

Overcoming Obstacles to a Recovery-oriented System: The Necessity for State-level Leadership

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I was asked by NASMHPD/NTAC to comment on overcoming the system's barriers to recovery. In other venues my colleagues and I at the Center for Psychiatric Rehabilitation have mentioned the lack of research on recovery outcomes (Anthony, 2001), suggested strategies for improving such research (Anthony, Rogers & Farkas, 2003), identified the components of a recovery oriented system (Anthony, 2000), and described the values underlying recovery programming (Farkas, Gagne, Anthony & Chamberlin, in press).

We've also opined on the threat to recovery oriented system planning inherent in the implementation of evidence-based practices and perfect model replication (O'Brien & Anthony, 2002). Other publications, including this news brief, have focused on these issues and other concerns related to recovery implementation, such as the workforce, funding, legislative support, advocacy, etc. However, if I had to emphasize a variable that is within everyone's control, yet if poorly implemented becomes an impossible obstacle to state wide recovery initiatives, I would have to stress statewide leadership with respect to the implementation of recovery.

In an attempt to examine state mental health policies and practices that promote recovery, Kathy Furlong-Norman and her colleagues at the Boston University Center for Psychiatric Rehabilitation conducted focus groups and implemented a brief survey instrument with selected state mental health commissioners and consumer administrators in state offices of consumer/recipient affairs. She reports that commissioners clearly identified that their leadership as "change agents" and bearers of public policy and values is an important factor in shaping recovery policies and practices. In addition, the data indicated that the commissioners emphasized the importance of carrying the "leadership mantel" with respect to recovery.

Statewide leadership is so fundamental because the vision of recovery is foreign to what has been masquerading as the mental health vision for the last century. Prior to this vision of recovery, the mental health system had no consumer-based vision, i.e. no vision that focused on what the consumer might get out of the system. Prior visions (using the word 'vision' loosely) emphasized the location of the services (institutionalization, deinstitutionalization, community support systems) or the breadth of the services (continuity of care, comprehensive services) but not the outcome for the person receiving the services.

Personally speaking, I have heard people express their goals with phrases such as decent housing, meaningful work, and/or having friends, but I have never heard people mention that their goal was “continuity of care.” If we are serious about the vision of recovery, then the mental health system of the last century—which for the most part was a system characterized by low expectations, control, and no consumer-based vision—must disappear. Massive system changes must occur if the vision of recovery is to become a reality for an ever-increasing number of people with severe mental illnesses. For this very different vision to become reality, brilliant leadership is required.

Over the past decade I have interviewed leaders in the mental health system about the dimensions of leadership. Their responses can be organized around eight fundamental principles (see Table below). Leaders who are guided by these principles can help make the recovery vision come alive. Conversely, leaders not oriented to these principles can become a major obstacle to recovery. I will elaborate on several of these principles with respect to leadership around recovery.

The essence of leadership is to motivate one’s employees to action around a shared vision, in this instance the vision of recovery. A shared organizational vision is like an organizational magnet—it attracts to it only people with special characteristics. The organization can be energized and mobilized by a shared vision of what is possible. The vision of recovery, as opposed to previous non-consumer focused visions, can provide a sense of purpose and meaning to people who work in the mental health system.

The recovery vision paints a credible picture or image of the future. The leader uses it to pull and push the system toward the future. The leader must communicate this vision repeatedly, through the use of stories, metaphors, anecdotes, and quotations. The vision of recovery allows the leader to tell an inspiring story, rather than the previous broken stories of maintenance and deterioration.

In addition, the story of recovery must appeal to people’s reason and emotion. The research periodically summarized by Harding (1994, in press) and the anecdotes of people recovering from severe mental illnesses (e.g., Spaniol & Koehler, 1994) are some of the tools used by leaders to make the recovery story both factual and inspirational.

It is up to the statewide leadership to create a system-wide culture that identifies and tries to operate consistent with key recovery values. Values are the organizational Velcro that binds vision to operations. Leaders must be clear about the values that underlie recovery, and that each major decision they make is guided by those values. Prior to the recovery vision, statewide operations were not typically evaluated by how they affected consensually defined values. Undergirding the vision of recovery are several key values around which consensus has emerged (Farkas, Gagne, Anthony, & Chamberlin, in press). Four of these values are self-determination/choice, full partnership, people first, and growth potential.

When the leaders are making decisions around various system functions (e.g., policy, budgeting, program regulations and funding, human resource development, evaluation strategies) they should consider how each decision is either consistent with or

antagonistic to these recovery values. The leader who anchors her or himself in the recovery values can ensure that system functions must pass through this “value funnel.”

For example, a system mission characterized by the recovery values of self-determination/choice, people first, and growth potential would be: “To assist people to improve their functioning so that they are successful and satisfied in the environment of choice.” A system mission that is unresponsive to all the recovery values might be: “To provide continuous and comprehensive services to mentally ill clients.”

Similarly, a policy consistent with all four recovery values might be: “People will have the opportunities and help necessary to choose and plan for those services they want to promote their recovery.” Conversely, a policy not passing through the recovery funnel might be: “People must be on psychiatric medication in order to access any residential services used by the mentally ill that are funded with state dollars.”

Another positive policy example that is consistent with all the recovery values is: “Any person with a severe mental illness who wants vocational services will receive them.” In contrast, a negative policy example with respect to self-determination/choice and full partnership might be: “People will undergo a specific test battery before being accepted into vocational services.”

A leader makes sure that the system’s major operations, be they clinical or managerial, are supportive of recovery values. A clinical process that values self-determination cannot co-exist with a management process that values obedience and control. It is through the explication of values that the leader shows what is important to the organization, and defines the corridors in which the state organization functions. In a state attempting to make the massive vision shift from forestalling people’s deterioration to promoting people’s recovery, the leader’s vision and corresponding values must be clear, they must evoke passion, and have consensus throughout the organization.

To implement a recovery vision in their respective states, leaders can be guided by the eight principles of leadership from Table 1. Simply put, recovery initiatives will not occur and be embedded within the system without effective statewide leadership. As pointed out by Kouzes & Posner (1995) leadership development is ultimately self-development. Musicians may have their instruments, and engineers may have their computers, and accountants may have their calculators, but leaders only have themselves.

Leaders are the instruments for system change to recovery. Leaders, through their words and actions, fill in the details of the recovery vision. The leaders’ metaphors, the anecdotes, the traditions, the celebrations of recovery successes all serve to elaborate on the vision’s significance. These elaborations make it easier for followers to be attracted to the vision to which leaders are committed.

Fortunately, current leaders can learn to be even better leaders in the implementation of the recovery vision. Good leaders are born and made—being born is the more mysterious part! Leaders can develop by accessing and using information on recovery, i.e. by observing what their colleagues are doing, by reading and attending conferences about

how recovery is being implemented in various states, by examining Web resources on recovery, and by basing their leadership on some or all of the aforementioned eight principles of leadership. This special issue itself becomes a source of leader development.

Yet in the final analysis, leadership remains an art as well as a science. Some of the tools of leadership are not simply the tools of an expanding knowledge base around leadership. Some remain the tools of the self.

THE PRINCIPLES OF MENTAL HEALTH LEADERSHIP

Principle 1. Leaders communicate a shared vision.

Principle 2. Leaders centralize by mission and decentralize by operations.

Principle 3. Leaders create an organizational culture that identifies and tries to live by key values.

Principle 4. Leaders create an organizational structure and culture that empowers their employees.

Principle 5. Leaders use a human technology to translate vision into reality.

Principle 6. Leaders relate constructively to employees.

Principle 7. Leaders access and use information to make change a constant ingredient of their organization.

Principle 8. Leaders build their organization around exemplary performers.

- Excerpted from Anthony, Cohen, Farkas, & Gagne, 2002.

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