

Hope for "Community Recovery"
(Geel Belgium: A Model of "Community Recovery")

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In general, we humans like to live a life of order. Some surprises and mysteries can add spice to our lives, but others create for us, either individually or as a society, with a sense of confusion and a perceived lack of control, one of the key stressors for all species, including humans. And so, to feel some sense of control in the face of such “mysteries,” we seek solutions.

Certain disciplines and professions make it their business to shed light on some of the more dire mysteries of life. Their efforts and successes can indeed make life easier. For example, individually or collectively we feel a greater “sense of control” when, we can be immunized against some disease. But some solutions that seem to offer hope end up being erroneous or incomplete and once again we experience a feeling of helplessness or hopelessness, now accompanied by a sense of frustration at having missed the mark in spite of our hopes. At that point, we might give in to despair or we even deny the existence of what we can’t explain or control.

But, poet Robert Frost offered what could be a more productive approach when he urged us to
Always fall in with what you're asked to accept. Take what is given, and make it over your
way. My aim in life has always been to hold my own with whatever's going. Not against:
with.

Today I want to talk about how that advice might help us, both as individuals and communities, to live with the mystery of mental illness. I’ve entitled the talk *Hope for “Community Recovery”* and though it’s a short title with no fancy words, I think it’s important to carefully consider each word before I talk about how we might better fall in with what we’ve been asked to accept from mental illness.

Many of you are perhaps familiar with the recovery model of treatment. This is an approach that strives to help individuals with a diagnosis of mental illness to live *with* that diagnosis: not against, with. Elements of this treatment model are individualized to include anything that would allow a person to live

a meaningful life, even with that diagnosis.

We all know the ultimate horror stories that came to be associated with large state hospitals and the new hope associated with a trend toward community mental health services that began to evolve about 50 years ago. That trend has become the norm and so community is the place in which recovery needs to occur.

And now the tricky word: hope, a belief that something is possible. Many times we've felt a sense of hope when some new treatment or understanding of mental illness promised to eliminate it from the list of mysteries that we must deal with. "Moral therapy" offered hope for cure, suggesting that mental illness was the product of some kind of severe stress and that asylums would offer a refuge from that stress, allowing the person to be healed so that they could return to a "normal" life. It worked for some but it was not a cure for all, and in spite of some benefits, it was pretty much forgotten when a new kind of hope emerged.

That new hope focused on the neurochemical basis of mental illness. And, in the beginning, it seemed that psychotherapeutic drugs might be to mental illness what antibiotics are to other forms of illness. There's no doubt that these drugs have improved the quality and meaningfulness of life for many people. But they are not the "magic bullet" that we'd hoped for and they have not rescued us from either mental illness *or* the stigma of mental illness.

And so, what of the "mystery" of mental illness? Do we have any reason to hope that we can live with it by "making it over?" Is it possible for an individual to live a meaningful life in spite of mental illness? The answer to that last question is pretty easy. All of us here have seen evidence that this is indeed possible because we all know success stories. It's not always easy, but it's certainly possible and the courage of those who succeed is inspiring. But you, attending this conference, must also deal with an additional mystery. That mystery has to do with the possibility, or the nature of, a relationship between

mental illness and criminal behavior. You must deal with it in a practical sense as you serve those who carry both a stigmatized diagnosis and a criminal record. And, you deal with it in a broader context because of a community belief that the two do go hand in hand. If there is a strong connection, you have a responsibility to protect community members from possible harm. But, the mystery remains: is there a strong relationship and, if so, what is the nature of that relationship? The question of whether individuals with serious mental illness are more prone to violence than the general population can only be addressed with complicated answers. First of all, we know that most acts of violence are *not* committed by people with a diagnosis of mental illness. While there does appear to be a higher incidence of violent behavior from individuals with certain diagnoses, there is neither agreement nor clarity as to the nature of this relationship. However, while researchers continue to try and understand the relationship, the public's understanding is often more decisive, it's based not on research but on those tragic news stories that naturally make the headlines. In this way, myths regarding mental illness and the accompanying stigma are kept alive and they deter progress and hope that could benefit all members of society.

My focus today is on the communities in which individuals with severe mental illness live, including those whose diagnosis has been complicated by behavior that must be dealt with by various agencies of law enforcement. While I will talk primarily about mental illness in the community, I think, in the end, we'll see how community acceptance of those with mental illness through a better understanding of mental illness, can indeed increase the possibility of acceptance for those whose mental illness may have caused them to engage in some kind of criminal behavior. And, right now I think that it's important to openly acknowledge that not all "criminal" behavior involves violence.

So, to begin with, is there any reason to hope that it's possible for communities to live with the fact of mental illness? Can community members forget the myths and learn the facts of mental illness so that they can live with it as "recovered communities?"

We can hope that communities are capable of this kind of enlightenment and tolerance, but hope alone doesn't assure success. We have to know how to achieve the success that we desire. Stanford social psychologist Albert Bandura defines this sense of knowing how to get what we want as *self efficacy*: “. . .the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations.”

Self efficacy refers to individuals who know how, but Bandura also described collective efficacy as the same kind of “know how” for groups of individuals. Research shows that there are two ways to gain a sense of either self or collective efficacy:

- 1) THROUGH DOING. We have all learned that practice makes perfect
- 2) THROUGH OBSERVING the success of others. Bandura says: “There is nothing more persuasive than seeing effective practices in use”

And, that's why I'm here: to encourage a sense of hope in individuals and communities by sharing stories of communities that are using effective practices in order to provide community care in caring communities.

What qualifies me for that role? If you're to gain anything from this talk, you should be asking yourselves, what gives her the authority to teach this message of hope? First, let me tell you what I'm not. I'm not a practitioner or program director and currently I have no regular contact with mental illness. I'm not a researcher. I don't write grants or collect data. By profession, I'm a teacher, by vocation I'm both a teacher and a student. And, my desire to learn has led me to identify and, when I can, to visit the kind of programs and communities that I believe can create a sense of collective efficacy in other communities.

In recent years I've coined the term “community recovery” to describe the kind of success that I found when I started to look for it. But, the story of what motivated my search started more than 20

years go, during my days as a real student. In 1982, in my final year as an undergraduate student -- a 40-year-old undergraduate – I read in a 1980 textbook of a unique, centuries old system of foster family care for the mentally ill. The story didn't occupy much space in that text book but it evoked in me a lingering fascination. And eventually, in January 1997, that led to my first visit to Geel, Belgium, the home of that legendary system. I've now made six trips to Geel, most recently this past summer, and though my original knowledge of Geel was sparse, I now know much more and I want to start to create in you a sense of hope for community recovery by sharing with you what I've learned as I've visited and studied Geel.

As you listen to this story, I expect that you might be inclined to think: “Can we do the same thing here, in this country?” or “Why can't we do the same thing in this country?” or even, “Well, we can't do the same thing in THIS country.” But, I'd like you to take those questions or comments off the table for now, because precise replication of Geel's system, or any other system, is not what this talk is about. As you'll see, Geel has experienced a kind of success that we might envy, but Geel's history is unique and that history can't be replicated. However, I believe there are other, more subtle, lessons to be learned from Geel's success. And, it's these lessons that we need to take home with us to our own programs and communities. So, I encourage you to think outside the box of replicating a system. Over the years, that's what I've been able to do and, by the time I've finished I will have shared with you my own observations and conclusions regarding what Geel can teach us. I hope that we can then use that as a starting point for sharing and identifying ways, among ourselves, that we can continue to build on our own successes.

First . . . what I've learned over the years and what I hope you'll learn today. I'll tell you about 1) the beginnings and history of Geel's approach to mental illness, 2) I'll also talk about the current status of their mental health services and 3) as I relate what has been identified as the “secret” of their success,

I'll also provide 4) evidence for similar success in our own country.

Geel's story begins with a 6th century legend of a pagan Celtic king, Damon, and his Christian wife, Odilla. There are variations of that legend and some evidence negating the legend itself. But, in general, the story goes something like this. . .

Damon was married to Odilla, a beautiful Christian woman. When their daughter, Dymphna, was born, the mother arranged for the child to be raised by a priest, and Damon had little to do with her. Then, when Dymphna was in her teens, her mother died and King Damon was so distraught that he insisted that his aids find him another wife as beautiful as Odilla. They reminded him that he did, in fact, have a beautiful daughter, mothered by his beautiful wife and she might be a good replacement for Odilla. The pagan Damon liked the idea, but Dymphna and her priest did not. So, they created a stall by asking for time to "think about it" and, during that time, fled across the North Sea into Belgium, taking refuge in St. Maarten's chapel in the forests outside of Geel.

Well, Damon didn't give up easily and he and his soldiers soon found Dymphna and the priest. Once again, he demanded that Dymphna marry him -- or die. But, even after seeing her priest beheaded, and faced with her own death, Dymphna would not submit to her father's madness, and she allowed herself to be beheaded.

Over the years, the site of her martyrdom, was associated with miraculous cures from madness and in the 13th century, based on a long history of reported miracles, Dymphna was canonized as the patron saint of the mentally ill. Of course, her sainthood brought even more pilgrims seeking religious treatment, and soon a guest house hospital was built near the chapel to accommodate the pilgrims. In the 14th century, to accommodate the continual and increasing stream of pilgrims, a new church building was begun. It was eventually completed in the 18th century and still stands today. But, even though a sickroom was added to the church in 1480, there were still more pilgrims than could be accommodated.

And so, church canons at that time asked local villagers to house the overflow and a new legend was born. The legend of St. Dymphna grew from an oral history. As I said, that oral history has taken many forms and even been denied. But, whatever "facts" or truths might be associated with the early legend are inconsequential in the face of a new documented legend: Geel's centuries old system of foster family care for the mentally ill. And here, I will hint at what may be an important lesson to consider. Geel responded to a specific and urgent need in a practical, and we can assume, compassionate manner, at least compassionate for the times.

The original system simply involved informal arrangements between boarder families and local families with some oversight by church officials. But, over the next 500 years, administration of the system changed several times. When Belgium was annexed to France during the revolution, the religious aspects of the system ended and there were even attempts to close down the system, but legends don't die easily and families still took in boarders on their own. In the early 19th century, the Geel Municipal Council took over administration, and foster family care in Geel has been administered by some governmental entity ever since. In 1850, Belgium national mental health law was enacted and Geel was designated as a special region, the Rijkskolonie or "state colony." But, the word "colony" is somewhat misleading. Geel still functioned as a "normal" community, as it always has, but, on paper, the whole area was somewhat of a "hospital without walls," with each boarder's room in the family home considered, on paper, as a hospital room. In 1862, an actual central hospital, for admitting and short term care, was built and it's still used today as one of four hospitals in Geel for those with mental illness. More on that later.

Though Geel is still governed by State statutes and receives State income, in 1991 significant legislation gave the OPZ, the Public Psychiatric Hospital, autonomous status as a Flemish Public Institution with a board assigned by the Flemish government. So now, decisions about OPZ activities are

made in the region and not in Brussels. This was an important change because there have been concerns about the future of Geel since the middle of the 20th century. Once again, it might also hint at another possible lesson to be learned from Geel: Perhaps, specific communities are in a better position to understand and oversee the way in which *they* can best handle mental health services for their area, based on their local resources and needs.

Over the centuries, the number of boarders in Geel has changed considerably. The highest number was right before World War II but the numbers started to wane in the '50s, at the same time that state hospital populations started to wane in our own country but also, ironically, at the same time that community health services were being seen as the wave of the future. The irony of this decrease in foster family care, even as there was an increase in emphasis on community, was noticed by some U.S. academics and, in 1965, it motivated the beginning of the ten-year long Geel Research Project, a Project with two goals: First, if possible, it was hoped that it would help to rescue the system from extinction. But, if that was not possible, or prudent, the Project at least wanted to provide documentation of the history of this legendary and unique program, something that had never been done before.

Leo Srole, a Columbia sociology professor, headed the project and for ten years he submitted annual reports and recommendations to the Belgium Minister of Health. In his last report, in 1974, he reported that GRP data indicated that foster family care may not survive beyond 1980. Even though there was still an overall availability of families, some established families were indeed leaving the program and fewer new families were applying. And, more significant, trends indicated that there was a decline in support and referrals from professionals in Geel and around Belgium.

You see, in Belgium, Geel had often been called the “city of fools” where half of Geel is all crazy and all of Geel is half crazy. So, Geel was not always seen as the most attractive alternative for those with mental illness, particularly not by the professionals.

One thing that makes Geel such an interesting case story, is that its long history gives it the status of somewhat of a historical microcosm of progress and problems related to mental illness. Though we should all be working together to solve or live with the “mystery of mental illness,” this is not always the case and often a tension exists between those who live with mental illness as a personal companion and those who have a professional commitment to treat mental illness. Through the work of the Geel Research Project, Dr. Srole had seen evidence of that tension in Geel. Who had the greater authority? Host families, based on their knowledge through experience, sometimes for generations in their own family? Or did authority rightfully belong to the professionals, given the knowledge that they had gained through science and education?

After generations of living peacefully, and for the most part successfully, with mental illness in their homes and community, host families and community members had dealt with mental illness by finding practical solutions to whatever problems might develop in the course of their family or community life. But, as modern treatments developed and modern medicine came up with explanations for the “mystery of mental illness,” the professionals didn’t always like the authority that had naturally fallen to the families over the centuries.

In a 1975 presentation, Leo Srole observed what life was like for a boarder in Geel, and his observations focused on *family*:

- 1) In most cases, the boarder becomes a functioning member of the family structure
- 2) The medical model does not play a role in the success of that family structure
- 3) But, the family offers to the boarder a caretaker, teachers, natural supportive parents, and behavioral role models
- 4) These experiences then allow boarders to learn the lessons necessary to function in a “normal” social world

Fortunately, Srole's prediction of extinction by 1980 did not come true and foster family care still exists in Geel. But, there have been changes and there's been progress. Today foster family care is only part of an overall system of comprehensive services. And, even though foster family care may not be suitable for all communities, it's still interesting to look at how Geel's system works and who it serves.

First, some statistics: As of July 2007 there were 399 boarders – 260 men and 139 women – living with 343 families. However, at that time there were also 38 rooms available for potential boarders. So, even now, foster family homes are still readily available as needed.

We may have a tendency to think of foster care as a temporary solution to a problem, particularly in our individualistic culture, where independence is considered to be a critical element in what we call a "meaningful life." But, in Geel, traditionally, once a long term boarder finds a stable home, they become a part of the family and they may stay with that family for generations. Many host families have taken a boarder from their parents' home, sometimes when they got married. Even today, though they may not stay with the same family, boarders may stay in the foster family system for years. In 2005, 31% of the 509 boarders had lived in a foster home for more than 50 years. This kind of longevity is evident in the age of the current boarders. As of July 2007, the age range of the boarders was from 24 to 94 years of age, with an average of 65 years ($SD = \pm 13$ years).

For those who must deal professionally with diagnosis, this information is interesting. And you can see that the two primary diagnoses are schizophrenia and mental retardation, with each category representing just a little over 20% of the population. But, in terms of "community recovery," let me also point out something that does not appear on this slide. Diagnosis is not something that is shared with foster family members, nor is it something of concern to family members. Because of the nature of their experience across the years, they're much more interested in the behaviors and needs of their boarder without reference to any particular category into which the boarder might fit.

In terms of professional considerations, who is a good candidate for foster family care? These are some of the primary criteria, or guidelines used in Geel: diagnosis of severe mental illness according to the DSM, an inability to integrate into normal daily life on their own, but yet, a need for dependence and attachment, and someone who is not aggressive. But, I want to insert a kind of foot note regarding that final criterion, something else that perhaps we can learn from Geel; something that might be of particular interest to those of you who are attending this conference. Normally aggressive patients are NOT considered as good foster family candidates. But, there have been cases where Geel has taken a chance on individuals who had problems with aggression in other settings. This kind of decision is based on “common sense” and individual evaluation rather than “hard and fast” rules, and that is a “foot note” that seems to me to be a critical factor in Geel’s success. There’s no data to tell us how often “common sense” has worked in this regard, but I’ve met patients who were thriving in Geel but whom, I was told, exhibited aggressive behavior in other settings. Professionals and families took a chance, because common sense regarding the person they were placing indicated to them that it was a chance worth taking, and they have often been correct in their judgment. And, there is, in fact, data indicating that violent behavior by boarders is not a problem in Geel. The only serious crime committed by a boarder in the 20th century occurred early in the century when the Lord Mayor was murdered by a patient. But, this was such an exceptional incident that it inspired several theatre pieces and, it had no apparent effect on trust in the system or the boarders because, as you’ve seen, Geel’s boarder population showed its greatest increase in the first 40 years of the 20th century.

In 1986, a Belgium research paper described the pattern of problem behavior by boarders in the previous ten year period. During that time there was a consistently low rate of delinquent occurrences such as physical fights and verbal fights between boarders, and, across the ten year period, there was actually an overall decrease in occurrences.

In 2000, I used archival data from 1996 to 1999 to compare patterns of violence by members of the community of Geel and the boarders of Geel. Comparisons in these four years were made for rates of three different types of violent acts: vandalism, aggression, and sexual acts, as well as totals for these categories. As you can see, there was an extremely low rate of violence for both boarders and citizens of Geel, with no significant difference between the two groups.

This is a good place to talk a bit about violence and mental illness. One factor that has been associated with an increased likelihood of violence by those with severe mental illness is substance abuse and, in Geel, patients with known alcohol problems are not considered to be good candidates to become boarders. But, pub life is an important part of everyday community social life in Geel, as it is in many European communities, and, as a rule, boarders are not kept out of the pubs. This is not usually a problem, probably because not only is Geel a community that happens to contain some foster homes, but Geel itself is a foster community, and, once again, common sense kicks in. If an incident with a boarder occurs in a pub and it's believed that alcohol was a factor, the boarder may be banned from that pub and that pub can be declared "off-limits" for boarders, creating economic consequences for the pub owners. Also, research suggests that it is alcohol or substance abuse in combination with medication noncompliance that is most significantly associated with violent acts by those with severe mental illness. Though boarders in Geel are allowed the freedom of living a normal life within the community, the nurturing nature of the system and the lack of a negative stigma associated with mental illness also ensures that boarders are compliant in following their schedule of medication.

Research also suggests that a sense of threat and hostility can increase the risk of violence by those with severe mental illness. But, the community of Geel itself has a low rate of violence and the city probably offers a relatively safe social environment for all of its citizens. I recall the preview of a 10:00 news item on my local TV station about a decade ago. I don't recall the film clip that was used in the

preview, but it was somehow made clear that individuals with mental illness were being shown. What I *can* remember and I can still hear clearly is the sound of the news anchor's voice saying, "Would you want *these* people living in your neighborhood?" Oftentimes fear of those with mental illness creates a "not in my back yard" attitude toward residential facilities for the mentally ill. And, it's possible that the product of that fear places individuals with mental illness in neighborhoods that do not enjoy the safest social environment and so they may be at greater risk of engaging in acts of violence in that type of environment. Perhaps the risk for violence by individuals with severe mental illness might be reduced if community housing facilities were located in more risk-free "backyards," even if those backyards are yours or mine.

If we're looking to see whether Geel has anything to teach us here, in the United States, in the 21st century, we might deny its instructional value if we only look at the past and are merely intrigued by the remarkable story of how foster family care came to be. But, though it may be a community inspired by its past, Geel is not a community that is living in the past. It is a modern, relatively affluent, community that has changed and evolved over time. The community has experienced what is probably a normal growth curve. In 1865, there were 5,000 people living in Geel. In 1936, just prior to World War II when the boarder population was at its highest, Geel's population was 20,000 and today its about 35,000.

There has also been a change in the economic culture of Geel. The city limits of Geel encompass 22,000 acres and, as in the past, it's still primarily an agrarian community. However, the southern area of the community has become highly industrialized and this statue, donated by AMOCO and standing in the town square, represents the link between tradition and modern industry that exists today. The change in economic culture may have produced some change in family availability, since a family cannot take in boarders if both the husband and wife hold jobs outside the home. However, as I said, there are still more

qualified families available than are needed.

In terms of the practical way in which Geelians have viewed mental illness, economic culture may have also produced an interesting, even amusing, change in the motivation of families. It's reported that, in 19th century Geel, the "madness" of boarders was viewed as a bonus to prospective foster families. At that time boarders were sometimes brought to the city in shackles and there was apparently a belief, among, some that, once freed, that shackled energy could be channeled into productive work. So, a 19th century farmer's perspective on the aggression of a prospective boarder was evidently very different from our 21st century perspective on aggression and mental illness.

Twenty-first century boarders do not do the same kind of work as their predecessors and working conditions for those who do work are obviously reasonable and humane. But, while work is not required, it is valued. Today's boarders are offered the opportunity to perform meaningful work, in the context of their interests and abilities, and that meaningful labor takes many forms. Even if they don't have a specific job, there are daily activities of all kinds available for all interests, and about half of the boarders regularly use OPZ activity centers.

When boarders arrive at a center to spend the day, they can do paid piece work or engage in activities such as gardening, printing, woodworking, sports, etc. Boarders also operate a bicycle repair shop in the city as well as supplying goods for an arts and craft shop that adjoins the bike repair shop.

Of course, we're familiar with sites such as day centers in this country, but good mass transit is not the norm here and transportation can be an enormous problem. Not so, in Geel. In Europe, bikes are a common form of transportation and many boarders ride their bikes to the centers. If the distance is too great, however, the OPZ also provides bus pick up and delivery.

As this slide shows, the financial situation of today's boarders offers much more freedom in terms of their life style. They can buy nice clothes, eat out, or even take their family members out to dinner.

Families with boarders receive about \$25 a day per boarder so there is some financial benefit for the families as well, but based on the pattern of long-term matches and the conversations that I've had with family members, it's clear that boarders provide more than a source of income for these families.

I mentioned previously that there has been, in the past, a tension between the authority of experience and the authority of education. Today the OPZ is making efforts to honor and tap into both types of authority and to officially show their respect for family members. A new addition is the Family Council, comprised OPZ staff, 10 family members and one city council member. These meetings offer an opportunity for dialogue between the hospital, the community, and the family. A variety of problems can be addressed including police issues or payments to families. And, there are also plans for a similar Boarder Council in the future.

Also, in recent years respite care for boarders also became available so that if, for any reason, a family must be away and cannot take their boarder with them, the boarder doesn't have to stay in the main hospital.

Even though the Family Council is new, for a very long time there has been a relationship between the OPZ and the family through the duties of the district nurse, who comes into the family home every two weeks and who is a key part of staffing for foster family care. During the home visit, the nurse will deliver prescribed medication and, in a casual fashion, make sure all is well. If there are problems, such as agitated or aggressive behavior by a boarder, the immediate concern of everyone involved is to stabilize the situation, and it's quite normal for the family to address and resolve such problems on their own. However, they can call their district nurse or the hospital if necessary, or they can simply discuss the problem, and how it's being handled, during the nurse's visit.

The OPZ oversees all mental health services in Geel, including the four hospitals that serve the city and the region. Facilities are modern, with the newest hospital being completed in November 2004,

and hospital staff for OPZ services, as you saw, include psychologists, psychiatrists, and other medical professionals.

In addition to normal activities, the OPZ also arranges special trips and group vacation travel, for example to the Spanish seashore. And, a few years ago, boarders pooled their money to buy some small lakes outside of town where, in the summer, they hold weekly fishing “competitions.” I was lucky enough to attend one of these competitions during my 2005 visit. And, here you see one of the boarders treating me to a lemonade. This is a woman who at one time had been kept in restraints in a state hospital because of her aggressive behavior. Psychologist Marc Godemont, who is now at Geel, worked in that hospital at that time and this lady was one of several patients whom he believed was aggressive *because* she was tied to the bed. To affirm his conviction, he first brought her into his home during the day to take care of his children. And, eventually he was able to get her transferred to Geel where she’s been a happy boarder ever since.

Other than the foster family care option, I’m sure that most of the things I’ve mentioned, don’t seem that new to you. You’re familiar with the “parts” that I’ve described, but, in Geel, what seems to be different is the way those “parts” come together to create a whole, a community, which is greater than the sum of the parts. In Geel, there is truly no negative stigma associated with mental illness. Community members, the community itself, “lives with” mental illness, apparently all because of an experience that the town created for itself, out of necessity, hundreds of years go.

Is it Dimphna that made all this possible? If so, it becomes just a nice story because we can’t rewrite our own history and there doesn’t seem to be a comparable legend inspiring mental health services in any of our own communities. It’s certainly true that, by the middle ages, the legend of Dimphna had become associated with Geel. And, the state of treatment for mental illness at that time was such that the church in Geel was apparently “the” place to go. The crowds of pilgrims necessitated a

response by the community. It started with an oral legend that created a need that led to a positive outcome which has only become more positive over the centuries.

In our own country, in the last half century, the closing of state hospitals and the mandate for community mental health services has certainly necessitated a response from our communities. When the need arose, Geel accepted the pilgrims into their community and into their homes. Has this kind of response happened in the United States? I have found evidence that it has in some places. Maybe not in enough places, but is it possible to turn the tide so that it is the rule rather than the exception?

The answer, it seems to me, depends on what “this” is. If “this kind of response” refers only to “foster family care,” the answer is not an unequivocal yes. Foster family care has been tried in this country, and in other countries, in various places and at various times, and it has worked in some communities under certain circumstances, but Geel’s foster family care system is limited as a model for treatment. It is not the answer to “falling in with what we’ve been asked to accept.” But, what Geel does have to offer goes far beyond a simple “model of treatment.” What Geel offers is evidence that we, as human beings do have the capacity to live with mental illness in our communities. Geel can provide us with a sense of collective efficacy so that we dare to hope community recovery is possible. And, this is a much more important message than any template for treatment.

As my visits to Geel continued over the years and I was able to see Geel’s contribution in that light, it became possible for me to seek out programs in our own country that offered that same kind of hope. These are not communities with Geel’s history or a Dymphna legend, but they are programs and neighborhoods that provide, I believe, examples of “community recovery.” They are here and they too can offer us hope and a sense of collective efficacy. But, they can only do that if we know that they exist and we make that fact known to fearful or doubting members of our communities. Unfortunately, these stories of success don’t get as much attention as the “horror stories” that make us all cringe as we read

the headlines.

As I started looking for and visiting hope-inspiring services in our own country, what I found began to look quite similar to what had happened in Geel. Almost all of the programs that I've visited or become familiar with, began when a group of interested citizens recognized a need and responded to that need.

My first visit took place in 2002 when I traveled to the Way Station in Fredericksburg, MD. Founded in 1978 by the Frederick County Mental Health Association, it now serves 3,500 clients with diverse programs operating in or from a new 30,000 square foot two story building located in the city's Historic District. The Way Station's vocational program has partnered with approximately 50 local businesses to provide jobs for Way Station clients. They also provide, or help to find, housing for clients in a variety of residential settings including, for some, independent living in the client's own home or apartment. But, Way Station's clients aren't only served by Way Station services; those clients also provide volunteer services for other community sites and projects. It doesn't take a giant leap of imagination to see similarities between what happens in Fredericksburg and what has been happening in Geel for centuries.

In 2004 I made my next visit to Chicago's Thresholds, a program that was, once again, begun in response to a recognized need. In 1957 the National Council of Jewish Women, recognizing the needs of patients returning to communities from hospitals began Thresholds in a small way, in a little office. Today they oversee 22 service locations and more than 40 housing developments in the Chicagoland area. One of their programs is a clubhouse in a lovely old home in a "high rent" district on the Northside of Chicago. One of the activities that's available here is a horticultural therapy program. From this program grew Urban Meadows, a florist service, which now operates as a florist shop in the lobby of the American National Bank Building in downtown Chicago, only one of several Thresholds consumer run businesses.

This past October I had the privilege of visiting Fountain House, in New York City. Founded in 1948, Fountain House is the prototypical clubhouse where those with mental illness are active members of an organization, a club, that provides educational, social, vocational, and recreational services. Their efforts and model have led to the building of hundreds of clubhouses in the United States and around the world.

During that same trip to New York, I was also able to visit a number of residential facilities in the Greater Manhattan area. Geel Community Services, inspired by the spirit of Geel, Belgium, was founded in 1976 in response to the institutional release of those with mental illness. Archie's Place, a part of Geel Community Services, was opened in 2003 and named after a beloved former director.

Common Ground's Times Square is the product of a fund-raising campaign that resulted in the renovation of a once grand, but subsequently run-down, hotel. It was re-opened in 1991 and is the largest mixed residential facility in the country, housing 651 residents including about a 50/50 split of those with disabilities and those with financial need. (And, due to the location of the building, many in financial need are aspiring actors.) In addition to serving those with disabilities or financial needs, the renovation of that hotel brought renewal to the neighborhood as well.

Community Access, started in 1974, by "family members" and friends of patients released from hospitals to the streets, offers transitional and permanent housing on about a 60/40 basis, for the disabled and those with financial need. Today Community Access provides housing for over 800 individuals in these two categories. Some of their buildings are renovations, but most are purpose built and this past fall they opened their newest permanent building, in the Bronx, with 73 apartments. The picture shows Community Access Director, Steve Coe, standing proudly in the lobby of this new building.

Broadway Housing was founded in 1983 by Ellen Baxter, a gentle but amazingly wise and strong woman, who was motivated by her post-graduate year in Geel, working on the Geel Research Project.

Today Broadway Housing is responsible for six housing sites, with apartments for both individuals and families. I visited their newest site, Dorothy Day apartments, with 70 apartments housing 190 children and family members, in a beautifully renovated building with a lovely river view. In this building, in addition to residential facilities, educational services are provided for residents of the building as well as for members of the surrounding neighborhood.

And, in January of this year, I was finally able to visit a site that had been on my short list for many years: The Village, an award winning program in Long Beach, California. The Village began in 1990, with a strong focus on recovery and a broad offering of “integrated services” for those who need support to live and work in their communities.

Also, during my January California visit, I had the privilege of learning more about Behavioral Health Courts when I visited Judge Mary Morgan’s remarkable court in San Francisco. And, while attending a meeting of the Council on Mentally Ill Offenders, I was pleased to learn that Mental Health Courts, in general, offer one of the greatest opportunities for flexibility in helping those with mental illness, a flexibility that allows each person to be supported according to their individual needs, rather than being “dealt with” as a member of some larger supposedly homogenous, stigmatized group.

One of my earliest experiences with mental health services began in the 1990s, even before my first visit to Geel. At that time, I became aware of a program that specifically addresses the need for friendship that we all have, including those with a diagnosis of mental illness. That program is Compeer, a non-profit agency that began in Rochester, New York, in 1976. The Compeer concept is to arrange friendship matches between consumers and community volunteers. Today there are over 80 Compeer agencies in the United States, including two in California, in Pacifica and in San Diego. For nine years, we were proud to have a Compeer Agency in Birmingham, Alabama. I’m sorry to say that a lack of funding forced us to close down at the end of 2002, but, in 2001, we initiated a cooperative effort with

our local Habitat for Humanity to build a Habitat House, which we named “Habitat Hope House.” And, this accomplishment helped to buffer the disappointment we were to feel a year later when we closed down.

In order to sponsor a Habitat building, the sponsoring agency needs two things: money and workers. We were able to obtain full funding from Forest Laboratories and our workers were primarily those who were interested in, or whose lives were affected by, mental illness: mental health professionals, family members, consumers, psychology and sociology students and pharmaceutical sales reps. This was the first such project of its kind and the most gratifying aspect of working at the site was seeing people work side by side, usually not knowing, and certainly not caring, whether their fellow workers were consumers, family members, therapists, students, or drug reps. Working together, we were all just people, with similar needs and desires.

All of us have basic needs and in 1943, in a paper on motivation, psychologist Abraham Maslow (1908 - 1970) described and ordered these needs. He said that, before anything else we are motivated to satisfy our survival needs: the need for air, water and food, the need for a home and safety, and the need for friends and a sense of personal value and esteem. Once these needs have been met, Maslow suggested that we pursue “growth” or being needs, allowing us to reach a higher level of what he called self-actualization. Some reach that stage, some don’t, but there is no doubt that all of us, on almost a daily basis, strive to fulfill our survival needs.

Maslow’s understanding and description of our needs is thorough and applies to all people everywhere, including those with mental illness. Mental illness itself can make it more difficult to fulfill one’s survival needs, but mental illness does *not* negate the need to do so. And, a community such as Geel, as well as exemplary mental health programs in our own country, appear to acknowledge the basic human needs of those with mental illness by offering opportunities to satisfy those needs.

Geel psychologist, Marc Godemont, has described what he believes to be the “secret” of Geel’s success. As I’ve visited and become familiar with successful programs in our own country, these factors also appear to be the foundation on which the “recovery model” is built:

- 1) Geel acknowledges and accepts the human needs of boarders
- 2) The community responds to those natural needs rather than acting on unfounded or exaggerated fears
- 3) And, most important, in Geel, boarders are not just members of a foster family, but of a foster community as well

What I’ve also noticed in Geel is a kind of flexibility. When the system of foster family care began, families were not trained or screened. They just had to use their common sense and practical experience. They are still not “trained,” and this flexibility is the tradition that is most obvious to me as an outsider. I’ve had the opportunity to visit families in Geel and I’ve seen it in action. I’ve also seen that the boarders are as important to the families as the families are to the boarders.

In 1997, I visited my first Geel foster family. There were two male boarders, living with a widow who had “inherited” her first boarder from her parents, when she and her husband married. Her husband and sons had built a successful mill business and the two boarders had worked in that mill when her husband was living and helped her to keep the business running after his death.

During my 2005 visit, I was hosted in the apartment home of a widow who lived above her antique shop. She had lived a full life, but not a life without stress. A number of years before, her husband, an alcoholic, had committed suicide. She had always had boarders, and the reason that Marc arranged for me to visit her home in 2005 was that her newest boarder spoke English. He was a highly educated man, apparently from a well to do family. He was a pleasure to talk to, but Marc had told me that he experienced a great deal of anxiety about small things, and this became clear as we rode in the

same car from the day center to his home. But, when we arrived in his home and were met by his “foster mother” a certain calm seemed to settle over him. As we interviewed the foster mother, with Marc translating, we asked her why she had boarders. A quiet woman, she paused and smiled gently but struggled to find an answer as if we’d asked her “Why do you breath?” At last she shrugged her shoulders and simply said, “I can’t imagine *not* having a boarder.”

During my most recent visit, in 2007, I had the joy of visiting with three women who call themselves the “three musketeers,” but I thought of them as the “Golden Girls.” Here were three distinct personalities, but there was a clear symbiosis that allowed each to easily and comfortably express their personality and their care for one another.

Also, during my 2007 visit, I was able to spend an entire day with a woman whom I had met in 2005. Madeline was born in the Netherlands but raised in the US, before she returned to Belgium as a teen, and so she speaks English fluently. Our day together in 2007 was the culmination of a “date” that we had made two years earlier. Madeline is happily married to Jeff and they have two grown sons and one or two grandchildren. But they have also chosen to open their home to two boarders and the four of them are, in every sense of the word, a family. Madeline and I correspond from time to time and earlier this year, a paragraph from one of her letters to me, speaks clearly of how important her “boys” are to her. She wrote:

Next week I've got an appointment with my employer and I hope very much that they'll fire me. Otherwise [the boys] will have to go back to the OPZ next July. I HOPE NOT! I couldn't live without them anymore. It might be selfish, but true. Keep your fingers crossed. It might help.

The Geel tradition began with an undocumented legend. Though the Dimphna legend has not been validated and today the religious significance is of little importance, Dimphna is still an obvious and

present part of the community. But, an even more important part of the community is not to be found in buildings or statues, and that part is documented. That is the unqualified acceptance of the mentally ill as people, important people, people with needs. People with something to offer. And what people believed about an oral legend motivated that outcome.

Unfortunately, in our own communities, what people believe too often becomes “legend” of a different sort, leading to a stigma related to mental illness based in part on half-truths and even myths. And that legend can get in the way of dealing with mental illness in a practical and humane manner. It can produce a negative stigma based on fear and even ignorance.

There are three ways to breakdown stigma: protest, education, and contact. Troublesome facts about mental illness are *not* to be ignored, including facts about how those with mental illness suffer from unfounded myths and stigma. We need PROTEST.

Furthermore, to live effectively, as either consumers or communities, we need to know *all* of the facts. We need EDUCATION. And, even more important, we also need to learn that we can live with mental illness. Promotion of community recovery encourages CONTACT. And, it has been shown that contact encourages community recovery. It’s that simple and it’s that difficult, but it *is* being done and that’s why I believe there is reason to hope for community recovery.

What can Geel teach us?

- Diverse communities have diverse needs AND resources; respond accordingly
- There are different kinds of “authority”
- Provide opportunities to interact in “normal” social environment
- Show concern for individual needs & behaviors, rather than “diagnoses”
- Provide a nonthreatening social environment
- Offer consumers opportunities to make contributions to community

Questions to Think about and Discuss

- What “legends” enhance or constrain your own program(s)?
- What can your clients give to the community (e.g., volunteer work, etc.)?
- How can you encourage community members and/or organizations to invest time (manpower) or money to involve your clients in community activities?
- How can programs be individualized to fill the needs of diverse clients and communities and, at the same time, seek to fill common or necessary needs?
- What opportunities do your clients have to interact with non-consumers? What non-consumer support groups are available?