Clin Soc Work J (2014) 42:312–320
DOI 10.1007/s10615-014-0487-0

ORIGINAL PAPER

Agility in Adversity: Integrating Mindfulness and Principles of Adaptive Leadership in the Administration of a Community Mental Health Center

Ann Fisher Raney

Published online: 5 March 2014

Abstract The combination of mindfulness and adaptive leadership principles is a means by which a community mental health center has achieved program innovation and financial stability in an environment of decreased public funding. Mindfulness is present-oriented and reflective, is willing to cultivate uncertainty, and approaches operational and client care practices from a non-judgmental frame of mind. In addition, adaptive leadership, an approach developed by Ronald Heifetz and associates, considers crises to be opportunities and offers a set of guiding principles that help to direct the organization's resilience while building mutual trust and creativity among administration, staff, and community. The case study focuses on how one community mental health center cultivates organizational agility in adversity, using mindfulness and adaptive leadership to guide the provision of resources for all stakeholders. As a result, staff members practice self-care at work, feel included in all administrative decisions, and participate in developing new and cost effective ways to serve the increasing needs of low-income clients in the midst of decreased funding. The relationship between administrators and clinicians is critical in creating a successful environment for serving clients.

Keywords Mindfulness · Adaptive leadership · Self-care · Stress · Community mental health

Why should clinicians care about administrative practice? In a national survey published in National Association of Social Workers & Center for Health Workforce Studies (2006), licensed social workers reported spending 72 % of their time engaged in administrative and management work. In the same survey, 73 % of the workers reported an increase in paperwork, 65 % noted an increase in caseload, and 68 % reported an increase in severity of client problems. It is understandable, then, that a frequent lament of clinicians is that increasing expectations of administrative work draw them away from their practice. Indeed, administrators who are charged with enforcing these rules are too often viewed as the "other" that must be rallied against. Social service agencies are particularly affected by these requirements, and many clinicians feel understandably frustrated in their efforts to provide excellent treatment while managing these responsibilities. Some become so discouraged that they leave agency jobs to seek other environments, such as private practice or other work altogether. It is imperative, however, that agency clinicians join with administrative leaders to take ownership of the therapeutic organizational system that demonstrates best therapeutic practices to clients and community. As we move to focus more holistically on treatment that combines the mind/body/spirit in practice, we must remember that these same concepts can establish the facilitating environment in which compassionate and healing practice occurs.

Effective and efficient clinical programs are essential to successful community mental health organizations. This is a crucial combination in a managed care environment where best practices must be accompanied by very careful decision-making to ensure the best use of resources. Just as important, administrative efforts must be founded on principles and shared commitments that focus on staff support and a shared sense of mission and purpose. Organizational health depends upon a clinical staff team that is mission-focused, is engaged with clients and community,

A. F. Raney (✉)
Turning Point Behavioral Health Care Center, 8324 Skokie Blvd, Skokie, IL 60077, USA
e-mail: araney1032@sbcglobal.net

and is in open communication with administrators. This paper considers the nexus of administrative direction and clinical practice in an urban community mental health center where the principles of mindfulness and constructs of adaptive leadership provide the foundation for continuous organizational monitoring and improvement of service delivery.

Socioeconomic conditions and historic circumstances establish the conditions for any social service organization. Currently, significant fiscal stressors at local, state, and federal funding levels intersect with an increasing severity of mental illness and social anxiety, resulting in a confluence of pressure upon community mental health centers to provide critical care in a very distressed environment (Goodman et al. 2013). Client needs often require expert, lifesaving responses while staff are stretched to provide best clinical practices and to meet ever-changing and extensive requirements for documentation. This situation is a challenge for everyone involved, from clients who deserve ready access to care and best treatment practices yet have difficulty finding adequate services (Santiago et al. 2013), to clinical staff who strive to provide client-centered interventions, to administrators who advocate for additional services with insurance providers as well as with local, state, and federal agencies. The implementation of the Affordable Care Act, although providing increased and well-deserved access to care, presents its own problems as providers scramble to understand requirements and provisions of these new measures. At the same time, providers are faced with the important responsibility of helping to support current clients who are making important decisions regarding their health care plans.

No one solution exists to address the challenges facing nonprofit organizations in a managed health care environment, but teams of administrators and clinicians of mental health institutions and other social service agencies, can develop an atmosphere of resiliency and organizational agility in spite of such adversity by incorporating mindfulness practices and principles of adaptive leadership. Agency clinicians can no more remove themselves from participating and intervening in the environment in which they work than social workers can view clients from only one therapeutic perspective and ignore the context in which their clients live and work.

Finally, it is important to note that these practices are derived from clinical work; they follow important clinical social work principles that honor clients and their preferences and prioritize a mission-focused perspective that considers mental health to be a right, not a privilege. In the following case study, examples come from one organization's efforts to unite administration with clinical work, a stance that is very different from the common path of administering on the basis of constraints and limited resources.

Primary Elements of Mindfulness and Adaptive Leadership

Mindfulness has become a prominent notion in approaches to physical and emotional health of individuals and recently has expanded to include social models as well. Originating from Buddhist principles, mindfulness practices have now begun to inform business culture. Boyatzis and McKee (2005) describe mindfulness as "the capacity to be fully aware of all that one experiences *inside the self*—body, mind, heart, spirit—and to pay full attention to what is happening *around us*—people, the natural world, our surroundings, and events" (p. 112, italics in original). This formulation resonates strongly with clinical social work's commitment to self-determination and recovery principles. Further, mindfulness is not simply an idea, it is an ongoing practice. Jon Kabat-Zinn's work with patients, now known as mindfulness-based stress reduction (MBSR), began at the University of Massachusetts Medical Center 33 years ago. Kabat-Zinn's approach is extremely practical and practice-based, requiring both commitment and acceptance of oneself as a practitioner. The author of many books and articles, Kabat-Zinn (2003) describes mindfulness as "the awareness that emerges through paying attention on purpose, in the present moment and nonjudgmentally to the unfolding of experience moment to moment" (p. 145).

A first principle essential for the success of this approach is the use of experienced clinicians as administrators: there is no hierarchy or exemption from rigorous self-reflection and from self-care for any agency member, and administrators have literally "been there," serving clients, participating in supervision and consultation, managing the changing demands of paperwork and audit reviews. Thus, leaders—administrators and clinicians—must demonstrably support mindfulness in effective, resilient social service organizations, beginning with their own practice (McGarrigle and Walsh 2011). They themselves and their team are essential to the organization's strength and success. What results is a critical relationship: organizational health depends upon the administration's structure and valuing of self-care as well as staff members' interest and capacity to participate in these activities.

Second, adaptive leadership is elucidated and enhanced in partnership with mindfulness. Adaptive leadership, developed by Heifetz and Linsky (2002), establishes principles that allow organizations to actually change and grow in response to challenges and opportunities. Like mindfulness, it is a dynamic method that requires the focus and

activity on the part of leaders and to result in a changed environment. Heifetz et al. (2009b) explain that, "Adaptive leadership is the practice of mobilizing people to tackle tough challenges and thrive" (p. 14, italics in original). Adaptive leadership is the underlying set of principles that leans toward, not away, from difficult situations, and when united with the practices of mindfulness, has allowed a community mental health center to maintain its agility in the face of adversity, to respond reflectively and creatively to current threats and challenges to its funding base, its capacity, and its ability to sustain its most essential resource: the staff who serve the clients and community.

Heifetz et al. (2009b) describe the difference between adaptive leadership that supports innovation and organizational creativity and more technical approaches that attempt to solve problems quickly with whatever is handy, often utilizing material resources. Technical approaches to significant challenges may be more immediately satisfying and more reflective of the changes in political climates, but they ultimately fail in the face of repeated stress and workplace fatigue.

Organizations that wish to thrive under these current circumstances must establish a framework for healthy, interactive communication that allows crucial conversations to occur, simultaneously cultivating resilience and flexibility in the workplace environment by remaining open to change and growth. Choosing the thorny—but essential—path of adaptive leadership, coupled with mindfulness practices, is a requisite element in the process of managing organizational obstacles and accessing the most creative possibilities for change.

Again, a critical component of this effort is the leaders' participation in the process. It is an essential element of adaptive leadership that "the teacher [administrator in this paper] is a co-learner and at the same time a model, practicing authority and leadership in public so that others may eavesdrop, watch, contend with, and learn" (Parks 2005, p. 232). Without demonstrable support and a clear sense of mutuality, this effort cannot succeed. In the case study, every senior administrator is a trained clinician and continues to serve in some clinical capacity.

Case Study: A Community Mental Health Center

During the past 5 years, a community mental health center that serves residents of a large metropolitan area has consciously attempted to follow mindfulness practices and adaptive leadership principles. No effort or combination of approaches can guarantee satisfaction, but commitment to these practices has resulted in an organization where staff and client satisfaction measures are consistently high, staff turnover is very low, community relationships are very strong, and the organization is fiscally sound in a climate where financial resources are very limited. There is a strong focus on mission and a commitment to the recovery perspective, well described by the Substance Abuse and Mental Health Services Administration (SAMHSA;Del Vecchio 2012) as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Nearly all (more than 80 %) of the clients served by this facility are designated as low-income, following federal poverty guidelines. Many of them are dealing with severe and persistent mental illness that has led to an inability to manage full-time employment, to complete their education, and to care for their families. Some adult clients are living at home with parents, and others reside in the agency's residential program. Many clients require medication for symptom reduction and many require case management services to build skills that will allow for the greatest range of independence and highest functioning. The organization offers a wide range of services, including individual, couples, and family therapy, a robust psychosocial rehabilitation program that clients attend daily, comprehensive psychiatric services, and an adult psychiatric respite program that provides a calming place for clients at risk of hospitalization.

The organization's work environment requires that staff bring a high level of awareness to its mission, excellent clinical skills, ongoing support and case consultation, and a shared sense of purpose and commitment to one another. As in most social service organizations, the effects of compassion fatigue and burnout always loom for all staff members, from clinicians who provide direct service to clients to administrative staff who welcome clients, answer questions, consult with all stakeholders, and perform other essential financial and operational functions.

Although there is no way to prevent stress in such an environment, the organization has chosen to consciously present and support opportunities for staff self-care. Compensation includes a minimum of 4 weeks' vacation for full-time clinical staff and partially subsidized tuition for paid days off for professional development. Additionally, the organization employs a senior supervisor who facilitates consultation groups made up of administrative as well as clinical staff. Throughout the year, a sense of community is fostered by hosting staff gatherings for purely social reasons, including potluck meals featuring ethnic dishes that celebrate the many cultures represented in this diverse community. Finally, the organization sponsors staff self-care days to recognize the emotional and physical stress related to provision of mental health care services, and staff strategy-team events to invite clinical and administrative staff to participate in seeking adaptive solutions to ongoing challenges.

Administrative Application of Mindfulness Practices

Focus on the Here and Now

Four mindfulness concepts have informed the administration of the organization. The first concept is simply to focus administrative work on the here and now. This is particularly important during times of threats to funding, sudden changes in documentation required for billing, and burgeoning waitlists in an environment where many neighboring providers have been forced to close due to funding cuts. The agency seeks to have a continuous process of evaluating itself, through monthly meetings that review financial reports, productivity, open positions, and staff and client survey results. Even the number of days worked during a particular period is evaluated on a monthly basis. These measures are presented to the board of directors on a quarterly basis in a dashboard format that describes effectiveness, efficiency, and quality of services. Solutions to problems are not found by simply increasing the number of clients that must be seen each month. Rather, the ongoing process of looking at the current statistics and characteristics of the system is key for effectiveness.

The administration's here-and-now focus is designed to be supportive of staff efforts. It is designed to support the organization's ability to predict how either maintaining or changing practices and programs may enhance services while continuing to focus on providing excellent, affordable care to all members of its community. Most importantly, it allows good news to be celebrated with sound data. At monthly all-staff meetings, good news is heralded and this data set serves as one resource to acknowledge great audit results, progress in advocating for clients rights and best practices, paperwork improvements, and education regarding time-saving measures, such as concurrent documentation. Just as important, the all-staff meeting begins with important non-data announcements, such as birthday wishes, introductions of new staff, and announcements of upcoming staff gatherings.

Practice of Reflection

A second mindfulness concept, the practice of reflection, helps ensure that both short-term and long-term benefits are considered. Although clinical practice and supervision are inherently reflective, administrative approaches do not always make a commitment to stop to reflect on how organizational actions impact the stakeholders, beginning with the staff who provide essential services. In this organization, the commitment to staff is demonstrated not only through statistical analyses but also through several specific activities and benefits that work to minimize compassion fatigue. For example, during the last several years the agency has sponsored a staff self-care day, with a morning discussion forum or educational workshop followed by health-promoting activities, such as yoga, Pilates, acupuncture, massage, stretching, and guided meditation throughout the day. Every member of the agency is included. The decision to suspend business practices and focus on self-care has short-term and long-term economic consequences. In this case, the cost of closing for a day is approximately $6,000, a sum that represents the money paid to staff for the day and lost revenues that might have been earned by providing clinical services during the same day. This is not an easy choice for any administration to make; however, it is the right choice for several reasons. First, self-care days clearly indicate the organization's commitment to its employees' health and well-being, thereby increasing the likelihood of employee retention and satisfaction. Second, it provides an important opportunity for staff to share time that is renewing and enjoyable; the significance of having fun and mutual play cannot be underestimated in an effort to minimize the effects of inherent job-related stressors. Finally, when the organization closes for self-care day, it signals to clients that it cares about staff, it values health-promoting activities, and it sends a message to the community that this is a place where the individuals providing the client care are highly valued.

This valuing is concurrently expressed in the organization's efforts to solicit staff input into operations and strategic planning. Every 5 years, the organization facilitates a staff retreat, most recently hiring an outside consultant to support the process, in an effort to recognize that every employee is challenged by the current climate of shifting and diminishing resources and increased client needs. More than three quarters of the staff attend this day-long conversation that invites expressions of concern, recommendations for change, and results in the establishment of three strategy teams made up of diverse staff, including clinicians and administrators. The organization provides paid time for these teams to meet, gather information, and prepare suggestions that will be presented at a separate half-day forum. Consequently, a culture is created and perpetuated that values each voice, even if ultimate decisions cannot always be exactly as every member wishes. A parallel may be drawn to clinical practice, where the therapists' curiosity and consideration for the client's experience is securely bounded. Any organization, just as with any therapeutic intervention, cannot always ensure that the system and the clients are happy. In this case, the administration makes a sincere effort to listen to the staff's needs and preferences and to respond with clear explanations and an invitation to deeper conversation, especially when staff needs cannot be met as desired. Similarly, clinical practice calls for a commitment to clarity, empathy, and appropriate limits or boundaries.

The decision to establish and support staff strategy teams has economic ramifications, because each team member is given 6 h of paid time to attend staff strategy meetings, conduct research on the team's behalf, or investigate possible solutions. With 24 staff (one third of the employees) volunteering, the monetary cost is approximately $6,000, or 1 day of billing. Past experience has been very important in guiding this decision; significant economic savings resulted from team strategies 5 years ago. In 1 year, more than $20,000 in either cost reduction or revenue enhancements was achieved through innovative changes that resulted from staff strategy teamwork. For example, one team's efforts to reduce expenses or increase revenues resulted in the establishment of a new clinical program that reduces wait time for clients and provides additional revenue to the agency as well as to the staff who work in the program.

During the process of meetings and deliberations there are lost revenues, but staff communication throughout the organization is so important that the administration is willing to suspend some billable hours as it awaits and participates in explorations and adaptive problem-solving efforts. It is important to stress that these teams are open to all staff members. Every senior staff member, including the chief executive officer, is a member of one of the three strategy teams. With communication and mutual support as key values, the organization depends upon all staff members' input, creativity, and capacity to see new possibilities for challenges and opportunities.

Cultivating Uncertainty

The third mindfulness concept consciously practiced by the organization is that of cultivating uncertainty. While this is paradoxically inherent in today's nonprofit climate, many organizations faced with uncertainty may continue to do what they have done in the past or hope for the best, despite poor outcomes. Kegan and Lahey (2009) have described how we, individually and collectively, are "immune to change." Although this response is understandable, it may be short-sighted and dangerous because it may create a sense of false assurance, an expectation that things will either stay the same or will not get worse.

The agency noted in this case study cultivates uncertainty; it invites comments and critiques, carefully gathering information, including statistics and current events, from a wide range of trusted sources, such as conversations with auditors, funding representatives, legislators, board and advisory council members, and other providers. Provider colleagues are critical in this conversation: the agency participates in numerous groups that support community health initiatives. Often, these meetings result in new ideas and collaborations that provide creative answers to important questions and complex problems.

Recently, administrators have been completely revising the part-time clinical program as a result of a staff retreat that prioritized paid time off for all staff. This process required that salary increases be delayed while cost considerations were figured in relation to the overall agency budget. Remarkably, all staff, including those who would not directly benefit, agreed to wait to receive increases while the part-time program was reviewed. As a result, 22 staff members have now received the choice to accept benefits or work as independent contractors (the latter option is available only to LCSW, PsyD, or PhD-level clinicians). This is a profoundly adaptive response by all members of the organization.

Non-judgment

Closely related to cultivating uncertainty is the fourth mindfulness practice, non-judgment. This difficult but crucial practice recognizes and warns against our natural tendency to make narrowly focused decisions, especially under the severe economic constraints of community mental health. Such a narrow focus leads us to "have little tolerance (or mental space) for unrelated thoughts" (Boyatzis and McKee 2005, p. 128). Thus, judging means preferring; under pressure of short timeframes and decreasing resources, agencies tend to make parochial, closed-in decisions that do not allow for the expansiveness of more creative and innovative solutions.

Inside the study organization, administrators have sought to mitigate against judging by seeking out staff recommendations and preferences. Most important is the response to staff input because staff relies on the assurance that their voices are heard, increasing the likelihood that staff will provide honest, thoughtful, feedback. This is a difficult process in a complex organization where not all employees can attend meetings, take part in surveys, or serve on strategy teams. The agency endeavors, however, to reflect on and encourage further conversation in all-staff meetings, email invitations, strategy team conferences, voting on proposals, or posting anonymous notes in suggestion boxes. Efforts are made to cultivate the facilitating environment Winnicott (1965) discussed in terms of being essential for growth and relationships, where it is the increasing availability of options and flexibility that define health as well as the capacity to respond to strain and stress with self-soothing measures.

The organization has enjoyed significant benefits from mindfulness-based visioning. For the past several years, it has participated in community meetings in which the lack of integrative care for low-income residents has been paramount. It is well known that low income persons who seek

mental health care often face obstacles to concomitant physical health treatment (Kaufman et al. 2012). In addition, persons with mental illness frequently have limited access to health care, including medical and dental care and preventive health care measures (De Hert et al. 2011). Through the practice of mindful visioning, the agency developed a detailed yet loosely defined set of ideas for what an integrative care center might look like: various providers who share similar visions and train one another, sharing resources and costs, knitting together needed services for individuals and families who face constant obstacles to health care that would allow for lifesaving, health-promoting, cost-effective results. At every opportunity, the choice was to focus on that message; such an integrative center would fill a crucial gap in community resources and promote healthy living for many underserved populations. The problem identification and integrated health center concept originated during conversations among the staff, the administration, and the board of directors; it was honed and shaped through internal reflections, external consultation, and the willingness to explore the uncertainty of possibilities. As a result of a site visit from a local foundation that inquired about the potential of this innovative plan and how it would serve the community, the organization secured funding for a significant expansion of physical space, and invited trusted providers to consider tenancy in the new facility.

In this case, mindfulness practices provided an effective tool towards sustainable service provision and employee retention for social service administrators. It was imperative that the mission of the organization serve as the centerpiece, maintaining support for staff and advocacy for clients. The iterative practice of mindfulness, moving from small to large perspectives, looking forward and back while maintaining present focus, committing to thinking freely and creatively without falling into usual ways of being, and inviting continuous conversations among all willing to participate served as the key to creating this new community.

Administrative Applications of Adaptive Leadership Principles

Adaptive leadership strengthens and grounds the practice of mindfulness. This combination has proven to be extremely effective in this time of economic uncertainty. Adaptive leadership tackles perplexing and complicated problems, especially the dynamic kinds of issues faced by community mental health centers, where "adaptive leaders acknowledge, and help others comprehend, the changing nature of the environment. The landscape is not static; it constantly morphs, transforming context and topography" (Breshears and Volker 2012, p. 43).

Adaptive leadership practices address these kinds of realities: tensions between different perspectives that are all true, situations where difficult learning and loss are required, and new competencies and loyalties are formulated in the crucible of experimentation and disequilibrium (Parks 2005, p. 9). This approach tackles problems that most successful organizations must navigate if they are to grow and change by developing sustainable resources of flexibility and resilience, including nurturing crucial relationships with a wide variety of stakeholders whom the organization regards as an important source of education, support, and mutual encouragement.

Leadership in this type of social service system invites and requires us to consider the activity from a perspective that eschews the familiar command and control, hierarchical approach. Leaders become mobilizers, participants in the process who frame and provide tough questions rather than fulfilling the expectation for answers (Heifetz and Laurie 2001). They step toward conflict, willing to be a part of difficult conversations in order to seek solutions that emerge from the community, solutions that may result in disruptive and effective changes that will allow the organization to build resilience and grow. A good leader resists the pull for easy answers without needed process. As Heifetz et al. (2009a) describe, "People clamor for direction, while you are faced with a way forward that isn't at all obvious. Twists and turns are the only certainty" (p. 2).

Practiced in this context, the premise of adaptive leadership is a perfect complement to mindfulness: it assumes that all organizations are groups of relationships and that reflecting in action is the basic activity of leadership. Adaptive leadership looks at what is happening (focuses on the present) and invites everyone into the conversation about what is possible, realizing from the outset that not everyone will be satisfied with the result. In fact, adaptive leadership explicitly states that what is required is disappointing people at a tolerable rate, understanding that change is difficult and that the outcome may be unknown. For that reason, adaptive leadership principles exhort administrators to "live dangerously," move towards suffering and uncertainty, and trust that attending to such practices while treating others with respect will yield often unimagined, new possibilities and outcomes (Heifetz and Linsky 2002). From a clinician's point of view "optimal frustration" with empathy and support must be available to respond to each agency member's experience of the "messiness" but allowing for the highest level of competency.

Agency administrators recently launched a wide conversation as they envisioned the aforementioned integrative care center. Building a new community where clients can seek a variety of services in one location is adaptive work (as opposed to technical work). It requires trust as new

bonds are established among professionals who used to work in separate facilities. It calls for a shift in the public appraisal of what integrative care looks like—for recipients of care as well as for funders and citizens. It is not the usual standard and in its first or second or third iteration, it might not work. Conversations and change will be required of the providers who are learning to work together to access new capacities, the clients who will avail themselves of new shared services, and the public who may not immediately recognize what is happening. Clear and frequent communications, open dialogue, and a sense of curiosity that begins with senior administrators will create the most hospitable environment for growth, change, and continuing improvement.

Mindfulness practice calls for a similar state of being, where the process is constantly iterative, changing, and reflective in its very nature. Inherent in adaptive leadership and mindful administration is a commitment to contemplation, where even present-mindedness means looking at or toward a circumstance, condition, or possibility. It suggests that those engaged in the process are sharing perspectives and defining their perspectives, first, individually, and then in conversation with one another. It underscores the goal that the environment will actually change as new ideas and possibilities come into view. As with any system, whether it be a family, group, or organization, there are always attempts to maintain the status quo or homeostasis. By continuing to encourage feedback and valuing input from all, any disappointment or difficulties can be heard and supported, even if the agency cannot return to "the way things used to be."

Clinical Applications of Mindfulness-Based/Adaptive Work in Mental Health

Uses of mindfulness and adaptive leadership practiced by this organization include administrative and clinical efforts. Senior administrators consciously seek to listen for new and unusual perspectives, to cultivate relationships with stakeholders whose appraisals might differ significantly from internal sources, and to seek new solutions to enduring problems. Recently, the organization convened a series of focus groups to design the structure for its new adult psychiatric respite program. The groups included clients and families, hospital emergency department staff, first responders, providers, and others. There were many areas of disagreement, but gradually the leadership developed a program that sought to address, as closely as possible, the expressed needs of these important stakeholders. Just as important, the dialogue continues with new focus group meetings, satisfaction surveys, and continuous quality improvement efforts. As a result, the program is both fundamentally solid and responsive to change, reliable and flexible.

Underlying these concepts is a commitment to novelty that arises from uncertainty and to a discipline of reflection that, although crucial, may feel tedious. From this point of view, budget building involves an annual survey of every line item, analyzing costs and revenues, looking for trends and history that will provide direction. In this way, present (mindfulness) focus is aided by adaptive leadership's commitment to seeing multiple perspectives and potentials, recognizing both patterns and particulars in the fiscal operations of the organization.

Frequently, this method has allowed the organization to discover something new, such as unexplored potential for creative collaborations and innovations in service delivery. For example, psychiatric services are extremely valuable and expensive in community mental health. During the past several years, the organization has formed a close relationship with a university nursing program and has now subcontracted with it to hire an advanced nurse practitioner (APN) who prescribes and dispenses medication under the supervision of a staff psychiatrist. Adding this practitioner to the psychiatric program diversifies the personnel, supports needed client hours for medication monitoring, and provides cost savings because of the differential in pay between APNs and psychiatrists.

Clinical staff are also frequently engaged in mindfulness practices and adaptive principles. For example, case managers demonstrate this approach as they listen to their clients' needs and preferences and conscientiously seek to find ways to solve problems and establish structures that the clients choose. Case managers are adaptive leaders, co-learners, in the process of discovering how to support clients on the journey of recovery, where there is the desired measure of support and freedom. Following this model, clients may struggle with social contact yet wish to establish new relationships. There are days when stepping outside their home feels very difficult. Case managers are present, waiting with their clients to see what this day may hold—a capacity to range outside or a decision to stay in. The managers wait with the clients, feeling the roiling uncertainty, perhaps wanting to promote the notion of a walk or a trip to a nearby destination, and yet they attend first to the clients, allowing them to make the choice rather than rush in with a technique to cope with their own anxiety. If feelings of fear or panic arise, the case managers may choose a mindfulness response, asking the clients to simply stand up and feel their feet beneath them, feeling the ground supporting them. They may breathe together in a meditative or rhythmic fashion that they have practiced before, seeking calm and clarity, managing distress with optimism about the outcome, ready for the clients' choice for this day.

Discussion

In this case study, the organization's efforts to incorporate the practice of mindfulness and principles of adaptive leadership emerge from the tension between a conscious desire to preserve resources and develop a vision beyond current circumstances. The administration actively faces crises and moves toward suffering, risk, possibility, and resilience. Leaders in the organization are natural students of these concepts, making concerted efforts to listen and learn as well as direct. Their mindful and adaptive visioning has led to a solid financial foundation, strong board oversight, and positive relationships with stakeholders, so it is well positioned to make potentially dangerous and revolutionary steps in achieving its organizational goals. By regarding crises as opportunities, it continues to survive ongoing economic threats that have led other organizations to decline or close.

Limitations

Contemporary social service organizations may not succeed in serving their communities unless they can find innovative ways to support their staff and provide consistent best practice services. Yet current conditions—economic, social, and political—may argue against the utility of mindfulness practice and adaptive leadership principles. Diminishing resources are too threatening to ignore, and, consequently, many voices admonish caution against risk-taking because risks may result in losses, and foolish use of commodities may result in waste and harm. At times like this, it appears that prudent spending may threaten more revolutionary methods of change (Hodgkin and Karpman 2010), and if these voices prevail, an organization's capacity to respond with courage and flexibility may suffer and so will the care it can provide to its deserving clients. Organizations may need to establish their own means of securing agility in adversity, joining with staff to support their essential work by encouraging regular feedback and placing a higher value on self-care. Mindfulness and adaptive leadership provide a framework for this new kind of organization health and vitality, resulting in a new kind of community that is resilient and responsive to change.

Implications

Integrating mindfulness with adaptive leadership principles is an administrative model that is available to any social service agency that wishes to find ways to sustain and renew itself during challenging times. Several ingredients are required for its application, beginning with the willingness of the leadership to participate in the process, practice mindfulness principles, and establish open lines of communication among staff and administrative teams. This includes cultivating a present-moment understanding of an organization's possible limitations of time, money, and other resources. The effort requires a commitment to maintain a difficult and necessary balance, evocative of Frankl's (1946/2006) dictum to remain hopeful while facing reality.

Though limitations of time, money, and other ingredients must be acknowledged, organizations that successfully utilize this approach must also have adequate amounts of these resources to support the effort. A thriving organization must place a high priority on grant-seeking and building strong relationships with funding sources; it is continuously engaged in community education and advocacy for its clinical services. Successful incorporation of the mindfulness-adaptive leadership model requires that the organization must be consciously and deeply invested in this process.

Finally, leadership must be willing to participate, where participation means listening, learning, and being open to change, just as others and the environment itself will change. Mindful and adaptive leaders must commit to a course of action "to mobilize people to face, rather than avoid, tough realities and conflicts" (Heifetz 1994, p. 23). Of course, the leader is also in the fray, modeling the characteristics of one who is both facing the difficulties and placing faith and trust in the innovations and knowledge of the organization.

Conclusion

The agency's efforts to stay committed to visioning and "here and now"-based conversation is an example of integrating elements of mindfulness and adaptive leadership to administrative practices. While the establishment of the integrative care center is a current effort, even more important is the mindset that commits to being present and aware, staying current yet respectful of history, and open to future possibilities. Leaders must be flexible about what is possible and clear about the boundaries established by funding, regulations, or other contingencies. Organizational limitations should not dissuade leaders or staff from fully accessing their capacity for imagination and creativity, especially in areas of problem solving.

It is absolutely necessary to welcome clinicians into this process. Indeed, without their participation, there is no point in providing any sort of leadership because the most important advice and the clearest consultation come from the individuals who provide direct service. They bear the burdens of not only responding to clients' needs but also meeting the requirements of an ever-changing and chaotic regulatory environment and knowing that, for nonprofit

organizations, financing is often threatened. That is why it is so crucial to find ways to practice mindfulness and adaptive leadership, reflecting in action: to sit down and listen, speak, hear, respond, move forward, and keep in touch with one another. Mindfulness and adaptive leadership is a shared process, a commitment between individuals who share common goals and mission focus.

In an evocative and moving essay, analyst Nina Coltart (1992) writes about a beast slouching through darkness into light. She describes the ways that we yearn to give form and definition to the beast, even when we cannot see more than a glimpse of its profile. We are uncomfortable with uncertainty, anxious to make the right decision, unwilling to wait. Henri Nouwen (1986) describes the ways that we preoccupy space before we inhabit it because we are so uncomfortable with not knowing what awaits us. Leading a community mental health center in current time presents its own array of slouching beasts and unknown territory. Only through a discipline that combines reflection and action can an organization—which is nothing but and everything including relationships—develop and maintain resilience and agility.

References

Boyatzis, R., & McKee, A. (2005). *Resonant leadership: Renewing yourself and connecting with others through mindfulness, hope, and compassion*. Boston, MA: Harvard Business School Press.

Breshears, E. M., & Volker, R. D. (2012). *Facilitative leadership in social work practice*. New York, NY: Springer.

Coltart, N. (1992). Slouching towards Bethlehem or thinking the unthinkable in psychoanalysis. In N. Coltart (Ed.), *Slouching towards Bethlehem* (pp. 1-14). New York, NY: Guilford Press.

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52–77. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048500/.

Del Vecchio, P. (2012, March 23). SAMHSA's working definition of recovery updated [Web blog message]. *SAMHSA Blog*. Retrieved from http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/.

Frankl, V. E. (2006). *Man's search for meaning, with a new foreword by Harold S. Kushner*. Boston, MA: Beacon Press. (Original work published 1946).

Goodman, L. A., Pugach, M., Skolnik, A., & Smith, L. (2013). Poverty and mental health practice: Within and beyond the 50-minute hour. *Journal of Clinical Psychology, 69*(2), 182–190. doi:10.1002/jclp.21957.

Heifetz, R. A. (1994). *Leadership without easy answers*. Boston, MA: Belknap Press of Harvard University Press.

Heifetz, R., & Laurie, D. (2001). The work of leadership. In Harvard. Business (Ed.), *Review on breakthrough leadership*. Boston, MA: Harvard Business School Publishing Press.

Heifetz, R. A., & Linsky, M. (2002). *Leadership on the line: Staying alive through the dangers of leading*. Boston, MA: Harvard Business School Press.

Heifetz, R., Grashow, A., & Linsky, M. (2009a). Leadership in a (permanent) crisis. *Harvard Business Review, 87*(7–8), 62–69.

Heifetz, R., Grashow, A., & Linsky, M. (2009b). *The practice of adaptive leadership: Tools and tactics for changing your organization and the world*. Boston, MA: Harvard Business Press.

Hodgkin, D., & Karpman, H. E. (2010). Economic crises and public spending on mental health care. *International Journal of Mental Health, 39*(2), 91–106. doi:10.2753/IMH0020-7411390205.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144–156. doi:10.1093/clipsy/bpg016.

Kaufman, E. A., McDonell, M. G., Cristafalo, M. A., & Ries, R. A. (2012). Exploring barriers to primary care for patients with severe mental illness: Frontline patient and provider accounts. *Issues in Mental Health Nursing, 33*(3), 172–180. doi:10.3109/01612840.2011.638415.

Kegan, R., & Lahey, L. L. (2009). *Immunity to change: How to overcome it and unlock the potential in yourself and your organization*. Boston, MA: Harvard Business Press.

McGarrigle, T., & Walsh, C. A. (2011). Mindfulness, self-care, and wellness in social work: effects of contemplative training. *Journal of Religion & Spirituality in Social Work: Social Thought, 30*(3), 212–233. doi:10.1080/15426432.2011.587384.

National Association of Social Workers & Center for Health Workforce Studies. (2006). *Licensed social workers in behavioral health, 2004. Chapter 1 of 7: Overview*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, University at Albany. Retrieved from http://workforce.socialworkers.org/studies/behavioral/behavioral_chap1.pdf.

Nouwen, H. J. M. (1986). Reaching out to our fellow human beings. In H. J. M Nouwen (Ed.), *Reaching out: The three movements of the spiritual life* (pp. 65–109). New York, NY: Image Books/Doubleday.

Parks, S. D. (2005). *Leadership can be taught: A bold approach for a complex world*. Boston, MA: Harvard Business School Press.

Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology, 69*(2), 115–126. doi:10.1002/jclp.21951.

Winnicott, D. W. (1965). *Maturational processes and the facilitating environment: Studies in the theory of emotional development*. London, UK: Hogarth Press.

Ann Fisher Raney, LCSW has served as Chief Executive Officer of Turning Point Behavioral Health Care Center since 2001. With advanced degrees in social work and religion, she maintains a private psychotherapy practice and provides leadership consulting to non-profit organizations, where she works to foster community-based responses to current social issues.