The thing I liked most at the outset of building the Village was that we didn't have to do anything a certain way because "that's the way it's always been done." We were all newly hired staff, who wanted to create a better way, and were willing to try new ideas and learn from our mistakes. We could chose to have our case managers act as payees, even though none of us had ever done that before, only to realize later that was a terrible idea and hire specialized financial planners to avoid money arguments destroying the case manager's relationships. We could chose to have our psychiatrists on staff at the local hospital and design our own admission and discharge criteria even though none of us had ever done that before and have it turn out great (until County DMH dismantled it years later).

This highly experimental approach made us keep our focus on what worked and what didn't. We didn't have to regulation driven, or payment driven, or even philosophy driven. We could figure out "whatever it takes" and do it. We learned very fast that way.

This is an early list of pragmatic "lessons learned."

20 Lessons of the Village

(1991)

1. Our chronically mentally ill members are diagnostically incredibly diverse. Most of them have multiple layers of difficulties to overcome. Therefore, rehabilitation plans must be incredibly individualized.

2. Careful, initial and ongoing diagnostic and medication evaluations have changed many members' diagnosis, especially undiagnosing schizophrenia, stopped some member's medications entirely, and significantly improved the medication cooperation and effectiveness for many others. Rarely were the members admitted on the best medications for them.

3. Having the same treatment team follow the members from the community into the hospital and out again improves the efficiency of hospital treatment and reduces lengths of stay. It makes the hospital serve the community treatment rather than the other way around.

4. Helping the member resolve a serious crisis without hospitalization is often an important step in both the member no longer thinking of the hospital as an integral part of their life and increases their willingness to take risks to grow again.

5. Having a caring, family-like, social community is a powerful healing force especially for members who have been isolated and excluded. For staff to be included in this real community, we must be real people with real lives and not just caring professionals. Dependency inducing roles must be replaced with equalizing ones.

6. Seeing a peer succeed at something decreases internal stigma and is often a powerful motivator for other members to try something too.

7. Homelessness can be effectively eliminated through a combination of apartment finding assistance, interim SSI funding, loans, credit assistance and money management. Most members can live independently with support.

8. Members continue to have new homelessness crisis that can be dealt with similarly. The most common causes of recurrent homelessness are substance abuse and non-payment of rent trying to beat the system.

9. For members who haven't worked in a long time, we must persistently persuade them and their families and friends that they can work. They usually must be supported especially initially to be able to succeed at work.

10. Work is the single most normalizing, self-esteem building, and destigmatizing activity for our members and therefore has become one of our highest priorities. This is partially because there are so few other social systems left to belong to.

11. Although our members do not have hardly any unrecognized medical illnesses, they do have large numbers of inadequately treated medical illnesses. Many have used support and assistance of varying kinds to improve their medical care.

12. Substance abuse has emerged as an important problem for a very large portion of our members. It is the primary, if not only, problem for a substantial number. We have found the engagement, persuasion, active treatment, relapse prevention model useful and many of our members have made substantial progress in this area.

13. A team case management approach provides a diversity of approaches and personalities, increased accessibility, increased continuity of care and decreased staff burnout. Combining professionals and non-professionals, including psychiatrists, has given us the best of both worlds.

14. Making spending decisions on an individualized basis by those staff most knowledgeable about the members' actual needs, in contrast to faraway impersonal decisions made by administrative decree, leads to vastly more creativity and effectiveness in using resources.

15. Offering a long-term continuous caring relationship promotes the trust, reliability, commitment and emotional attachment that are necessary conditions for a true treatment alliance.

16. Once families believe in our reliability, long-term commitment and crisis resolution capabilities they often reduce their protectiveness of the member and support risk taking growth activities.

17. After proving we can support a member through a crisis, further crisis management can focus more on long-term goals instead of on immediate relief.

18. Maintaining high expectations for members instead of accepting their illnesses as a reason for lack of achievement leads to actual achievements. That's the benefit of viewing symptoms as obstacles to achievement instead of as the main focus of their lives.

19. Enabling has a bad reputation especially when we're enabling someone to do something positive. It's almost always worse to do something for someone than to enable them to do it themselves.

20. The true locus of change is in the member not the staff. As a result, staff is actually powerless to force a member to change, and members must be empowered to change themselves.

As I reread this list over a decade later, I'm struck by how fresh and "out of the box" most of these ideas still are. They're not about building a recovery based program. They're about being open to new understandings of how things work. They would eventually lead to a new recovery model, but even at this point it's striking how many of these ideas are still unacceptable just because they're not what "everybody knows." Even more striking is how few of these ideas have been implemented in other programs, even recovery based programs.

I wonder how many of them would have been discovered if we hadn't created an open, risk taking "learning culture" at the Village from the beginning. I wonder how many of them will be implemented in transformed programs if they don't create an open, risk taking "learning culture" from the beginning.