THE FRIENDSHIP HOUSE

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The Friendship House Project is a joint endeavor of the Boulder County Mental Health Center and The Naropa Institute in Boulder, Colorado. It is a long-term group therapeutic household (Fortuna, 1987) for five chronically mentally ill adults in Boulder County. In the larger sense, it is a full therapeutic community comprising a vital learning environment for its thirty members. The Project formally opened on January 9, 1989 following an eleven-month gestation period.

This report will document the history of the Friendship House Project, its current structure, and significant events of the initial six months of clinical work.

I. THE HISTORY OF THE FRIENDSHIP HOUSE

In February, 1988 the directors of the Boulder County Mental Health Center (BCMHC) met with representatives from The Naropa Institute Master's Program in Psychology (TNI) to explore the possibility of a joint clinical project. This meeting was an expression of a long-standing mutually beneficial relationship between the agency and the school. For example, the BCMHC has provided quality internship training for TNI graduate students for the past fifteen years. Many of these students have since become BCMHC staff clinicians. During this meeting it became clear that Federal grant funds were available for the purchase and renovation of a residence for treatment of the chronically mentally ill. It

seemed possible that such treatment could utilize the "technology" developed by Maitri Psychological Services (Podvoll, 1985; Fortuna, 1987) and the principles of environmental treatment developed at TNI. A steering committee representing the two organizations was formed to design the project which soon proposed the name of "Maitri House." "Maitri" is a sanskrit term that means "loving kindness."

The administrative director of BCMHC called upon a variety of community action people who quickly became enthusiastically involved. A HAVEN-Habitat[1] task force volunteered labor, material, and funds for renovation of the spacious, four-story brick house that was purchased. The American Association of Architects donated design-consultation as part of their nation-wide program "Search for Shelter." For each of these groups, this was the first project devoted to the welfare of the chronically mentally ill. The School of Environmental Design at the University of Colorado, in Boulder, hosted this Association's activities. Students were asked to create original designs for model healing environments adapted to the multi-team approach. These were critiqued and resulted in the final renovation plans. This author was hired as the program director and, together with Edward Podvoll, M.D., created the clinical paradigm. Our intention was to adapt the one-patient-per-household approach of Maitri Psychological Services to the conditions of public mental health care, without compromising the integrity of the original model. We decided to risk treating five mentally disturbed persons in one household, since this provided intriguing possibilities for a closely-knit therapeutic community.

Dr. Podvoll and I conducted an extensive client search and interview process within the Boulder County area over several months. The admission criteria for clients specified that they have a long-standing major mental illness, the need for a long-term supervised residence ("homeless" meant, in this context,

no home outside of repeated and expensive residential or inpatient care), and significant interest in working with others.

A cultivated sensitivity to the "history of sanity" (Podvoll, 1983) informed every aspect of the interview process. We selected two men and three women with ages ranging from 21 to 43 years. All had been suffering with a severe mental illness that was seriously life-disruptive for at least eleven years and all were taking complex prescriptions of psychiatric medication. Each person expressed an urge to improve their living conditions and to re-establish a sense of forward movement in his or her life. The interviews were especially poignant to us given the severity of the chronicity of pain and confusion we witnessed. Many patients appeared too difficult to treat, and we often regretted having to abandon someone to a deteriorating life course. Others did not want to risk a hard-won yet tenuous hold on reality by joining our experimental setting. One young man who had been in a dismal ward of the state hospital for the past year was extremely depressed, withdrawn, and suspicious. During the interview he asked for a cigarette from the interviewer and noticed it was a quality brand. For the first time he raised his head and eyes and smiled at us, saying "This is a really fine cigarette!" That brief moment of his appreciation and our mutual contact was central in our decision to accept him into the program.

As mentioned, the program was originally named "Maitri House" by the steering committee. This embodied our understanding that "loving kindness" is key to the treatment of and recovery from mental disturbance. However, the Board of Directors of the BCMHC felt that this name suggested a private interest group with religious inspiration, perhaps since TNI is a Buddhist-inspired college. The director of the HAVEN-Habitat task force, herself a devout Christian, then suggested the name "Friendship House," as a loose translation of "maitri." Initially, this sounded embarrassingly naive, sentimental and "unprofessional." However, the committee real-

ized that this name highlighted the creative tension between formal therapy and genuine friendship, an issue we have been exploring for many years. The following statement by Chögyam Trungpa, concerning the "medicine" of maitri, expresses this:

> Basic sanity applies to every person, no matter how disturbed he or she may be. It is not true that, if someone has seemingly gone too far into neurosis, we can't do anything. We *can* help people, even those who have gone too far, beyond the regular channels of communication. The basic point is to evoke some gentleness, some kindness, some basic goodness, some contact. When we set up an environment for people to be treated, it should be a wholesome environmental situation. A very disturbed or withdrawn person might not respond right away—it might take a long time. But if a general sense of loving kindness is communicated, then eventually there can be a cracking of the cast-iron quality of neurosis; it can be worked with. This can be arduous. But is possible, definitely possible. (1983, pp. 9-10)

Such a view is non-doctrinal, non-religious. There is no proselytizing of any religious belief or practice at the Friendship House. We are, however, very concerned with the binding factors of the community, "spiritual" or otherwise. We recognize the function of non-sectarian awareness practices in the recovery from mental disturbance *and* in the training of clinicians. Such disciplines, which synchronize mind and body, may be practiced as formal training or be discovered and strengthened *within* one's ordinary activity. The common results are glimpses of intrinsic health and natural kindness, or "maitri" towards oneself and others (Wegela, 1988). A current patient of the Friendship House states:

> At the Friendship House, we carry that attitude of maitri into our daily life by getting totally involved. We prepare meals together and do our chores, such as vacuuming the rug or cleaning the smoking room. Sometimes we compete and argue over who's more neurotic or less. Later, we drop our territoriality and cooperate again. I have learned that working with territoriality in a community setting is hard work, but it's the first step toward peace in the world... The Friendship House is a good place to learn to clean up after yourself. To paraphrase the Zen Buddhist master Suzuki Roshi: when you get totally involved in meditation and everyday life, you don't suffer as much.

These principles of contemplative psychotherapy are discussed later in this report. In general, we are attempting to

cultivate a non-sectarian, practical approach to recovery that allows the best of everyone to come forth.

The eleven months of program development were characterized by attention to innumerable details, humorous comradery, and creative, sometimes hectic, brainstorming about numerous thorny issues. How were we to dispense complex daily regimes of psychiatric medications with no nursing staff? How were we to schedule the clinical time of twenty-five staff members comprising five interlocking teams? How were we to design a system of clinical records to suit the strict requirements of federal funding as well as to provide the means for candid inter-staff discussion of "personal process?" How were we to join the practice of an open system involving minimal hierarchy and consensus decision making (Jones, 1982) with the time constraints of group meetings and respectful deference to our "counsel of elders," the senior clinical staff? Initially, the least of our worries seemed to be our work with five highly disturbed patients!

These early months were alternatingly inspiring and discouraging. One insurmountable obstacle after another would appear—a seemingly endless series of problems of funding, budget, zoning, licensing, building permits, and fearful neighbors. When the sense of obstruction became overwhelming, the means for further progression would soon be discovered. This cycle of claustrophobic obstruction followed by ventilation and forward movement continues to operate on the programmatic level as well as in the developmental journeys of both patients and staff members within the household. For example, one live-in staff member repeatedly experienced feelings of "I can't take this anymore! I've got to move out!" during times of crisis. But each time he was able to find some "fresh air" from his willingness to stay and communicate with the situation at hand. He later commented that he found such fresh air and truthfulness to be closely linked.

THE STRUCTURE OF THE FRIENDSHIP HOUSE

A. The Joint Relationship

The steering committee of the Project is made up of the administrative and medical directors of the BCMHC, the directors of TNI Master's Program in Psychology, and the Friendship House director. This is the senior decision-making group, meeting at least quarterly. The BCMHC is generally responsible for administrative and budgetary support, personnel and program policies, and legal liability. TNI is responsible for the clinical paradigm and mission, staffing (especially in providing graduate student interns), and for the welfare of the therapeutic community. Each partner has the "right of refusal" or the option of withdrawing from the Project. The BCMHC might do so if it judged excessive risks were involved, such as an overly rapid reduction in medications or reckless disregard of friendship-intimacy. TNI might do so if the integrity of the paradigm was compromised; for example, if budget cuts threatened the cohesion of the teams or compromised the quality of internship training. It has been openly acknowledged that the joint relationship and the success of the Project is based on strong mutual trust. The partnership has proved to be exceptionally supportive and productive.

B. Funding

The residence was purchased and renovated with a federal grant of $150,000 procured by the BCMHC to provide shelter for the homeless mentally ill. A program development grant of $6,000 was received from a private foundation. Extensive labor and resources were donated for the renovation.

Three sources of ongoing funding currently exist to support the annual operating budget of $136,000. Medicaid insurance

provides the primary income for psychiatric services, such as case management, group, and individual therapy. An important admission criteria is that a patient have this insurance coverage for a major mental disability. County Foster Care Funds, which specifically provide for decent supervised housing for the disabled, augment patients' individual incomes from various government agencies, such as supplemental security income. Fundraising is active in the Friendship House community in order to provide additional funds for special purchases and increase patient allowances.

The cost per patient is $75 per day. This is relatively inexpensive for such dignified living conditions and intensive, individually-tailored treatment. Intern and volunteer labor are not figured into this daily cost. There is no expense to the BCMHC to support this program. This was a condition at its inception since other BCMHC programs were being trimmed back. The Friendship House has actually saved the BCMHC thousands of dollars in inpatient costs for these five patients. State mental health officials and Medicaid administrators have expressed interest and support in this innovative project. The success of the experiment remains to be seen.

C. Clinical Paradigm

The Setting

The Friendship House is a six-bedroom, four-story home in a quiet residential neighborhood of Boulder. The front porch is large and welcoming. The basement has two bedrooms for one staff member and one patient. There is also a room that accommodates both meetings and the laundry, and a small locked medication/records room. On the main level, there are two large, comfortably furnished common living areas, a spacious dining room, the kitchen, and a closed-in back porch that

serves as a smoking area. The second floor has four bedrooms for one staff member and four patients. The top level is a large common area with a skylight and expansive views of the Western mountains. This is an exceptionally bright and uplifted room that is used for staff meetings and retreats, team meetings, and therapy sessions. There are no staff offices. Community meetings are held in the dining area. The ceilings are high, the walls are an ivory color, the large windows provide generous light, and the interior doors and trim are thick dark hardwood. All the rooms have been furnished through donations from local churches and patrons. The overall impression the residence gives is a sense of time-tested sturdiness and simple, functional elegance.

An elaborate housework and meal-preparation rotation schedule, including patients and housestaff, insures a well-kept, well-nourished household.

The Pattern of Relationships

There are currently five patients and two live-in, full-time housestaff members, one male and one female, in residence. In addition, there is a half-time program director, a part-time volunteer psychiatric consultant/supervisor, a part-time attending psychiatrist, five half-time senior clinicians ("team leaders"), eight Naropa graduate student interns, and eight volunteers. These comprise the community of thirty-one members, although this number may vary as interns and volunteers enter and leave the community.

There are five treatment teams. Each team is composed of nine members, including a patient, who serve the following functions:

1. The *team leader/case manager* oversees the clinical activity of team members, monitors the "comprehensive care plan", and serves as liaison to other community services

and the patient's family. The group of team leaders is supervised by the program director.

2. Four volunteer *interns* attend to the patient and the household in three-hour blocks of "basic attendance" (Podvoll, 1985). This amounts to ten blocks per week with more during a crisis. Each intern is a member of two teams and is individually supervised by the team leader.
3. The *individual psychotherapist* meets with the patient two times a week in individual psychotherapy. The team leader for one team serves as the psychotherapist for a second team. The group of individual therapists is supervised by the psychiatric consultant.
4. The two *house staff-members* belong to each of the five teams. Exceptional challenges face these two staff members living intimately with several disturbed persons. Extensive support and supervision is provided by the entire community and especially by the program director. In particular, they rely on personal contemplative discipline and the grounding of experience in ordinary household activity to remain steady within the chaos of psychotic mind.

These teams of therapists and patients meet once a week to discuss all aspects of the team work. During crises additional team meetings are scheduled. Please refer to Podvoll (1985) and Fortuna (1987) for detailed descriptions of this paradigm.

The system of clinical records has three parts. A public record of progress notes which closely follows the care plan is meticulously kept to document therapeutic contacts for billing purposes. A private record of process notes that details each team member's personal experiences and observations of the patient and staff is openly shared within the community. In addition, a "household log" is kept to communicate domestic concerns among members of different teams. The latter two

logs are not available for legal or insurance scrutiny and are regarded as confidential to the community.

There are a variety of meetings, both formal and informal, that bring people together. All-community meetings are held twice per week, with a new leader, either patient or staff, volunteering each time to chair the meeting. A house meeting for the seven residents is held once a week and is chaired by the team leaders on a monthly rotation. An array of staff, planning, study and training sessions, and special task forces also occur.

What must appear to be a staggering number of roles, meetings, and activities, has, with alertness and a sense of humor, had a valuable and beneficial influence on everyone involved. Precision of scheduling is attended to as a major life discipline, and provides powerful boundaries between drifting off and being present with the situation at hand. No one is left alone to drift aimlessly into the future.

This team approach creates five interlocking "households," or "families" within the Friendship House which comprise the greater community, or "clan." "Families/clan" is a metaphor for our sense of respect for the tendency of an extended family to gather around an ill member. It also emphasizes a special loyalty within the team that allows it to persevere through difficult times. However, such loyalty must not become blind and enmeshed as the recent, very painful, discharge of a disruptive patient has shown us. She was a woman who had spent twenty-five of her forty years in psychiatric treatment, never having functioned independently. She was prone to explosive, abusive verbal outbursts in response to perceived pressure by authority, particularly concerning medication. She was also a fine sculptress, an excellent housekeeper, and was quick to apprehend and point out the politics of therapy. This was a bitter but necessary medicine for the staff. However, her level of excitement was so extreme at times that it was beyond our ability to contain or work with. Perhaps the household envi-

ronment was too stimulating or unstructured. Worn down by constant struggle, the team therapists at last decided to discharge her. Guilt feelings of abandoning a "family member" arose, but in spite of the knowledge that we were repeating the primal scene of her expulsion from her family of origin, we followed through. This was a hard lesson. The lofty ideal of "never giving up on anyone" met the practical limits of our ability to tolerate abuse and contain psychotic excitement. Retreating from such an unworkable situation felt devastating, yet we also noticed the familiar fresh air that came with facing the facts and realizing our limits at the time.

This paradigm of interlocking households has the virtue of creating a shifting yet controlled array of "healing circles." This is an important topic requiring further discussion at another time. The variety of circles and inter-personal gatherings begin with the intention of nurturing *all* the members' health and sanity. In such circles, leadership is flexible and open, there is a minimum of "therapeutic" fixation on the patient, and communication extends freely among all present. Our allegiance is to give proper voice to the truth at hand. Occasionally we are less than kind with each other, and divisiveness prevails. However, with the touchstone of our original compassionate intention we have so far been protected against situations going too far in any destructive direction.

The clinical design of the Friendship House is an adaptation of the homecare model developed by Maitri Psychological Services (Podvoll, 1985) to the current conditions of public mental health. At this time, certainly, other experiments in residential treatment are viable and necessary. The point is to remain open and flexible rather than rushing to institutionalize any particular innovative therapeutic techniques.

Community Values

What the common values of the Friendship House community are, and should be, is a vast and sensitive area, with significant diversity of opinion among members regarding priorities of attention. A good deal of community effort has been devoted to articulating our respective values and sense of mission under the guidance of a consultant skilled in organizational development. Three primary principles of environmental treatment that form the foundation of the Friendship House community are:

1. Respectful attention to the domestic details of daily life and physical well-being;
2. Truthful and genuine communication among all community members;
3. The clarifying of mental functions and the stabilizing of attention.

These principles apply to both patients and staff. In this way, the community exists for every member's benefit. Participating in such a healing community becomes an intensely personal experience, not easily ignored or forgotten. We all have much to learn about how to handle ourselves and our households, about authentic friendship, and about mental clarity and an attitude of compassion. This approach acknowledges that both patients and staff will face personal challenges within a community environment that provides a flexible container for growth. A graduate student intern describes an experience of such growth:

> Following a serious accident last April, a resident with whom I had been working for several months came by and visited with me. We ate ice cream and drank tea. I could feel his attention was now on me, instead of the other way around. At first I found it difficult to relax and wanted to draw him out about his feelings. With his head and shoulders held high, he insisted that I relax and rest. He expressed his feelings of concern and care for me. It was a very powerful experience, one of relaxing into the truth of caring relationships.

Such learning is facilitated by personal awareness practice. At this point, all staff members are expected to practice some form of awareness discipline, such as meditation or a martial art. The patients are not expected to pursue a formal practice, however an attitude of mindfulness and respect for self and others is encouraged in ordinary activities, such as sweeping the floor or sharing a meal together. The limited role of psychiatric medications is understood in this context of clarifying, not clouding consciousness. On admission, our patients were taking large doses of these drugs after many years of institutional treatment. We have undertaken conscientious study of current research documenting the effects of such drugs and have had many discussions concerning cautious withdrawal. This is a slow and often painful process for the patients, marked by impatience and discouragement with their dependence on this form of mental restraint. However, as the patients strengthen their sense of confidence and well-being and engage attentively with their surroundings, less medication seems necessary. Two patients are currently participating in a regime of paced systematic medication reduction according to the "10% formula" described in *Dr. Caligari's Psychiatric Drugs* (1987).

Although articulating community values has brought a larger perspective and an historical context, we realize we have a very long way to go.

CONCLUSION

It is not within the scope of this paper to comprehensively report on the initial six months of clinical work and community development. This is simply a brief description of the history, structure, and initial experiences of the Friendship House Project. It is anticipated that this is the first in a series of papers documenting the program's growth and impact on the greater mental health community.

Noteworthy events have occurred. Incidents of extreme anger and violence have flared among some of the patients and towards staff. Police officers have been summoned and more than once a patient has been led away in handcuffs to a locked hospital for a brief stay. Tobacco, caffeine, and street drugs are often abused, complicating the medication treatment plan. Several of the patients have reversed sleep patterns and are enjoying a surreptitious night-life, to the dismay of the house staff. The house staff often experience a conflict between living as ordinary, eye-level roommates with the patients and authoritatively setting behavior limits in the manner of ward attendants. The politics of communication remains a charged issue. On the other hand, a vital learning environment and a safe, stable household are slowly taking root. The training of socially committed therapists with a specialty in comprehensive care of the severely disturbed is being carried out with increasing precision. The patients are settling into their new community home with a renewed sense of personal dignity and appreciation of human relatedness. They are beginning to treat each other with more consideration, exercising long-neglected compassionate impulses. The patients are simply waking up to their current life circumstances. At the same time, they may experience fleeting glimpses of the possibility of recovering a meaningful life.

For all of its complexity and youthful awkwardness, the Friendship House Project remains a bright and fresh appearance in the history of healing communities. Friendship House is dedicated to the welfare and growth of all of its members and by extension, to that of the surrounding community and culture.

NOTES

[1] HAVEN is a program within the Mental Health Center of Boulder County, Colorado dedicated to providing decent, affordable housing for the mentally ill in Boulder County, Colorado. "Habitat for Humanity" is a nation-wide non-profit corporation providing housing for the homeless in the United States.

REFERENCES

Dr. Caligari's Psychiatric Drugs. Berkeley, CA.: Network Against Psychiatric Assault, 1987.

Fortuna, J. "Therapeutic Households." *Journal of Contemplative Psychotherapy, 4,* 1987, 49-73.

Jones, M. *The Process of Change: From a Closed to an Open System in a Mental Hospital.* Boston, Mass.: Routledge and Kegan Paul, 1982.

Podvoll, E. "The History of Sanity in Contemplative Psychotherapy." *Naropa Institute Journal of Psychology, 2,* 1983, 50-64.

Podvoll, E. "Protecting Recovery from Psychosis in Home Environments." *Naropa Institute Journal of Psychology, 3,* 1985,71-89.

Trungpa, C. "Creating an Environment of Sanity." *Naropa Institute Journal of Psychology, 2,* 1983,1-10.

Wegela, K. "'Touch and Go' in Clinical Practice: Some Implications of the View of Intrinsic Health for Psychotherapy." *Journal of Contemplative Psychotherapy, 5,* 1988, 3-24.