Principled Leadership
in MENTAL HEALTH SYSTEMS AND PROGRAMS

William A. Anthony and Kevin Ann Huckshorn
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FOREWORD

Many books have been written about leadership, but few, if any, have addressed leadership in the world of mental health services. Historically, books on leadership have fallen primarily into three categories: those written by academics who have researched the topic, those written by consultants who make a living advising corporate executives on leadership, and those written by successful executives who tell their own story and articulate the principles of leadership that they created or followed. Unlike business leadership books that focus on sustainable competitive advantage, top-line growth, and/or improved profitability, *Principled Leadership* has human satisfaction and success as its outcome metric. For the authors, as well as the leaders who were interviewed for *Principled Leadership*, the desired outcome of an effective mental health organization is people who can live, learn, and work in the environments of their choice.

Anthony and Huckshorn have studied leadership, advised leaders in the field of mental health, and have been leaders themselves in transforming services for people who experience mental illnesses. Each has played a critical role in shaping a mental health movement—psychiatric rehabilitation and seclusion/restraint reduction, respectively—and each has extensive leadership experiences in mental health that are value based, outcome focused, and recovery oriented. Yet this book is not about Anthony and Huckshorn’s leadership activities. In line with the leadership principle advanced in chapter 8, which is to build organizations around exemplars, Anthony and Huckshorn have organized this book around exemplary leaders who model principled leadership.

The vision, values, principles, and tasks discussed by these leaders go beyond any one specific approach to solving the difficult problems faced by the people affected by serious mental illnesses and their families who support them. Effective leadership, as described in this book, is based on understanding the possibilities of transformation, rather than predicting and controlling probabilities. Most of all, *Principled Leadership* offers leaders, and would-be leaders, a vision that goes beyond methods and approaches that can be divisive and exclusive. It describes mental health systems and programs that are driven by the unifying constructs of recovery, hope, and choice, and it articulates the principles and tasks that are critical for effective leadership of these organizations.

Anthony and Huckshorn convince us that principled leadership in mental health is necessary and possible—and that principled leaders can make a difference in the lives of people and in our society. They convince
us that principled leaders can be developed, and they provide a blueprint for doing so. Further, they argue that a critical mass of principled leaders can transform our mental health system—and that it is our responsibility to build that critical mass of principled leaders.

I congratulate the authors on this breakthrough book, which I believe will be a landmark in the leadership literature. Like *Principled Leadership*, business leadership books stress the importance of outcomes—but profit and market share outcomes are not focused singularly on helping people, families, and communities to become more successful and satisfied. Unfortunately, too often the goals of our business leaders create the conditions for human suffering, rather than human success and satisfaction. *Principled Leadership* is an invaluable text for leaders and future leaders in the mental health field—and the basic principles and tasks articulated in *Principled Leadership* are relevant for all business leaders.

BARRY F. COHEN
EXECUTIVE VICE PRESIDENT
PARAMETRIC TECHNOLOGY CORPORATION
In our respective travels, nationally and internationally, we have been intrigued with the drastic differences in how mental health organizations innovate and change. Some organizations (centers, hospitals, programs, units, etc.) embrace the opportunity to improve. Others are much less enthusiastic about the possibility of improvement and seem to impede or ignore their prospects for continued progress. We attribute much of these organizational differences to leadership, and it is that strong belief that led to this book.

In the United States, during the latter part of the 20th century and the beginning of the 21st century, the need for transformational change in the mental health system has been magnified by reports of commissions, mental health research, and the voices of people with psychiatric disabilities and their advocates. Mental health organizations are pressured from all corners to develop recovery-oriented practices and systems. Some mental health leaders have distinguished themselves by their capacity to initiate this needed change. We set out to learn from these successful transformational leaders.

During the course of writing this book, we were amazed and heartened by the leaders’ accounts of their leadership experiences. Many leaders were nominated by us and their peers as people who had brought about positive change in their organizations. All leaders we approached (save one) consented to be interviewed. Each leader agreed to be tape recorded and spoke with one of us for one to two hours. They were informative, modest, and self-critical. What we learned from these leaders about leadership in public mental health settings provides the foundation of this book. We hope you learn from reading it, as we learned from writing it.

William A. Anthony
Kevin Ann Huckshorn
Introduction

Leadership remains an art as well as a science—some of the tools of leadership are not simply the tools of science—some are the tools of the self.

—William A. Anthony

There are questions many of us in the mental health field have thought about repeatedly. Such as:

- Why do some organizations prosper while others deteriorate?
- Why do some organizations flourish during a period of change while others calcify?
- Why do some organizations, previously known for their mediocrity, become exemplary organizations?

For years questions such as these have intrigued, puzzled, and bothered people in the mental health field (Anthony, 1993a). They often are summarized in the plaintive question of advocates, taxpayers, consumers, administrators, and practitioners—“Why isn’t our program progressing as well as theirs?” Indeed, it is clear that there are some state departments of mental health, mental health centers, hospitals, rehabilitation centers, or individual units or programs that are just more advanced than others.

It is the thesis of this book that many, if not most, of the fundamental differences between organizations are due to differences in the quality and effectiveness of the leadership. The focus of this book is on the leadership within those organizations that serve people with severe mental illnesses. Big or small, public or private, independent of professional discipline, the book’s spotlight is on
the leadership as a major source of what makes one mental health organization more successful than another.

_Principled Leadership_ is also a call for the development of a new type of leader. Leaders are urgently needed who can respond to the mental health field’s new paradigms and challenges, as outlined in this introductory chapter. Especially needed are leaders who respond to these new opportunities with the requisite direction and strategies.

**THE NEED FOR LEADERSHIP IN MENTAL HEALTH**

As a result of many new developments in the mental health field, the need for leadership in serving persons with severe mental illnesses has never been greater. As we begin the 21st century, change seems to be the only constant factor. Leadership is needed to take advantage of the opportunities that accompany environments characterized, not only by constant change, but by a change so dramatic that the very foundation of the mental health system is being built anew. Some of these changes are due to the evolution of the field itself, such as a better understanding of the comprehensive needs, wants, and potential of persons who have serious mental illnesses. Others have been thrust on the field by forces operating in society in general, such as the movement toward managed care; the increasingly articulate and powerful voices of the people our field serves; the release of the first surgeon general’s report on mental health in 1999 (U.S. Department of Health and Human Services, 1999); the Institute of Medicine’s _Crossing the Quality Chasm_ series (2001, 2005); and the _President’s New Freedom Commission’s Report on Mental Health Care in America_ (2003).

The most telling changes, however, will be driven by new ways of thinking that now exist with respect to the consequences of serious mental conditions, as well as the potential for recovery from these illnesses. Concerning the consequences of mental illnesses, previously the negative effects of mental illnesses were seen primarily as symptomatic impairments of mood or thought. This is
The emergence of the rehabilitation paradigm has enlarged the potential consequences of severe mental illnesses to include not only symptom impairment but also dysfunction, disability, and disadvantage (Anthony, 1979; Anthony, Cohen, Farkas & Gagne, 2002). The importance of psychiatric rehabilitation services to address the now apparent, more comprehensive needs of people with serious mental illnesses was emphasized by the Community Support Program, initiated by the National Institute of Mental Health in the late 1970s (Turner & TenHoor, 1978). Gradually over the last quarter century, the mental health system not only became concerned with how to impact the person’s impairment or symptoms, but also the person’s ability to perform tasks (dysfunction), roles (disability), and deal with the discrimination and poverty (disadvantage) that he or she may face. (See table 1.)

The philosophy underlying psychiatric rehabilitation also brought to the field of mental health its unique value base that emphasizes values such as a person’s involvement, choice, strengths, and growth potential, as well as outcome accountability for providers (Anthony, 1979). The inclusion of a rehabilitation paradigm and the push toward community support services (Turner & Shifren, 1979) enlarged the scope of the mental health system and its values, and challenged the leadership to think more comprehensively and respectfully about how to help people with serious mental illnesses. Outcomes related to improving people’s skills; impacting people’s residential, vocational, and educational statuses; increasing people’s satisfaction, as well as reducing the effects of poverty and discrimination on people with mental conditions began to be included within the concerns of mental health leadership.

The other more recent, dramatic major change within the mental health field itself has been the growing acknowledgment that people with severe mental illnesses can and do recover (Anthony, 1993b, 2000; Deegan, 1988). While there are many definitions of recovery from severe mental illnesses (Ralph, 2000), a succinct and straightforward definition is, “the development of
### Table 1—The Psychiatric Rehabilitation Model: The Negative Impact of a Severe Mental Illness

<table>
<thead>
<tr>
<th>Stages</th>
<th>I. Impairment</th>
<th>II. Dysfunction</th>
<th>III. Disability</th>
<th>IV. Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
<td>Any loss or abnormality of psychological, physiological, or anatomical structure or function</td>
<td>Any restriction or lack of ability to perform an activity or task in the manner or within the range considered normal for a human being</td>
<td>Any restriction or lack of ability to perform a role in the manner or within the range considered normal for a human being</td>
<td>A lack of opportunity for an individual that limits or prevents the performance of an activity or the fulfillment of a role that is normal (depending on age, sex, social, cultural factors) for that individual</td>
</tr>
<tr>
<td>Examples</td>
<td>Hallucinations, delusions, depression</td>
<td>Lack of work adjustment skills, social skills, ADL skills</td>
<td>Unemployment, homelessness</td>
<td>Discrimination and poverty</td>
</tr>
</tbody>
</table>

new meaning and purpose as one grows beyond the catastrophe of a severe mental illness” (Anthony, 1993b). Consensus has been achieved on what some of the major characteristics are included in this new vision of recovery. As described in a report of a consensus conference (del Vecchio & Fricks, 2007), these dimensions include such fundamental elements and principles as self direction, individualized and person-centered interventions, strengths based focus, responsibility and hope. The bottom line is that we now know that the majority of people with severe mental illnesses do not need to get worse. This progressive and worsening illness paradigm, upon which most of the mental health service direction of the 20th century was based, is no longer the case. Adequate supports and relevant services provided in a way that empowers people to manage their own illness can result in growth, development, healing, and recovery.

This paradigm of recovery was largely absent from the last century’s diagnostic schemes (American Psychiatric Association, 1987, 2000) and maintenance-type interventions (Bachrach, 1976; Grob, 1983; President’s New Freedom Commission on Mental Health, 2003). Even worse, for much of the previous century, throughout North America and Europe, not only were people with severe mental illnesses not expected to recover, they often were dehumanized and devalued by both society and treatment professionals alike (Braslow, 1997, 1995; Grob, 1994a, 1994b, 1996; Micale & Porter, 1994). The traditional and pessimistic view that people with mental illnesses lacked potential for growth and change, and responded only to interventions designed to prevent deterioration, has gradually changed (Coyle & Williams, 2001; Hinshaw & Cicchetti, 2000). As a result, within the last several decades, state mental health systems have witnessed a major shift in the conceptualization of how mental health care should be delivered. Most state mental health systems no longer view the course of serious mental illnesses as necessarily deteriorative (Sartorius, Gulbinat, Harrison, Laska & Siegel, 1996; Harrison, Hopper, Craig, Laska & Siegel, 2001; Harding Brooks, Ashikaga, et al., 1987a, 1987b; DeSisto, Harding, McCormick, 1995a). The recovery paradigm began to guide policies and practice in many individual states (see for example, Beale & Lambrick, 1995; Jacobson & Curtis, 2000; Legislative
Summer Study Committee of the Vermont Division of Mental Health, 1996; State of Nebraska, 1997; State of Wisconsin Blue Ribbon Commission on Mental Health, 1997), and more recently the federal government (President’s New Freedom Commission on Mental Health, 2003), as well as other countries, such as New Zealand (Lapsley, Nikora & Black, 2002).

The significant challenge for mental health leadership is the fact that mental health systems, developed over the last century and which still exist today, have been built on the mistaken assumption that serious mental illnesses are almost universally associated with a poor prognosis for recovery (American Psychiatric Association, 1987; President’s New Freedom Commission on Mental Health, 2003). As a result, the current mental health practice paradigm and approach is seriously out of date, as are the academic programs that are training the newest members of our workforce (Huckshorn, 2007). Fortunately, the data are mounting that will require serious and committed leaders to transform our current care systems to one founded on a rehabilitation and recovery paradigm. It is up to the leaders in our system of care to answer the call of this new reality.

Fortunately, the data are mounting that will require serious and committed leaders to transform our current care systems to one founded on a rehabilitation and recovery paradigm. It is up to the leaders in our system of care to answer the call of this new reality.

With respect to new data, in the last several decades, several sources of information have converged to demonstrate that people with serious mental conditions are achieving higher levels of role functioning, subjective well-being, and much improved adjustment than had previously been considered. One source of information is the writing of people with mental illnesses who have recounted numerous instances of recovery (e.g., Anonymous, 1989; Deegan 1988; Houghton, 1982; Leete, 1989; McDermott, 1990; Unzicker, 1989). Another source of knowledge is the synthesis and dissemination (Harding, 1994; 2003) of long-term outcome studies, which suggested that a significant percentage of people with serious mental illnesses were dramatically improving over time. In 2003, Harding reviewed ten U. S. and international longitudinal studies of 20 to 30 years duration demonstrating the recovery and community integration of many people with schizophre-
nia and other serious mental illnesses (Bleuler, 1972; Ciompi & Müller, 1976; Desisto, Harding et al., 1995a, 1995b; Harding, Brooks et al., 1987a, 1987b; Hinterhuber, 1973; Huber, Gross & Schuttler, 1979; Kreditor, 1977; Marinow, 1974; Ogawa et al., 1987; Tsuang, Woolson & Fleming, 1979). A final source of data are the research studies suggesting that substantial improvements in role functioning can be effected through mental health and rehabilitation interventions (e.g., Bond et al., 2001; Cook & Razzano, 2000; Drake et al., 1996; 1999; Mueser, et al., 2002).

In addition to challenges to leaders brought about by the new knowledge underlying the paradigms of rehabilitation and recovery, the way the entire system of mental health services has been organized is changing dramatically. Private managed care systems are being expanded to provide services to consumers of mental health services who are covered by publicly funded dollars. Many states are consolidating their state hospitals (a euphemism for state hospital closures). Capitation rather than fee-for-service is becoming an accepted payment method.

Leaders in the 21st century must lead in this unsettling time. Seemingly different concepts or procedures are being stressed simultaneously. There is an emphasis on more quality services at the same time services are being curtailed in the spirit of cost containment. Ongoing monitoring must include both subjective and objective outcome indicators. New medication interventions are now known not to be “the be-all and end-all” that was hoped for in the late 1990s (Swartz et al., 2007). While, periodically there is a renewed interest about the advantages of asylum, a much stronger focus on community integration remains. There is an increasing emphasis on involuntary procedures (such as outpatient commitment), yet at the same time the principle of consumer choice is being promoted. The private sector has entered the public service delivery system in some states—and is being warmly received by some and shunned by others.

The need for effective and principled leadership is unremitting. New paradigms, a new vision of recovery, a developing knowledge base, new organizational structures and financing schemes must become part of the leader’s lexicon. New concepts, principles, and settings materialize regularly. It is in this context
that effective leadership is required, to resolve conflicts and pursue a new direction. Leadership is needed to guide us through changes stimulated by new concepts, principles and settings; leadership is needed to interpret the impacts of new paradigms; leadership is needed to illuminate the common themes underlying apparent differences. The need for effective mental health leadership has never been stronger.

The challenge to transform the mental health system has been made at the highest levels of government (Curie, 2005; President’s New Freedom Commission on Mental Health, 2003). By transformation these leaders don’t mean change at the margins of the system, but at its very core. This kind of transformative shift in paradigms, mission, and vision will require the kind of change that Quinn talks about (Quinn, 1996). He says that “change can be incremental or deep”...and that “the former is the more familiar to most of us than the latter.” Quinn defines “deep change” as more similar to revolutions as such change includes new ways of thinking and behaving that are discontinuous with the past and irreversible once begun. Quinn describes “Deep change”...“as walking naked into uncertainty” and calls this true transformational change (Quinn, 1996, p. 3). True transformation of the entire system of mental health care is the means to realizing a system built on a recovery and rehabilitation paradigm. Such a transformation demands strong and effective leadership (Anthony, 2004; Mazade, 2005).

LEadership and Publicly Funded Organizations

It is not uncommon to think of the impact of leadership on business or political organizations. Leaders in these fields have been credited with “turning a company around” or “restoring faith in the system.” In contrast, very little discussion is held about leadership’s role in human services, including services to people who have been diagnosed with serious mental conditions. Principled Leadership has been written for the audience of committed and capable leaders needed to guide the mental health public sector, as well as those leaders in private and not-for-profit mental health systems of care. We often share the provision of care to the
same people and their families; the leadership principles and tasks detailed in *Principled Leadership* can apply to all mental health providers.

Mental health leadership presents unique challenges to one's leadership capacity. These unique threats and opportunities are related to the fact that people who are serving folks with psychiatric disabilities are typically funded, either partially or totally, by taxpayer dollars. Whether the funds come from the state legislatures, the state departments of mental health, from counties, and/or federal dollars (through Medicaid or Medicare and the SAMHSA Mental Health Block grants in the United States), or still other sources, services to people with severe mental illnesses often are seen as taxpayer supported. Even if the organization is a privately managed care firm or a private nonprofit agency, the presence of a significant amount of public dollars makes the leadership pressures unique. Inefficiency and ineffectiveness are seen as a drain on the taxpayers’ pocketbook and a further betrayal of the public trust. Leaders in mental health have different people looking over their shoulders than do their counterparts in business settings.

Consider the environment in which the mental health leader works. Executive and legislative bodies regularly oversee and change the organization’s budget. Court rulings may quickly alter how services are provided. The media is on the alert for the appearance of mismanagement. Citizen boards and individual taxpayers provide oversight. Advocacy groups add to the pressures to perform. Of course this does not mean that effective leadership is impossible in organizations funded by public dollars—but it is complicated. Furthermore, many of these overseers have little knowledge about the complexities of delivering public mental health services. Also, leaders operating in publicly funded organizations typically do not have the opportunity to reward their followers with extrinsic rewards, such as bonuses and incentive pay.

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**LEVELS OF LEADERSHIP**

Like the privately funded sector, leadership in the publicly funded arena occurs at all levels. A hospital ward, a component of a community mental health center, a program in a clinic, a resi-
dential setting, a work unit in a vocational program, a self-help program; each of these are settings that require leadership. The information explosion has created organizations that expect more leadership at more circumscribed organizational levels. Leadership is not limited to the highest levels of an organization, such as CEO, executive director, or unit chief levels. Leadership behaviors are now required at all organizational levels. Routine, centralized, and exclusive decision making at higher or broader organizational levels now is seen as inefficient as it misses the tremendous benefits that come from the organization’s human capital and the people being served.

Every staff person can act like “the CEO” in his or her own sphere of influence, no matter how broad or circumscribed, and indeed, this kind of work is what will lead to successful transformation of the mental health system.

WHAT IS LEADERSHIP?

If a relatively high position on the organizational chart does not uniquely define leadership, then what does? Over four decades ago, Vance Packard (1962) defined leadership in the following statement. “In essence leadership appears to be the art of getting others to want to do something you are convinced should be done” (p. 170). Fortunately, later definitions have modified Packard’s leadership definition. Possibly the most relevant is Gary Wills (1994) definition: “the leader is one who mobilizes others towards a goal shared by leaders and followers” (p. 17). Both definitions infer the importance of “others,” “goals,” and “movement.” Stressed in the later definition by Wills, and consistent with other current concepts of leadership, is the phrase “shared goals” as compared to a goal that the leader alone is “convinced needs to be done.” Implied by its absence is the leaders’ use of explicit force, even when one’s followers don’t want that goal or can’t understand the direction.

Another way of understanding the definition of leadership is to look at the defining parameters of leadership. Wills (1994) states that there are three elements of leadership—leaders, followers, and goals. Nanus (1992) has added the environment as a critical ele-
ment, that is, most leaders exercise their leadership within an organization that has some identifiable boundaries and resources within which the leader is free to operate. Combining the analyses of Wills and Nanus, the critical elements of leadership seem to be leaders, followers, goals, and an organization with identifiable boundaries and resources. We add the dimension of a shared vision. (See chapter 1 for examples of the power of a shared vision.) Thus, we define leadership as creating a shared vision and mobilizing others toward specific organizational goals consistent with the vision.

**MANAGERS AND LEADERS**

Sometimes it is easier to understand the definition of leadership by contrasting the stereotypical descriptions of managers and leaders. Bennis and Nanus (Bennis, 1989; Bennis & Nanus, 1985; Nanus, 1992) have without a doubt articulated the distinction between management and leadership most artfully. While managers are skilled in solving problems, leaders build the organization’s future. Leaders are more apt to inspire, influence, and guide while managers are more apt to control and administer. Effective leaders create new possibilities (Carkhuff & Berenson, 2000a, 2000b). In the field of mental health, leadership and management are not mutually exclusive, nor is one more needed than the other. In mental health, leaders in smaller organizations or units of organizations are often also managers. Many leaders emerge from managerial roles. However, because the functioning and goals of leaders and managers are so very different, good mental health managers are not always good mental health leaders—and vice versa.

**CAN LEADERSHIP BE TAUGHT?**

But from where will these new leaders emerge? Undoubtedly they will come from the ranks of mental health staff, students, and managers. While some leaders are “born leaders” many are “made.” Kouzes and Posner (1995) describe three different ways in
which the development of new leaders can be improved. Leaders, in essence, learn to lead by 1) trial and error, 2) from other people, and 3) from education and training.

In the field of mental health, most leaders learned about leadership through trial and error. Unfortunately their errors in leadership were other people's trials! It is certainly true that one learns to lead by having the opportunity to lead. However, leading by doing the task of leading does not ensure that one ever learns to do it well. It seems that the trial and error method of learning to lead should be combined with the other two methods in order to improve leadership effectiveness. Experience is a great teacher of leaders but some people only have one experience and repeat that same experience over and over again in new situations. Other leaders never seem to take the time, nor are they encouraged to reflect on and discuss with others their previous learning experiences. It is this time for reflection that allows for insights about one's own leadership to be developed.

Mental health leaders also can learn from other leaders; leaders from whom they have been led personally, or from leaders in the field at large. Would-be leaders themselves experience the effect of good and bad leadership. Once again, in order to learn from other leaders, it is necessary to reflect on one's discrimination about what makes one a good or poor leader. While no one wants to be led by an ineffective leader, in this type of situation one still can learn what not to do. If you can't learn about leadership from your own personal experience of effective leaders, the next best thing is to learn from acknowledged leaders in the field. Read what they have written, attend conferences at which they speak, find their followers and speak to them. If you can't interview the leaders themselves, interview their followers.

The final method of learning to be a leader is, by itself, the least important strategy. The skills of leadership are not learned simply by classroom education and training. It is difficult to learn leadership solely in a classroom. Indeed, what classrooms offer best is a chance to reflect in a group on the common experiences of leadership, and to interview and read about acknowledged leaders in the field. Interestingly, classroom settings that teach interpersonal skills or problem solving skills are teaching some of the
building blocks of leadership. In the field of mental health, interpersonal skills and problem solving skills often are thought of as clinical skills rather than leadership skills. However, some of the same skills that make someone a good clinician also are fundamental to effective leadership.

This book would have no purpose if one did not assume that leadership can be improved. By reflecting on one's own experience of leading or being led, and by learning from acknowledged leaders in the field, one can indeed become a better leader. Each one of us has leadership potential. Most of us who are committed to the field of mental health will at some point in our career have the opportunity to lead, if not an entire state mental health system; a hospital, mental health center, rehabilitation center, outpatient clinic, a self-help group, or a unit or program within these larger entities. Without skilled leadership at the program or unit level, the leaders of these larger organizations will not be successful. Many of us will be leaders and followers simultaneously. For example, we might be leading an individual program in a managed care network and following the leadership of network director; or leading a program in a hospital unit and following the direction of the unit chief.

Leaders try to create the system, program, and/or unit in which mental health practitioners can do good work and in which consumers can prosper. The task of mental health leadership is to ensure that the process of helping can take place. The goal of mental health leadership is to increase the probability that people with severe mental illnesses are helped to recover in a setting and through a process that is both effective and efficient.

THE PURPOSE OF THIS TEXT

This text is designed for the current and future leaders who work or plan to work in mental health settings. The text explains and illustrates the leadership principles and accompanying tasks that acknowledged leaders in the mental health field have identified as critical for effectiveness and change sustainability. Based on interviews with leaders throughout the country, the author’s eight leadership principles are advanced. By understanding these princi-
ples, by reading examples of these principles in action, and by reflecting on one’s own personal development as a leader in relation to these principles, current and would-be leaders can improve their own leadership performance.

The leaders whose interviews form the foundation of this book are considered to be effective leaders by their peers. Some are well known nationally, others are known only by their local followers. All have, at one time in their career, led an organization or an organizational component that provided direct services to people with serious mental illnesses. Some possess a variety of formal mental health credentials; others possess none. Their leadership achievements have each been guided by one or more of the eight principles of leadership described in this text. They have shared their personal experiences in relation to these principles. In so doing they have allowed others to profit from their own leadership accomplishments. The analysis of these eight leadership principles and the experiences of leaders in relation to them provide the grist for readers of this book to reflect on and discuss the field of mental health leadership.

Historically, the opportunity to learn about the principles of mental health leadership and the experiences of mental health leaders has been rare indeed. As mentioned previously, leadership courses and texts are focused routinely on leaders in the corporate sector. Very little attention is paid to leadership issues in the publicly funded sector, and especially in the mental health field. According to Drucker (1996), however, the nonprofit sector has the largest number of leadership jobs in the United States and the greatest opportunities for growth. It is the public sector from which exemplary leaders of the future may emerge. As Handy (1996) has suggested:

Until and unless business creates a cause, bigger and more embracing than enhancement of the shareholders, it will have few great leaders. We are more likely to find them in the nonprofit arena. If that is so, than that sector may yet become the training ground for business and perhaps even politics (p. 9).

As previously discussed, the leadership challenges in public mental health arenas are considerable. Mental health leaders are
subject to directives from all levels of executive and legislative bodies, the judicial system’s constant interpretation of mandates and boundaries, the machinations of special interest groups, unmatched media focus, and budget decisions beyond their control. This text provides the leadership principles and experiences of our current leaders as a point of departure in our journey to improve the knowledge base in the field of mental health leadership.

PRINCIPLED LEADERSHIP

What is meant by the title of this book? Principled leadership is characterized in two different ways. The most straightforward explanation is that the focus of this book is on those principles that guide effective leaders’ actions. Answers are sought to the questions about the common principles and accompanying tasks that guided leaders in creating, building, and/or maintaining needed services. Examples from the leader’s work are used to illustrate the principles in real-life detail, and not to describe each leader’s characteristics or the components of the system that they led.

Leadership also is referred to as “principled” because the services provided by the leader’s organization are designed to help people recover from serious mental illnesses. We were concerned only with learning from leaders whose organization was moving toward increasing the opportunities for people to recover as compared to leaders whose primary concern was financial viability or maintaining the status quo. These leaders’ strategies for changing their organizations differed; the place where they started from varied; the characteristics of their organizations, their personalities, and their strengths did not conform to one model; but universally held was their belief that promoting recovery from severe mental illnesses was the direction their organization must pursue. In that context, the leaders included in this text were “principled” in pursuing this new paradigm of recovery.