Hope for "Community Recovery:" Legendary and Modern Examples of Community Mental Health Care in Caring Communities

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Abstract:
In Geel, Belgium, 700 years ago, a successful system of community integration emerged out of necessity. Geel's foster family care system continues to function and has evolved into a comprehensive system of mental health programs. In striving to implement programs that promote community integration, it can be helpful to look at a city whose history offers a microcosmic view of challenges associated with community integration and mental health, in general. Using as criteria factors associated with Geel's success coupled with stated goals of the recovery model, a sampling of successful programs in our own country is also identified. The community of Geel and successful United States programs are considered in the context of a proposed concept of *community recovery* – i.e., a community's ability to live comfortably with the realities of mental illness. Community recovery may depend on the hope that these goals are possible. Furthermore, hope and the necessary sense of efficacy to achieve positive goals can be potentiated through vicarious reinforcement from existing successes.

Research Methodology
This poster is descriptive, based on the author's six trips to Geel, between 1997 and 2005, and an ongoing collaboration with staff, administrators, and host families in Geel. In addition, the author has visited successful programs in the United States (e.g., Way Station, in Maryland; Thresholds, in Chicago; Dane County in Wisconsin) and is continuing to visit other such programs to gather information for a book that she is currently writing on the topic of this poster. She is also doing extensive reading research relative to our own history with mental illness, specifically in terms of the interface between community and the mentally ill.

Learning Objectives:
- Introduction of "community recovery" as a way to conceptualize the process that communities must go through to move towards community integration.

- Familiarization with the history and current status of a legendary Belgium city, home of the oldest continuous community mental health program in the world. Geel, Belgium, is a legendary example of *community recovery*.

- Familiarity with examples of exemplary community programs and agencies in this country, comparing how their outcomes and motivation match those of Geel.

- Motivated by these examples of *community recovery*, development of a sense of collective efficacy, defined by Albert Bandura (1997) as "a group's shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainment (p. 477)," there being "nothing more persuasive than seeing effective practices in use (p. 514).

- Based on a sense of group, or community, efficacy, generation of "hope" that *community recovery* can lead to community care in caring communities

TABLE OF CONTENTS

NOTE: Due to space limitations naturally imposed in a poster presentation, this handout contains expanded poster material.

INTRODUCTION

The current recovery model of treatment sidesteps the issue of cure and suggests that consumers can live successfully with the realities of mental illness (Drake, Green, Mueser, & Goldman, 2003; Davidson, O'Connell, Tondora, Lawless & Evans, 2005). Opportunities for community integration are a part of the recovery process and successful recovery can also facilitate community integration. Since community plays a key role in the consumer's recovery process and outcome, it is logical to assume that "community recovery" (i.e., communities living successfully with the realities of mental illness) is also a desirable goal.

Substance Abuse and Mental Health Services Administration (SAMSHA) (n.d.) has identified hope as "the catalyst of the recovery process." That statement has validity for the community as well as the consumer. The individual hopes for the ability to live a satisfying life in spite of mental illness. Community recovery would be based on a hope that the community can overcome their biases and fears in order to achieve community integration.

Though hope promotes and is the product of recovery, hope alone, in any context, seldom produces positive outcomes. In this case, both consumers and communities must also have 1) evidence that a positive outcome is possible and 2) an understanding of the means by which they can attain the desired outcome.

However, some community members are isolated from contact with consumers. Their only contact with mental illness could be through media reports or literary narratives which too often offer little hope (Shain & Phillips, 1991; Wahl, 1995). Both are more apt to focus on dire or dramatic stories that catch the public attention and feed a negative stigma related to mental illness. A preponderance of such stories can create a community sense of hopelessness regarding our ability to live comfortably with mental illness. It is less common to read news or literary stories that engender hope, stories of those who are adjusting to or coping with their illness and who are living productive lives. Factual, well researched media stories that reveal bias and abuse are an absolute necessity in that they insist on desperately needed, necessary reform. However, in order for reform to occur, people and communities need models for reform and, equally important, they need the accompanying sense of hope that successful models can provide. Knowing of such success stories can give mental health workers and communities a vicarious sense of efficacy as they seek to implement the mandate of community mental health treatment and to live successfully with mental illness.

One such story can be found in Geel, Belgium, a community of 33,000 and home to the oldest known continuous community mental health care system. Its origins are in the 15th century when mentally ill pilgrims in search of healing at the Church of St. Dymphna (the patron saint of mental illness) overflowed the church and citizens of Geel began to host these pilgrims in their own homes. Though it has gone through many transitions, that legendary foster family care system exists even today as an integral part of a comprehensive modern system of mental health care, providing diverse services to the community and the region (Goldstein & Godemont, 2003; Roosens, 1979). The community has always been comfortable with the reality of mental illness. Though Geel residents have no formal training regarding mental illness, they have learned to accept it and do not appear to be burdened with the stigma of mental illness in their approach to mental health care. Geel's foster families, and even the community itself, have learned to serve as "mental health providers" through experience and contact alone,

While Geel's experience has resulted in a lack of stigma relative to mental illness, our own experience, in the United States, particularly as a product of those years when we were sheltered from contact with the mentally ill due to the prevalence of institutional care, has produced a persistent stigma that often interferes with diagnosis and treatment (Corrigan, 2004; Corrigan & Penn, 1999; U.S. Department of Health and Human Services, 1999; President's New Freedom Commission on Mental Health, 2003). On the whole, we have not learned to live successfully with mental illness. However, there are many exemplary mental health care systems or programs in our own country whose existence may not be well known to community members who do not use their services. Often even those who staff one of these praiseworthy programs are not aware of other such programs.

Geel's foster family care system has served that community and region well and Geel's success does offer hope for other communities. However, it is not suggested that the foster care model is appropriate for all communities or all clients and, in fact, Geel currently offers a range of alternatives for care and treatment of those with mental illness. What is more worthy of notice when looking at Geel is the outcome of services that allow for near total community integration. Geel, along with exemplary models in our own country, can encourage hope and a sense of collective efficacy, through vicarious reinforcement, that can help communities to recover from their fear of community integration, and lead to community care in caring communities.

RECOVERY – FOR THE INDIVIDUAL AND THE COMMUNITY

The current recovery model of treatment sidesteps the issue of cure, suggesting that consumers can live successfully with the realities of mental illness. SAMSHA (n.d.) has identified the 10 fundamental components that are key to both recovery and to establishing programs that encourage recovery. These are:

HOPE	non-Linear
Self-direction	Strength-based
Individualized & person-centered	Peer support
Empowerment	Respect
Holistic	Responsibility

For consumers, programs that offer recovery can lead to an ability to live as active members within a community of choice. Since individuals who have recovered from mental illness are not necessarily "cured" of mental illness, such an outcome suggests that communities must also "recover" to the extent that they too must learn to accept and live with the realities, rather than the myths, of mental illness.

THE ROLE OF HOPE IN ACHIEVING RECOVERY

Hope is a key factor in the recovery process (Ochocka, Nelson, & Janzen, 2003; SAMSHA, n.d.). It can promote recovery and it is an outcome of recovery (Bledsoe, 2001). Jacobson and Greenley (2001) describe hope and its role as

> . . . the individual's belief that recovery is possible. The attitudinal components of hope are recognizing and accepting that there is a problem, committing to change, focusing on strengths rather than on weaknesses or the possibility of failure, looking forward rather than ruminating on the past, celebrating small steps rather than expecting seismic shifts in a short time, reordering priorities, and cultivating optimism. (p. 482).

Yet optimism alone seldom produces positive outcomes. It must be fueled by a sense of self-efficacy, "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (Bandura, 1997, p. 3). Groups can also experience *collective efficacy*, "a group's shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainment" (Bandura, 1997, p. 477). The development of collective efficacy, as with self-efficacy, often comes from vicarious sources as "there is nothing more persuasive than seeing effective practices in use" (Bandura, 1997, p. 514). Knowledge of successful community integration, can provide vicarious reinforcement, motivating a sense of self efficacy for consumers and collective efficacy for those involved in the field of mental health, thus justifying the hope that is necessary for successful recovery of both the consumer and the community.

COMMUNITY RECOVERY
GEEL: A LEGENDARY EXAMPLE

History

A sixth century legend tells the story of Dimphna, the daughter of a pagan Irish king, who chose martyrdom over the madness of her father's incestuous demands. Over the years, the site of her martyrdom near Geel, Belgium, came to be associated with miraculous cures and in 1247 Dimphna was canonized as the patron saint of the mentally ill. Reports of miracles led to Dimphna's canonization, and, in turn, her sainthood assured a continued influx of pilgrims seeking religious treatment. In 1286, a guest house hospital was built in an effort to accommodate the pilgrims and, as pilgrims continued to come, a new church building was begun in 1349.

On that same site still stands, the Church of St. Dimphna, completed in 1749. But even with the addition of a sick room to house the pilgrims added to the church in 1480, they still overflowed the church and, out of necessity, Geel citizens were asked by local canons to host these pilgrims in their own homes as "boarders." Such boarding exists even today as one alternative in a comprehensive system of mental health care..

Administration

Over the years the administration of Geel's system of foster family care, and eventually overall mental health services, has undergone changes. In 1850, when Belgium's national mental illness law addressed poor treatment of the mentally ill nationwide, Geel was designated as a special region – the Rijkskolonie, or State Colony – with the national government assuming administrative responsibilities for mental health services. Though it still functioned as a normal community, Geel was also considered to be a psychiatric institute, a sort of hospital without walls.

Today Geel's Public Psychiatric Hospital, the Openbaar Psychiatrisch Ziekenhuis or OPZ, supervises the family care system, and, in 1991, though still subject to Belgian Hospital laws, the OPZ gained autonomous status as a Flemish Public Institution. This was an important change for, with an independent Board of Directors, decisions about the future of the hospital are now made in Geel, rather than in Brussels.

Early days: oversight by local canons
1797: French revolution leads to end of religious system
1811: French decide to end system; never carried out
1838: Geel Municipal Council
1850: Belgian government (Ministry of Justice); designation as Rijkskolonie (State Colony)
1948: new Ministry of Public Health
1991: central hospital (OPZ) becomes autonomous

Staffing

There are four Family Service teams within the system, each one serving approximately 125 boarders in approximately 100 homes.

Psychiatrist	Social worker
Generalist	Three nurses
Psychologist	

A key staffing element for the family care system is the district nurse who visits each family approximately every two weeks or as needed. During their visit, the nurse delivers prescribed medication and makes sure everything is

going well. If a situation develops where a boarder becomes agitated or aggressive, the immediate concern is to stabilize the situation. It's normal for the family to attempt, on their own, to calm the patient. Since many families have decades of experience, their efforts are usually successful. If the problem persists, they can call the hospital or their district nurse who is a link between the family and the system itself. As with the family / boarder relationship, the nurse / family relationship is normally long term.

Organization of Services

The OPZ is governed by the same hospital statutes and receives the same state income as all other psychiatric hospitals. The only difference is that, since 1991, the Board consists of members assigned by the regional Flemish government.

For centuries there has been a hospital in Geel to provide medical services and any necessary acute psychiatric care for foster family boarders. In modern times there was also an additional hospital that provided mental health services for non-boarders in the community and region. In recent years, however, the hospitals were restructured into four separate divisions and buildings, with the newest of these buildings being completed in November 2004 and providing adult care for a region of 250,000.

Various wards in the new hospital are designated for specific categories of mental health problems and the rooms in each of these wards surround a garden / patio area, with a separate outside area for each of the wards. Specialized therapy rooms allow patients to cook, do woodworking, or perhaps participate in music therapy. There is also a separate sports building with an adjoining basketball court.

In addition to foster family care services and hospital services, a new drop-in center for non-boarder consumers, is located in a neighborhood of up-scale homes. Also, in the community are a bicycle repair shop manned by consumers and a craft shop where a range of simple to elegant consumer created artwork can be purchased.

Candidates for Geel

Most patients are referred to Geel by other Belgian psychiatric hospitals, and come from a radius of about 32 miles *(50 km)* around Geel. Patients considered to be good candidates for relocation to Geel fit the following criteria:

- Diagnosis of severe mental illness according to DSM-IV criteria. Inability to integrate into normal daily life on their own
- Need for dependence and attachment.
- Normally, aggressive patients are not considered (though exceptions are made)

In-take Procedure

This procedure can take from a few weeks to several months and includes the following steps:

- Written request from referring institution
- Patient record studied by intake team
- If referral is good candidate, team visits patient at institution where they're currently housed.
- If visit goes well, patient moved to Geel observation home with normal home environment to determined ability to live in family environment and, if necessary, where skills can be learned that will help them to live successfully in a foster family home.
- Foster family identified from those currently available. Normally waiting list of families. Families primarily assessed regarding social behavior, infectious disease, family stability, and housing conditions. Part of housing criteria requires every boarder to have own room in foster family home.
- Several meetings with prospective family in their home – i.e., not at hospital.
- If both patient and family feel match is compatible, patient moves in with family.
- Final decision made by reviewing panel, with only rough matching procedure, based primarily on wishes and needs of both family and patient.
- Match monitored and referring institution receives report at four months and one year after placement.

Many boarders stay in the foster family system for years (e.g., in 2005 31% of the 509 boarders had lived in a foster home for more than 50 years). It would be more accurate, however, to say that many boarders stay in a foster *family* (i.e., less emphasis on "system" and more on "family") for years, for once long term boarders have found a stable foster home, they become a part of that family and may stay with them for multiple generations, i.e., many host families simply take in a boarder from their parents' home as the parents age. Though most boarders become long-term residents, today some younger patients (e.g., 18-40) are placed with a family for 2-5 years with the hope that being part of a family network will improve their social skills and allow a more independent life style outside a foster home.

Boarder Demographics As of June 30, 2006, there were 460 boarders living with 355 care-taking families. The age range is from 24 to 93 and sixty-six percent of these boarders are men. Currently 112 boarders have been diagnosed with schizophrenia or psychotic disorders (79 men and 33 women) while 99 have been diagnosed with mental retardation (62 men and 37 women). The number and diagnostic distribution of boarders changes over the years, however. For example, in 2004, there were 516 boarders: 233 diagnosed with mental retardation and 110 with schizophrenia or psychotic disorders).

Geel Boarder Population, by year	
Year	**Population**
1855	800
1900	1900
1920	2277
1929	2694
1938	3800
1950	2459
1960	1934
1970	1386
1980	992
1990	773
1999	549
2001	571
2003	516
2006	460

Age of Current Boarders (6/30/06)	
Age	**% of Boarder Population**
<30	4
31-40	17
41-50	38
51-60	98
61-70	135
71-80	127
81-90	39
>90	2

Boarder DSM Category (as of 6/30/06)	
Diagnosis	**% of Boarder Population**
Schizophrenia / psychotic	24.3
Mental Retardation	21.5
Impulse Control	12.0
Bipolar	11.1
Anxiety	5.2
Somatoform	4.8
Drugs / Alcohol	2.6
Sexual	1.1
Adjustment	1.1
Personality	0.9
Dementia / other cognitive	0.4
Eating	0.4
Dissociative	0.2
Other	14.1

Changes over Time

Though many things have changed in Geel across the centuries, and even decades, the foster family tradition has persisted. The population of the city itself has increased over the years, from 5,000 in 1885 to 20,000 in 1936, with the 2000 census reporting a population of about 33,000.

The City limits of Geel encompass 22,000 acres. While part of the town is still primarily agrarian, as in early times, the southern part of the town is highly industrialized. A link between tradition and modern industry is evidenced by a sculpture, "A Tribute to the Geel Family Care System of Mental Patients", that was donated to the town by Amoco Chemical, one of the area industries, and sits in the town square.

In recent years, Belgian sociologist Eugene Roosens, a member of the GRP research team, surveyed 108 long term foster families to see how they perceived their community and what changes, if any they perceived. Important findings from this survey revealed that:(Roosens & Leuven, 2005)
e boarder is recognized in "his/her full human dignity" (p. 1). This is seen in terms of the social integration of the boarder into the life of the community, as well as the life of the host family. Both in the homes and in public places, the boarder is treated as a member of the community.

Geelians acknowledge a difference between "normal" and "abnormal," and abnormal behavior may be rejected, but the person is not. Rejection of behavior may include joking, such that community members "recognize the boarders, listen and talk to them, but [in the presence of abnormal behavior] stop taking them seriously and show it (p. 6)."

Foster families feel more respect from hospital personnel, as evidenced by greater communication between upper level administration and families.

Meaningful Work

Many boarders live with families who have farms or small family businesses and these boarders are able to work with or for the family. Today with more residential options available for individuals with mental illness, those who board in Geel are often those who are not able to handle as much job responsible as past boarders.

Even if boarders don't have jobs, they're all busy during the day with about half regularly using OPZ activity centers. They can ride their bikes to the centers or there's a bus that will pick up and deliver boarders. At the various centers they can do paid piece work or engage in activities such as gardening, printing, woodworking, or even sports. The OPZ also arranges day trips and even group vacation travel. In the summer a favorite pass-time is the monthly fishing "competition" held by boarders on a pair of nearby small lakes that they, the boarders, purchased for themselves several years ago.

"Secret" to Geel's Success

Following a ten-year study of Geel's foster family care system, the Geel Research Project (GRP), sociologist Leo Srole (1975) observed that the foster family takes in a stranger who becomes a functioning member within the family structure. The role of the family as caretaker, teacher, natural supportive parent, and behavioral model allows the boarder to function in the "normal" social world in spite of their illness. Geel psychologist Marc Godemont, after 28 years in Geel's mental health care system, describes what he believes to be the "secret" of Geel's success, i.e., factors that are present today and, to some degree, have probably always been present::

- Geel acknowledges the human needs of boarders
- The community responds to those needs by providing social opportunities and meaningful work in the community
- The mentally ill in Geel are members of both a foster family and a foster community

COMMUNITY RECOVERY IN THE UNITED STATES

Because of its unique historical experience, there is a lack of stigma relative to mental illness in Geel. Our own experience in the United States, particularly decades where the norm was institutional care for the mentally ill, has produced a separation of consumers and community, a separation that is both a product of and catalyst for a persistent stigma that often interferes with diagnosis and treatment. On the whole, we have not learned to live successfully with mental illness.

Though Geel's foster family care system has served that community and region well, it is not suggested that such a model is appropriate for all communities or all clients and, in fact, Geel currently offers other alternatives for care and treatment. What is more worthy of notice when looking at Geel is:

- The outcome of a model that allows for near total community integration.
- Facilitation of community integration in the absence of a negative, myth-based stigma.
- Flexibility in the care of individuals with diverse symptoms and in the services offered for these individuals.

A community in this country might be considered to be a "recovered community" if, as in Geel, the community:

- Acknowledges the human needs of boarders
- Responds to those needs by providing social opportunities and meaningful work in the community
- Accepts those with mental illness into the community, as members of same
- Shows flexibility in programs and approaches in order to address *individual* needs of clients

These goals are consistent with the recovery model and many programs in this country have had particular success in meeting some or all of these goals. Following is a small sample of such programs (the author has visited or participated in the programs or sites with an *):

*Alabama's Annual Consumer Recovery Conference (in its 14th year in 2006)

In 1992 the Office of Consumer Relations in the Alabama Department of Mental Health and Mental Retardation first sponsored what has become the nation's largest statewide mental health conference organized for and by consumers. Since 1997 the conference has been held in a large rural conference center near Talladega, Alabama. In 2006, 700 consumers and 200 staff members attended the three day conference to hear speakers, participate in workshops, put on a talent show, and enjoy the lovely grounds (Alabama Department of Mental Health and Mental Retardation, n.d.).

*Compeer, Inc, Rochester, New York

Compeer, a non-profit agency, coordinates friendship matches between community volunteers and individuals recovering from mental illness. It began in Rochester, New York, in 1976, and today there are over 100 Compeer agencies in the United States (Compeer Program, n.d).

*Compeer of Birmingham's Habitat Hope House, Birmingham, AL, 2001

In 2001, Compeer of Birmingham initiated a cooperative effort with the local Habitat for Humanity, the first such project of it's kind. With full funding of $45,000 from Forest Laboratories, workers whose lives were affected by mental illness (e.g., consumers, family members, mental health workers) built a Habitat home for a family that included a member with a physical disability. (Compeer of Birmingham & Greater Birmingham Habitat for Humanity, 2001).

*Dane County, Madison, Wisconsin

As pioneers in community mental health services, Dane County services are referred to as the Madison Model. An important aspect of this model is the Program of Assertive Community Treatment (PACT). Dane County provides a full range of community services including Yahara House, established on the clubhouse model. It is also a training ground for mental health professionals from around the world. (Dane County Department of Human Resource (2006); LeCount, 1998))

*Thresholds Psychiatric Rehabilitation Centers, Chicago, Illinois

In 1957 Chicago's National Council of Jewish Women sponsored a social program to help former mental patients transition into community. Today Thresholds has 22 service locations and more than 40 housing developments in the area. They sponsors a host of other programs and business enterprises including Urban Meadows, a commercial flower shop, staffed by consumers and housed in the lobby of a landmark office building in Chicago's financial district (Thresholds Psychiatric Rehabilitation Centers, 2006).

*Way Station, Inc. Frederick Maryland

Begun in 1978 by concerned members of the Frederick County Mental Health Association, Way Station now serves 3,500 clients with diverse programs operating in or from a new 30,000 square foot two story building located in Frederick's Historic District. Their vocational program has partnered with ± 50 local businesses to provide jobs for Way Station clients. Clients are also providers of volunteer services for other community sites and projects. Way Station provides or helps to find housing for clients in a variety of residential settings, including, for some, independent living in their own home or apartment (Way Station, a subsidiary of Sheppard & Enoch Pratt Foundation, 2006).

Broadway Housing Communities, New York City

In 1975, following college graduation and a one year research fellowship in Geel, Ellen Baxter, founded Broadway Housing Communities where she remains as Executive Director. " [Their] supportive housing is distinctive for its integration of the healthy and disabled. . .[including] those with mental disabilities, HIV/Aids and other chronic health conditions, and many in recovery from addiction." (Broadway Housing Communities, n.d., ¶ 1-2)

Fountain House, New York, NY

The original "clubhouse" and the model for today's count of over 400 clubhouses in 30 countries, was founded in 1948. They have motivated world-wide expansion of the model and facilities today include a rural version of the clubhouse model, the 480-acre High Point Farm, a working farm in Northern New Jersey (Fountain House, n.d.).

Gould Farm, Monterey, Massachusetts

Founded in 1913 on 650 acres in the Berkshire Hills of Massachusetts, this is considered to be America's oldest therapeutic community for people with mental illness. It provides a community where residents can work and learn new job skills. When they are ready, residents may transition into a larger community in the Boston area (Gould Farm, 1998-2002).

Spring Lake Ranch, Cuttingsville, Vermont

Established in 1932, by Wayne Sarcka, an Finnish immigrant, and his Long Island wife, Elizabeth Man, by a mountain lake, the programs and social environment were inspired, in part, by Elizabeth's belief in the value of family life and her familiarity with the Geel community. Residents come to the Ranch from hospitals, home or schools, needing some type of structure and nurturing but not hospitalization. A typical stay is 6-8 months and many leave to enter an after-care program in a nearby community of 18,000. Even while experiencing community integration in there, however, they can still participate in activities and services at the Ranch (Spring Lake Ranch, n.d).

The Village Integrated Service Agency, Long Beach, CA

" The Village's Designed Care Approach is a Menu Driven approach. . .[offering] an array of options for members which supports individuated services in all quality of life areas (i.e. employment, residence, social, substance abuse, etc)." Staff focus on encouraging members "free choice of any menu option at any time" (The Village Integrated Service Agency, n.d., & 2).

SUMMARY and CONCLUSIONS

The recovery model encourages consumers to focus on living with the realities of mental illness, rather than hoping for a cure. Furthermore, the positive outcome of this shift in focus offers hope for living an active life in a community of their choice. For full recovery to occur, it is logical to believe that communities must also shift their focus in the same manner. Such an outcome is often deterred by a myth-based stigma relative to mental illness coupled with a sense of hopelessness when community members are not aware of successful models of community treatment. Such a model has existed in Geel, Belgium, for centuries. In addition, since community mental health treatment has become the norm in this country and, many programs have successfully encouraged and implemented community integration. However, community members are often more made more aware of shortcomings and the necessary need for reform than of successful programs that offer hope for recovery. Both types of knowledge and understanding are necessary in order for community mental health care to continue to evolve such that it exists in the context of caring recovered communities.

Request for Information:

In order to instill hope for community recovery, the poster author is currently working on a book that, in one section, will provide details of the centuries old history and current status of Geel, Belgium. In another section, readers will be learn of exemplary mental health agencies and programs in our own country. If you feel that your agency or program can offer hope to others and thus deserves a chapter in this book, please contact Dr. Goldstein (see contact information on front of handout).

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HISTORY OF GEEL

Author will provide complete bibliography of publications about Geel upon request.

6th-7th c.	According to legend, beheading of Dimphna, daughter of an incestuous Irish king, and her guardian priest, Gerebern. Evidence of devotion to memory of Dimphna and miracles attributed to her from this date forward. Original worship takes place in small chapel containing relics of Dimphna and Gerebern
10th -11th c.	Spread of word regarding miracles necessitates building of larger church.
1247	Canonization of Dimphna as "patron saint of demented victims" because she resisted incestuous advances of her father who was believed to be "possessed by the devil"
	First written record of St. Dimphna legend, by Belgian canon Peter van Kamerijk
1280	Baron of Geel builds guest house hospital near St. Dimphna's chapel.
14th c.	Heavy influx of lunatic pilgrims seeking miracles
1349	Building of present church begun (completed 1749)
1480	Sickroom built onto church. Pilgrims housed here for nine days of treatment.
1532	College of 10 clerics established to oversee colony boarding system. Prior to this, church priests provide informal supervision of family care.
1687	Church and sick room had been destroyed several times by fire and storm New sick room built to accommodate more pilgrims; divided into four rooms with small dark cell in each..
1797	French revolution results in closing of church by French government. Many pilgrims still come to Geel. Received by private individuals.
1803	Since boarders remain in Geel, legislation requiring inspections passed but Geelians object to interference
1811	French Minister of Justice decides to abolish family care in Geel but, due to delaying tactics by local government, decision never acted on.
1815-30	Belgian part of United Kingdom of Netherlands
1821	Etienne Esquirol, student of Phillipe Pinel, visits and writes *Des Maladies Mentales*. Criticizes program due to lack of: 1) medical staff, 2) therapeutic environment of hospital, and 3) moral treatment regimen
1832	In context of new Belgian legislation requiring every municipality to take charge of their own mentally ill, four doctors nominated to oversee medical needs of mentally ill pilgrims.
1838	Organization of family care in Geel comes under local government

1850 National Mental Illness Law passed in Belgium intended to protect patients as well as Belgian population. Article 6 of law finally included to recognize family care. Accommodation in family care given same legal status as admission to normal psychiatric institution

1852 Administration of colony taken over by state. Program formally designated as Rijkskolonie (State Colony) and Medical Director named

1862 First inpatient facility built. Used for entry examination, treatment of somatic problems, and rehospitalization when problems with foster family developed

1875 Law passed to forbid acceptance of patients into sick rooms of church. Law not actually executed until 1881 when last patient stays in church

1885 Psychiatric hospital of Lierneux (in province of Liège) founded for French speaking patients of Geel

1922 Division for mentally handicapped children founded

1935 Original church converted to museum

1936 Visit to Geel by: Charles D. Aring, Cincinnati neurologist. Results in 1974 *JAMA* article, most often cited in American psychology textbooks

1948 Mental health care, including the Rijkskolonie, transferred from Ministry of Justice to new Ministry of Public Health

1960 Drs. Matthew Dumont and Knight Aldrich, University of Chicago, spend two weeks in Geel and are disturbed to discover diminishing patient population

Dumont and Aldrich present findings at 117th annual meeting of American Psychiatric Association in Chicago (presentation published in *American Journal of Psychiatry* in 1962)

1963 Belgium's "Health insurance law" puts psychiatric hospitals to liability of health insurance

"Hospital Law" gives existing, old, psychiatric institutions status of normal hospitals

1965 Division for mentally handicapped children removed from Geel Colony

1966 Dr. Leo Srole, Columbia University sociologist, visits Geel and agrees to design and direct Geel Research Project

Grace Foundation, Inc. and Family Care Foundation for the Mentally Ill, Inc. formed by John Moore, President of Grace Line and father of mentally ill daughter, provide funding for summer research project

1967 NIMH grant to Dr. Srole for pilot study of Geel Family Care

1970 Dr. Srole's first letter to Belgian Minister of Public Health recommending: increased Colony staff, increase in financial support of Colony professionals and foster families

1970-78 NIMH grant awarded for 3 year project, "Geel Foster Family Care Research Project"; project extended to 5 years w/out add'l funding and 3 more years w/ some supplemental funding (Other`

funding during life of project from: N.Y. State Psychiatric Institute, Belgium Ministry of Health, Leuven University.)

1975 International Symposium on Foster Family Care held in Geel in May in conjunction with St. Dimphna celebration (held every five years).

1979 Publication of *Mental Patients in Town Life: Geel - Europe's First Therapeutic Community* written by Dr. Eugeen Roosens, head of anthropological team.

1991 Rijkscolonie and Lierneux (see 1885) attain autonomous status as Flemish Public Institute subject to Belgian hospital laws. Entire system now referred to as Openbaar Psychiztrisch Ziekenhuis Geel (OPZ, Public Psychiatric Hospital of Geel)

1997 Dr. Jan Schrijvers assigned as Director of OPZ

2000 May 19-20, International Symposium, Congress 2000, Geel

September, Dr. Schrijvers retires, Jan van Rensbergen assigned as Director of OPZ

2004 November: completion of new adult care hospital; currently four hospitals for 1) adult care, 2) adolescence, 3) geriatrics, 4) rehabilitation, including foster family care services

2005 May 12-13, Geel Congress 2005, Balanced Care: Innovative Perspectives on Psychiatric Rehabilitation (see program at: http://www.opzgeel.be/en/nieuws/htm/congress_2005.asp)

2006: February: Director van Rensbergen resigns for new post outside of Geel; nursing director and hospital manager Hans Verbiest assumes position of temporary director

GEEL CONTACT INFORMATION

State Hospital (including foster family care program)

Openbaar Psychiatrisch Ziekenhuis Geel
Pas 200
2440 Geel
Belgium
Phone: 32 (country code) 14 (city code) 578111
Fax: 32 14 580448
Interim Director as of February 2006 (General Administrator): Hans Verbiest
Psychologists: Marc Godemont (marc.godemont@opzgeel.be)
Wilfried Bogaerts (wilfried.bogaerts@opzgeel.be)

Museum

St. Dimpna en Gasthuismuseum, v.z.w.
Gasthuisstraat, 1
2440 Geel
Belgium

Tourist Office

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Belgium
Phone: 32 14 570955, 570952
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