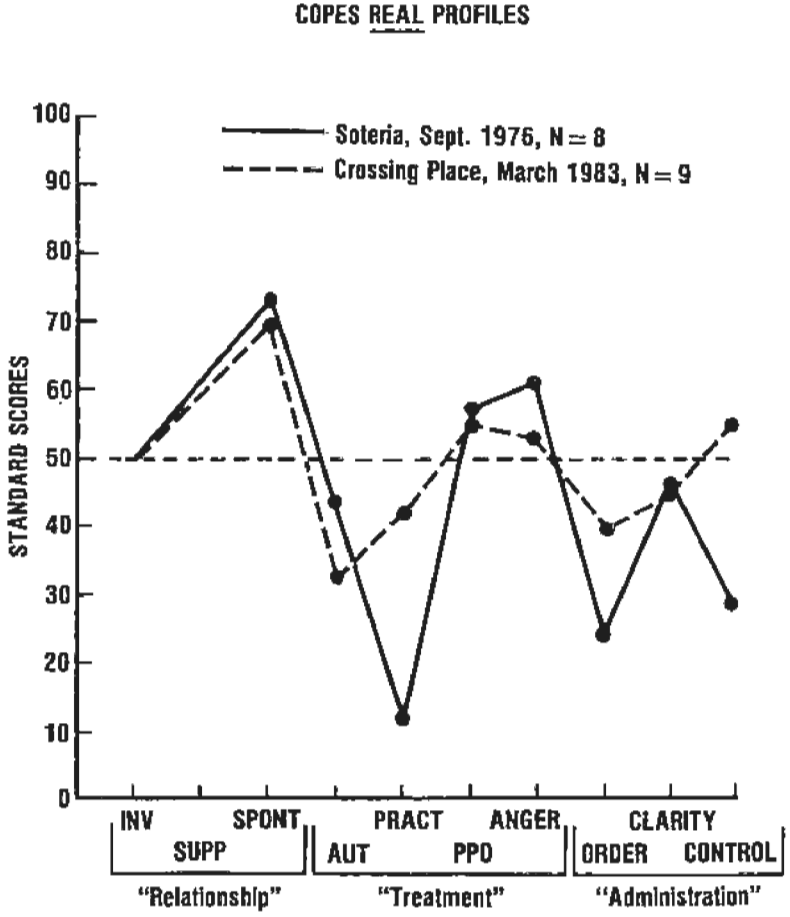


FIGURE 9.1
Program Comparisons: Staff
Soteria and Crossing Place

ticality, and order and organization. They are one or more standard deviations higher on the three psychotherapy variables—involvement, support, and spontaneity—and on the treatment variables of perceived personal problem orientation and staff tolerance of anger. The overall shapes of the two profiles have almost point-by-point correspondence on six variables and similar profile shapes on the other four. The congruence between clinical descriptive and standardized assessment findings is both noteworthy and gratifying (Mosher et al., 1986).

The two programs also conform well, by both clinical description and systematic assessment, to the literature-derived descriptions of effective therapeutic milieus for acute and "veteran" clients outlined earlier.

RESULTS OF THE SOTERIA PROJECT

A. *Cohort I (1971–76) (Soteria subjects N = 30, control subjects N = 33)*

Six-week and two-year outcome data from the subjects admitted between 1971 and 1976 have been reported in detail elsewhere (Mosher & Menn, 1978; Matthews et al., 1979.) Briefly summarized, the significant results from the initial, Soteria House only, cohort were:

1. Admission characteristics: Experimental and control subjects were remarkably similar on ten demographic, five psychopathology, seven prognostic, and seven psychosocial preadmission (independent) variables.
2. Six-week outcome: In terms of psychopathology, subjects in both groups improved significantly and comparably, despite Soteria subjects' not having received neuroleptics.
3. Community adjustment: Two psychopathology, three treatment, and seven psychosocial variables were analyzed. At two years postadmission, Soteria-treated subjects from the 1971–76 cohort were working at significantly higher occupational levels, more often living independently or with peers, and had fewer readmissions; 57% had never received a single dose of neuroleptic.
4. In the first cohort, despite the large differences in lengths of stay during the initial admissions (about one versus five months), the cost of the first six months of care for both groups was about $4,000.

B. *Cohort II (1976–82) (Soteria and Emanon subjects N = 45, control subjects N = 55)*

Admission, six-week, and milieu assessments replicate almost exactly the findings of the initial cohort. However, at two years there are no significant

differences between the experimental and control groups in symptom levels, treatment received (including medication and rehospitalization), or global good versus poor outcomes. Consistent with the psychosocial outcomes in cohort I, cohort II experimental subjects, as compared with controls, had become more independent in their living arrangements at two years.

Interestingly, independent of treatment group, good or poor outcome is predicted by three measures of preadmission psychosocial competence: level of education (higher), living (independent), and work (successful) (Mosher, Vallone, & Menn, 1992). It was also associated with the presence of clear precipitating events in the six months prior to study entry. Good outcome was defined as having no more than mild symptoms *and* either living independently or working or going to school at both one- and two-year follow-up.

In summary:

1. It is possible to establish and maintain an interpersonally based therapeutic milieu that is as effective as neuroleptics in reducing the acute symptoms of psychosis in the short term (six weeks) in *newly diagnosed psychotics*.
2. The therapeutic community personnel did not require extensive mental health training and experience to be effective in the experimental context. They did, however, need to be sure that this was the type of work they wanted to do, be psychologically strong, tolerant and flexible, and positive and enthusiastic. Finally, they needed good on-the-job training and easily accessible supervision and backup.
3. Longer-term outcomes (two years) for the experimental groups were as good or better than those of the hospital treated control subjects.
4. Although it is difficult to confirm or dismiss from the data, it appears that the positive longer-term outcomes achieved by cohort I experimental subjects, as compared with cohort II, were at least in part due to the spontaneous growth of easily accessible social networks around the facilities. These informal networks provided interpersonal support, housing, jobs, friends and recreational activities on an as-needed basis to clients and staff. Unfortunately, these networks disintegrated as it became clear that the facilities would close. Hence, in contrast to cohort I, cohort II subjects did not receive as much of the *peer case management* provided by the social networks around the houses during their two-year follow-up.

Based on 12 years of experience in the Soteria project and 14 years and more than 1,400 clients in Crossing Place, we have identified what we consider to be the nine essential therapeutic ingredients of these special social environments. They are:

1. Positive expectations of recovery and learning from psychosis.
2. Flexibility of roles, relationships and responses.
3. Acceptance of psychotic persons' experience of themselves as real—even if not consensually validatable.
4. Staff's primary task is to *be with* the disorganized client; it must be specifically acknowledged that staff need not *do* anything.
5. Normalization and usualization of the experience of psychosis by contextualizing it, framing it in positive terms, and referring to it in everyday language.
6. Tolerance of extremes of human behavior without need to control it except when there is imminent danger.
7. Sufficient time in residence (one to three months) for development of surrogate family relationships that allow imitation and identification with positive characteristics of staff and other clients.
8. Sufficient exposure to positively valued role models to identify, experiment with, and internalize strategies for problem-solving that provide a new sense of efficacy, mastery and competence.
9. Readily available post-discharge peer-oriented social network with which contact is begun while in residence.

The reader will note that most of these have been previously described in Chapter 7.

Transitional Residential Programs ("Half-way Houses")

Transitional housing is a clear departure from usual living arrangements and therefore not optimally *normalizing*. Transitional facilities and programs should be arranged in a way that delivers the *"this is a temporary arrangement"* message clearly and consistently. In contrast to what we espouse for both alternatives to hospitalization and supported nontransitional housing, we believe that halfway houses should be somewhat institutional and have a social organization that expects, promotes, and reinforces independence in the context of support. Their social structure will produce the desired independence-promoting effect only if they are closely associated with supported nontransitional housing programs. Repeated separations from friends and family and housing instability are known to be associated with increased rates of psychiatric disorder. For these reasons,

the thrust of transitional programs should be toward helping clients establish permanent housing and stable social networks.

What kind of "institutional" characteristics should such facilities have?

1. They should house more persons than an extended family. Hence, 15 to 25 clients is a good number of clients for such places.
2. Program rules should specify the independence-oriented behaviors desired:
   a. Length of stay should be limited.
   b. There should be few private rooms and clients should have only minimal say in roommate selection.
   c. Outside the house day-time activity should be required. Consistent school attendance or paid work should result in paying less rent.
   d. All therapy should take place outside the facility.
   e. Residents should be involved in the day-to-day running of the house as training and practice for their own living environment.
   f. Attendance at client-run in-house meetings focused on dividing up chores and planning educational, social, and recreational events should be required.
3. The program should be relatively lightly staffed so that staff are forced to focus on helping the client group develop into a reciprocal-help, peer-based support network. Foremost in each staff member's mind should be the question: "How can I foster groupness?" Ideally, instead of turning to staff for help, clients will use each other. Subsets of the networks that develop can be helped to move out together into the associated housing program.
4. The setting should be regarded by staff (and thence transmitted to clients) *as if* it were a college dormitory. The resident managers (not counselors or therapists) should be there after 4 p.m. and overnight and leave in the morning as clients are expected to do.

The rules should function to prevent settling in and the dependency it tends to foster. This is intended to help minimize problems with leaving. It is an intentional social environment focused on restricting in-house freedom for the sake of promoting out-of-house autonomy. It is meant to make the nontransitional housing program look very attractive by comparison. The program should provide individualized training to those who need it in cooking, cleaning, doing laundry, and personal care. This training can be continued as clients make the transition to new residences.

Halfway houses in the 15–25-bed range can also provide on site (if space

is available) a variety of general health-oriented activities—aerobics, yoga, meditation, safe sex education, etc. The literature contains a number of specific models for these types of programs (Budson, 1978; Budson, Meehan & Barclay, 1974; Glasscote, Cumming, Rutman, Sussex & Glassman, 1971; Golomb & Kocsis, 1988; Jansen, 1970; Landy & Greenblatt, 1965; Purnell, Sachson & Wallace, 1982; Rausch & Rausch, 1968; Rothwell & Doniger, 1966; Spivak, 1974). Above we've attempted to provide flexible principles that can be adapted to fit local conditions.

A 100,000-person catchment area will need about 50 halfway house spaces. Their daily cost should be about $40 per client.

Supported Non-Transitional Housing

There are a number of contextual factors in the U.S. that make the inclusion of decent, affordable housing a critical element in an effective community mental health system. They are:

1. At the present time, because of its progressive nuclearization and frequent disorganization as a consequence of divorce, remarriage, and absent fathers, the American family is not a reliable source of housing for its adult children or the grandparental generation. In the U.S. fewer than half of community-based mental health clients live with their families. By way of contrast, about 80% of such clients in Italy live with their families.
2. Politicization of the homelessness problem has added fuel to the "irresponsible deinstitutionalization" fire surrounding mental health policies and programs. This attribution has further eroded public confidence in community mental health programs and resulted in a call for a return to institutional care. Mental health programs must become able to absorb into their programs those homeless individuals who are truly disturbed and disturbing and seek permanent housing. This is not only humane but good public relations for community mental health. It is worthwhile in this context to point out that Italy's closing of its large psychiatric institutions nearly 10 years ago has not resulted in a substantial increase in the homeless population in that country. This cross-cultural difference is probably due both to the strength of the Italian extended family and the system's focus on *preventing* institutionalization rather than on deinstitutionalization.
3. Users of the public system are almost by definition poor. SSI recipients receiving about $380 a month (the present Washington, DC rate) cannot, by themselves, afford housing in most urban areas. By seeking housing in an ongoing way, a mental health program can find bargains, negotiate leases, guarantee payment and upkeep to landlords, and serve as housemate brokers for the clientele. Program staff can also develop the expertise necessary to access the local housing subsidy program on behalf of its users. There are, of course, other ways of assuring the availability of housing to mental health system users. In fact, setting aside a percentage of units in public housing programs is in many ways a more normalizing option and should be used if feasible. There are many ways to skin the housing cat; all should be tried.

We estimate that the average U.S. public psychiatry program will need about 200 supported independent living *spaces* (beds) for a 100,000-person catchment area. Clients should not have to pay more than about a third of their incomes for housing. Programs may add a modest consultation fee to the amount paid for rent (e.g., $20 per month) to help the program pay for itself. Doing so (assuming clients cover the rent one way or another) will result in a very economical housing program; the equivalent of six or seven full-time staff for 100 spaces will cost approximately $1500 per space per year after startup costs.

In keeping with the principle of normalization, we believe that community residences (group homes, apartments, Fairweather lodges) developed by mental health programs should be labeled *nontransitional*. This is designed to promote security, stability, predictability, and "ownership" in the lives of users. Persons seeking housing who are not mental health system clients are not ordinarily (assuming the terms of the lease are met) subject to arbitrary length-of-stay rules or required to leave places they've leased to make room for others who also need a place to live. So we believe it is best, *insofar as feasible*, for programs to make clear to clients that the program will turn over its lease to the clients in residence if they wish to remain there. It should also make clear that they are always free to leave to find a place of their own choosing. This policy most nearly approximates what ordinary citizens experience in the role of "tenant." This means that mental health programs will need to seek replacement housing units in an ongoing way. However, we also recognize that the transfer of a lease to a client group will probably not be the modal experience. It is just too difficult when groupings are formed at least in part based on program needs for a three-, four-, or five-person group to be compatible enough to remain together.

So *in practice* many units in housing programs will be transitional and thereby remain in the program. The important point is that if clients know there is no *programmatic* barrier to their making the unit into "home" it

will tend to encourage them to take care of it as if it were theirs. Thus, an important normalizing expectation is facilitated by program policies. Creative program staff will attempt to be housing matchmakers; for example, when program users find friends in the group, staff should facilitate their efforts to move in together and eventually take over a lease.

Most community mental health experts agree that ghettoization of the mentally ill in community-based residences is just another form of segregation from so-called normal society. Hence, it is typically recommended that housing for clients be scattered in the community and only a minority of units in multi-unit apartment buildings be leased to them. We agree completely. However, is restricting the types of persons eligible for the housing to the mentally ill not also a form of segregation? We therefore recommend that community mental health housing programs attempt to make their units available to nonmental-health-program-related persons in need of housing. Although administratively cumbersome, having a mix of mental health clients and "normal" people in the housing has several things to recommend it:

1. It continues the process of desegregating the so-called mentally ill.
2. For a "normal" person it provides direct day-to-day experience with a person carrying a "mentally ill" label and vice versa. This is the most effective way to destigmatize mental health clients.
3. The "normals" provide role models clients can imitate and identify with and from whom they can learn various coping skills. The users provide the "normals" with access to life experiences they've likely never had.
4. It provides housing that some of the "normals" might not have been able to afford.

Where are such persons to be found? Students and persons on public housing waiting lists come immediately to mind. Actually, persons with limited incomes might be recruited via newspaper ads.

This mixing of populations may prove difficult to implement because of bureaucratic and administrative issues, but it does highlight a continuing problem with segregation of the mentally ill even in good community programs. It will need to be addressed before clients can be truly embedded in the community.

Having posited above that ghettoization of the mentally ill is not good practice, we must say that if one conceives of this clientele as a *subculture* that need not be mainstreamed into "normal" society another type of housing option becomes tenable. Pioneered by Mandiberg and Telles (1990), the notion of *clustered apartments* to encourage the development of a subculture, along with a *peer support* model, was demonstrated to be an effective option within a variety of supported nontransitional housing programs. To be viable, the model requires a closely located group of 60–100 clients and a respite apartment for clients who decompensate.

We like to apply our oft-used analogy of the smorgasbord to the types of living arrangements possible in housing programs. The nontransitional housing smorgasbord should vary widely along two continua: type of living arrangement (e.g., group home, apartment, Fairweather lodge) and amount of interpersonal *support* provided by the mental health system. We prefer the term "supported" independent housing to the more commonly used "supervised," as it has less of a child-like, dependency connotation. This is in keeping with the normalization principle; everyone needs support, whereas only specially designated groups, like children, need supervision. No living group should be larger than an extended family, i.e., six to eight persons. If possible, the group should decide whether or not it will be mixed or of one gender only.

Ideally, program support should be flexibly available to all living arrangements in the system, so that it is *brought to clients* when they need it—including those living at home with their families. This arrangement makes it possible for individual units to become independent of mental system support—a salutory development when it occurs. Having to move into a new living situation when more support is needed only adds the stress of moving to those already being experienced; hence, bringing support to the client to prevent this stress makes good clinical sense. Of course, if sufficient in-residence support can't be arranged or if the family or house or apartment mates are feeling no longer able to tolerate the crisis, then a move to a hospital alternative or some other intensively staffed transitional facility is warranted. One interesting way to structure a program is to have the staff consultants based in an apartment that can also be used as needed for temporary intensive respite care.

We recognize that a comprehensive housing program will need to include nontransitional settings that provide 24-hour on-site supervision and caretaking. Foster care, board and care, boarding houses, single room occupancy hotels, and nursing homes will be required to care for a subset of the population. Staff support should be available to clients and caregivers as needed. We have not highlighted these settings because we believe it's better to aim a bit high rather than too low with regard to the degree of independence clients are able to sustain in the community. However, clients should be free to trade some of their freedom and autonomy for reliable on-site caretaking if they so choose.

An array of support and intervention should be available in housing programs—family meetings, house meetings, single and multi-apartment

group meetings. In-residence training sessions focused on cooking, cleaning, doing laundry, and personal appearance should be provided as needed, usually to clients new to the program. It must be remembered that what clients learned in other settings will not necessarily transfer to new ones. Staff should generally view themselves as consultants to *households* (i.e., the living group), not to individuals. This attitude will help foster collectivity in the group and self-help and independence on the part of the individuals. Staff should focus their efforts on helping clients learn to solve their own in-residence issues by modeling an approach that attempts to deal with problems at the level at which they occur. For example, a problem between two roommates should be dealt with by meeting with them (assuming they've already tried to solve it themselves), *excluding* others in the same apartment if they're not *directly* involved in the problem.

If housing program developers keep in mind the principles of normalization and preservation of power we've described, program policies should flow logically from them. Doing so will enable the program to avoid the oft-made mistake of creating mini total institutions in the community. For example, we are frequently asked what kind of rules should be made with regard to sex and alcohol in residences. Our response is that *insofar as feasible* the clients in each unit should make whatever rules are needed. We advise that program staff look at the issue from the perspective of their *own* group living experiences. Externally introduced (i.e., program) rules should be kept to the absolute minimum consistent with the program's functioning. Society's views on the particular issue should be used as guidelines in developing program rules. That is, society allows alcohol consumption, so a housing program should not have a *blanket* rule against it. However, individual units should be free to decide to not allow alcohol. Also, if a unit seems to be having a problem with alcohol that is unresolved after a series of staff consultations, a temporary, externally imposed (from staff) rule against it can be made. By way of contrast, we believe that housing programs affiliated with the mental health system should have an explicit rule against illegal drugs in their facilities.

Staff should remember that rules are easier to make than to do away with. Also, given the realities concerning the amount of staff time available to supported housing, staff's ability to enforce externally applied rules is limited. For example, in a discussion of a program's rule against having sex in its housing, a staff member wryly remarked, "Yes, they don't have sex in the house between 4 and 8 p. m.—when we're there!"

Many clients in these residences will have had long institutional experiences. A large part of their difficulties adjusting to the community will stem from their expectation that, if they agree to abide by a series of institutional rules governing their behavior, they will be totally taken care

of. A good community program should not replicate this institutional experience in its housing. This is not to say that clients with long institutional experiences can be expected immediately to be individually self-governing and to participate appropriately in within-unit discussions. However, these should be overarching long-term goals to be pursued in collaborative relationships between staff and users. Deinstitutionalization should be an active process—not a state designated by the fact the clients are no longer in the hospital. Because the degree of institutionalism evident in clients will vary widely, it will take experience and good clinical acumen to be able to walk the ever shifting line between expecting too much and asking too little of individual clients.

Supported independent housing programs are fortunate that their rental units do not usually require a special permit or license that would bring their presence to the attention of the community. Halfway houses, because of the number of residents involved (e.g., 10–15), are not usually so fortunate. Community opposition to such facilities is a reality. What is needed is patience, strong backing from official agencies, good legal counsel, and good diplomacy with and responsible reassurance of the community by the program.

Discriminatory zoning regulations have been consistently struck down in the courts. Hence, the most frequent legal grounds used in support of community protest is not usually viable when court tested. In addition, evidence from the study of the implementation of the Willowbrook decision indicates that community fears were unfounded and quieted rapidly as group homes in the community were established and filled (Rothman, 1980). Hence, if programs can quietly and consistently maintain pressure they will eventually overcome opposition. Once in place they can actually begin to expect a rather neutral or even positive view of them by the community. This process is easier if the agency has a good reputation, if it does something that actually enhances property value (e.g., repair and renovation), and if staff are sensitive to the needs of the neighbors. Tincture of time seems once again to be a useful medicine, this time for dealing with community opposition to mental health clients living in its midst. The passage of the Fair Housing Amendments in 1988 and the Americans with Disabilities Act in 1992 provide new legal backing for the movement of clients into "normal" neighborhoods.

There are a number of mental health housing program models (Arce & Vergare, 1985b; Carling, 1984; Carpenter, 1978; Chien & Cole, 1973; Fairweather et al., 1969; Goldmeir, Shore, & Mannino, 1977; Kresky, Maeda, & Rothwell, 1976; Mannino, Ott, & Shore, 1977; Murphy, Engelsmann, & Tcheng-Laroche, 1976; Randolph, Lanx, & Carling, 1988; Segal, Baumohl, & Moyles, 1980; Solomon & Davis, 1984). Unfortunately (at least from our

perspective), they are too often designated as "transitional" and "supervised." We believe that calling them *nontransitional* while expecting that most will in fact be used as transitional housing is preferable in terms of the expectations engendered. Readers interested in day-to-day implementation, administrative and program management issues can find that information in these publications.

In many locales bureaucratic regulations will make adherence to the principles outlined above difficult. However, they do set out relatively ideal program guidelines against which current program realities can be compared.

DAY AND EVENING PROGRAMS

The literature indicates that only 20–25% of all persons discharged from psychiatric hospitals are competitively employed (Anthony & Dion, 1986). Hence, the majority of mental health clients lack the organizing, structuring, expectant daytime environment associated with working. They also lack the rewards for accomplishment that flow from successful work.

Community-based day and evening programs should be focused on providing intentional social environments that address the interpersonal and instrumental competence deficiencies of the clientele. They should provide concrete vocational and social success experiences in the context of a supportive group. Optimally, these success experiences will come from learning the skills they lack, or are deficient in, and from flexible programmatic attention to their individual needs. The expectation should be one of making the transition, with proper training and support, to a more normal way of life (including a job) in the community.

While functioning as nonresidential alternatives to hospitalization, day programs should also be able to provide for clients who are either unwilling or unable to be involved in an organized, structured group exercise. That is, acutely disorganized clients using the program as an alternative often find the environment of a large, well-organized psychosocial rehabilitation center or day hospital just too stimulating, confusing, and overwhelming. This is also true of a number of clients recently discharged from intensive residential care (e.g., alternative or hospital). They will drop out or appear only irregularly. For these clients a low intensity, low demand, simple, casual, "drop in" social environment should be provided. This requires a sound-dampened room with soft, comfortable furniture and the availability of optional low-key activities like art, cards, checkers, VCR movies, community outings, and the like. The social interaction should be mostly dyadic or triadic. Staff should be patient, non-intrusive and nondemanding. Small groups discussing sports, the soaps, the VCR movie, etc., can be organized. We highlight this need because in our experience day programs do not often attend to the special needs of this subset of clients. This results in unnecessary utilization of the system's most expensive component—intensive residential care.

Two different types of day programs have proliferated over the past three decades and dominate the field: day hospitals and psychosocial rehabilitation centers based on the Fountain House Model. Both have been shown to be effective in shortening impatient stays and reducing relapse rates (to 10% a year as compared with an expected rate of 40% per year) among formerly hospitalized patients (Anthony, Buell, Sharratt, & Althoff, 1972; Beard, Malamud & Rossman, 1978; Bond, Witheridge, Setze, & Dincin, 1985). Day hospitals have, in addition, been shown to be an effective alternative to 24-hour impatient care for selected clients (usually those with involved families) (Herz, Endicott, Spitzer, & Mesnikoff, 1971; Washburn, Vannicelli, Longabaugh, & Scheff, 1976; Wilder, Levin, & Zwerling, 1966). Both seem to be ideal environments in which to implement the kinds of individual social skills and family intervention programs recently found to be effective in reducing relapse and enhancing community adjustment (Bellack, Turner, Hersen, & Luber, 1984; Falloon et al., 1982; Hogarty et al., 1986; Leff et al., 1982).

Although day hospitals and psychosocial rehabilitation centers grew out of different cultures (medical versus rehabilitation), the social environments they provide serve the generic milieu functions we describe in the chapter on residential alternatives for their clientele. Most day hospitals are what the name denotes: an eight-hour-a-day hospital staffed mostly by medical personnel. Their focus is on providing specific treatments (medications; individual, group, and family psychotherapy) in the context of a highly organized, structured program format. The usual medical hierarchy may be muted but M.D.'s are usually in charge. Psychosocial rehabilitation centers tend to have a practical down-to-earth focus, while day hospitals tend to focus on resolution of personal problems. Day hospitals tend to be smaller—20–40 persons versus 75–150 in rehabilitation programs. Psychosocial rehabilitation centers frequently have their own housing programs; day hospitals usually do not. Day hospitals generally take patients with involved families; psychosocial programs take persons from any type of living arrangement.

Propelled by a key NIMH training grant, active involvement in the development of the NIMH Community Support Program (see Mosher, 1986, for a more complete explication), and the development of two centers focused on the rehabilitation of the mentally ill (at Boston University and the Thresholds Psychosocial Rehabilitation Center in Chicago), psychosocial rehabilitation programs have proliferated rapidly. At the present time there are about, 300 "clubhouses" attended by about 25,000 clients throughout

the U.S. It is for this reason we are reprinting portions of the classic article on the Fountain House model of psychosocial rehabilitation—a model that dominates the field at the moment. It, or a variant, should be included in the smorgasbord of community-based facilities.

Because of day hospitals' medical/psychiatric/individual psychopathology focus, we are ambivalent about recommending their inclusion in a community array. If reframed as day centers and focused on family, network and systems interventions, they can provide a useful additional element in a community array. This is especially true if they are not in, or on, the grounds of a hospital. Day hospitals have often been established because they are sufficiently medical in their orientation, programming, and staffing to qualify for third-party reimbursement. To the authors this seems to be an example of penny wise and pound foolish. They usually cost $200–300 per day as compared with $30–40 per client per day for psychosocial rehabilitation centers. Unfortunately, there are no random assignment studies comparing outcomes of clients seen in psychosocial rehabilitation centers with those in day hospitals. Until the issue can be resolved empirically we advise program planners to chose the less costly option. Having said this, we suspect that day hospitals *may* be best suited to the treatment of a subset of clients: middle- and upper-class depressed persons with well established occupations as housewives or white collar workers and only temporary loss of social competence. For this group, something called "hospital" may be more legitimate and acceptable than a rehabilitation center, a term they tend to associate with serious physical disabilities.

We estimate that a catchment area of 100,000 persons will need about 100 or so day program spaces. This is a crude estimate that will need to be modified in areas that have large numbers of veteran clients.

THE FOUNTAIN HOUSE MODEL*

The Fountain House model is a social invention in community rehabilitation of the severely disabled psychiatric patient. Fountain House itself is an intentional community designed to create a restorative environment within which individuals who have been socially and vocationally disabled by mental illness can be helped to achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

Fountain House conveys four profoundly important messages to every individual who chooses to become involved in its program:

*From Beard, J. H., Propst, R., & Malamud, T. J. (1982). The Fountain House Model of Psychiatric Rehabilitation. *Psychosocial Rehabilitation Journal, 5*, 1, 47–53. Reprinted with permission.

1. Fountain House is a club and, as in all clubs, it belongs to those who participate in it and who make it come alive. As with all clubs, participants in the programs at Fountain House are called, and are, members. The membership concept is considered a fundamental element of the Fountain House model. Membership, as opposed to patient status or client status, is regarded as a far more enabling designation, one that creates a sense of the participant's belonging, and especially of belonging to a vital and significant society to which one can make an important contribution and in which one can work together with fellow members in all of the activities that make up the clubhouse program.
2. All members are made to feel, on a daily basis, that their presence is expected, that someone actually anticipates their coming to the program each morning and that their coming makes a difference to someone, indeed to everyone, in the program. At the door each morning every member is greeted by staff and members of the house, and in all ways each member is made to feel welcome in coming to the clubhouse.
3. All program elements are constructed in such a way as to ensure that each member feels wanted as a contributor to the program. Each program is intentionally set up so that it will not work without the cooperation of the members; indeed, the entire program would collapse if members did not contribute. Every function of the program is shared by members working side by side with staff; staff never ask members to carry out functions which they do not also perform themselves.

   To create a climate in which each participant feels wanted by the program is the third intentional element in the Fountain House model. It is to be seen in stark and radical contrast to the atmosphere created in more traditional day programs, especially the attitude, almost universal in such programs, that persons coming to participate are doing so not because they are wanted by the program but because they are in need of the services provided to them by the program.
4. Following from the conscious design of the program to make each member feel *wanted* as a contributor is the intention to make every member feel *needed* in the program. All clerical functions, all food purchases and food service, all tours, all maintenance, and every other ongoing function of the clubhouse program are carried out jointly by the staff and members working together. Fountain House thus meets the profoundly human desire to be needed, to be felt as an important member of a meaningful group, and at the

same time conveys to each member the sense that each is concerned with all. Mutual support, mutually caring for the well-being, the success, and the celebration of every member is at the heart of the Fountain House concept and underlies everything that is done to ensure that every member feels needed in the program.

These four messages, then, of membership, of being expected, being wanted, and being needed constitute the heart and center of the Fountain House model.

Additionally the model is informed with four fundamental and closely related beliefs:

1. A belief in the potential productivity of the most severely disabled psychiatric client.
2. A belief that work, especially the opportunity to aspire to and achieve gainful employment, is a deeply generative and reintegrative force in the life of every human being; that work, therefore, must be a central ingredient of the Fountain House model; that work must underlie, pervade, and inform all of the activities that make up the lifeblood of the clubhouse.

   Thus, not only are all activities of the house carried out by members working alongside staff, but no opportunity is lost to convert every activity generated by the clubhouse into a potential productive contribution by members. Such involvement in the work of the clubhouse is a splendid preparation for and source of increased confidence in each member's ability to take gainful employment in the outside world.

   Further in support of this profoundly held belief, Fountain House guarantees to every member the opportunity to go to work in commerce and industry at regular wages in nonsubsidized jobs (see Transitional Employment Program, below). Indeed, Fountain House considers this guarantee part of the social contract that it makes with every member.
3. As a parallel concept to that of the importance of work and the opportunity to work is the belief that men and women require opportunities to be together socially. The clubhouse provides a place for social interchange, relaxation, and social support on evenings, weekends, and especially holidays, seven days a week, 365 days a year.
4. Finally, Fountain House believes that a program is incomplete if it offers a full set of vocational opportunities and a rich offering of social and recreational opportunities and yet neglects the circumstances in which its members live. It follows that the Fountain House model includes the development of an apartment program, which ensures that every member can live in adequate housing that is pleasant and affordable and that provides supportive companionship.

Program Components

The following program components of the Fountain House model will be seen to flow naturally and logically from the underlying concepts discussed above.

- the prevocational day program
- the transitional employment program (TEP)
- the evening and weekend program (seven days a week)
- the apartment program
- reach-out programs
- the thrift shop program
- clubhouse newspapers
- clubhouse name
- medication, psychiatric consultation, and health
- evaluation and clubhouse accountability

PREVOCATIONAL DAY PROGRAM

The psychiatric patient returning to the community faces extraordinary difficulties in achieving vocational objectives. Employment interviewers in industry do not look favorably on previous psychiatric hospitalization. The psychiatric patient often lacks self-confidence in his or her ability to perform a job and typically does not have the job references essential in securing employment. The Fountain House prevocational day program provides many opportunities for members to regain vocational skills and capacities.

All of the day program activities are performed by members and staff working together. What everyone does is clearly necessary to the operation of the clubhouse. In working side by side with members the staff become aware of each member's vocational and social potential and the Fountain House member begins to discover personal abilities and talents that can lead to greater social effectiveness and more meaningful work.

At Fountain House, as in other clubhouse settings, members view their daily participation in the prevocational day program as a "natural process" that is essential to the growth and well-being of all individuals. They are members of a club and voluntarily provide their help and assistance. They do not regard themselves as undergoing a formal rehabilitation process, in

which something is being done to them. The goal is to establish a foundation of better work habits, enriched social skills, and a more helpful view of the future. Many discover that although they are viewed as disabled, there are many ways they can still be constructive, helpful, and needed.

In time, this newly discovered self-awareness can be translated into a more rewarding, nondisabling way of life, free of financial dependency and perpetual patienthood.

In brief, the prevocational day program provides a diversified range of clubhouse activities that clearly need to be performed and that, if reasonably well done over a period of time, will not only be personally rewarding to individual members but in a most fundamental sense will give them the self-confidence and awareness that they can successfully handle a job of their own or an entry-level job in the business community. These opportunities are guaranteed to all Fountain House members through the transitional employment program.

TRANSITIONAL EMPLOYMENT PROGRAM (TEP)

The Fountain House transitional employment program makes it possible for members to work at jobs that other members have held before them and that industry has made available specifically to Fountain House to facilitate the work adjustment of the vocationally disabled.

The major ingredients of the transitional employment program are as follows:

1. All job placements for the severely disabled mentally ill are located in *normal places of business*, ranging from large national corporations to small local firms employing only a few individuals.
2. All job placements are essentially *entry-level employment, requiring minimal training or job skills*.
3. The *prevailing wage rate is paid by all employers* for each job position, ranging from the minimum wage to considerably above minimum wage.
4. Almost all jobs are worked on a half-time basis so that one full-time job can serve two members. A few TEP placements, however, are available on a full-time basis.
5. *Most job positions are performed individually by a member in the presence of other workers or employees.* Some job responsibilities, however, are shared by a group of six, eight, or even ten individuals from a community-based rehabilitation facility. In that case members relate primarily to one another on the job.
6. *All placements*, both individual and group, *are temporary* or "transitional" in design, providing employment for as little as three months to as long as nine months or a year.
7. TEP provides a guaranteed opportunity for disabled members to maintain temporary, entry-level employment through a series of TEP placements or to use such employment as a link or step to eventual full-time, independent employment.
8. *Job placements are maintained only if the individual member meets the work requirements of the employer.* No adjustment or lowering of work standards is made by employers.
9. *Job failures on a TEP placement are viewed as a legitimate and essential experience for most vocationally disabled members* in their effort to eventually achieve a successful work adjustment. In setting up a TEP with employers Fountain House agrees that if a member does not come to work, *another member or a staff person* will be selected to do the job. No matter what an individual member's vicissitudes may be, employers can count on the job assigned to Fountain House being done every day.
10. In the work experiences of normal or nondisabled individuals, failure or withdrawal from entry-level employment often occurs, and *TEP employers emphasize that job turnover rates are not typically greater for the vocationally disabled mentally ill on TEP placements than for the normal or nondisabled employee.*
11. *New TEP placements in the business community are always first performed by a staff worker for a few hours*, longer if necessary, so that an accurate assessment can be made of the requirements that must be met if the job is to be handled successfully by individual members. Staff initiating new TEP placements are also able to evaluate the work environment and its compatibility with the needs of the vocationally disabled individual.
12. Through direct familiarity with the work environment, staff have immediate access to a work site whenever vocational difficulties occur that require prompt evaluation and assessment of a member's performance.
13. All TEP placements are allocated to Fountain House by the employer and the selection process to fill TEP placements rests with Fountain House and the individual members its serves.
14. *No subsidy is provided to the employer* with respect to wages paid by the employer to a member on a TEP placement.
15. The unique collaboration or rehabilitation partnership between the business community and Fountain House is not a charitable act on the part of the employer. It is an agreed-upon arrangement that is of mutual benefit to the employer and the member who is

seeking a higher, more rewarding level of work adjustment through the vocational services of the TEP.

16. The TEP provides a unique opportunity to enrich and expand the evaluation process concerning vocational potential and work adjustment. Assessment is made through guaranteed positions in a normal work environment, one that only the business community can provide, rather than through evaluations based solely on an individual's past work adjustment, performance in sheltered environments, or personal interviews and psychological assessment.
17. *In the TEP it is not assumed that a member's prior history of vocational disability or handicap is necessarily indicative of his or her inability to successfully meet the minimal requirements of entry-level employment* provided as a primary service within the supportive, comprehensive delivery system of a community-based clubhouse.
18. TEP placements remove or circumvent barriers that typically preclude or diminish the possibility that psychiatric patients will seek and secure entry-level employment:
    a. A history of psychiatric hospitalization does not prevent the member from having the opportunity to secure entry-level employment.
    b. No attention is given to the duration of a member's hospitalization, which may frequently be as long as 20 or 30 years or more.
    c. The number of psychiatric hospitalizations is irrelevant to a member's opportunity to assume a TEP placement.
    d. The absence of a work history, the presence of an extremely poor work adjustment, or lack of, or very poor, job references does not prevent or serve as a barrier to TEP work opportunities.
    e. An individual's inability to pass a job interview is not viewed as a relevant to working on a TEP placement.
    f. A TEP job placement is an opportunity guaranteed to all clubhouse members. It is not a requirement, therefore, for the disabled member to have sufficient motivation to seek employment independently. In the TEP it is believed that the ability of a member to perform a TEP placement productively is not necessarily correlated to the individual's motivation to seek employment independently.

The presence of guaranteed part-time, entry-level work opportunities within the rehabilitative environment emphasizes to the members that *mental illness is not viewed as the sole or even primary explanation for vocational disability*. It is, rather, a personal experience, one that typically prevented members from having normal opportunities to experience the real world of work and to develop capabilities to perform work productively and meet job requirements.

Transitional employment programs have been developed as a rehabilitative function of the normal work community. Although designed to meet the needs of the more severely disabled mentally ill, TEP placements have been integrated from the beginning with the work community rather than intentionally simulating the real world of work, yet clearly separate and apart, as in the case of the sheltered workshop.

THE EVENING AND WEEKEND PROGRAM

The evening, weekend, and holiday social-recreational programs offered by Fountain House are designed to meet the members' needs for companionship and socialization. Fountain House members can experience being with each other, taking part in art programs, photography, chess and other table games, dramatics, chorus singing—indeed, in a rich and varied program. In addition members have the opportunity to be participants in outside volunteer-led activities such as bowling, movies, tours, theater, and sporting events.

The evening and weekend program enables members to maintain long-term contact with the clubhouse after they have become fully employed, which is of primary importance to their adjustment in the community. Such contact enables the member to continue to benefit from the supportive relationships developed at Fountain House, as well as from specific services such as the educational and employment programs. Members must know that there is assistance and encouragement available to them in their efforts to obtain a better job or to pursue their educational aspirations.

The evening program is also helpful to members when difficulties arise, such as when a job is lost or there is a recurrence of illness. Through the evening program, staff and members become aware of such problems and are able to assist the member who is in difficulty. This might involve helping someone to get to a clinic for a change in medication, or to become hospitalized, or to return to full-time participation in the Fountain House day program.

THE APARTMENT PROGRAM

In an effort to provide less institutional, more normalized housing alternatives, Fountain House some years ago began to lease modestly priced apartments and to make them available to two or three members living together. It was felt that not only could Fountain House provide much more attractive apartments, furnishing them with contributions to the thrift

shop, but that members living together could provide support, comfort, and understanding for each other. All apartments have kitchen facilities so that members may cook their own meals. Members pay their fair share of the rent and utilities.

Although the leases are initially held by Fountain house itself, it is entirely possible for a member or members to take on the lease once they have become stable and employed in the community. Apartments are located in various neighborhoods of New York City and many of them are located just across the street or in the immediate neighborhood of the clubhouse.

The apartments serve other important purposes. Resident members often host a new member who is still hospitalized and who is interested in exploring the kinds of living arrangements Fountain House provides as well as the activities of the clubhouse itself. With assistance from staff and other members, apartment residents have the opportunity to learn or relearn needed living skills, including housekeeping, cooking, budgeting, and getting along with a roommate.

Residence in a Fountain House apartment carries with it continuing active involvement in the clubhouse program as long as such participation facilitates the adjustment of the member. Fountain House does not provide apartments to individuals who are in need of housing but who are not at the same time seeking membership in the full Fountain House program.

REACH-OUT PROGRAMS

Often a member stops coming to Fountain House and it is not clear why he or she has done so. At other times a member requires rehospitalization. In both instances Fountain House feels that a reach-out effort from the clubhouse to the member is important, both to carry the message that the member is missed by fellow members and staff and to ascertain whether there is some way in which the clubhouse can help the member.

The reach-out function is intended to convey important messages to members—not that they must come back to the clubhouse, but that they are cared about, that they are missed when they don't come, and that Fountain House will try to supply whatever assistance they may require.

THE THRIFT SHOP PROGRAM

Many years ago Fountain House began to receive a number of telephone calls and written inquiries from people interested in its programs, some of whom expressed their willingness to make donations of goods they thought might be of value to Fountain House.

In response to these generous offers Fountain House established a thrift shop with several goals in mind. First, the shop makes possible the sale of donated goods at reasonable prices both to community residents and to members of Fountain House. The income from these sales converts donated goods into cash donations to the Fountain House program. Second, operation of the thrift shop provides opportunities for a variety of prevocational experiences for the members: warehousing, classifying, sorting and pricing merchandise, arranging merchandise attractively in the store, and meeting the public both as salespersons and as operators of the cash register. Volunteering in the thrift shop has been particularly appealing to, and effective for, older members.

CLUBHOUSE NEWSPAPERS

Some years ago it was felt that there should be a vehicle for alerting members of Fountain House to the activities available within it and to current news about fellow members and staff. A clubhouse newspaper was established that from the beginning was a cooperative effort of staff and members. The newspaper contributes to bringing the membership together, it provides a variety of work activities in the prevocational day program, and it also serves as a very powerful communicating tool that informs staff and members of other clubhouses about Fountain House activities.

Members have the freedom to say what they wish about the programs of Fountain House, about experiences in the house, about successes and failures, in articles that they are free to publish. This helps both the members who write articles and the members who read them to experience a deepening sense of participant contribution to and shared responsibility for the club that they and the staff bring to life and help to flourish.

CLUBHOUSE NAME

Fountain House believes that one of the very significant acts a clubhouse program can undertake is to establish its own name. In many instances—and there are many—when a clubhouse is a component of a larger mental health consortium, such as a community mental health center, it is critical that the clubhouse establish its own identity and a separate location in its own building. The name of the clubhouse thus comes to signify not only its identity but also its independence as a program. The name also can reflect the feeling the program is meant to convey. For example, The Green Door suggests a welcoming place; more traditional names of facilities are often not as suggestive.

MEDICATION, PSYCHIATRIC CONSULTATION, AND HEALTH

Fountain House plays an important role in helping members maintain themselves on prescribed medication and in ensuring that they get required psychiatric care. Most of the members view medication as both necessary and helpful in their adjustment and they are of significant assistance in

reinforcing this attitude among other members. Staff and members become aware when other members seem to be suffering a relapse and often help the member in getting to the clinic or hospital for assistance. Part-time psychiatric consultation is also available at Fountain House in emergencies.

Members and staff also help other members utilize community health facilities. This is extremely important to members who do not have the financial and personal resources to secure such help independently. In this important sense, Fountain House plays a crucial family role in encouraging members to get the care they are entitled to and require.

EVALUATION AND CLUBHOUSE ACCOUNTABILITY

Fountain House believes it is imperative that a continuing effort be made to evaluate the effectiveness of its programs, a belief shared by responsible community-based day programs for chronically mentally ill patients living in the community. Characteristically, however, the justification for the necessity of evaluations has been the staff's need to know the effectiveness of programs. Fountain House believes that this central reason for evaluation must include the members' right and need to know what kinds of successes and failures each of the programs of Fountain House is contributing to in the lives of fellow members.

Fountain House considers it both natural and desirable that members themselves become significantly involved in the procedures that are utilized to evaluate program effectiveness. The major evaluation effort currently undertaken by Fountain House and other clubhouse programs, the Categories of Community Adjustment Study, is therefore to a very large extent being carried on by members of Fountain House with the assistance and guidance of staff.

* * *

In our view Fountain House type rehabilitation programs are especially well suited to persons with substantial institutional experience who are in the process of leaving, or have recently left, hospitals. Their comprehensiveness and steady, gentle tug toward community reintegration is responsible deinstitutionalization at its best. The potential problems with such programs have to do with their size, which invites hierarchization, and their sometimes doctrinaire commitment to *the* Fountain House Model. Also, in day-to-day operation they seem to have bought into the genetic-biologic-chronic-disease model of disturbed and disturbing behavior that's so fashionable among today's biologic psychiatrists and Alliance for the Mentally Ill members. This ideology runs counter to the program's push for true community integration of clients and makes us somewhat uncomfortable.

VOCATIONAL REHABILITATION

Transitional employment has been a feature of Fountain House Model programs for many years. This form of in-vivo paid work training and adjustment is clearly more normalizing than more traditional approaches centered on sheltered workshops and training for placement. In the U.S. there are presently 131 TEP programs, with 557 employers, providing over 1,360 jobs, yielding earnings of over five million dollars. The Fountain House research team recently surveyed the results of TEP programs, They found:

1. Following the start of a TE placement, the percentage of those who are independently employed steadily increases from 11% at the end of one year to 40% working on independent jobs at the end of three and a half years. Studies elsewhere report only 10–20% employment rates for similar populations.
2. Those who spent the longest period of time in Fountain House *prior* to entering the study also had the highest rate of independent employment—66%.
3. Length of time spent by individuals on TE was significantly related to the securing of subsequent independent employment.
4. The entire study sample represents the "target population"—severely vocationally disabled chronic psychiatric patients—and, in addition, no significant differences in background descriptive characteristics were found for those independently employed versus those who were not.
5. Psychiatric rehospitalizations following TE placement were both few (from 2 to 4% at any time) and of short duration (an average stay of only 26 days). Both of these figures represent a substantial change in pattern in the prior histories of the study sample. (Fountain House, 1985)

More recently, the rehabilitation field has begun to focus on "supported employment." This movement began in the early 1980s among the advocates and providers for the mentally retarded. By the mid-80s, after strong multiorganization lobbying efforts, the U.S. Congress passed a series of amendments to the Rehabilitation Act of 1973 that mandated supported work programs for persons with serious mental health problems. Supported work is of interest because, while overlapping with transitional employment, it is different from it in several more normalizing respects (Anthony & Blanch, 1987):

1. The trainees are involved in identifying work slots for themselves that are commensurate with their interests, abilities, career aspirations, and likes and dislikes. Hence, *non-entry-level jobs are possible.*
2. The jobs are sought via the usual application process (TEP's are usually given to programs). The difference between job complexity and job *stress* is factored into the process.
3. The reality of stigma is acknowledged and attempts to get around it are made. That is, for example, program support to the employee may not be given on the job site, and the employer may not know his employee has a history of mental health involvement. Support and a low stress environment during non-work hours are seen as critical.
4. The jobs are permanent and have, hopefully, career ladders.

For readers wishing more information, the entire October 1987 issue of *Psychosocial Rehabilitation* is devoted to supported work.

A brief note about several other work-oriented community-based rehabilitation programs is warranted:

The Fairweather Lodge program (Fairweather et at., 1969) provides a model that combines housing and work. It is a program that has been replicated many times across the U.S. As always, there are local variations, but the basic notion is to form a living group of mental health clients that will also sell their services in the open marketplace (e.g., maintenance, gardening, etc.).

In Italy, the cooperative is a common form of client-operated business. Prototypical cooperative activities are cleaning, gardening, and working in restaurants that feed both mental health clients and the public at large. Housing is not generally part of the arrangement.

The Boston Center for Psychiatric Rehabilitation, directed by William Anthony, Ph.D., has recently developed a new vocationally focused continuing education program that is both innovative and promising. Their brochure describes it as follows:

> What is a Career Development Program?
>
> A career development program is an innovative rehabilitation program that teaches young adults with psychiatric disabilities how to develop and implement a career plan. Students attend classes on a university campus to learn new skills that enable them to make decisions about choosing an occupation or additional education or training that leads to an occupation. With support from staff and other resources, students are helped to take the steps necessary to change their role from patient to student and worker.
>
> Students learn how to develop a profile of themselves as workers and then to match these profiles to occupations. They develop short-term and long-term goals to begin the process of acquiring the occupations of their choice.

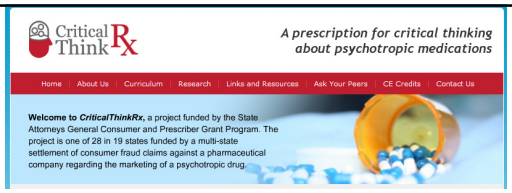
We have mentioned sheltered workshops only in passing for several reasons:

1. These traditional work programs are well-known and extensively used already (Bennett & Wing, 1963; Black, 1970; Wadsworth, Wells, & Scott, 1962; Wansbrough & Miles, 1968).
2. They are mostly nontransitional (in practice, if not theory), hence more dependency-producing and perpetuating than we like.
3. They violate our normalization principle. We would like their use to be kept to a minimum.

The Incentive Issue

Despite extensive experience with vocationally focused programs, there remains a major problem in the field around incentives. That is, at the present time most clients who successfully obtain work in entry-level jobs do not earn enough to make it worth their while to go off welfare principally because it usually comes with health insurance (Medicaid or Medicare). Mental-health-affiliated transitional employment programs basically train clients (when successful) to become members of the working poor. Whether this will also be true of supported work programs remains to be seen. The notion is only now really beginning to catch on. In many respects the working poor are the most disadvantaged group in American society; they usually can't afford decent housing, have no health insurance, and have jobs with no career ladders. The principal reward successful clients get is the satisfaction that comes from accomplishing the work task—but at the price of considerable security if they give up their welfare benefits.

Supported work and transitional employment programs are clearly preferable to sheltered workshops, "make work" in day programs, or long-term "employment" in clubhouse maintenance or volunteer work without prospects of eventually becoming paid. However, they have not yet solved the incentive conundrum described above. What appears to be needed now is a variety of experimental programs that focus on the issue of how to enable clients to get themselves out of the welfare-poverty-dependency cycle via truly rewarding work. Unfortunately, such programs have to operate within the United States' current welfare context. It is this context that makes it so difficult for clients to step out of the ranks of the poor and dependent. We wish we had a solution to offer to this very important problem but we do not. We hope that identifying and acknowledging it will begin a problem-solving process.



A Critical Curriculum on Psychotropic Medications

Critical Think Rx

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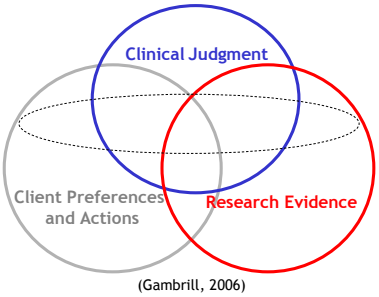
Module 8

Alternatives to Medication: *Evidence-Based Psychosocial Interventions*

Part A

What is Evidence-Based Practice?

The integration of *best research evidence* with *clinical judgment* and *client values*



(Gambrill, 2006)

6

A philosophy *and* a process designed to unite research and practice in order to

maximize chances to help clients

minimize harm to clients (in the name of helping)

(Gambrill, 2006)

Deeply participatory

EBP is "anti-authoritarian"—it urges all involved to question claims about what is known *and unknown* about treatments

(Gambrill, 2006)

8

EBP difficulties

- ☑ Threats to business-as-usual
- ☑ Limited training and supervision
- ☑ Concerns about cultural sensitivity
- ☑ Worries that "cook book" methods mask real-world complexity

(Barratt, 2003; Chorpita et al. 2007; Duncan & Miller, 2006)

9

An intervention should have *at least some* unbiased observations or tests supporting its usefulness with particular problems and clients

10

Some criteria for judging an intervention

- ☑ Sound theoretical basis
- ☑ Low risk for harm
- ☑ *Unbiased* research exists
- ☑ Therapist and client concur

11

Available "evidence" no guarantee of usefulness

Published evidence is influenced by funding sources, researcher biases, and conventional wisdom

Statistically significant differences between treatment groups means simply that more clients in one group had some type of response (partial to complete)

(Hoagwood et al. 2001; Ingersoll & Rak, 2006)

12

However, on average, *all major therapies produce equivalent results.*

Clients' improvement may result from *factors common to every therapy*

(Elkins, 2007; Hubble, Duncan, & Miller, 1999)

13

Most improvement has little to do with therapy or technique

Factor	% improvement explained
Client + outside therapy factors	87
Client-therapist alliance	8
Therapist allegiance to model	4
Therapist technique	1

(Hubble, Duncan, & Miller, 1999; Wampold, 2001)

14

Healthy skepticism

"We would do well … to remain optimistically humble on the matter of evidence-based practices in mental health" by accepting that all assumptions are "provisional and reversible"

(Norcross, Beutler & Levant, 2006, p. 11)

15

A clinician's "rubric" for EBP

"Adhere when possible, adapt when necessary, assess along the way"

(Amaya-Jackson & DeRosa, 2007, p. 388)

16

Choosing proper interventions rests on

- ☑ a clear understanding of the problem from a person-in-situation perspective
- ☑ addressing the complexity of the problem
- ☑ a policy of **"First, do no harm"**

Part B

Deconstructing the Diagnosis:

What is this child's problem in behavioral terms?

Bio-psycho-social or bio-bio-bio?

- ✓Complex problems in living reduced to "brain disorders"
- ✓Complex life events reduced to "triggers"
- ✓Medicalization of distress and disability leading to false hopes of "quick fix" via pills

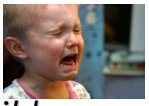
(Read, 2005) 19

We often ignore environmental influences on behavior

- ☑ Poor parenting, neglect, abuse
- ☑ Schools' failure to motivate children
- ☑ Poverty, lack of access to resources
- ☑ Violence in media, society, neighborhood
- ☑ Culture's emphasis on instant gratification
- ☑ Drug culture ("take," not "talk")
- ☑ Lack of tolerance for differences

(Bentley & Collins, 2006) 20

Children's distress: "Disorders" or complex adaptations to distressing life experiences?



*By seeing children as real persons with their own view of their situation, one ascribes a different **meaning** to their behavior*

(Donovan & McIntyre, 1990) 21

"Understanding" rather than "diagnosing"

A developmental-contextual approach views actions as "communicative": attempts by individuals to cope, adapt, struggle with their life experiences

(Donovan & McIntyre, 1990) 22

Here's a list of feelings and behaviors from DSM-IV-TR criteria of "disorders" commonly diagnosed in children

Note the similarities…

"Attention-Deficit/ Hyperactivity Disorder (ADHD)"

Feels:

- Angry, irritable, frustrated

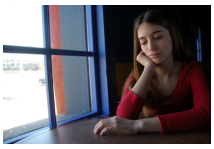
Acts:

- Fidgets, squirms
- Easily distracted, forgetful (difficulty thinking, concentrating)
- Interrupts others (acts impulsively)
- Acts aggressively

24

"Major Depressive Disorder"

Feels:
- Sad, empty
- Afraid, anxious
- Angry, irritable, frustrated



Acts:
- Eats, sleeps too little (or too much)
- Moves, speaks slowly
- Acts impulsively
- Acts aggressively
- Easily distracted (difficulty thinking, concentrating)

25

"Anxiety Disorder"

Feels:
- Afraid, anxious
- Angry, irritable, frustrated

Acts:
- Cries, throws tantrums
- Freezes, clings
- Fidgets (psychomotor agitation)

26

"Conduct Disorder"

Feels:
- Angry, irritable, frustrated, hostile

Acts:
- Bullies and threatens
- Fights
- Steals, lies
- Runs away
- Destroys property

27

"Oppositional Defiant Disorder"

Feels:
- Angry, irritable, frustrated, hostile

Acts:
- Disobedient
- Loses temper
- Argues with adults
- Annoys people
- Refuses to follow rules

28

"Bipolar Disorder"

Feels:
- Alternating sad and euphoric
- Alternating fearful and reckless
- Angry, irritable, frustrated

Acts:
- Easily distracted (difficulty thinking, concentrating)
- Moves, speaks fast (agitation)
- Acts impulsively
- Acts aggressively
- Does not sleep well

29

"Psychotic Disorder"

Feels:
- Sad, empty
- Blunted feelings, expressionless
- Angry, irritable, frustrated
- Afraid, anxious

Acts:
- Apathetic
- Refuses to speak
- Dresses inappropriately
- Cries frequently
- Sees or hears things

30

"Post-Traumatic Stress Disorder"

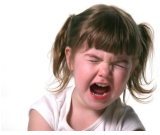
Feels:
- Sad
- Afraid, anxious
- Angry, irritable, frustrated
- Helpless, guilty, shameful

Acts:
- Agitated, impulsive, re-enacts trauma
- Hypervigilant: distrustful, withdraws
- Dissociated: forgets and can't focus

31

"Reactive Attachment Disorder"

Feels:
- Afraid, anxious
- Angry, irritable, frustrated



Acts:
- Watchful, frozen
- Avoids attachments
- Seeks approval or can't be comforted
- Disregards danger cues

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The common elements

Experiencing negative emotions
(sadness, fear, anger, irritability)

Difficulty controlling oneself
(impulsivity, aggression, inattention)

Seeing self and world negatively
(hopelessness, helplessness, shame, withdrawal)

33

What are we medicating?

Negative emotions leading to disruptive actions—especially under stressful conditions that tax the child's adaptive capacities

(Schore, 1994, 2003)

34

Most commonly medicated

Impulsive aggression

"a key therapeutic target across multiple disorders"

(Jensen et al. 2007, p. 309)

35

DSM's scientific value seriously challenged in all disciplines

✓ internal inconsistency in the manual (rejects categorical approach in intro but then lists 300+ categories)

✓ overlap between categories leads to "co-morbidity"—with no increase in understanding

✓ persistent problems of unreliability, especially with children's diagnoses

✓ lack of fit between categories and empirically observed symptom clusters

(Caplan, 1995; Duncan et al. 2007; Maj, 2005; Kirk & Kutchins, 1992, 1994; Jacobs & Cohen, 2004; Mirowsky & Ross, 1990)

36

More recent DSM critiques…

- ✓ more behaviors now seen as "mental disorders" (from 106 in 1952 to 365 in 1994)
- ✓ political lobbying determines inclusion or exclusion of diagnoses
- ✓ all DSM task force members on mood and psychotic disorders tied to drug industry
- ✓ practitioners focus on diagnosis rather than client, losing client's actual story
- ✓ still no "gold standard" validity—no specific bio-marker linked to *any* disorder

(Andreasen, 2006; Tucker 1998; Charney et al. 2005; Kutchins & Kirk, 1998)

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Critical list of DSM "accomplishments"

- ☑ increases people's interest to classify psychosocial problems as medical disorders
- ☑ Helps justify more studies to see how many people can fit how many DSM categories (which often change)
- ☑ led to modest increase in diagnostic reliability since 1980
- ☑ now used by most practitioners in main schools of thought—mostly to obtain third-party reimbursement?
- ☑ brings financial revenues to the American Psychiatric Association from sales of DSMs and training materials
- ☑ strengthened psychiatry's leadership in mental health system (as official definer of mental distress)

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Part C

Empirically-supported psychosocial interventions for children and adolescents

Focus: Trauma, Resilience and Child Welfare

Trauma and early loss

For thousands of children every year, loss and trauma due to disrupted attachments to biological parents result in foster care placements

(Jones Harden, 2004; Racussin et al. 2005)

41

Additional, placement-related traumas

- ✓Emotional disruption of out-of-home placement
- ✓Adjusting to a foster care setting
- ✓Relative instability of foster care
- ✓High turnover of workers

(Jones Harden, 2004; Racussin et al. 2005)

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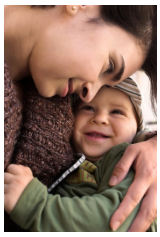
Neurobiology of attachment



Brains develop in a *socially dependent manner*, through secure attachments and *consistent*, *competent* adults attuned to the needs of the child

(Schore, 1994, 2001, 2003; van der Kolk, 2003)

43

Child's "job": to form close, trusting attachments with caregivers

Adolescent's "job": to expand attachments using secure base with caregivers

(Gunnar et al. 2006; Mash & Barkeley, 2006; Moran, 2007; Wolfe & Mash, 2006)

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Trauma, abuse, and neglect

- ☑ disrupt a child's ability to form secure attachments
- ☑ impair brain development and regulation
- ☑ make self-control difficult
- ☑ alter identity and sense of self

(Bowlby, 1988; Cook et al. 2005; Courtois, 2004; Creeden, 2004; Jones Harden, 2004; van der Kolk, 1994)

45

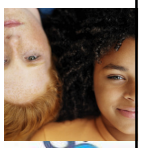
Resilience

The ability to function well despite living or having lived in adversity rests mainly on normal cognitive development and involvement from a caring, competent adult

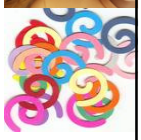
(Agaibi & Wilson, 2005, Masten et al. 1990; Schofield & Beek, 2005)

46

- ✓Risk and protective factors in the foster child, foster-families, agencies, and birth family interact to produce upward or downward spirals



- ✓Understanding resilience helps create interventions that produce positive turning points in children's lives



(Schofield & Beek, 2005)

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Three key elements

1. Secure base: *is child strengthening sense of security and able to use foster-parents as a secure base?*
2. Sense of permanence: *is placement stable and foster-parents offering family membership?*
3. Social functioning: *is child functioning well in school, with peers?*

(Schofield & Beek, 2005)

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Treatment goals

- ✓Enhance sense of personal control and self-efficacy
- ✓Maintain adequate level of functioning
- ✓Increase ability to master, rather than avoid, experiences that trigger intrusive re-experiencing, numbing, and hyper-arousal

(Ford et al. 2005; Kinniburgh et al. 2005)

49

What could help?

Activating child's internal reparative mechanisms through *dyadic interventions* and creating secure attachments

- dyadic therapy mobilizes the completion of interrupted biological and emotional developmental processes

(Amaya-Jackson & DeRosa, 2007; Courtois, 2004; Ford et al. 2005; Pearlman & Courtois, 2005)

50

A sensorimotor approach

Children's internal stimuli, can trigger dysregulated arousal, causing emotions to escalate

- Integration of cognitive, emotional and sensorimotor levels is crucial for recovery

(Ogden, 2006)

51

Why would this help?

Child develops the ability to take in, sort out, process, and interrelate information from the environment — leading to self-organization of internal states and self-control of behavior

(DeGangi, 2000; Kinniburgh et al. 2005; Schore, 2003; van der Kolk, 2006)

52

How would this help?

By enhancing children's:

- ✓social skills
- ✓ability to understand and express feelings
- ✓ability to cope with anger and distress
- ✓ability to problem-solve and think helpful thoughts
- ✓skills to self-direct and create goals

(Bloomquist, 1996; Kinniburgh et al. 2005)

53

Alternatives to medication

- ☑ Consistent, structured, supportive adult supervision
- ☑ Opportunities for self-expression and physical activity, to give children a sense of mastery over their minds and bodies

(DeGangi, 200; Faust & Katchen, 2004)

54

Helpful activities

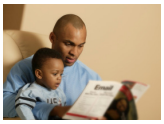
- ☑ Teaching problem-solving and pro-social skills
- ☑ Modeling appropriate behaviors
- ☑ Teaching self-management
- ☑ Helping children learn to comply and follow rules

(DeGangi, 2000; Faust & Katchen, 2004)

55

Helpful interactions

- ☑ Desensitizing hyper-reactivity
- ☑ Promoting self-calming and modulation of arousal states
- ☑ Organizing sustained attention
- ☑ Facilitating organized, purposeful activity



(DeGangi, 2000)

Expected outcomes

Children learn to develop appropriate responses, self-organization and control, which in turns leads to

MASTERY AND SELF-ESTEEM

(Kinniburgh et al. 2005)

57

Many treatment alternatives

Symptom-focused: Behavioral, cognitive-behavioral, and interpersonal therapies, attachment-based therapies, trauma-focused therapies

System-focused: Treatment foster care (TFC), Multi-dimensional treatment foster care (MTFC)

(Farmer et al. 2004; Racussin et al. 2005)

Focus: Dysregulated "moods"

"Depression" and "Anxiety"

60

The New York Times

Talk Therapy Pivotal for Depressed Youth

February 6, 2007

In Rigorous Test, Talk Therapy Works for Panic Disorder

By BENEDICT CAREY

61

Link to child maltreatment

Abuse leads to "hypervigilance" to threat, resulting in anxiety and hopelessness

Neglect results in dysregulated "moods"

(Greenwald, 2000; Lee & Hoaken, 2007) 62

"Traumatized children tend to communicate what has happened to them … by responding to the world as a dangerous place by activating neurobiologic systems geared for survival, even when objectively they are safe"

(van der Kolk, 2003, p. 309)

Therapy or no therapy?

Some 30-40% recover without intervention

Approximately 50% of treated patients improve within 8 weeks

A friendly sympathetic attitude and encouragement are key

(Roth & Fonagy, 1996) 64

Consensus strongly favors cognitive-behavioral therapy (CBT) as **first-line** treatment *above* medications

(APA Working Group, 2006; March, 1995; Roth & Fonagy, 1996; Velting et al. 2004) 65

Other effective interventions

1. Interpersonal psychotherapy
2. Psychodynamic psychotherapy
3. Exposure-based contingency management
4. Problem-solving and coping-skills training

(APA Working Group, 2006; Roth & Fonagy, 1996) 66

Patient preference

When given a choice, patients express a preference for psychosocial interventions over medications

(APA Working Group, 2006)

67

"Bipolar Disorder" and "Schizophrenia"

68

Very rare in children (~1%)

Diagnosis controversial:

- no laboratory "test"
- "symptoms" may be manifestations of ordinary developmental differences

(Birmaher, 2003; Birmaher & Axelson, 2006; Cepeda, 2007; Correll et al. 2005; Danielson et al. 2004; Irwin, 2004; Findling, Boorady & Sporn, 2007; Roth & Fonagy, 1996)

69

High risk of over-diagnosis

NIMH Review: 95% of 1500 children referred for high clinical suspicion of childhood-onset schizophrenia did not meet DSM criteria after careful inpatient observation *off all medications*

No evidence that they would have developed psychosis if left untreated

(Shaw & Rapoport, 2006)

70

Link to child maltreatment

Child abuse and neglect considered a causal factor for psychosis and "schizophrenia"

- Content and severity of psychotic symptoms related to severity of past abuse

(Cepeda, 2007; Morrison et al. 2005; Read & Ross, 2003; Read et al. 2004, 2005)

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Many children improve when treated with family-based psychosocial interventions, *even without medications*

- High rates of "relapse" observed on medication

(Birmaher, 2003; Birmaher & Axelson, 2006; Cepeda, 2007; Correll et al. 2005; Danielson et al. 2004; Findling et al. 2007; Irwin, 2004; Roth & Fonagy, 1996)

72

Effective psychosocial treatments

Child- and Family-Focused CBT combined with interpersonal and "social rhythm" therapy to stabilize mood, activities and sleep

Community support and social acceptance through day programs and sports/cultural activities

(Findling et al. 2007)

73

Who recovers and why?

Psychiatric literature is mostly silent about the characteristics of people who fully recover from psychosis and how and why they do so

(Siebert, 2000)

74

Focus: Disruptive behaviors

Disruptive behaviors: the most frequent reason for referral of children to mental health services

(Brestan & Eyberg, 1998; Butler & Eyberg, 2006)

76

For disruptive behaviors and conduct "disorders"

☑ Family-based behavioral interventions

(APA Working Group, 2006; Brestan & Eyberg, 1998; Diamond & Josephson, 2005; Kazdin, 2005, 2000, 2000b; Kazdin & Weisz, 2003; Thomas, 2006)

The New York Times (2006, December 22)

TROUBLED CHILDREN

Parenting as Therapy for Child's Mental Disorders

Fabrizio Costantini for The New York Times

TJ Van de Walls attention deficit problems have improved in response to parenting techniques, his mother Dawn, right, said.

78

Effective parenting: the most powerful way to reduce child and adolescent problem behaviors

(Caspe & Lopez, 2006; Johnson et al. 2005; Kumpfer et al. 2003) 79

Strongest evidence base

1. Parent management training (PMT)
2. Problem-solving skills training (PSST)
3. Brief strategic family therapy (BSFT)
4. Functional family therapy (FFT)

(Brestan & Eyberg, 1998; Butler & Eyberg, 2006; Farley et al. 2005; Kazdin, 2003; Kazdin & Whitley, 2003; Springer 2006; Thomas, 2006) 80

Goals of parent training

- ☑ Promote parent competencies & strengthen parent-child bonds
- ☑ Increase consistency, predictability & fairness of parents
- ☑ Produce behavior change in children

(Kazdin, 2003; McCart et al. 2006; Webster-Stratton & Reid, 2003) 81

"Problem" children or "problem" adults?

Coercive parenting was the only factor linked to children's failure to improve their conduct after family treatment

(Webster-Stratton, Reid & Hammond, 2001) 82

Maltreatment consistently linked to aggressive behaviors

- ☑ History of trauma virtually *universal* in youth with conduct "disorders"

(Greenwald, 2000; Lee & Hoaken, 2007) 83

Children in foster care

- ✓ have socio-emotional problems ***3 to 10 times more often*** than other kids
- ✓ Coercive interactions only result in escalation of aggressive behaviors

(Nilsen, 2007) 84

Parent-training in child welfare

Promising programs exist to train biological and foster parents

Goal is to break the cycle of coercive parenting and child oppositional behavior

(Barth et al. 2005; Nilsen, 2007)

85

"ADHD"

Large evidence base exists for behavioral interventions, incl. parent training, social skills training, and school-based services

- Results equivalent to stimulant medications *without the health risks*

(APA Working Group; Chronis et al. 2004, 2006)

86

Focus: Mentoring

Children's development depends upon reciprocal activity with others with whom they have a strong and lasting bond

(Jones Harden, 2004; Rhodes et al. 2006)

Mentorship

A relatively long-term, non-expert relationship between a child and non-parental adult, based on acceptance and support, aiming to foster the child's potential, where change is a desired but not predetermined goal

(Dallos & Comley-Ross, 2005; Rhodes et al. 2006)

Significant effects

Meta-analysis of 55 studies found significant effects of mentoring programs

- Community-based programs more effective than school-based programs

(DuBois & Silverthorn, 2005)

90

Mentoring in foster care

Survey of 29 programs found mentoring provides a bridge to employment and higher education, helps with transitional problem-solving

(Mech, Pryde & Rycraft, 1995)

91

Common factors for success

- ☑ Frequent contacts
- ☑ Emotional closeness (attunement)
- ☑ Longer duration
- ☑ Structured activities
- ☑ Ongoing training for mentors

(DuBois & Silverthorn, 2005; Gilligan, 1999; Rhodes et al. 2006) 92

Mentors enhance resilience

Sensitive mentoring increased self-esteem and well-being, reduced aggression and opened new relationships beyond care system

- *prevents negative outcomes as youth leave foster care*

(DuBois & Silverthorn, 2005; Gilligan, 1999; Lemon et al. 2006; Legault et al. 2005; Rhodes et al. 1999, 2006; Schofield & Beek, 2005) 93

Reduces violence

"Having someone to count on when needed" softened the impact of trauma and reduced likelihood of youth engaging in violent offenses

(Maschi, 2006) 94

Part D

Conclusions and Recommendations

Medicalized approach to distress and disability pathologizes children's behaviors and ignores the context of their experiences

- "Understanding" rather than "diagnosing" changes the meaning of those behaviors and can lead to more helpful interventions

96

Abuse, neglect and trauma disrupt secure attachment and impair the child's ability to self-regulate

- "Repair" occurs through the formation of secure attachments, rather than by medication

Irritability, impulsivity and aggression appear in criteria for most DSM diagnostic labels used on children

- We are medicating children's negative emotions and immature self-control

98

Growing consensus

Just Say 'No' to Drugs as a First Treatment for Child Problems

(Duncan, Sparks, Murphy, & Miller, 2007)

99

Attempt psychosocial interventions *before* initiating medication

Ample evidence supports their use as effective first-line options for children's behavioral problems, *with no apparent risk of medical harm*

100

Fundamental issues of efficacy and safety of psychotropic medications in children remain unresolved

Therefore, medicating children should be avoided

101

A Critical Curriculum on Psychotropic Medications

Module 8

The End

www.CriticalThinkRx.org

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