## ACMHA ARM CHAIR REFLECTIONS

# Training the Next Generation of U.S. and Global Mental Health Leaders: Competencies and Needed Actions

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## The Need

We need to develop the next generation of mental health leaders in the United States and other developed countries and the first generation of leaders in developing countries. Over 40% of the U.S. workforce is over age 40. As many as 40% of senior managers in behavioral health as well as public administration are expected to retire in the next five years.

Kathryn Power, Director of the Center for Mental Health Services, frequently discusses how critical leadership is for transforming the mental health system. The Annapolis Coalition, in its comprehensive assessment of behavioral health workforce needs in the United States wrote that leadership is essential and that explicitly developing training for the next generation of mental health leaders is a critical need for achieving transformation of current service systems and models of care. The Coalition set as "Goal 5: Actively foster leadership development among all segments of the workforce," Objective 2: Identify effective leadership curricula and programs and develop new training resources to address existing gaps," and "Objective 3: Increase support for formal, continuous leadership development with current and emerging leaders in all segments of the workforce":

> ...the competencies necessary for leadership roles in behavioral health must be identified. Particular attention must be given to developing core leadership competencies that can be adapted to the different sector of this field... Available curricula for leadership development must be identified and further developed to ensure that the core competencies are adequately addresses. Increased support should be allocated to the formal, continuous development of emerging leaders in the field (Annapolis Coalition, 2007, 19-20).

From 1977-1984, training mental health leaders was a high priority in the United States. The Federal government sponsored the National Institute of Mental Health Staff College to promulgate the goals of the Community Mental Health Centers (CMHC) Act. As part of this, Noel Mazade directed the Advanced Training Program in Mental Health Administration for cohorts of CMHC directors. It involved ten four-day retreats with pre and post activities. Hundreds of people went through the program, but then it ended, creating a serious gap in

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leadership training. The Annapolis Coalition report points out that stipends for mental health training fell from $117 million in 1972 to less than $1 million now.

Globally, the need for mental health services is great. In 2007, The Lancet published a series of five articles that documented the current evidence for global mental health with a focus on low and middle income countries. The final paper in the series made a call to scale up evidence-based packages of services for people with mental disorders with a commitment to human rights (Patel, Garrison, de Jesus Mari, Minas, Prince, Saxena, 2008). The World Health Organisation in October 2008 began the Mental Health Gap Action Programme to address this large treatment gap (www.WHO.int/mental_health/MHgap). The World Federation for Mental Health (www.mentalhealthngo.org) recommended ten strategies "for civil society to scale up services for people living with mental disorders." The Movement for Global Mental Health (www.globalmentalhealth.org) was initiated after the launch of the Lancet series.

About 500 million people have some form of mental disease and incidence is expected to increase from 12 to 15% of the world's population by 2020. Mental health related illnesses account for six of the top twenty causes of life lived with disability among persons ages 15-44. Unipolar major depression is the leading cause of global disability losses, and four of the top ten DALYs are unipolar major depression (1), alcohol use disorders (3), schizophrenia (5), and bipolar disorders (7). One in every four persons will develop one or more mental disorders at some point in their life. The provision of these services is minimal especially in developing countries, and much leadership is needed if we are to make any progress in this area (McDaid, Knapp, Raja, 2008; Shah and Beinecke, 2009; Sherer, 2002).

**The International Initiative for Mental Health Leadership (IIMHL)**

IIMHL is a "virtual" agency that works to improve mental health services by supporting innovative leadership processes. Supported by the governments of Australia, Canada, England, Ireland, New Zealand, Scotland, and the United States (SAMHSA), IIMHL runs an annual leadership exchange and conference (this March was in Australia; in May 2010 it will be in Ireland), supports sub-groups and research, and maintains an active dialog through its web site, www.iimhl.com. Membership is currently around 1750 and is free through its web site. The IIMHL "Cincinnati Group" (renamed the "Brisbane Group" after the Australia meetings) which focuses on leadership development is collaborating on linking efforts across countries to encourage research in leadership within the mental health sector and to share the development of training concepts.

**Leadership Theory and Training in the IIMHL Countries**

In collaboration with IIMHL, I published a study of leadership theory, programs, and competencies in the IIMHL countries, the first in 2007 and an update in February 2009 that also included Wales: "Leadership Training Programs and Competencies for Mental Health, Health, Public Administration, and Business in Seven Countries." It is available at www.iimhl.com and

is one of the most comprehensive global reviews of leadership training. Numerous programs in the countries are described and compared. Among those in mental health in the U.S. are those of

- ACMHA and the National Center for Healthcare Leadership Behavioral Excellence Network (LENS)
- The National Council for Community Behavioral Healthcare Leadership Academy and Middle Management Academy
- The California Healthcare Foundation's California Institute for Mental Health Leadership Institute
- The alcohol treatment centers' (ATTCs Leadership Institutes, and
- The leadership training programs of Open Minds.

From my analysis of the leadership training programs in mental health as well as health, public administration, and business, I conclude that all of the IIMHL countries strongly believe that leadership development is a critical challenge that needs to be addressed. There is much theory and sometimes debate on the subject, and many people and organizations are devoted to defining models and competencies. Many leadership training programs are being offered locally, regionally, and to a lesser degree nationally in the IIMHL countries.

The problem is that in most countries, the United States being a prime example, leadership training is scattered and only partially covers many of the needed areas. It is not well organized or coordinated. Program availability varies greatly depending upon where one lives. There is no central site to find such programs. I spent many hours searching the literature and the internet and contacting many helpful people in order to compile what is still a very incomplete list. In some countries, I had great difficulty identifying any one with knowledge of this area. In others, even my core correspondents do not have a directory or full knowledge of the programs in their countries. If I had such difficulty, imagine the challenge facing a middle manager searching for a place to strengthen his or her leadership skills. The first priority needs to be to create programs and give people access to them. Unless we devote attention and resources to this problem, the next generation of mental health, substance use, and health leaders will not be equipped to take on the new roles that they will be assuming.

A major barrier to this is funding. In the United States, government funding for leadership as well as most other training has been substantially cut back since the heydays of the 1980s and it is very limited if it exists at all. Mental health agencies' resources are stretched by demands for training in other areas, for example information systems, learning the recovery paradigm of care, or evidence-based clinical practices. Budgets are very tight. The first thing to go is usually professional development and supervision. Pressures continue to grow to use one's time for direct service, not to go to conferences and seminars. Many agencies are struggling to keep up with the present, never mind prepare for the future.

IIMHL and this study have focused on well developed English speaking countries where, compared to much of the rest of the world, stigma for mental illness is relatively low, treatment is fairly good, professionals are relatively numerous, and funding is comparatively high. Mental health services, personnel, and financial resources are extremely limited in much of the world. Faced with continuing epidemics of infectious diseases and also the "perfect storm" of chronic diseases and rising injury rates, training of mental health leaders in much of the world is not even close to being on the global radar screen. Mental health is the most under appreciated epidemic in the world, and is an issue that will need capable leadership if it is ever to be addressed.

**Leadership Competencies**

Leadership theorists and programs offer many competencies that an effective leader should have or surround him or herself with people who have these skills. To cite two of many examples, leadership competencies are summarized in *The Transformation Leadership Competencies Wheel* (Figure 1) (SAMHSA (May/June 2005, 2; www.samhsa.gov/matrix_mh.aspx)

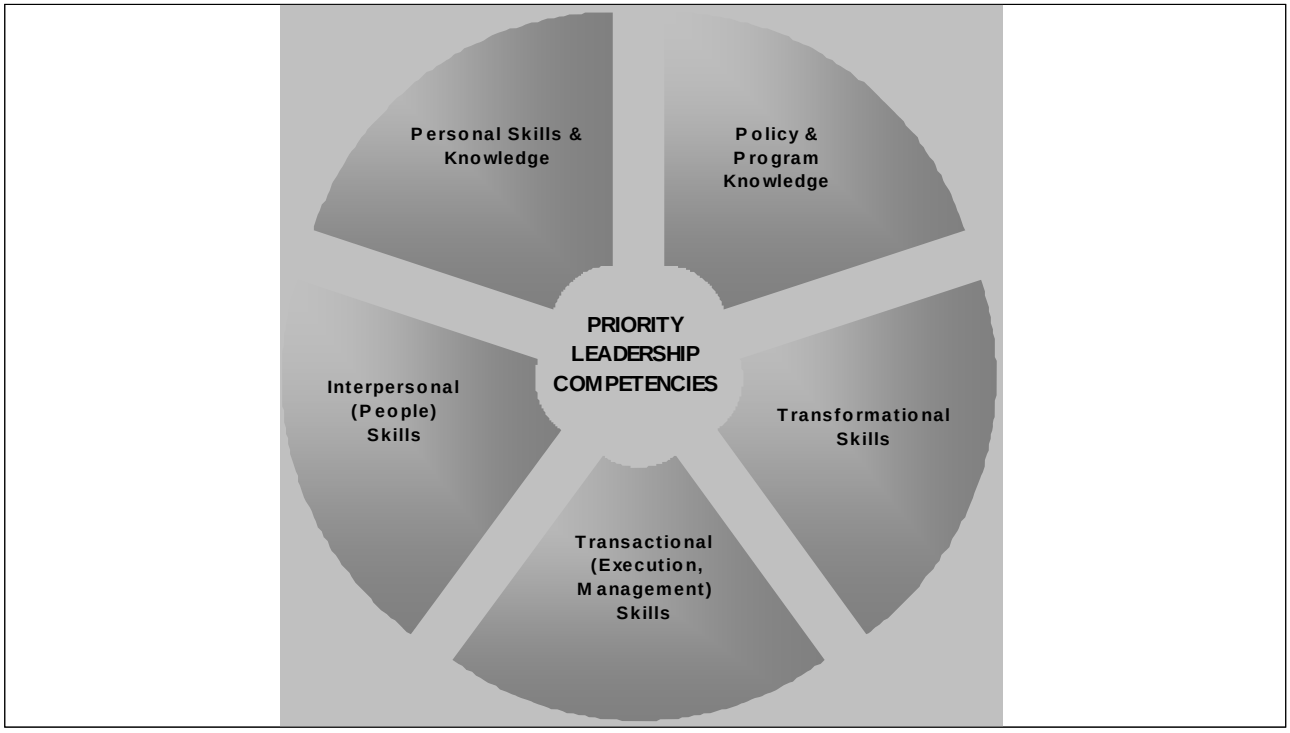
**FIGURE 1: The Transformation Leadership Competencies Wheel**

The National Center for Healthcare Leadership's model (NCHL, 2005; www.nchl.org/ns/documents/CompetencyModel) takes 26 leadership competencies critical to the field of health and assigns them to one of three domains – Transformation, Execution, and People – that serve to capture the complexity and dynamic quality of the health leader's role 2(Figure ):

**FIGURE 2: NCHL Competency Model**


Comparing the many models that I found, I created the Leadership and Management Skill Set (Figure 3):

**FIGURE 3: The Leadership and Management Skill Set**




Analyzing the number of times that competencies appeared in my reviewed programmes, the most common (but not the only ones) are:

- Personal Skills and Knowledge: Emotional intelligence, leader's values and beliefs, ethics, adaptability, reflective thinking;

- Interpersonal Skills: Communicating, teamwork, coaching, negotiating and conflict resolution;

- Transactional Skills: Quality management and accountability, human resource management, finance and budgeting, organizational theory and design, information systems and technology;

- Transformational Skills: Visioning, managing complex change, goal setting;

- Policy and Program Knowledge: Government and political knowledge, funding and legislation, recovery and other health issues, knowledge of diverse stakeholders.

Are leadership competencies for mental health different from those in health or public administration and do these competencies differ depending upon the country in which they were used? In my first four areas, they are not. Core leadership competencies are universal. On the other hand, the knowledge needed of policies and programs are different for mental health than for health and vary depending upon the country or locality where they are applied.

I agree with the Annapolis Coalition that leadership training needs to be provided to a wide variety of stakeholders including consumers and family members and supervisors. The programs in my report do so. They suggest that while core competencies are similar for every level of training, the specifics may vary depending upon the target audience. In addition to leadership competencies, training needs to include knowledge of recovery, the basics of evidence-based practice, and other current behavioral health knowledge. This is particularly true as people without either personal or clinical experience move into leadership positions and as much leadership training is done through health, public administration, and business programs rather than specialty behavioral health organizations.

I was initially surprised that transactional skills are the ones most being taught in training programs. However, that makes sense since many managers move up into leadership and management programs from clinical and lower level positions, and these skills are not part of their training or experience. Other skills such as quality improvement and performance management and information systems have only recently become important in our fields and thus need to be learned by many managers and leaders.

In an ideal world, a competent leader should be strong in all of these competencies. Given the reality of who we are, that is usually not possible. We all have our strengths and areas of weaknesses. One solution is for a leader to support and surround him or her self with team members with complementary skills.

Similarly, a full leadership training program will cover all of these areas. While much of that may be possible in a degree offering graduate education program, people in continuing education programs do not have the time or resources to do so. Thus, national, regional, and local programs must prioritize and select the areas of most need and train leaders in a variety of competencies and a mix of program offerings.

**The Future**

At the IIMHL meetings in Australia, a number of important issues were raised. We need to do much more to put mental health on the global health agenda. Mental health has strong relationships with other health problems as well as poverty and economic development, the demographic challenge, education, war and migration, environmental sustainability and global warming, and global problem solving. Yet even in Jeffrey Sachs' (2008) excellent book that addresses many of these issues, there is no mention of it. We need case studies of successful mental health interventions in developing as well as developed countries to demonstrate its

value, and identify best practices. Like ACHMA's efforts to include mental health with health reform, mental health needs to be addressed in U.S. and world foreign policy initiatives.

We need to continue to track leadership training programs (periodically update my IIMHL report), creating a one stop source for information on mental health and other training programs to help people locate these programs and to facilitate exchange of best practices and other information about them.

Just as evidence-based practices need to be developed for clinical practices, we need EBPs for leadership. We need to justify our expenditures on these programs. What works and what does not? Despite the many training programs, more research is needed on what types of leadership education and training are most effective and have the best outcomes for individuals, and to change and sustain programs and systems as well as policies. What skills and competencies should be taught for people in clinical delivery and at the policy level, and in high and low resource environments? Are there minimal core skills that everyone needs to know and/or particular skills depending upon where and at what level one works and the situation one is in? What are the best teaching methods and approaches for traditional students, working professionals, consumers and family members, and those in third world development? What factors other than training influence success in the field and how can emerging leaders be trained to take advantage of these opportunities?

How do we best train leaders in developing countries where systems and human and financial resources are few, vision and hope may be more important than transactional management skills, and few people are available to hire to get things done? How do we follow up on training to facilitate change over time, so that we don't "look, promise, and then leave?"

How do we fund training programs and needed research on them? How do we use IIMHL, conferences, the internet, and other venues to continue this dialogue among people interested in working in mental health and health leadership training?

These are issues that the Brisbane Group will work on following our Australia meeting. We welcome others who want to be part of our work or kept informed of our group's activities. Please contact me at rickhbeinecke@comcast.net or IIMHL through their web site. Please join the movement to improve mental health services throughout the world.

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