The Village is a good example of a recovery based program. However, the history of the Village is not a good example of how to build new recovery based programs. Our origins are simply too idiosyncratic, and in some ways too ideal, to replicate. We have to find other ways to build more recovery based programs.

We all know that going to a single training or workshop rarely leads to a change in practice and yet that's our most common approach to continuing education. If we're not thoughtful, it will also be how we approach building new recovery based practices and programs. The papers in this set all reflect different approaches to facilitating learning and real change.

Let's start with leadership.

Time after time people leave our 3 day immersion trainings at the Village excited only to return to their programs and be frustrated because their leadership won't support any of the new things they were inspired to try. After a while we became convinced that genuine buy-in and promotion by leadership is crucial for transformation to occur. We began recommending that program and system leaders come for training either before or with their staff. Most wouldn't, so David Pilon, our director of Outcomes and Training, and Bruce Anderson, a managing partner of his own Community Activators consulting business that focuses on organizational change and community development in social service agencies and systems, spent a lot of time together developing the principles of Recovery-Oriented Leadership and began leading 1 ½ day Recovery-Oriented Leadership workshops around the state. Creating a cohort of local leaders who understand recovery, have connected recovery to their own underlying values, and are therefore committed to it seems to be a powerful tool for system transformation.

The four values in the paper below are their attempt to synthesize the most important values leaders need to bring to a recovery culture. In the workshop they have the leaders themselves progress from values to program and system elements. Then the leaders are more invested in supporting these elements.

This paper contains the program elements I think are most important to support the four values, not necessarily those that leaders defined for themselves. Think of it as my arrogant answer key. David and Bruce don't use it in their workshops because leaders shouldn't be given answer keys. They'll be more likely to truly lead if they've created the answers. Also there's a good chance they'll know things about what will work for them that I don't know.

A Guide for Recovery-Oriented Leaders

(2005)

It is important as we attempt to transform our mental health system to a recovery-based system that we actually transform our culture instead of just changing the sign on the door while doing the same old things inside. To be able to tell the difference, we must be able to clearly identify the core elements of a recovery culture when we see them. The MHA Village has made several efforts in this regard. This

paper attempts to define key elements for each of the four broad values in a recovery culture we have identified for recovery-oriented leaders: Hope, Authority, Healing, and Community Integration.

1) **Hope**: Hope is clearly the first step in anyone's recovery and our culture must actively promote it.
    1) Stories and celebrations of hope should be spread by both staff and consumers.
    2) Hiring of people who are open about their mental illnesses fills the program with living examples of hope.
    3) Goal setting for both consumers and staff should focus on growth rather than stability or risk avoidance, building on strengths as well as overcoming obstacles.

2) **Authority:** The distribution of authority has widespread implications for promoting empowerment, self- responsibility, risk-taking, and learning from mistakes for both staff and consumers.
    1) Decentralized decision-making gives line staff real authority in the program. Giving staff money for them to be responsible for and chose how to spend is a concrete, powerful step.
    2) The program should include a substantive consumer voice at every level of the program's decision-making process.
    3) "Consumer driven" needs to be an overt, highly discussed part of the culture to ensure that decisions flow, as much as possible, up from the needs of the people we're helping rather than down from administrative authorities.
    4) Planned risk-taking, not care-taking or reckless abandonment, needs to be actively encouraged for both consumers and staff if growth is going to occur.
    5) Boundaries between staff and consumers need to be as low as possible to decrease "us vs. them" stigma.
    6) Staff and consumers need to have multiple roles and multiple kinds of relationships with each other for consumers to move beyond illness roles in their recovery. Staff and consumers helping each other without "that's not my job" or "that's your job" defensiveness is a concrete, powerful step.
    7) Staff and consumers both should feel important, valued, even treasured by those who have "*positional* authority" over them. Everyone is an expert in some way, a "chief" of something, with "*personal* authority".

3) **Healing:** In a recovery program the focus is on healing and growth for the person rather than symptom relief for the illness.
    1) The first priorities are engagement, welcoming, and relationship building because the foundation of a good recovery process is a good relationship, not a good diagnosis.
    2) A "counterculture of acceptance" needs to be established within the program to create an emotionally safe place for these "unacceptable", rejected people to recover within.
    3) The usage of respectful language rather than prejudicial, clinical language needs to be so pervasive that people can read their own charts or overhear staff discussing them and feel accepted and understood.
    4) A healing environment is an emotionally rich environment filled with open displays of caring and connection.

5) To be effective, staff need to be in touch with why their hearts brought them into this work and be energized by practicing their gifts.

4) **Community Integration**: To achieve meaningful roles in life we cannot stay isolated away from the world.
    1) Both staff and consumers must be mobile and actually work together out in the community on "real life" issues.
    2) The program must demonstrate accountability to the community by collecting "socially responsible", quality-of-life outcomes like housing, jailing, employment, and finances.
    3) The program needs to focus on community coalition building and "giving back" to the community if it and the people it works with are going to be accepted.
    4) Staff and consumers need to be actively involved in the difficult work of fighting stigma if our world is going to become a better place for people with mental illnesses to live in.

It has become increasingly clear to us that leaders need to treat staff the way they want staff to treat consumers. Only staff who have hope, personal power, responsibility and meaningful roles can help consumers have hope, personal power, responsibility and meaningful roles.