INTERNATIONAL INITIATIVE FOR MENTAL HEALTH LEADERSHIP

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IIMHL

Leadership Training Programs
and Competencies for Mental Health, Health,
Public Administration, and Business
in Seven Countries

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Leadership Training Programs and Competencies for Mental Health, Health, Public Administration, and Business in Seven Countries

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ACKNOWLEDGEMENTS

A NOTE ON SPELLING. Because this is a collaboration among seven primarily English speaking countries, the paper includes minor differences in spelling of some words such as "organization"/"organisation", "center"/"centre", and "program"/"programme." Rather than select one spelling and to maintain the integrity of their individual use, the different spellings are used when appropriate for each situation. I also use "carers" as well as "families" to denote families of persons with mental illnesses.

EXECUTIVE SUMMARY

Developing the next generation of leaders is a critical challenge in mental health as well as public and private administration. This is a study of mental health leadership training programs and competencies in seven developed countries: Australia, Canada, New Zealand, Scotland, United Kingdom, United States, and Wales. Health leadership programs are also covered as well and, to a lesser extent, those in public administration. The original report was published by the International Initiative for Mental Health (IIMHL) on its web site *(www.iimhl.com)* in April 2007. This update is based on follow-up research in the summer and fall of 2008[1]. The major additions to this report are much more information from Canada and information now from Wales. The greatest loss in the closure of the Scottish Leadership Foundation led by Zoe van Zwanenberg and the uncertainty of who will take over their important role in the future.

This research is a partnership with the IIMHL Collaborative for Leadership Development for Service Improvement, a project of IIMHL. The Collaborative is working on linking efforts to encourage research in leadership within the mental health sector and to share the development of training concepts.

Searches for leadership theory and training programs were made through contacts in each of the countries, the Internet, and literature reviews. This is an ongoing process and I welcome additional programs and sources.

Issues in leadership theory are reviewed: what is leadership, transactional and transformative leadership, leadership compared to management, can leadership be learned, what are leadership competencies and can or should they be taught. I define "competencies" in a very broad way, including the variety of these skills and attributes, as well as the critical attitudes and values that underlie these and which form an important part of effective leadership. I acknowledge and respect the different definitions used in the many programs that we have found. I agree with those who believe that transactional and transformative qualities are both needed in a competent leader, as are both leadership and management skills if one defines them differently.

Descriptions of leadership programs that I identified in each of the IIMHL countries follow. My focus is primarily on mental health and secondarily on health training. In addition, because I am finding that many core competencies are universal, I include more generic leadership training programs as well, although my listings for these are not as complete.

With Justin Spencer, my original research associate, I created five areas that nearly all of the mental health, health, and public administration models and programs covered, whether in one course or in a group of courses and culled out the competencies from each to create a comprehensive list. Our five leadership competency areas are:

- Personal Skills and Knowledge
- Interpersonal (People) Skills
- Transactional (Execution, Management) Skills
- Transformational Skills, and
- Policy and Program Knowledge.

Using our competency list, we went back and reviewed the programs and counted the number of times each of these competencies appeared. This gives us some information on what competencies are being most taught and which are not, which appear to be priorities and which are not. I recognize that because our information on any program may be incomplete or lack detail, our findings are not exact. However, I do have enough information to gain a clear picture of the field.

This is one of the most comprehensive global reviews of leadership training. The IIMHL countries strongly believe that leadership development is a critical challenge and they are trying to address it. The research shows that 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 that I have studied, the

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[1] Special thanks to Justin Spencer, my Research Assistant and co-author of the first report. He has now graduated from Suffolk and moved on to the real world of health administration.

the United States being a prime example, leadership training is scattered and only partially covers many of these 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.

Funding is another problem. Budgets are tight and clinical needs are high. Resources for leadership training are very limited if they exist at all.

The next steps that we recommended are still valid; that:

- This list and descriptions continue to be updated presented and discussed, and shared through a web based directory of programs
- Building upon those who contributed to this project, a web site or list serve is created to share information and foster discussion about leadership training and foster dialog about best practices
- This study is expanded to other countries
- A study is conducted of the methods used to teach leadership and the best practices in them
- Most important, that countries fund, develop and link mental health and health leadership training programs at all levels. In the United States, the recommendations of the Annapolis Coalition's "An Action Plan for Behavioral Health Workforce Development" should be seriously considered.

INTRODUCTION: THE NEED FOR MENTAL HEALTH LEADERSHIP TRAINING

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.

These initiatives have clearly demonstrated that mental health is a major problem in the world. Diagnosable mental illness is expected to increase from 12 to15% of the population by 2020 (McDaid, Knapp, Raja, 2008). Approximately 450-500 million people worldwide suffer from some form of mental disease (Sherer, 2002). Mental-health related illnesses account for six of the top twenty leading causes of life lived with disability among those ages 15-44, and neuropsychiatric disorders contributed 28 percent of non-communicable diseases causing disability-adjusted life years in 2005. One in every four people develop one or more mental disorders at some stage in life. Mental health problems cause many hard to define economic and social costs, are outcomes of war and forced migration, and contribute to poverty and stigma (Shah and Beinecke, 2009).

The Lancet series and other recent activities have done much to raise awareness about global mental health and to spur initiatives in many areas. To meet the ambitious goals of improving mental health care, we need to train the next generation of mental health leaders in developed countries and the first generation in low and middle income countries (Beinecke, Daniels, Peters, and Silvestri, 2009).

The Annapolis Coalition, a not-for-profit organization focused on improving workforce development in the behavioral health field in the United States, concludes that "leadership development, as a strategic goal, offers high potential to transform behavioral health." To achieve this strategic goal,

> ... 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 sectors of this field... Available curricula for leadership development must be identified and further developed to ensure that the core competencies are adequately addressed. Increased support should be allocated to the formal, continuous development of emerging leaders in the field. (Annapolis Coalition, 2007a, 19-20)

This report is an update of a study originally published in April 2007 of mental health leadership training programs and competencies in eight countries: Australia, Canada, the two Irelands, New Zealand, Scotland, United Kingdom, and the United States. For this edition, I have dropped the Irelands due to lack of information. Wales is not a member of IIMHL, but since I have received interesting information from them, I have included them. Health leadership programs are also covered as well and, to a lesser extent, those in public administration and some in business.

IIMHL. This research is a partnership with the IIMHL "Cincinnati Group" which focuses on leadership development. This Group 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.

IIMHL is a "virtual" agency that works to improve mental health services by supporting innovative leadership processes. IIMHL seeks a future where everyone with a mental illness/mental health problem and those who care for them have access to effective treatment and support from communities and providers who have the knowledge and competence to offer services that promote recovery. To achieve its vision, IIMHL provides an international infrastructure to identify and exchange information about effective leadership, management and operational practices in the delivery of mental health services. It encourages the development of organisational and management best practices within mental health services through collaborative and innovative arrangements among mental health leaders. IIMHL's key goals are to:

- Provide a single international point of reference for key mental health leaders
- Strengthen workforce development and mentoring of mental health leaders
- Identify and disseminate best management and operational practices
- Foster innovation and creativity
- Expand the knowledge of:
  i. Building community capacity
  ii. Implementing best practices for consumer recovery
  iii. Expanding methodologies for integration with other health and social systems
- Promote international collaboration and research.

As of December 2008, organizations participating in IIMHL are:
- The National Institute for Mental Health in England (NIMHE)
- The Substance Abuse and Mental Health Service Administration (SAMHSA) of the US
- Mental Health Corporations of America (MHCA) of the US
- The Mental Health Directorate of the Ministry of Health New Zealand (MOHNZ)
- The Scottish Executive (SE)
- Department of Health and Children (DoHC) in Ireland
- Department of Health and Aging (DoHA), Australia
- Health Canada (HC) and the Mental Health Commission (MHCC), Canada.

Membership is currently around 1750 and is free to mental health leaders through the IIMHL web site.

Beginning in 2003, over 1200 mental health professionals have attended IIMHL Leadership Exchanges in England, the United States, New Zealand, Scotland, and Canada (August 2007). The next meeting is scheduled for Brisbane, Australia in March 2009, and other member countries in future years. IIMHL also publishes a semi-monthly **Update**, facilitates the sharing of innovative projects and processes, and consults to countries developing community mental health services *(www.iimhl.com)*.

A new limited edition publication: **Make It So** commenced in November 2008. This e-bulletin aims to assist national and state leaders of IIMHL countries by:

1. Describing best practice that has been replicated from one IIMHL country to another.
2. Describing how a problem in one country is helped by assistance from another.

METHODOLOGY. The idea for this research originated at an IIMHL meeting in Washington, D.C. in April 2006, and the first sources of information were presentations made at that meeting. In the years since, I conducted an extensive and ongoing literature review on mental health leadership and leadership more generally. I contact a growing list of persons and organizations in the participating countries to identify mental health, substance use, health, and public administration leadership training programs and reports and other related publications. For this update, I updated the literature review and received additional information from the listed countries. In many cases, I am having ongoing exchanges with our contacts to locate other information and to review our drafts. I follow up on any web sites given to me and further search the web for additional sources. However, for this update, I have not been able to double check every source from the original and readers should check each where needed. Whenever possible, I identify specific leadership competencies. As this update shows, I view this process as an ongoing one and welcome additional sources as well as other countries wishing to join us. An unintended, but very welcome outcome is that many of these contacts discovered each other and began communicating with each other about issues raised by this project.

I believe that I have the most extensive listing of mental health and probably health leadership training programs in our countries. I am less sure that I have identified most of the public administration training programs and describe a sampling of the many leadership programs offered by and to the business community. A full discussion of the many issues of what is a leader or a manager is beyond the scope of this paper, although I review some of these topics in the first section and refer to these issues throughout the paper. Nor does this paper describe in much detail the methods by which these programs are offered or the issues of what are the best ways to teach and train. A vast amount of literature on these topics and excellent summaries are available through other sources and are frequently discussed in training seminars, management courses, and journal articles/book chapters (see, for example, the discussions of how to train

the mental health workforce in publications of the Annapolis Coalition (*www.annapoliscoalition.org)*.

From the many feet of information, I have made every effort to summarize the programs as accurately as possible, without bias. I encourage the reader to go to the listed sources to learn more about these many programs and ideas.

This project is self-funded. My former Research Associate, Justin Spencer, and I conducted the research and wrote the first report; I have done the update.

WHAT IS LEADERSHIP? Leadership is a complex topic that continues to engender much debate and discussion, as well as many different ways of defining it. Burns (1978, 2) wrote "leadership is one of the most observed and least understood phenomena on earth." Middlehurst's statement is as true now as it was in 1993 (Middlehurst, 1993):

> The idea of leadership is complex, difficult to capture and open to numerous definitions and interpretations. Neither in common parlance nor in the literature on the subject is there consensus about the essences of leadership, or the means by which it can be identified, achieved or measured. Although it is spoken about as a concrete and observable phenomenon, it remains an intangible illusive notion, no more stable than quicksand.

Part of the challenge is that the understanding of what leadership is has changed significantly in the last hundred years. It no longer simply includes traits and skills of leaders and/or their relationships (behavioral approach) and situations (contingency approach), although these are still important (see Alimo-Metcalfe, Alban-Metcalfe, Samele, Bradley, and Mariathasan, 2007 for an excellent critical review of the historic models of leadership). Modern leadership theory is about leading and managing complex adaptive systems that operate as a series of networks with multiple stakeholder interests. Situations that leaders face have been likened to working in a swamp, as compared to clear, hard ground (Parks, 2005). Problems and issues such as those facing mental health leaders are "wicked." There is no definite formulation of the problem, each problem is essentially unique, often has not been faced before, and is entwined with other problems. The search for solutions never stops. Solutions are not good or bad or limited, but are judgment calls and are often difficult to measure.

> Wicked problems often crop up when organizations have to face constant change or unprecedented challenges. They occur in a social context; the greater the disagreement among stakeholders, the more wicked the problem. In fact, it is the social complexity of wicked problems as much as their technical difficulties that make them tough to manage (Camillus, 2008, 100).

Heifitz (1994) calls these situations when there is no obvious definition of a problem or a solution Type III situations or adaptive problems. He contrasts these with Type I problems, technical problems, where the problem is definable and can be solved with technical knowledge and abilities and Type II problems when the problem is clear but the solution is not. More and more, leaders face Type II and III situations that require new leadership skills and competencies, a dynamic process that emphasizes the need for quality, flexibility, adaptability, speed, and experimentation. They "bring to mind the idea of an energetic dance that binds the leader and followers, in which each side is fully present, active, and able to shape the other. In that sense, the teaching of leadership can –in fact, must- be a life-giving activity (Warren Bennis in Parks, 2005, xi). Systemic leadership puts shared values, responsible and empowered members, and effective communication and information sharing as critical needs (Lawrence Whyte, 1/23/07; Kanji and Moura E Sa, 2001).

Type II and III situations are complex, multi-framed, cross-boundary, and hard to solve. They often require collaborative leadership, a set of theories that has emerged in the 2000s and that demands styles that are facilitative and empowering, catalytic and connective (Sullivan and Williams, 2007). Leaders in these situations need to inspire commitment and action, lead as a peer problem solver, build broad based involvement, and sustain hope and participation. They "convene, energize, facilitate, and sustain this process" (Chrislip and Larson, 1994, 146).

Luke (1998, 6-7) writes that public problems in the past were often simple engineering-type problems. Today problems are much more difficult to define, analyze, and solve because they are intertwined with other related problems and cross jurisdictional, functional, and generational boundaries. They involve

mutual dependence where actions of one individual or agency influence or constrain actions of another. The interconnected nature of public problems is:

Characteristics of Interconnected Problems	Impact on Public Leadership
Problems cross traditional boundaries:	*Requires cross boundary thinking and action:*
Problems cross organizational and jurisdictional boundaries.	Interorganizational arrangements required to address the problem.
Issues are often "cross-cutting," transcending functional boundaries.	Cross-functional teams required.
Problems cross temporal and generational boundaries.	Must consider intergenerational impacts.
Involved in interrelated web of other problems; "wicked" or nontame; caught in swamp.	Extremely difficult to untangle cause-and-effect relationships; difficult to find just one "cause".
Problems are socially constructed:	*No natural consensus on problem definition:*
Range of problem representations depending upon one's cognitive and emotional biases.	Multiplicity of conflicting problem definitions; public leader influences definition process.
Strategies emerge from one's definition of problem and "mental model" of causes and effects.	Agreement on problem definition is critical for concerted action.
No optimal solutions:	*No quick fixes or easy remedies:*
Problems are intractable and never entirely solved.	Seek improvements in conditions or outcomes rather than problem elimination.
Technical remedies ineffective; real progress requires deeper systemic changes.	Multiple strategies needed, a "portfolio of strategies" rather than the one, right solution.

Anthony and Huckshorn (2008, 11) define leadership as creating a shared vision and mobilizing others toward specific organizational goals consistent with the vision." It includes five elements: leaders, followers, goals, environment, and shared vision.

Rowitz (2001, 23-24) singles out ten leadership abilities and practices as especially important for leadership in the 21st century. Leaders:

- Must be knowledge synthesizers
- Need to be creative
- Need to be able to create a vision and get others to share the vision and demonstrate a commitment to the vision and the mission it represents
- Need to foster and facilitate collaboration
- Need to possess entrepreneurial ability
- Are systems thinkers
- Must set priorities
- Need to form coalitions and build teams
- Must put innovative ideas into practice, must become masters of the latest management techniques, and
- Acts as a colleague, a friend, and a humanitarian to everyone in the organization.

Crosby and Bryson (2005) emphasize an integrated approach to policy change through the use of eight main leadership capabilities:

- Leadership in context: understanding the social, political, economic, and technological "givens"
- Personal leadership: understanding self and others
- Team Leadership: building productive work groups
- Organizational leadership: nurturing humane and effective organizations
- Visionary leadership: creating and communicating shared meaning in forums

- Political leadership: making and implementing decisions in legislative, executive, and administrative arenas
- Ethical leadership: adjudicating disputes and sanctioning conduct in courts
- Policy entrepreneurship: coordinating leadership tasks over the course of policy change cycles.

Key competencies to do this are

- Inter-personal skills
- Appreciation of strategic interdependencies and systems
- Ability to perform as a translator by understanding the diverse meanings and aspirations of disparate constituencies
- Creative ability with a propensity for innovation and experimentation
- An ability to construct a learning environment…and to promote reflection, conceptualization, and thinking
- A commitment to disbursed forms of leadership through empowerment strategies and decision making processes (Sullivan and Williams, 2007; Williams, 2008).

Williams (2008, 5-6) argues that individual actors, "boundary spanners," have a critical and central role in this process. This role has a number of key elements (Figure 1):

Figure 1: Boundary Spanning Elements and Competencies	
KEY ELEMENTS OF BOUNDARY SPANNINGROLE	COMPETENCIES (skills, knowledge and experience)
RETICULIST	• skilled in networking
ENTREPRENEUR	• creative and innovative • brokering • entrepreneurial skills
LEADER	• skilled in different influencing strategies • negotiation, mediation and facilitation • political skills and diplomacy • builds coalitions and consensus seeking • manages multiple accountabilities
INTERPRETER AND COMMUNICATOR	• builds and maintains inter-personal relationships • comprehensive communication skills •active listening • empathizing • framing and sense making • develops and promotes trusting relationships
EXPERT	• understanding of policy context including roles and motivations • trans-disciplinary knowledge • inter-organizational and intersectoral experience • analytical skills

Leaders need to be "conceptualizers, providers of reasoning and context, facilitators, and profound questioners" (Feyerherm, 1994, 268) who

- surface or illuminate assumptions or beliefs
- create new alternatives and frameworks and social consensus, coupled with supporting, bridging, and facilitating, and
- initiate collective action to form structures and develop and present proposals (Williams, 2008, 20).

Being a facilitator is a critical leadership role and the term that best describes what I and many other leaders do. The core beliefs of facilitative or engaging (as compared to traditional directive) leaders are:

- People are intelligent and capable, and they want to do the right thing.

- Everyone's opinion has value, regardless of an individual's rank or position.
- Groups can make better decisions than individuals acting alone.
- People are more committed to the ideas and plans that they create.
- People will take responsibility and assume accountability for their actions and can become partners in the enterprise.
- The role of the leader is to evoke the best possible performance from each member of the team (Bens, 2006, 8-9).

The guiding principles of each action are (1) empowerment, (2) collaboration, (3) creativity, (4) transparency, (5) systems thinking, (6) feedback, and (7) ongoing learning and development (Bens, 2006, 41-42).

The defining feature of facilitative leaders is that they offer process and structure rather than directions and answers. In every situation, they know how to design discussions that enable group members to find their own answers (Bens, 2006, 93).

This process is "adaptive work," "the learning required to address conflicts in the values people hold, or to diminish the gap between the values people stand for and the reality they face. The exposure and orchestration of conflict – internal contradictions – within individuals and constituencies provide the leverage for mobilizing people to learn new ways" (Heifitz, 1995, 22). As an amateur concert pianist himself, for Heifitz the leader is the conductor of the very diverse orchestra. As its members each find their own answers in relationship to the others in the group, they come together as an effective team.

Critical to this is constant movement between action and reflection, theory and practice (Shon's **The Reflective Practitioner**, 1984), moving between being an active participant on the complex dance floor and pulling back to looking down from the balcony where you can see and reflect on the larger pattern of interactions (Heifitz, 1995), being amongst the trees and looking down on the forest.

Gardner (1990, 1) defines leadership as "the process of persuasion or example by which an individual (or leadership team) induces a group to pursue objectives held by the leader or shared by the leader and his or her followers." He describes the tasks of leaders as:

- Envisioning Goals: goal setting and motivating. "Leaders point us in the right direction and tell us to get moving."
- Affirming Values
- Regeneration of Values
- Motivating
- Managing
    > planning and priority setting
    > organizing and institution building
    > keeping the system functioning
    > agenda setting and decision making
    > exercising political judgment
- Achieving Workable Unity
- Building Trust
- Explaining
- Serving as Symbol
- Representing the Group, and
- Renewing.

Van Wart (2005) considers leadership to be a complex process, "The Leadership Action Cycle," involving the acts of

1. Assessing one's organizational and environmental demands, and one's leadership constraints and priorities;
2. Developing the numerous necessary leadership characteristics, traits and skills (such as integrity, self-confidence, a drive for excellence, and skill in communications and influencing people);
3. Refining and modifying one's style for different situations;
4. Achieving predetermined goals by acting in the three major areas of task-oriented, people-oriented, and organizational-oriented behaviors; and

5. Continually self-evaluating one's performance and developing one's potential.

The United States Army (October 2006, 1-1 – 1-3, A-1) considers leadership to be "the process of influencing people by providing purpose, direction, and motivation while operating to accomplish the mission and improving the organization." The definition contains three basic goals, many of which are present in civilian leadership models: to lead others, to develop the organization and its individual members, and to accomplish the mission. Its "enduring expression is BE-KNOW-DO: BE – the values and attributes that shape character; KNOW – the knowledge that leaders should know in leadership; and DO – what leaders do or leader actions. It involves Influencing (purpose and vision, direction, motivation), Operating (influencing others), and Improving (capturing and acting on important lessons of ongoing and completed projects and missions). The Leadership Requirements Model outlines the attributes and competencies Army leaders develop to meet these goals. Attributes (what an Army leader is) are

A Leader of Character
- Army values
- Empathy
- Warrior ethos

A Leader with Presence
- Military bearing
- Physically fit
- Composed, confident
- Resilient

A Leader with Intellectual Capacity
- Mental agility
- Sound judgment
- Innovation
- Interpersonal tact
- Domain knowledge

Core leadership competencies (What an Army leader does) are:

Leads
- Leads others
- Extends influence beyond the chain of command
- Leads by example
- Communicates

Develops
- Creates a positive environment
- Prepares self
- Develops others

Achieves
- Gets results.

Rosabeth Moss Kanter (1983, 65) called innovative leaders "Change Masters: Those people and organizations adept at the art of anticipating the need for, and of leading productive change." (Preface). They are "adept at reorienting their own and other's activities in untried directions to bring about higher levels of achievement. They will be able to acquire and use power to produce innovation." They encourage open communication, ensure a set of supportive peers and networks, organize teams, set up a culture for enterprise and innovation, and energize the grassroots, involving and empowering employees in innovation and change. They educate (build a broad base of support through coalition building), gather data and communicate it effectively and broadly, create structures for problem solving and mobilizing action, and institutionalize participation.

TRANSACTIONAL AND TRANSFORMATIVE LEADERSHIP. A great amount of theory and debate about types of leadership is present in the literature. Much of it focuses on the different dimensions of leadership.

Leadership theory has made a progression from authoritative through transactional to more transformative models (Van Slyke and Alexander, 2006). In recent mental health literature and policy thinking, transformation "has become the organizational imperative for public and private mental health systems" (Mazade, January 2005, 3). For example, it is a core and often cited concept in the President's New Freedom Commission on Mental Health report (New Freedom Commission, 2003; Mazade, January 2005).

Long before this, it emerged as an important leadership concept. Burns (1978, 4) distinguishes between transactional and transformational leadership. "The relations of most leaders and followers are transactional – leaders approach followers with an eye to exchanging one thing for another." They accept and work within the system as it is. Transactional leadership is the most common style in organizations. Someone who is a strong transactional leader stresses efficiency, planning and goal setting, competency, structure, and maintaining the organization. He or she may be more reactive and supportive of the status quo.

The transforming leader, by contrast, "looks for potential motives in followers, seeks to satisfy higher needs, and engages the full person of the follower. The result of transforming leadership is a relationship of mutual stimulation and elevation that converts followers and leaders and may convert leaders into moral agents" (Burns, 1978, 4). By engaging followers' higher needs, transformational leaders move followers beyond their self-interest to work for the greater good, and, that as they do so, they become self-actualizing, and become leaders themselves. One who is more of a transforming or engaging leader emphasizes personal relationships and development, teamwork, communication, autonomy and creativity, an empowering culture, honesty/integrity, humility and generosity, and continuous learning. He or she has current and future situational awareness, a vision of the future, and believes in proactive change, adaptability, and entrepreneurship. He or she is responsive to others needs and interests and responsible and accountable to stakeholders. (Alimo-Metcalfe and Alban-Metcalfe, 2006; Bass, 1993 and 1998; Heifitz, 1994; Mazade, January, 2005; Murphy, 2005; Thorn, 2006).

Bass (1998) developed the Multifactor Leadership Questionnaire (MLQ) to measure transformational leadership (inspirational/charismatic, individualized consideration, intellectual stimulation), transactional leadership (contingent reward, management by exception), and laissez faire management and showed that while every leader does some of each, transformational components are correlated with effectiveness, satisfaction, and extra effort in public and private sectors.

Alimo-Metcalfe and Alban-Metcalfe in the United Kingdom have extended this U.S. work in their development of the engaging leader and the Transformational Leadership Questionnaire (see the UK section and elsewhere in this paper for details).

> Engaging leadership is a style of leadership that shows itself in respect for others and concern for their development and well being, in the ability to unite different groups of stakeholders in developing a joint vision, in supporting a developmental culture, and in delegation of a kind that empowers and develops individuals' potential, coupled with the encouragement of questioning and of thinking which is constructively critical as well as strategic. Engaging leadership is based on integrity, openness and transparency, and genuine valuing of others, along with being able to resolve complex problems and to be decisive (Alimo-Metcalfe, Alban-Metcalfe, Samele, Bradley and Mariathasan, 2007, 26).

Organizations may have differing degrees of transactional or transforming cultures. Those that are highly transactional will be characterized by rules, regulations, rigid structure, explicit contracts and controls, while those that are more transformative have strong vision and purposes, support change, and have much more trust, interaction and interdependence of their leaders and staff (Alimo-Metcalfe and Alban-Metcalfe, 2006; Bass, 1993 and 1998; Burns, 1978).

The distinction between transactional and transforming leadership is similar to Bradford and Cohen's metaphors of the leader as technician and the leader as conductor, one based on the craftsman with his or her skills and the other on managing people effectively (Cohen and Bradford, 1991).

Senge (2006) argues that leaders in "learning organizations," those that are open to change, need to be designers, teachers or coaches, and stewards of the organization. This requires skills including ability to share a vision, challenge prevailing mental models, and foster more systematic patterns of thinking (Kanji and Moura E Sa, 2001).

The Conference Board identified four essential roles for future business leaders: master strategist, change manager, relationship/network builder, and talent developer (Barrett and Beeson, 2002).

George (October 30, 2006) writes that the only valid test of a leader is his or her ability to bring people together to achieve sustainable results over time:

> What then is the 21st leader all about? It is being authentic, uniquely yourself, the genuine article. Authentic leaders know who they are. They are "good to their skin", so good they don't feel a need to impress or please others. They not only inspire those around them, they bring people together around a shared purpose and a common set of values and motivate them to create value for everyone involved...

He states that they usually demonstrate five traits:

1. Pursuing their purpose with passion
2. Practicing solid values
3. Leading with their hearts as well as their heads
4. Establishing connected relationships
5. Demonstrating self discipline.

Some writers (e.g. Bass, 1993; Thorn, 2006) consider the transactional style to be a "carrot and stick" or a more hierarchical approach to leadership. They argue that the transformative style is more effective and satisfying to staff and thus should be preferred or even replace the transactional approach. For example, transformational leadership is what Gardner (1990) calls "renewing":

- To renew and reinterpret values that have been encrusted with hypocrisy, corroded by cynicism or simply abandoned; and to generate new values when needed.
- To liberate energies that have been imprisoned by outmoded procedures and habits of thought.
- To reenergize forgotten goals or to generate new goals appropriate to new circumstances.
- To achieve, through science or other modes of exploration, new understandings leading to new solutions.
- To foster the release of human possibilities, through education and lifelong growth.

Others such as Sturdier et al (2000) and Murphy (2005) assert that effective leadership requires a balance between transactional and transformative leadership, and that both are needed depending upon the situation. Effective leaders will be versatile; they will use different styles depending upon the situation. Transformational leadership is not a substitute for transactional leadership; conversely it complements, develops, and enhances it.

Luke (1998, 37) calls this mix of leadership styles "catalytic leadership." The tasks of the leader are:

1. Focus attention by elevating the issue to the public and policy agenda.
2. Engage people in the effort by convening the diverse set of people, agencies, and interests needed to address the issue.
3. Stimulate multiple strategies and options for action.
4. Sustain action and maintain the momentum by managing the interconnections through appropriate institutionalization and rapid information sharing and feedback.

It is non-hierarchical and inter-organizational, collaborative with concerted action, convenes stakeholders and facilitates agreements for collective action, is facilitative and asks the right questions, and, while having a stake in getting to agreed upon outcomes, encourages divergent ways to reach them (Sullivan and Williams, 2007; "collaborative leadership" styles, based on Luke).

Kotter (1996; Kotter and Rothenberg, 2006; *www.ouricebergismelting.com*) defines "the eight step process of successful change." All of the competencies in this paper essentially support these key activities:

1. Set the Stage: Create a Sense of Urgency.
2. Pull Together the Guiding Team.
3. Decide What to Do: Develop the Change Vision and Strategy.
4. Make It Happen: Communicate for Understanding and Buy In.
5. Empower Others to Act.

6. Produce Short-Term Wins.
7. Don't Let Up
8. Make It Stick: Create a New Culture.

Challenge Day is a powerful day long experiential program begun in 1987 for high school students, their parents, and teachers that demonstrates "the possibility of love and connection through the celebration of diversity, truth, and full expression" *(www.challengeday.org)*. The "Be the Change" mission is "to inspire people to be the change they wish to see in the world, starting with themselves, through compassion and service using the formula for change: NOTICE, CHOOSE, and ACT." Nearly all the complex theories of change and examples of training for change described in this paper can be distilled into this simple process that has now been taught to thousands of students around the world.

LEADERSHIP AND MANAGEMENT. Some authors distinguish between leadership and management (see Kanji and Moura E Sa, 2001 for an excellent review of this debate). Kotter (1990, 6) considers them to be very distinct. However, both are needed if an organization is to prosper (Figure 2):

Figure 2: Management and Leadership		
	Management	Leadership
Creating an agenda	Planning and Budgeting	Establishing Direction
Developing a human network for achieving the agenda	Organizing and Staffing	Aligning People
Execution	Controlling and Problem Solving	Motivating and Inspiring
Outcomes	Produces a degree of predictability and order and has the potential of consistently producing key results expected by stakeholders	Produces change, often to a dramatic degree, and has the potential of producing extremely useful change

Anthony and Huckshorn (2008, 11) based on Bennis and Nanas suggest that while "managers are skilled at 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… In the field of mental health, leadership and management are not mutually exclusive, nor is one more needed than the other."

For Gardner (1990), leaders are different from managers in that they think longer term, grasp relationships to larger realities and organizations, reach and influence constituents beyond boundaries, emphasize intangibles of vision, values, motivations, and non-rational and unconscious elements, have political skill to deal with multiple constituencies, and think in terms of renewal.

For example, in the activity of agenda setting, leadership is establishing direction, while management is planning and budgeting. Human resource development for a leader is getting others to be enthusiastic and joining in a vision, while a manager organizes the staffing. A leader motivates and inspires; a manager controls and problem solves. A leader produces change, and a manager produces efficiency (Alimo-Metcalfe, 1/21/07).

What Is Leadership (www.ldc.govt.nz/?/resources/whatisleadership) argues that leadership is typically considered to be inspirational (transformative) while management is transactional (Figure 3). They can be distinguished but should not be compared.

Figure 3: How Leadership and Management Are Typically Differentiated	
Leadership – inspirational	**Management - transactional**
Produces change and development	Produces order, consistency and predictability
Visioning and direction setting	Planning and budgeting
Shaping of goals	Responsiveness to goals
Creative and inductive	Practical and deductive
Concerned with ideas and desires for the future	Concerned with necessities of organization structure
Aligning staff with direction through communication	Organizing and staffing through systems
Motivating, inspiring, and energizing	Use of control mechanisms and problem solving
Encouraging the taking of opportunities with some resulting risk	Focus on risk management and preventing operational failure
Gains the extra 25% discretionary effort	Obtains an honest days work
What things mean to participants; the substance	How things get done through participants; the procedure
Strong emotional intelligence (self-awareness, self-regulation, empathy, social skills)	Intelligence and analytical skill

Instead, leadership behavior enriches the management role (Figure 4):

Figure 4: How Leadership Behaviour Enriches the Management Role	
Management (the role) involves:	**Leadership (the behaviour) adds value by:**
Developing and communicating vision and strategy	Communicating vision in ways that generate motivation, enthusiasm, and commitment. Linking the contribution of individuals to the vision and "bigger" picture.
Shaping an organisation's culture to reflect required values, give effect to the vision, and deliver results	Modeling and finding other creative ways to champion all aspects of the desired culture and values
Building a high performance workforce and recognizing the aims, aspirations, and employment requirements of all staff	Treating people at all times in ways that epitomize the ethics, values, and standards expected throughout the organization
Enabling people from different backgrounds to work together	Actively promoting the value of diversity
Apply sound general management practices to ensure the business operates effectively and efficiently	Using the systems, processes, and practices in ways which reflect the style and intent of the desired values and culture
Managing multiple working relationships with clients and stakeholders to enhance understanding and co-operation	Connecting with people in ways that build a network of constructive external relationships
Having the functional and technical knowledge and skills appropriate for achievement in the role	Encouraging and empowering others to lead in technical areas

Others feel that these are not separate functions or roles but are different dimensions that all leaders share and utilize differently depending upon their position or task. The authors of What Is Leadership

(www.ldc.govt.nz/?/resources/whatisleadership) believe that a good manager needs to be a good leader. Management is a role which underpins an organisation's ability to perform, while leadership is a behavior that breathes life into organizational performance. Together they communicate vision, shape an organisation's culture, build a high performing workforce, promote diversity, apply sound management practices and business operations, create networks of external relationships, and apply functional and technical knowledge.

CAN LEADERSHIP BE LEARNED? The nature/nurture debate is a longstanding one in psychology, while the management as art versus science has filled many public and private management journals. Early writers argued that leadership is innate and cannot be learned. Most authors, and certainly the programs described in this paper, believe that leadership can be developed in a person, just as business, public administration, and other fields can be taught in our schools. Leaders also change over the course of their active career. Thus, ongoing training is critical to their development.

> Many dismiss the subject (development of leaders) with the confident assertion that 'leaders are born not made.' Nonsense. Most of what leaders have that enables them to lead is learned. Leadership is not a mysterious activity. It is possible to describe the tasks that leaders perform (Gardner, 1990, xix).

> Leadership can be developed...leaders can improve their own effectiveness across a wide range of situations, from those requiring change and innovation to those with diverse populations and different cultures to those in crisis (Conger and Riggio, 2007).

COMPETENCIES[2]. Mackay (1997) defines competencies as "individual characteristics which must be demonstrated to provide evidence of superior or effective performance in a job. ...The complete competency set or model for an individual role identifies all the knowledge, skills, experiences, and attributes a person should display in their behaviour when they are doing the job well."

The Health Research Council of New Zealand (July 2005, 1) describes competencies as "the combination of attributes, skills, and knowledge that contribute to a person's ability to perform a job to an appropriate standard" and that they include personal attributes, knowledge, and skills (see New Zealand section for details).

Ross, Wenzel, and Mitlyng (2002, xii) write that "core competencies refer to a set of interrelated skills that can be defined and categorized. These competencies transcend unique organizational settings and are applicable across the environment."

Alimo-Metcalfe, Alban-Metcalfe, Samele, Bradley, and Mariathasan (2007) have another way of describing these issues. They distinguish two aspects of leadership: leadership competency, and the engaging leader. These are similar to the distinctions of leadership and management, or transactional and transformative leadership. Leadership competency ("what a leader does") is defined as

> a competent leader is someone who enables the development of an organization in a way that is goal directed, and geared to developing processes and systems. This enables staff at all levels to plan effectively and efficiently, in order to achieve agreed goals.

A transformational or engaging leader ("how they do it," the process)

> is someone who encourages and enables the development of an organization that is characterized by a culture based on integrity, openness and transparency, and a genuine valuing of others.

Both are complementary and are needed to be an effective leader and both are essential to bring about sustainable change. However, competencies alone are insufficient. One needs to also use one's talents to get the job done. Or, competencies are sheet music, a diagrammatic representation of the melody. It is only in the arrangement, playing and performance, however, that the piece truly comes to life" (Hollenbeck and Bolden & Gosling in Alimo-Metcalfe et al, 2007, iv). Thus, training needs to include both leader development (actions performed competently) and leadership development (actions performed in an engaging way) (Alimo-Metcalfe et al, 2007, 37).

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[2] One of the best annotated review of readings on leadership that I have found is Bolden (2006). At the end, there is an excellent discussion of issues of leadership competencies as well as other leadership issues.

Not everyone believes that improving competencies should be the focus of leadership training. McCall and Hollenbeck (2007, 88) argue that the process of identifying competencies and then training leaders in them is an expensive and time consuming process, is ineffective, and, while appealing, is misplaced.

> The focus instead should be on using *experiences* to develop competence (italics theirs) rather than on preconceived competencies that may not have anything to do with effective leadership.

A more effective approach may be what has been called "action learning:" identify key leadership challenges not competencies, use these to develop critical developmental experiences, and help people learn from these experiences.

> Leaders are forged by the fires of experiences: the assignments, people, challenges, and screw-ups that, over the course of a lifetime, push us beyond what we are. What matters is not their competencies but their competence... how effective they are at doing the work and getting the results the organization needs (89).

I agree that experience and experiential learning is important. Reflection, discussion, and experience are important. Most of the training programs described in this paper incorporate that approach into their training. Nevertheless, certain competencies are necessary to be an effective leader, and they can be taught with didactic as well as experiential approaches.

> Organisations should endeavor to develop opportunities for their members to articulate and explore their experience of leadership in all its richness. To use a musical metaphor, we should encourage people in leadership roles to not only develop their musical reading and basic playing skills (i.e. competencies) but also their interpretation, improvisation, and performance skills (i.e. emotion, intuition, moral judgment, experience, etc. (Bolden, 2006, 24).

Bolden (2006) makes the important points that one must consider not just the qualities of the leader but take a systems approach that considers the roles of others (e.g. followers) in the leadership process and context, a systems perspective. One needs to take into consideration the many other people involved in any group interaction.

Depending upon the mission of the organization, the level of a person within the organization, and the tasks that he or she faces, certain competencies may be needed at any given time or position. For example, one needs to be careful as competencies are defined not to assume that a given set of competencies can be implemented for every situation (Steve Onyett, Personal communication. 11/07/06). There are many kinds of leaders in many different settings. Effective leadership is a combination of a particular context and the attributes needed to lead in that context (Gardner, 1990, 39). A great leader draws differently upon the arrows in his or her quiver of knowledge depending upon the situation and is able to be flexible and creative in their use.

I will not try in this report to summarize all of the literature listing leadership competencies, but several examples can help us set the stage as we compare what we have collected from programs in different countries. From their review of the literature, Kanji and Moura E Sa (2001) describe the core competencies for leadership excellence as

- Ethics and principles
- Communication,
- Customer orientation,
- Organizational change
- Structures and systems
- Measurement, evaluation, and reporting
- Process improvement
- Team development
- Developing subordinates
- Developing partnerships
- Innovation and continuous learning.

Dering (1998) considers these to be

- Vision and purpose
- Customer
- Organizational, change
- Measurement, evaluation, and reporting
- Process improvement
- Developing subordinates
- Team development
- Meetings effectiveness, and
- Innovation.

Martin (2005, 6) interviewed 31 leaders and found that the key leadership skills "today" were
1. Interpersonal openness/relationship building
2. Commitment
3. Demonstrated knowledge (technical skills)
4. Organization skills (project and time management)
5. Persuasion/negotiation
6. Patience
7. Confidence
8. Decisiveness
9. Ethics/integrity, and
10. Positive attitude/optimism.

Predicted future trends did not greatly vary. Openness was closely followed by organizational skills. There was a rise in the skills of communication, delegation, and visionary.

In a 2007 online Center for Creative Leadership survey of 1,131 people, 76 percent of respondents believed that leadership had changed over the past five years, 91 percent felt that the challenges they face are increasingly complex, and more than 40 percent said that their organizations had faced a complex challenge for two years or more, showing that challenges are either resisting solutions or morphing into new challenges. Forty-nine percent of respondents (and 97 percent of senior leaders) said that collaboration was the top skill needed for the future, but only 30 percent believed that their leaders were skilled collaborators. Other critical skills for the future were change leadership (38%), building effective teams (33%), influence without authority (33%), driving innovation (29%), coaching (26%), building and mending relationships (25%), and adaptability (25%) (Martin, 2007).

Mau (2009) compared the core leadership competencies for senior public service employees in the Ontario Canada Leader-Manager Competency Model, the Canadian Federal Competencies Model, the Australian Senior Executive Leadership Capability Framework, and the United States Executive Core Qualifications and found them to be very similar. All had an area of transformation/ strategic thinking/leading change, one included "connects/engagement/cultivates working relationships/building coalitions," another of "delivers/management excellence/achieves results", and a fourth of "inspires/values and ethics/personal integrity/leading people." Effective communication, business acumen, and continual learning were also present in some.

Koh and McCormack (2006; also described in Debuono, Gonzalez, and Rosenbaum, 2007) outline seven elements or competencies of public health leadership, a model known as the "servant leader":

1. The Ability to Acknowledge the Unfamiliar and the Ambiguous
2. The Ability to Cultivate the Higher Value of Interdependence
3. The Ability to Recognize Crisis Leadership as an /Evolving Part of Public Health
4. An Understanding of the "Public" Part of Public Health Leadership
5. Sensitivity to and Respect for the Community
6. The Capacity to Nurture the Spirit
7. The Ability to Hone Succinct and Concrete Communication.

After a two year study, the Association of Schools of Public Health, identified core competencies for the master of public health degree in public health programs including the areas of health policy and

management and those for communication and informatics (*www.asph.org*). Those for Leadership ("the ability to create and communicate a shared vision for a changing future, champion solutions to organizational and community challenges, and energize commitment to change") are:

- Describe the attributes of leadership in public health
- Describe alternative strategies for collaboration and partnership among organizations focused on public health goals
- Articulate an achievable mission, set of core values, and vision
- Engage in dialogue and learning from others to advance public health goals
- Demonstrate team building, negotiation, and conflict management goals
- Demonstrate transparency, integrity, and honesty in all actions
- Use collaborative methods for achieving organizational and community health goals
- Apply social justice and human rights principles when addressing community needs
- Develop strategies to motivate others for collaborative problem solving, decision making, and evaluation (Calhoun, Ramiah, Weist, and Shortell, 2008).

Debuono, Gonzalez, and Rosenbaum (2007) describe eighteen national and local cases of successful public health individuals and organizations. They all share three basic qualities: vision, commitment, and thoughtfulness.

The above distinctions are important to more fully understand what leadership is and are worthy of continuing discussion and debate (see for example the ongoing debate in **Leadership Quarterly** (Hollenbeck, McCall, Silzer, 2006). This paper has a more "pracademic" purpose: to understand the elements that are needed as we train the next generation of mental health and health leaders. Therefore, I define "competencies" in a very broad way, including the variety of these skills and attributes. I acknowledge and respect the different definitions used in the many programs that we have found.

I agree with those who believe that transactional and transformative qualities are both needed in a competent leader, as are both leadership and management skills if one defines them differently. Any leader's style is some mix of the two. Great leaders are either strong in both and/or surround themselves with peers who as a group have these attributes. Thus, leadership training programs need to support both sets of skills and, as we shall see, often do.

I also respect the concerns of some that while competencies can define observable skills, knowledge, and behaviors, they may not be able to define the critical attitudes and values that underlie these and which form an important part of effective leadership (Christina Pond, Personal communications, 11/19/06; 1/23/07). For example, Goleman (1998, 2000) believes that emotional intelligence (self-awareness, self-regulation, motivation, empathy, and social skills) makes a good leader. Hernez-Broome and Hughes (2004) argue that the affective quality of the leader's relationships with others, as well as how people think about themselves and critical reflection about how one re-evaluates many aspects of one's life (self-directed change and growth) are critical and many leadership training programs now reflect this personal and interpersonal emphasis.

Gardner (1990, 39) takes a very broad view of what good leadership is and lists the following dimensions of what it takes to be a good leader:

- Attributes
    - > Physical vitality and stamina
    - > Intelligence and judgment in action
    - > Willingness (Eagerness) to accept responsibilities
    - > Task competence
    - > Understanding of followers (constituents) and their needs
    - > Skill in dealing with people
    - > Need to achieve
    - > Capacity to motivate
    - > Capacity to win and hold trust
    - > Capacity to manage, decide, set priorities
    - > Confidence
    - > Ascendance, Dominance, Assertiveness

> Adaptability, flexibility of approach

- Moral Dimension
  > The release of human possibilities
  > Dependence of individual and group
  > Law, custom, belief
  > Individual initiative and responsibility

- Communication
  > Knitting together
  > Networking
  > Coalition building
  > Compromise

- Community
  > Wholeness incorporating diversity
  > Shared culture
  > Good internal communication
  > Caring, trust, and teamwork
  > Group maintenance and government
  > Participation and sharing of leadership tasks
  > Development of young people
  > Links with outside world

- Skills
  > Agreement building
  > Networking
  > Exercising non-jurisdictional power
  > Institution building
  > Flexibility

- Renewing oneself and one's organization.

I believe that training programs can help leaders to better understand beliefs as well as particular competencies and that an important component of training is to facilitate greater self-awareness including that of one's values.

LEADERSHIP DEVELOPMENT METHODS. This report's focus is not on how to best train leaders. A full discussion of the most effective teaching methods is well beyond its already large scope. Throughout the literature review and program descriptions, critical points are made about effective teaching approaches as well as ones that do not work well. One of the most comprehensive reviews of mental health workforce competencies is the report and three edited editions of Administration and Policy in Mental Health by members of the Annapolis Coalition (Annapolis Coalition, a, b, c; Hoge and Morris 202 and 2004; Hoge, Morris, and Paris, 2005). These papers do not look specifically at leadership competencies. But they do provide a harsh critique of current academic and continuing education in the mental health field. They argue that many programs do not teach appropriate content. Nor are they taught in ways that people can effectively learn.

Six trends will have a major role in the future in leadership development (Hernez-Broome and Hughes, 2004, 29):

1. Leadership competencies will still matter;
2. Globalization/internationalization of leadership concepts, constructs, and development methods;
3. The role of technology;
4. Increasing interest in the integrity and character of leaders;
5. Pressure to demonstrate return on investment;
6. New ways of thinking about the nature of leadership and leadership development.

In the past, leadership training often focused on a limited group of senior or emerging leaders. The programs

described in this paper work with leaders and managers at all levels of organizations. They utilize a growing variety of leadership development methods.

Classroom training is still the dominant mode of teaching but increasingly it is complemented by or supplemented by other activities when they are linked to or embedded in a person's ongoing work and when they are an integrated set of experiences. Coaching, mentoring, action learning in which real time problems are addressed, 360-degree feedback, and team activities are among the common methods being used to integrate the competency and whole person approaches. They are ongoing and not a single program or event (Hernez-Broome and Hughes, 2004). "People cannot simply be told what they need to know in the complexity of practice. They must learn to see for themselves" (Donald Schon, Educating the Reflective Practitioner, in Parks, 2005, 5). Effective leadership training must incorporate aspects of all approaches – personal growth experiences, awareness building, conceptual development, feedback, and skill building (Conger, 1992).

Bolden (2006) among others raises the concern about whether leadership training really has any real impact. He argues that leadership is a process and training fails if just a small group of individuals are taught in isolation from organizational culture, context, objectives, and other factors. Many of the programs described in this paper do take such an integrated approach.

LEADERSHIP PROGRAMS AND COMPETENCIES IN THE COUNTRIES

Descriptions of leadership programs that I have identified in the IIMHL countries follow. My focus is primarily on mental health and secondarily on health training. In addition, because I am finding that many core competencies are universal (see the section, "Comparison of Leadership Competencies"), I include more generic leadership training programs as well, although the listings for these are not as complete.

AUSTRALIA. Australia is a Federation, with differing responsibilities for the delivery of mental health care at National and State levels. Consequently workforce leadership issues have been tackled at different jurisdictional levels.

Nationally, the Australian Mental Health Workforce Advisory Committee (NMHWAC) *(http://www.health. nsw.gov.au/amwac/ahwoc/mhwac_refer.html)* is responsible for coordinating national mental health workforce activities, facilitating information sharing and providing expert advice on workforce related issues. NMHWAC is responsible for the implementation of the National Practice Standards for the Mental Health Workforce *(http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-pubs-n-workstds)* that articulates the key knowledge skills and attitudes of the mental health workforce. Standard 9 requires mental health professionals to demonstrate skills in the planning, development, implementation, evaluation and management of mental health services. Skills such as strategic planning change management, ability to use continuous improvement systems etc. are described with the standard. The standards are widely used in curriculum development and continuing education programs. NMHWAC is currently undertaking a project to explore their implementation in acute inpatient settings. Mental health has also been identified as an important issue by the recent Productivity Commission *(http://www.pc.gov.au)*.

The NSW Institute of Psychiatry (2007; *www.nswiop.nsw.edu.au*) runs a wide variety of mental health clinical and management training programs including Management and Leadership Skills in Mental Health Services Levels I and II. Topics include becoming a manager, organizational theory, leadership in health, health policy, learning management and leadership skills, strategic planning, management of change, clinical governance, and health economics.

The School of Population Health Centre for International Mental Health at the University of Melbourne *(www.cimh.unimelb.edu.au)* offered a successful pilot of the Australian Mental Health Leadership Program (ausMHLP), in 2005-2006, continued it in 2006-2007, and offered it in 2008. It is aimed at Australian senior trainee and early career psychiatrists interested in making a contribution to mental health policy and system development. It is a nine month part-time programme provided through a series of four intensive three day residential seminars. It includes

- Formal structured teaching of theory and research on leadership, management, and organizational development
- Structured discussion of reading materials
- Informal discussions with Australian mental health leaders
- Practical workshops focused on project work
- Assessment using the 360º Leadership Questionnaire, and
- A two day national conference.

The International Mental Health Leadership program *(http://www.cimh.unimelb.edu.au/mimh/)*, now in its seventh year, is a joint initiative of the Centre and the Department of Social Medicine, Harvard Medical School. It has over 100 graduates in 18 countries. The IMHLP includes

- intensive two week seminars on global mental health, policy development, services design and evaluation, and mental health systems research and project design
- Self-directed learning using CD-ROM and on-line learning
- Supervision of project work
- Mentoring by senior colleagues in the participant's own countries,
- Continuing peer support, and
- Regional meetings, workshops, seminars, and conferences, and the International Mental Health Development conference.

The Centre also offers a Master of International Mental Health that includes courses in mental health policy development and mental health services design.

Victoria has established three mental health education and training clusters to support collaboration between mental health services. At least one cluster has developed a leadership training program which brought together senior clinical leaders for half a day per week for 20 weeks. Based on a generic health leadership course, the program contextualized key leadership principles such as emotional intelligence, motivation, change management etc. into a mental health context.

The South Australian Health Commission (Sutton, F. and Crabtree, A., January 1997) offers a six month clinical leadership program for mental health nurses. The Management Theory and Practice unit includes models of management theory and processes, traditional and modern theories of organization and their relevance to nursing and mental health care, the changes in mental health care in South Australia and implications. The Leadership Theory and Practice unit includes leadership theory and styles, leadership skills, decision making theory and practice, and problem solving models and practice. The Management and Leadership Process and Application unit covers human resource management (staff requirements, teams, people skills, and evaluation) and work practices and context (legal, community based practice, quality management).

The Royal Brisbane Hospital has a Senior Registrar in Administrative Psychiatry available each year for a senior trainee to experience the day to day issues faced by mental health leaders. It has been running for six years and half of the trainees completed either Postgraduate Certificates or Masters degrees in Health Administration after their degree.

The Queensland Workplace Culture and Leadership Centre provides core leadership development targeted to the needs of clinical and non-clinical executives and emerging leaders, managers, indigenous leaders, and supervisors. Its framework includes workshops and meetings, individual and team exercises, feedback and diagnostic/assessment tools, and coaching.

A number of Australian business and public administration schools offer leadership degrees, courses, and training programs. Among these are

- The Australian School of Business: Leadership Pathways for executive leaders, middle managers, and general managers
- Melbourne Graduate School of Management
- The Australian and New Zealand School of Government (ANZSOG).

CANADA. Most Canadian leadership training offerings are not specifically targeted at mental health and addiction services and most mental health people do not know about them.

The Canadian Health Leadership Network (CHLNet) *(www.chlnet.ca)* is a coalition of emerging and senior leaders that "aims to identify, develop, support, and celebrate leaders throughout the leadership continuum and transcending all health professions," and "to address the imminent leadership shortage by focusing on the lifecycle of leadership." It is a network that delivers "central access to an array of health leadership development research, tools, and dialogue" in both virtual and real time. Its members include academic health sciences centers and universities and colleges, regional health authorities, local health integration networks, hospitals and other delivery organizations, provincial and Federal health ministries, national health organizations, and Canadian health charities. Its core values and beliefs are Leadership, Professionalism, Excellence, Value based, collaboration, Responsiveness, Life long learning, and succession. It is a model for what needs to be done in each country, and its concept paper of November 2007 is a useful guide for doing so.

Initiated in 2006 by an ad-hoc "coalition of the willing" healthcare leaders, in May 2007, 100 health system leaders met at the CHLNet Summit to discuss ways that CHLNet could enhance healthcare leadership. It is developing a central health leadership development resource center or portal (eCLHCNet) and hosting research roundtables and forums. Another priority was to develop a Pan-Canadian Health Leadership Capabilities Framework that builds on existing models throughout Canada.

The Canadian Health Services Research Foundation *(www.chsrf.ca)* promotes and funds management

and policy research in health services and nursing. A priority research theme is workforce and the workforce environment including leadership. CHSRF commissioned a group of researchers from the Centre for Health Leadership and Research at Royal Road University in British Columbia to conduct the necessary research and develop the framework. The report of this work is available from CHSRF.

The HealthCare Leaders' Association of British Columbia *(www.hclabc.bc.ca)* is a professional association that sponsors an annual Leadership Conference each October.

Leaders for Life *(www.leadersforlife.ca)*, affiliated with HCLABC, is an individualized, focused, accelerated leadership enhancement initiative for the BC system. Current learning opportunities include self assessment of leadership capability and 360 degree assessment based on the LEADS framework (see below), an individualized personal learning plan, custom career planning assistance, one on one coaching, mentoring, credit and non-credit courses, online learning, action learning projects, work experience outside the usual workplace, and exposure to international health systems.

The LEADS framework was created by Leaders for Life in 2006. According to the LEADS framework, effective leaders in the 21st century are able to

1. Lead Self (are self aware, manage themselves, develop themselves, and demonstrate character)
2. Engage Others (foster the development of others, communicate effectively, create engaging environments and healthy organizations, build teams)
3. Achieve Results (set direction and inspire vision, align decisions with vision, values, and evidence, take action to implement decisions, and assess and evaluate outcomes)
4. Develop Coalitions (build partnerships and networks, be committed to customers and service, mobilize knowledge, and navigate socio-political environments)
5. Systems Transformation (demonstrate systems/critical thinking, encourage and support innovation, are strategically oriented to the future, and champion and orchestrate change).

Royal Roads' work was based on the LEADS project as well as a health leadership symposium, literature review, comparative analysis of health leadership competency frameworks, and leadership interviews and focus groups. Its four main assumptions, two of which may challenge some of the discussion in the early part of this report, are

1. Leadership is different from management.
2. Effective leadership is best defined as capabilities, not competencies.
3. Effective leadership can be defined and deliberately developed.
4. The capabilities framework is intended to have a practical impact on the leadership gap.

The framework continues to emerge and evolve.

On September 10-12, 2008, the 1st annual CHLNet symposium, Leadership in Motion: Changing Systems, Creating Results, was held in Quebec. Part I, Senior Leadership in Action, covered Leadership that Creates Results and Issues and Insights: Building a Leadership Toolbox. Part II was on Attraction and Retention: What Works and What Doesn't and Mentoring for Results. After the annual general meeting of CHLNet, Part IV was on Changing Systems to Create Results and Individual Learning Contracts.

 "EXTRA/FORCES (Executive Training for Research Application Formation) *(http://www.cche.net/projects/ extra.asp; http://www.chsrf.ca/extra*; Goering, 2006) sponsored by the Canadian Health Services Research Foundation, is a two year fellowship program designed to train health service leaders to become even better decision makers by learning how to find, assess, and interpret research-based evidence. The program, which has several partners, encourages leaders within Canada's health system – nurse, physician, and health administration executives – to find and apply research in their day-to-day work, facilitate evidence-based decision-making, and participate in executive development activities. It is a useful case study on different leadership skills needed for one particular application. Its modules are:

- Module 1: Promote use of research-based evidence in healthcare organizations. Strategies to promote its use, political factors, strategies for managing politics and policy, nature of evidence and use in organizational decision making.

- Module 2: Demystifying the research world, evidence based practices

- Module 3: Becoming a leader. Leadership issues, personal capabilities, issues of inter-professional collaboration, communication and diplomacy skills.

- Module 4: Using research-based evidence to create and manage change. Influence of organizational cultures and politics on design and application of research and evidence. Incentives use. Communities of practice.

- Module 5: Sustaining change in an organizational context.

- Module 6: Building a community of practice

A health management and leadership program is offered by the McGill Management School *(www.McGill.ca/imhl)*. It is modeled on the international program in practicing management developed by Henry Mintzberg at INSEAD in France. Also the University of Toronto and Queens offer Masters Programs in Health Administration and Royal Roads University in Victoria BC offers a masters in leadership. All of these programs cost at least $40,000, and there are no subsidies available, so many leaders in the community sector would be unable to participate, unless they could arrange private financing. Also given the pressure on hospital budgets, there is likely not much support for this type of education even in the institutional sector. Athabasca University offers a distance education MBA which some colleagues in health care have taken. A number of business schools such as Schulich (York University, Toronto) have partnered with NGO organizations such as United Way and foundations to offer subsidized leadership and management training programs (non degree) to the NGO sector. These programs are not targeted at health or mental health but are available to people working in the NGO sector. (Steve Lurie, 2/1/07).

The Canadian Management Centre, an affiliate of the American Management Association *(http://www.cmctraining.org)*, offers a variety of leadership seminars including Advanced Leadership Communication Strategies, Moving from an Operational Manager to a Strategic Leader, Developing Executive Leadership, Advanced Executive Leadership Program, Leadership Through People Skills, Leading with Emotional Intelligence, Coaching, Leadership and Team Development, and Leading Innovation.

The Niagara Institute *(www.niagarainstitute.com)*, a private non-profit foundation established in 1971 which became part of the Conference Board of Canada in 1994 offers a wide variety of leadership training programs, customized leadership development and certified executive coaching to government and non-governmental organizations and business. Among them are the Leadership Development Program (LDP), Executive Leadership Program, Building Leadership Essentials, Leading Through Change, and leadership programs in French. The LDP is a five day program that covers leveraging differences, understanding ethics and culture, valuing diversity, being adaptable, leading change, and fostering global awareness. It includes personal assessments, one on one coaching, and follow-up 360 assessment and feedback.

The Canada School of Public Service (*www.myschool-monecole.gc.ca*) offers leadership development programs exclusively for people working in the Federal public service including those at Health Canada and the Public Health Agency of Canada. Among their programs are the Management Trainee Program (MTP), Direxion (CAP Educational Component), Accelerated Executive Development Program (AEXDP) for executives with the capacity to become Assistant Deputy Ministers, Living Leadership: The Executive Excellence Program, an advanced strategic comprehensive leadership program, and the Government of Canada Financial Management Certificate.

At least two Canadian universities have graduate leadership degrees. The University of Guelph offers an intensive MA Leadership degree. It is a two-year program that incorporates two intensive residential courses with six online courses, each structured on the basis of eight week modules, a major research paper and a final residential component that is dedicated to having the student present the results of their MRPs. The University of Guelph has also just received authorization from the provincial government (first cohort is to be Fall 2009) to offer a PhD in Management; one of the specializations in that doctoral program will be Organizational Leadership *(www.uoguelph.ca/cme/phd-management.shtml)*.

Royal Roads University's Centre for Health Leadership and Research has a Graduate Certificate in Health Systems Leadership. Its Centre for Applied Leadership and Management has a variety of custom leadership development programs, a Developing Leadership Impact Executive Retreat and five graduate certificates

certificates in Executive Coaching, Health Systems Leadership, Project Management, Public Relations Management, and Strategic Human Resources Management. An MA in Leadership with a specialization in Health, an MBA in Executive Management with a specialization in leadership, and many continuing education course offerings are available through Roads' School of Leadership Studies. A Strategic Leadership in the Public Sector and an E-Master of Arts in Leadership and Training are among the university's other leadership offerings. Mental health staff have also attended management and leadership training courses at Queens, Rotman, and Schulich.

NEW ZEALAND. The Blueprint programme is the only training programme for mental health and addiction leaders in New Zealand. The unique characteristics of the programme are the approach of training consumer leaders, managers and clinical leaders in the one programme, hence modeling the work being done in the sector. The programme is run under the umbrella of Te Pou – the national mental health workforce and research centre for New Zealand – *www.tepou.co.nz*, and Blueprint has a corporate partnership with Waikato University to deliver papers for the programme. The partnership with the University means that programme participants also secure academic credits and after completing the 2 year programme will have a PGCertMgtSt, as well as the sector specific leadership experience/learning.

The Leadership and Management Programme ELMP is a complete programme and is delivered over a 12 month period. On successful completion of the ELMP programme participants can apply to do the Advanced ELMP (another 12 months). This builds on the ELMP networks and provides the opportunities for enhanced sector specific learning. There is significant emphasis in both the ELMP and AELMP on participation, application and accountability. The programme is delivered through Training Days, Learning Sets and self directed learning tasks.

The content of the programmes cover:

ELMP – Year 1	AELMP – Year 2
Leadership and Management Models and tools (Skillscope)	Self Awareness and Goal Application (MBTI and FiroB)
Personal Style	Culture and Leadership
Creating an Ethical Environment	Political Awareness in action
Creativity and Innovation	Change Management
Using Data Strategically	Health Budgeting
Communication and Media Management	Managing for Results
Human Resource Management	Reflective Leadership
Social Inclusion – Working across the system	Managing for Outcomes

The Programme works to a matrix delivery model and throughout the training facilitators and participants are asked to consider the following key perspectives:
- Consumer
- Clinical
- Cultural
- Service and Organisational
- Family/Whanau and Community.

Consumer perspectives	• Meaningful consultation "our customers are not with us by choice but by circumstance" • Active participation with Service Users and Whanau • Responsiveness to consumer needs
Cultural perspectives	• Drivers as a Maori/PI manager • Multiple accountabilities • Community relationships • Processes
Clinical perspectives	• Best practice • Evaluation of Services • Inclusion of MDT perspectives • Differing clinical philosophies (in absence of clinical evidence)
Service and Organisational perspectives	• Uniqueness of 'your' service, vision, goals, values, priorities • Drivers for decision making • Understanding your own organisation including key players, key drivers etc • Future direction
Family/Whanau and Community perspectives	• Meaningful and active participation • Planning participation and consultation with Community and Whanau

Based on the Cambridgeshire and Peterborough Management and Leadership programme in the UK, the programme focuses on the following eight core competencies:

- Building Vision and Purpose
- Motivating and Inspiring Others
- Decision Making
- Realizing Talent
- Responsiveness and Flexibility
- Personal Integrity
- Innovation and Creativity
- Managing Relationships.

Te Pou is also now developing a leadership programme for mental health funders and planners. This will be a specialist programme looking at leadership development requirements of people who are involved in contracting, funding and planning mental health services for district health boards and the non-government organizations in New Zealand. It is anticipated this programme will commence in 2007. For more information on the leadership programme content, go to either the Blueprint or Te Pou website.

In relation to work being done on leadership competencies – this work will be combined with work being done on development of a mental health and addiction competency framework – the project is being lead by the Ministry of Health and is called "Lets Get Real" – real skills for people working in mental health and addictions. As well as core competencies (knowledge, skills and attitudes)for all staff who work in services, the framework will include specialist competencies for profession and specialist groups. Leadership competencies will be threaded throughout the Real Skills framework. More information is available on the Ministry of Health website *http://www.moh.govt.nz/moh.nsf/indexmh/letsgetrea*

New Zealand is training its mental health clinicians and leaders using a recovery orientation and competencies. Recovery Competencies for New Zealand Mental Health Workers (Mental Health Commission, 2001) says that a competent mental health worker understands recovery principles and experiences, supports the personal resourcefulness of persons with mental illnesses, understands and supports diverse views on mental illness, communicates respectfully and develops good relationships with service users, protects

users' rights, understands discrimination and social exclusion, acknowledges different cultures, has knowledge of community services and resources and encourages users to use them, supports the service user movement, and supports families.

The Health Research Council of New Zealand (July 2005) describes the competencies of mental health consumer advisors as

- Personal Attributes: experience (in mental illness, service experience, recovery, self-awareness), convictions (passion, belief in recovery), ethics (personal and professional integrity), nature (resilient, empathetic, sense of humour, honest). and approach (assertive, motivated, collegial, open-minded)

- Knowledge: Consumer advisor role, the Treaty of Waitangi, the health sector and standards, models of health, illness, and treatment, the consumer movement, recovery, community awareness and alliances, and legislation

- Skills: management (leadership, project management, conflict resolution), personal (professionalism, self management, ethics), professional (systemic advocacy, organizational vision and strategies, continuous quality improvement, evaluation, learning presentations, interviewing, facilitation), communication (written, verbal interpersonal skills, networking), and organizational (administration, information technology, drivers license).

There are a number of non-mental health leadership and management programmes that are available in New Zealand. The 2007 National Health Leadership Programme: Leading Performance Improvement run by R.H. Penny Ltd. (*www.rhpennyltd.com*) designed to transform and develop the practices of middle to senior level health care managers and professionals and clinicians is three, three day modules delivered over five months. It is based on the transformation model of the Institute of Health Improvement in Boston, MA (www.ihi.org) that shows that exemplary leaders use leadership which
- is based on self awareness,
- inspires a shared vision that moves across service boundaries and shares a community of interest with patients and providers,
- leads and manages productive change in community, organizational, and group performance improvement based on patient-centered promises, influences subordinates and peers to act and improve performance, and
- encourages a healthy organizational culture.

Developing leadership is a partnership approach that brings together self awareness of participants (the bottom half of Figure 5) with formal and didactic learning experiences (the top half):

Figure 5: Developing Leadership & Performance Improvement in Healthcare: A Partnership Approach
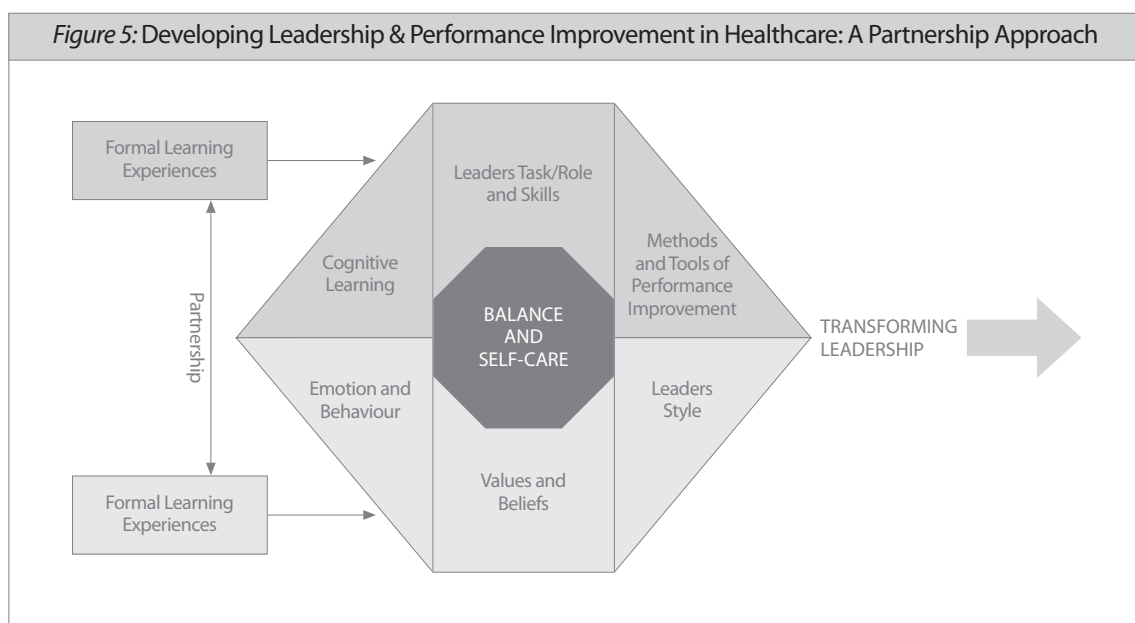
Covered topics include understanding one's own leadership and personal style, values, and beliefs, the leader and improving performance, building effective teams, concepts of change and systems thinking and change management, mobilizing support, and tools and methodologies to prevent waste.

District Health Boards New Zealand is an umbrella organization for the 21 District Health Boards. They have a leadership programme for new and emerging leaders in the health sector. DHBNZ have developed a set of leadership competencies attached to their programme (see attached). For more information on the Leadership and Management Programmes (LAMP) see the DHBNZ website *www.dhbnz.org.nz*

Competencies under LAMP include:

Competency	Element
Demonstrating personal insight	Self awareness, mature confidence, resilience, adaptability
Models organisation values	Leads by example, ethical, earns respect
Values Diversity	Recognizes individual differences, demonstrates interpersonal and cultural sensitivity, upholds The Treaty of Waitangi
Creates a shared vision	Thinks strategically, envision the future, enlist others to the vision
Makes decisions	Demonstrates insight into key issues, understands the nature of the health sector analyses and solves problems, focuses on effective action
Inspires commitment	Motivates others, builds relationships, communicates with influence
Gets things done	Provides direction, sets demanding goals, delivers on commitments, tackles performance issues, recognizes contributions and celebrates successes
Finds better ways	Implements effective systems and processes, demonstrates innovation, removes barriers
Develops self and others	Coaches and develops others, focuses on personal learning and growth, stimulates learning and manages knowledge

The Leadership Development Centre (LDC) *(www.ldc.govt.nz)* is a programme set up specifically for those leaders who work in the government sector including government ministries, police and other state sector organizations. The programme includes training, sector workshop, mentoring and development content. Their website is a gateway site for leadership with links to other leadership programmes including ANZSOG, The Australia and New Zealand School of Government, IPANZ, The Institute of Public Administration New Zealand, and Leadership New Zealand which offers seminars and clinics. LDC offers Leadership in Practice, a comprehensive nine month programme concentrating on putting personal leadership and leadership knowledge into action, the Executive Leadership Programme aimed at preparing public sector senior managers for future leadership roles, as well as clinics, workshops, master classes, and Chief Executive "armchair forums."

Several of their publications are particularly useful. After defining competencies (see our "Introduction"), Competencies and Competence: What Are They and What Part Do They Play (Mackay, 1997) gives an example of a Competency Dictionary for a Service Organisation. It includes

- Core Competencies (customer service, interpersonal skills, achievement orientation, and commercial acumen)
- Management Competencies
- Managing Business (knowledge of the business, financial management, information management, managing change, marketing, planning, project contract management, and quality management)
- Managing People and Relationships: Human Resourcing (managing and developing people's performance, leadership, teamwork, managing conflict, negotiation, networking)

- Managing Staff (analytical thinking, conceptual thinking, judgment, autonomy and accountability, flexibility, innovation, and personal effectiveness).

The Management Development Centre was established in 1995 as a centre for the promotion of excellence in the education, training, and development of public service leaders and senior managers. One of its first projects, New Zealand Public Service Senior Executive (Management) Competencies (Management Development Centre, March 1997), was developed based on extensive research, in collaboration with many managers, and describes generic competencies for chief executives. The competencies are "based on the highest level of responsibility and span of control contained within the role," are "targeted at high performance," are written aspirationally and are readable, and are "practical, customer focused, and interesting." The model includes identification of values and aspects of personality alongside behaviour, skills, and knowledge (Figure 6). While all of the competencies are viewed as essential for exceptional performance, they appear in order of their relative importance to the role of a senior executive (manager).

Figure 6: Competency Architecture
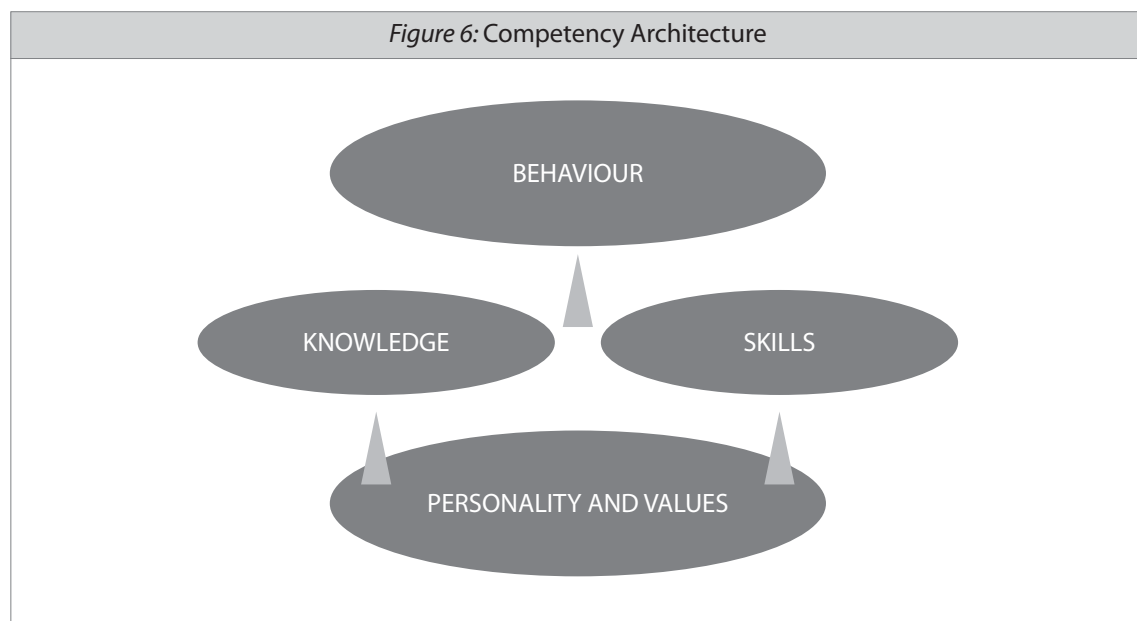
The capabilities (described in much more detail and length in the report with signs and signals of the "exceptional executive" and "below par") are:

1. Strategic Capability: strategic thinking, aligning business processes, positioning the organization for the future
2. Relationship Management: managing the political interface, stakeholder management, effective networking, management team working including listening and negotiating
3. Management Values: integrity, courage, competence, responsibility
4. Action and Outcome Orientation: focus on delivering results, decisiveness, perseverance and follow through
5. Resource Management: people and performance management, organisational management (finance and budget, human resources, management information systems, organizational metrics and measurements, policy development processes and service delivery, lead critical tasks)
6. Organisational Development: culture shaper, innovation and change management
7. Applied Intellect: incisive thinking and problem solving, judgment.

Many other organizations and universities run leadership and business development programmes in New Zealand. The major universities all have business management and/or executive programmes, and there are a number of smaller organizations that cater for smaller groups. One such programme is Navigate who run a leadership and management programme which have smaller numbers but ability to focus on individual needs. The programme looks at individual strengths and areas of development with strong emphasis on self awareness and developing tools and techniques for positive leadership. Navigate offers a two day Leadership Development Programme for specialists and thought leaders at

senior levels, a five day Leadership and Management Development Programme, and many short events, as well as providing organizational and leadership consulting. More information can be sought via the navigate website: *www.navigate.co.nz*

A number of District Health Boards have also embarked on internal leadership development programmes aimed at clinical leaders developing their knowledge of management.

SCOTLAND. Scotland's National Mental Health Leadership Plan supports leadership development including participation in IIMHL. Scotland recognizes the need to develop both leadership and management with both users and carers at all levels of managers in multi-disciplinary, multi-sector, and multi-organisational ways (Van Zwanenberg, April 2006). Its 2003 health white paper, *Partnership for Care*, included a commitment to leadership development. In May 2005, the Scottish Executive Health Department launched the NHS Scotland Leadership Development Framework, *Delivery Through Leadership*, which was accompanied by the *Leadership Development Plan* – 2005-2007 which details the actions required for practical implementation (NHSScotland, April 2004; NHSScotland, May 2005). A priority within the plan is to develop current leaders and teams, including a Post Graduate Certificate, Learning to Lead. The NHS Management Training Scheme (NHSScotland, 2006) *(Learning to Lead)* is a two year training for front line NHS staff that leads to a Masters (Post Graduate Certificate) by NHS Education for Scotland (January 2006). It takes a personal development approach:

- Leadership: understanding self, understanding one's impact on others, developing self and others, inspiring others, building relationships and trust, leading change and strategic decision making, influencing, encouraging innovation, understanding and gaining cooperation, managing conflict, setting strategic direction and vision

- Management: managing people and teams, verbal communication skills including negotiation and presentation, financial management, developing new business, project management, information management, organizing, planning, and implementing, risk management, service redesign and performance improvement, managing change, the policy and legal framework

Leading Change in Mental Health Services in Scotland (SLF, 2007) is a leadership development programme funded by the Scottish government rooted in the local mental health systems that will be driving the redesign/improvement work around achieving Delivering for Mental Health. The programme works with teams of up to eight persons on a significant change project within a local NHS Board area. This programme is now running with its second tranche of about eighty people and will run a third tranche in 2009/10. It is the only existing programme that actively seeks to bring all the key stakeholders and partners together.

Delivering the Future is a national programme to develop future strategic clinical leaders in NHS Scotland (NHS Scotland, April 2006). It is funded centrally and is set in the context of *Delivery Through Leadership*. It trains high level clinical leaders, began in January 2006, and was delivered to up to 24 participants over a twelve month period. Its themes are personal qualities (self leadership, leading others, collaborative working), service excellence (delivering excellence through others, managing complex change, improving the patient's experience), future focus (political awareness, strategic dexterity, aligning agenda/creating culture), knowledge and skills, competence with a core of competence, knowledge, and skills. The key challenges facing clinical leaders and the descriptors of leadership qualities are contained in Appendix 1.

Developing a Frontline Management and Leadership Programme for NHS Scotland (NHS Education for Scotland, January 2006) was a workshops/scoping activity. The NHS contacted 23 Scottish Health Boards about their leadership training programmes. Twenty-two submitted details. The most frequently cited accredited programmes were Professional Certificate in Management and Clinical Leadership Programme including Rural model (7 Boards), Introductory Certificate in Management (6), Masters Degree in Business Management (4), and Full Certificate in Management (2). The report concluded that while many leadership and management training programs were being developed in Scotland, there were no "products of choice." From this survey NES defined the most important elements of such a programme as

- Skills
  - > Communication skills including listening
  - > Coaching and mentoring
  - > Financial including budget management

- > Generic management skills
- > Human resources including appraisal training
- > Mentoring and coaching
- > Problem solving, partnership working
- > Finance

- Knowledge
  - > Managing and leading change
  - > Models and theories of leadership and management
  - > Creativity and innovation, decision making, empowering people, building trust, managing conflict
  - > Finance
  - > Policies
  - > Managing service improvements
  - > Managing patient care
  - > Performance management
  - > Managing and leading change

- Attitudes
  - > Personal development
  - > Problem solving
  - > Emotional intelligence

- Behaviors
  - > Competent
  - > Confidence
  - > Self-awareness
  - > Team working.

Founded in 2001, the Scottish Leadership Foundation (SLF, 2007) was a membership-based organisation that worked with the National Health Service and many other groups to support leadership development. Sadly, on 18 August, 2008, the Foundation closed its doors as expected business did not materialize. (Van Zwanenberg, 8/13/2008).

> With the closure of SLF, it is really hard to think of one agency that has the brief for leadership development and training in public services/mental health in Scotland. There will be a range of agencies that people can connect with but they will be disparate. Any agency would need to take cognizance of leaders in the NHS, Social Care, NGO sector, "consumer" and carer orgs and networks and increasingly public health (Gregor Henderson, 12/5/08; Nigel Henderson, 12/16/08)

The Foundation's web site, now closed, was a gateway to many publications and leadership training opportunities in Scotland. They include:

- Change Through People, a four day forum focusing on the people dimension of the change process.
- Leading to Deliver, a major initiative of a leadership development programme targeted to middle managers providing social care or integrated services.
- Smarter Leadership, six morning sessions on Thinking, Feeling, Talking, Working, Growing, and Leading Smarter.
- Collaborative Leadership for Scotland, a postgraduate diploma developed and taught by the Scottish Leadership Foundation and Lancaster University Management School.
- Executive Clinical Leadership Programme, developed by the Scottish Leadership Foundation and The Scottish Association of NHS Medical Directors, a twelve month programme for medical and nursing directors, directors of health, and directors of managed clinical networks.
- Women at the Heart of Leadership Series a variety of single and multiple day support environments for women to develop their leadership capabilities and confidence.
- Mentoring Programme.
- Organisational Raid, a half or full day group learning opportunity where senior managers visit another organization to learn how they manage a particular issue or range of issues.
- People Exchange.

- The SLF Change Forum.
- Great Leadership, Great Culture, Great Performance, a one day event between the Pacific Institute and Lauder College in March 2007.
- Workshops in Leading Change for senior human resource and organizational development specialists, at the University of Glasgow.
- A Post-Graduate Certificate in Clinical Leadership, accredited by Queen Margaret University and run by NHS Lanarkshire.

Having led on the development of *Delivery through Leadership*, Ashleigh Dunn was leading the development of a leadership and management framework for public services across Scotland, on behalf of the Scottish Leadership Foundation (SLF). This work was commissioned by the Scottish Executive. The Framework was to seek to integrate understanding of and provide a model to connect leaders/managers, leadership/management and (sustained) organizational performance (Dunn and Van Zwanenberg, 2006). The customized version of the generic framework that was developed for social care services is being adopted and implemented across the social care field and the ownership of this leadership framework has passed to the Scottish government. I have been unable to find out the current status of the generic framework, though I understand that it is being used informally by some organizations and services. Ashleigh is no longer working in this field.

The RCN Clinical Leadership Programme (CLP) (*www.rcn.org.uk*) is a one year programme that has trained over 2,000 leaders in the past ten years in Scotland, Wales, England, and now Australia. It covers
- Human resources
- Performance management
- Managing diversity
- Emotional intelligence
- Team development
- Negotiating and influencing skills
- Service improvement and redesign
- Understanding the challenge of joint future
- Coaching for success – believing in potential
- Leading and influencing team performance.

UNITED KINGDOM (ENGLAND). A great amount of work on leadership theory, development, and training is taking place in the United Kingdom, with some of it devoted to mental health. The Leading Modernization Programme (LMP) was originally developed by the NHS Leadership Centre, an arm of the Modernization Agency. Paul Plsek, as well as colleagues in the service redesign, notably Helen Bevan, worked with them on the design of the programme (Plsek, 2002). The essence of the programme was to develop leadership skills for service modernization. Catherine Hannaway was initially the project manager. The programme included modernization leads from the Strategic Health Authorities in the first instance and later staff from NHS trusts. The programme only ran for two years. Catherine's work now for Yorkshire is based on the original national programme as well as a survey of leading health and other "thinkers" (Hannaway, 2007; *http://www.yhpho.org.uk/lhip.aspx*). Yorkshire's Leadership for Health Improvement Programme (LHIP) is a one year programme with six events.

The LMP has three intersecting domains: leadership, improvement science, and care delivery systems. The LHIP focuses on the intersection of leadership, improvement skills and knowledge, and health improvement systems. Leadership as described by Hannaway is "the art of getting things done by enabling others to do more than they could or would do otherwise." The LHIP Framework is Appendix 2.

The Modernization Agency, with the Hay Group, also developed the NHS Leadership Qualities Framework (LQF) (Figure 7) and the 360° Assessment. *(http://www.nhsleadershipqualities.nhs.uk/)*. It describes the qualities expected of existing and aspiring leaders. It reflects core NHS values: valuing diversity, focusing on patients, creating a culture in inclusion and involvement of patients and the wider community, empowerment of patients and staff, collaborative working, taking calculated risks, and recognizing that making mistakes or misjudgments is an essential part of learning. The LQF and the Assessment can be used across the NHS to underpin leadership development for individuals, teams, and organizations. The Framework does not relate to the Skills for Health work per se (see below) as it defines values and

attitudes as well as skills rather than competences.

Figure 7: LQF
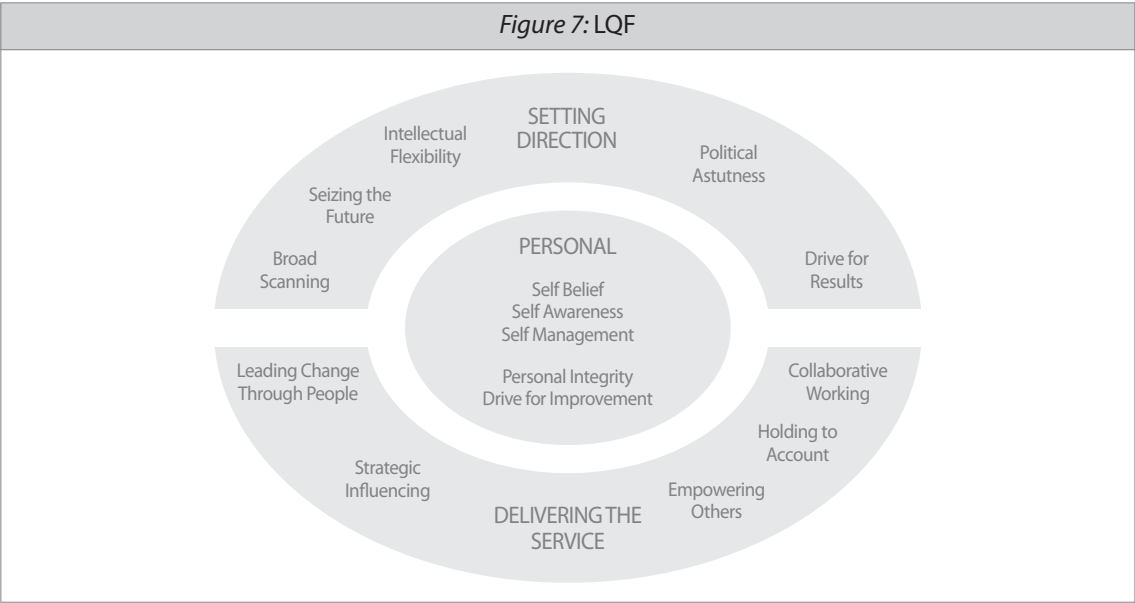
Neither the Modernization Agency or the Leadership Centre exist now. In 2005, the new NHS Institute for Innovation and Improvement was formed, replacing the role of the Modernization Agency as a resource for local leadership development and service improvement for adults, not social care. When they were disestablished, much of their work transferred to the Institute *(www.institute.nhs.uk)*. The Institute has a leadership directorate which focuses on board level development, graduate training schemes, and other activities. The LQF is still used to support this work. Its 2008-2009 Business Plan *(www.institute.nhs.uk/ businessplan)* has a great emphasis on leadership development. Its staff supports two networks of Chief Executives who are committed to improvement (Delivering Through Improvement networks), the Strategic Health Authorities (SSAs), and the Practice Partners Network (PPN), as well as many other groups. They work on medical leadership with the Academy of Medical and Royal Colleges, recruit graduates into graduate schemes and bring leaders into the NHS from other sectors, and plan to launch a Breaking Through programme for managers from black and minority ethnic backgrounds.

The Academy of Medical and Royal Medical Colleges' Enhancing Engagement in Medical Leadership Project *(www.institute.nhs.uk/m/cf; www.institute.nhs.uk/medicalleadership)* after extensive literature reviews, comparative analysis of leadership frameworks, analysis of specialty medical curricula and interviews and consultations beginning in 2006 developed the Medical Leadership Competency Framework that "describes the leadership competencies that doctors (and medical students) need to be more actively involved in the planning, delivery, and transformation of health services." It is a tool to inform the design of training curricula and development programs, highlight individual strengths and development areas, and assist with personal development planning.

Medical Leadership Competency Framework

The five domains and their elements are

Personal Awareness
- Self awareness
- Self management
- Self development
- Acting with integrity

Working with Others
- Developing networks
- Building and maintaining relationships
- Encouraging contribution
- Working with teams

Managing Services
- Planning
- Managing resources
- Managing people
- Managing performance

Improving Services
- Ensuring patient safety
- Critically evaluating
- Encouraging innovation
- Facilitating transformation

Setting Direction
- Identifying the contexts for change
- Applying knowledge and evidence
- Making decisions
- Evaluating impact.

Details on what competent doctors should demonstrate in each of the bullets are in the framework description.

The College developed a Medical Engagement in Leadership Scale, a self assessment tool for organizations to assess the level of engagement within their organization. It was successfully piloted and is now available for the NHS.

The United Kingdom has developed national workforce competencies that are used to define the skills and knowledge required to perform a function and to underpin and inform competence-based workforce planning, skill mix, service redesign, curriculum development, training, and education. When recognized as National Occupational Standards they form the basis of vocational qualifications and awards. They have a UK wide application with sector skills agreements.

Skills for Health, established in April 2002, is the licensed Sector Skills Council for Health, UK wide and sector wide (the Management Standards Centre, 2005; Pond, April 2006; Skills for Health, 2006). It is part of the National Health Service. Its goal is to develop a skilled UK workforce. Skills for Health does not provide training directly. One of its projects is to develop competencies. It has created 96 competencies in mental health. Management Standards were developed in 1997. Management and Leadership Standards were further developed in 2002-2004 including mapping to each other by Skills for Business *(www.management-standards.org)*. The Management Standards Centre *(www.management_standards.org)* published the "Management and Leadership National Occupational Standards (NOS) Best Practice Guide" based on the Management and Leadership National Occupational Standards which were approved in 2004. It defines key outcomes, behaviors, and knowledge required for effective performance at various management levels. The goal is to help put in place performance management systems and organizational development using NOS as a guide. The standards are divided into six areas:

A) Managing self and personal change
B) Providing direction

C) Facilitating change
D) Working with people
E) Using resources, and
F) Achieving results.

Each area contains a number of units. The six groupings and fifty-six functions are listed in Appendix 3. It is one of the most comprehensive listing of leadership competencies that I have found.

In 2005, the Care Services Improvement Partnership (CSIP) emerged as an umbrella organization encompassing service development and improvement agencies for persons with mental health problems and learning difficulties across the age ranges (Onyett, 2006). The principles of these activities include achieving positive improvements rather than just rectifying deficits; clinical leadership "is the quality of the relationship between leader and follower that matters most to performance-relevant attitudes and behaviour (Millward and Bryant 2005 in Onyett, 2006, 5). A system level vision for improvement is needed. Users (consumers) and the people that support them need to be dually involved. Senior leadership must set up effective teams at all levels. Leadership training must be based on what is known to work. Measuring and monitoring and a focus on outcomes are critical. Both process and structure should be addressed.

The CSIP supports a wide variety of national and regional leadership development and support activities. They emphasize the team based nature of their work, work with complex systems, culture, working appreciatively, ambitiously, and respectfully with stakeholders, particularly users, carers (families), and clinicians, working across boundaries, understanding different perspectives, communications, data and information, clarifying needs, objectives, vision, and change, and reflective thinking (Onyett, April 2006).

In January 2007, the Learning for Improvement Network on Leadership and Teamwork Development on the Knowledge Community for CSIP was begun (*http://kc.csip.org.uk/about php?grp=449)*. Its aims are to share and test out new ideas, enhance personal development, support leadership capacity for a range of stakeholders in health and social care, and be a central source for leadership training resources (Onyett, 1/12/07).

A wide variety of service improvement and leadership training programs are offered in England. "The effective teamwork and leadership programme" (ELP) (Onyett, 2002; Onyett and Borrill, 2003) is a seven day action based program for 21 people funded by the Leadership Centre and rolled out by the CSIP Development Centres. It received very positive evaluations from users. Covered topics include:

* listening to users and their supports, different perspectives
* visualizing where want to go
* clarifying values
* team climate, working and meetings
* learning/peer coaching
* action learning
* complex systems and change and service improvement methods
* better verbal communication
* decision making, power, accountability, responsibility, outcomes measurement
* making better use of information, meetings, and
* staying effective, looking after ourselves.

Another important project is the Service User and Carer Development Programme - twelve learning days over a nine month period, accredited by the University of Surrey.

In line with the White Paper, "Our Health, Our Care, Our Say", the "New Ways of Working" Programme and the paper by the National Clinical Director for Primary Care, Dr David Colin-Thome – "Keeping It Personal", the charity Primhe (Primary care mental health and education), in November 2006, launched its Masters (General) Practitioner and Commissioner with a Special Interest in Mental Health (GPwSI MH) Course. (Chris Manning, 3/4/07). This was accomplished with the full support of Prof Louis Appleby (the National Clinical Director for Mental Health) and the Royal College of General Practitioners. Accredited by Staffordshire University, the Course consists of eight modules; the first two are compulsory and crossover. Module 1 is "Mental Health: Facts, Values, and Beliefs," Module 2, based on the NHS Leadership Course and the work

of Jim Kouzes, is "Leadership and Enablement." Other Modules will be "Therapies, Interventions, and Treatments," "Service Redesign," "Research Methods and Critical Analysis," "Mental Health Legislation & Ethics: Consent and Capacity," "Clinical Care: Depression & Anxiety, Bipolar Spectrum Disorder, Psychosis," "Spirituality & Mental Health", "Child & Adolescent Mental Health", "Elders Mental Health" and "Developing a Mentally Healthy Primary Care Team."

All the Modules are grounded in values-based practice and based on recovery principles. Students have considerable opportunity for reflective learning and co-mentorship and full support is given by both the University and the charity throughout the Course.

Primeh's (General) Practitioner with a Special Interest in Mental Health focuses on leadership development. Its Leadership Module and other content are now being used in Primhe's training with the Improving Access to Psychological Therapies Programme primary care leads trainings as well as other trainings for Regional CSIP Development Centres and SHAs including some pharmacists, Third Sector Training (Turning Point), and Mental Health Commissioners.

The Department of Health (DH) agrees with Primhe that PwSI training, especially in mental health, must include the development of leadership, interpersonal, communication and networking skills. Primhe's objective is to have a number of GPwSIs MH emplaced in all NHS localities. Support to pump-prime this initiative has been obtained from key Pharmaceutical Industry partners, Servier, Sanofi-Aventis and Wyeth, working in close conjunction with the Association of the British Pharmaceutical Industry (ABPI).

Other leadership programmes include the

- Senior leadership and management development programme that began in the South East starting in March 2006.
- Learning sets for senior leaders in social care that meets bi-monthly with an annual residential
- Leading Change Networks seminar series
- Leadership programme linked to the Race Equality Programme
- A proposal for whole systems leadership for improvement programme
- Various programmes for commissioner development.

Many regional leadership programmes are offered for mental health, social care, health, criminal justice, older people, children, young families and families, and learning disabilities. In mental health, for example, the North East CSIP offers five leadership programmes on key topics (commissioning, involving people, equality, social inclusion, and new ways of working for psychiatry). The North West supports the user/carer development programme, the ETL, and links to the Delivering Race Equality Programme. The East Midlands has a Performance Development Support Group. London uses an action learning model to work with particular tiers such as middle managers, offers ETL, and has a fast track service improvement programme for a small number of change managers. The Eastern region targets senior managers, a commissioning program, ETL, and a Whole Life Programme that drives a social inclusion and recovery agenda. The West Midlands has a focus on leaders in the voluntary and community sector and links to IIMHL. The South East began the senior leadership and management development programme, widely applies ETL, has the fast track service improvement program, and the user/carer leadership programme (Updated table of CSIP leadership activity and proposals. From Onyett, 1/12/07).

The Nottinghamshire Healthcare NHS Trust (*www.nottinghamshirehealthcare.nhs.uk*) created and implemented the Development for Leaders (D4L) programme. The six general areas of leadership development for Trust managers are:

- Partnership – the need to build more trust between different partners and common goals and greater skills in communicating especially to large groups and the need to develop conflict handling skills.
- Performance Management – the need for greater understanding of change and how to manage it. Enhanced understanding of process working, programme and project management as well as management of performance. Holding people to account and dealing with problems as they arise.
- Team Working – the need to develop teams to resolve issues closest to their origin which requires coaching, support, encouragement and good role models. Use of core competencies to measure progression.

- Broader Thinking – to support integration and understanding of the bigger picture. There is a need for planning skills (strategic, business and resource), increasing commercial awareness and financial understanding, and increased abilities to lead teams.
- Inclusion – issues to do with thinking about how people can start to feel empowered and in control of their roles, teams or departments. The need for greater support for decision making, learning from mistakes and general management skills.
- Raising the Game – need to look at the bigger picture and develop innovative thinking and the use of technological developments that may change the landscape rather than within the boundaries of what has been.

The functional competencies of leaders in this programme are that they:

1. Involve others in building the strategy in order to promote a common sense of purpose for the Trust.
2. Are open-minded and encourage others to put forward their ideas.
3. Have established a view, and are willing to commit to a decision and be held accountable for it.
4. Make a highly professional and credible impact across a wide range of audiences and issues.
5. Foster relationships based on teamwork and mutual trust.
6. Plan their own time to maximize effect, delegating responsibility and authority appropriately.
7. Demonstrate integrity in actions, decisions and relationships.

Much work in England is based on the "Transforming Leadership Questionnaire" ("TLQ") model, now renamed the "Engaging Leadership Questionnaire" ("ELQ"), developed by Alimo-Metcalfe and Alban-Metcalfe (Alban-Metcalfe and Alimo-Metcalfe, 2000; Alimo-Metcalfe and Alban-Metcalfe, 2000a and b; Alban-Metcalfe and Alimo-Metcalfe, 2006; Alimo-Metcalfe, Alban-Metcalfe, Samele, Bradley, & Mariathasen, 2007; Alimo-Metcalfe and Alban-Metcalfe, 2008; Alimo-Metcalfe, Alban-Metcalfe, Bradley, Mariathasen, & Samele, 2008). They conducted a large investigation of leadership (over 3,500 managers and professionals), focusing on "nearby" leadership. From this they developed the Transformational Leadership Questionnaire (360-feedback instrument). It strongly predicts outcomes of reduced stress, increased motivation, and increased motivation to exceed beyond expectations, increased job satisfaction, and satisfaction with leadership style. Their newest endeavor is "The Leadership Culture and Change Inventory" based on their assessment that leadership is the best predictor of an organization's culture.

The key values in this are "showing genuine concern for others, supporting their development, empowering them, encouraging them to question the status quo, the importance of relationships in organizations, and shared vision", in other words "engaging transformational leadership," or what they now refer to as "engaging leadership" (Alban-Metcalfe and Alimo-Metcalfe, 2006, 4; Alimo-Metcalfe & Alban-Metcalfe, 2008).

Their current key leadership dimensions are:

- Personal Qualities and Core Values
  > Being honest and consistent
  > Acting with Integrity

- Engaging Individuals
  > Showing Genuine Concern
  > Enabling
  > Being Accessible
  > Encouraging Change

- Engaging the Organisation
  > Supporting a Developmental Culture
  > Inspiring Others
  > Focusing Team Effort
  > Being Decisive

- Moving Forward Together
  > Building Shared Vision
  > Networking

> Resolving Complex Problems
> Facilitating Change Sensitively

They emphasize the importance of producing evidence to substantiate any proposed model of leadership. Their models have been tested and their validity is supported, including by a three year longitudinal investigation for the Department of Health (with partners at the Sainsbury Center for Mental Health, Kings College, London University) of the impact of their model of engaging leadership on the performance, morale, and well-being of Crisis Resolution Teams in mental health (Alimo-Metcalfe et al, 2007). In this, they distinguished two aspects of leadership: leadership competency and the engaging leader (defined earlier in this paper). They found that leadership quality as defined by their scales of engaging with others, visionary leadership, and engaging with others were positively correlated with staff attitudes to work and their well-being at work. Engaging with others but not visionary leadership or leadership capability was positively related to organisational performance. Also critical to performance were contextual factors such as staff/case ratio and alternatives to inpatient care. When context was controlled for, engaging leadership still predicted unique variance in performance.

Their instrument has been used by The Improvement and Development Agency in their Advanced Leaders Programme for senior managers, with several city and district councils, and with several large NHS (healthcare) organizations, fire and rescue, local government, police, and university organizations.

A wide variety of university and corporate leadership programmes are also available in England. For example, the University of Exeter Centre for Leadership Studies offers undergraduate modules in leadership studies, executive education and business development including short courses and regional programmes, and consultancies, an MA in Leadership Studies, and an MPhil/PhD in Leadership Studies.

A search of the Research & Development Learning for Courses in the UK site (www.rdlearning.org.uk) using the terms "leadership" and "management" located many health leadership courses and programmes including those at Ashridge Business School Public Leadership Centre, Bangor University, City University, Coventry University, Durham University, Industrial Technology Systems Limited, Institute of Healthcare Management, Keele University, Liverpool University, Peninsula Medical School, Rostrum. Royal Holloway University of London, Staffordshire University, Thames Valley University, University of Aberdeen, University of Bedfordshire, University of Birmingham, University of Bradford, University of Central Lancashire, University of Chichester, University of Cumbria, University of Glamorgan, University of Huddersfield, University of Leeds, University of Leicester, University of Manchester, University of Northampton, University of Southampton, University of Suffolk, University of Teesside, University of Winchester, and University of Worcester. Many other universities are not listed in this directory. Programmes include various Bachelors, Masters (MA, MSc, MBA) and Doctorate degrees, post-graduate certificates and diplomas, on line courses, short courses such as four two day modules and privately offered courses and training.

UNITED STATES. Health and Behavioral Health.

The Need: 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 leadership training (Mazade, 2006). Its content included:

- Conscious use of self - theories of leadership, instruments, coaching, personal reflection
- Small group/team development
- Organizational dynamics - governance, structure, decision making and problem solving
- Organizational/environment interface - inter-organizational relationships, stakeholder relationships, media, influence pattern
- Skills development - conflict resolution, mediation, meetings, group process, listening,
- Business acumen - performance contracting, financial management, marketing, business plan creation, risk management, mental health law.

In March 2007, the Annapolis Coalition, released its *An Action Plan for Behavioral Health Workforce*

Development, a comprehensive assessment of behavioral health workforce needs in the United States with recommendations for change. The Coalition identified training the next generation of mental health leaders as a critical need for the future in the United States (Annapolis Coalition, 2007b). The report points out that stipends for mental health training fell from $117 million in 1972 to less than $1 million now. The Coalition wrote that

> Leadership is essential and needs to be explicitly developed among all segments of the behavioral health workforce, including persons in recovery and families, educators, prevention specialists, treatment providers, policy makers, and the individuals who manage accreditation, certification, and licensure systems. In fact, developing and expanding a cadre of leaders among persons in recovery, youth, and family members is particularly critical in achieving transformation of current service systems and models of care. Leadership must be broadly defined to encompass not only organizational and change management, but also coalition and community building, team and program management, and the provision of supervision (Annapolis Coalition, 2007a, 19).

The Coalition set as "Goal 5: Actively foster leadership development among all segments of the workforce." It set Objectives and Action Items for this goal, "Levers for Change, and groups that could address each of these:

- **Objective 1:** Identify leadership competencies tailored to the unique challenges of behavioral health care.
    - > *Action 1:* Conduct a comprehensive review of available leadership competency models.
    - > *Action 2:* Develop a leadership core competency model tailored to behavioral health.
    - > *Action 3:* Finalize development of supervision competencies tailored to behavioral health.
    - > *Action 4:* Disseminate broadly the core leadership and supervision competencies.
    - > *Action 5:* Adapt the core leadership competency model and supervision competencies to the needs of diverse sectors of the field.

- **Objective 2:** Identify effective leadership curricula and programs and develop new training resources to address existing gaps.
    - > *Action 1:* Identify existing leadership curricula and programs and evaluate those using selective criteria.
    - > *Action 2:* Develop and disseminate a catalog of available leadership curricula and programs.
    - > *Action 3:* Identify gaps in leadership curricula and training models and develop resources to close the gaps.

- **Objective 3:** Increase support for formal, continuous leadership development with current and emerging leaders in all segments of the workforce.
    - > *Action 1:* Allocate funding to support the expansion or development of competency-based leadership development initiatives.
    - > *Action 2:* Allocate funding and time to support the participation of individuals in leadership development initiatives.
    - > *Action 3:* Establish mentorship programs.
    - > *Action 4:* Provide competency-based training to all supervisors.
    - > *Action 5:* Provide incentives, recognition, and rewards for participation in leadership development programs.

- **Objective 4:** Formally evaluate leadership development programs based on defined criteria and revise based on outcomes.
    - > *Action 1:* Apply data-based continuous quality improvement methods in all leadership development initiatives.
    - > *Action 2:* Commission independent evaluation of leadership development initiatives.
    - > *Action 3:* Develop, maintain, and routinely disseminate a summary of findings from the evaluation of leadership programs to support ongoing quality improvement of leadership development efforts (Annapolis Coalition, 2007c).

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored several studies on behavioral health leadership training at the state level. The National Association of State Alcohol and

Drug Abuse Directors, Inc. and Abt Associates, Inc. (July 9, 2004; *www.partnersforrecovery.samhsa.gov/docs/ NASADAD_Leadership_and_Management_Development.ppt* – Text Version) in an inquiry to its membership defined topics in leadership and management and asked how many states were covering training for state directors, staff, and providers. Thirty-nine of fifty-one states responded. The following numbers of states covered these topics in some form:

LEADERSHIP			
Topic	Directors	Staff	Providers
Anticipating trends/strategic planning	15	20	12
Motivating by communicating vision and goals	18	14	9
No training	14	11	16
Balancing diverse needs	13	13	6
Policy and financial development	13	6	6
Acting collectively	13	11	9
Risk taking	11	6	2
Mentoring	10	8	3
Communicating effectively	8	9	5
Other	8	7	7

MANAGEMENT			
Topic	Directors	Staff	Providers
No training	13	6	18
Building teams	17	12	5
Communicating organizational visions	13	15	9
Project planning and management	14	12	8
Imparting organizational values	14	2	6
Marketing and product development	13	10	8
Running meetings	11	11	7
Financial/budget management	9	10	8
Other	5	9	6
Managing/recruiting personnel	8	7	7

The study found that leadership and management development initiatives "are insufficient and inconsistent across States." It identified only one comprehensive program specifically designed for the behavioral health profession. State, Federal, foundation, corporate and other funding including private and non-profit funding, grants from local sources, and self-pay were very limited and were expected to be reduced in the future due to budget constraints and other priorities.

SAMHSA asked TASC Inc. to interview 36 recognized leaders in a variety of areas. The leaders believed that management involves infrastructure, organization, product development, and team building. Effective leaders need passion, commitment, interpersonal and collaboration skills, vision and focus on key goals, policy savvy, communication, and ability to motivate others. Leadership can be learned. It can be self-taught through reading and experience. Mentoring and supervisory relationships are the key to fostering a culture of leadership.

However, early leaders are nearing retirement. There is no formal plan for leadership transition. No culture of leadership and leadership development exists within the field. Few leadership training opportunities are present. There are no defined management training tracks or "career ladders." Many clinical staff move into management without management training. The broader field does not have a blueprint for advancement. We need to identify, attract, train, mentor, and retain individuals with passion and commitment to the field. We need to develop cultures of leadership within our organizations, coordinate leadership development efforts, and articulate and embrace the common ground of a diverse field (*http://partnersforrecovery.samhsa.gov/docs/Leadership_Development_slides.rev.ppt.*).

Kathryn Power, Director of the Center for Mental Health Services, frequently discusses how critical leadership is for transforming the mental health system (Power, June 24, 2005; Power, April 2006). She argues that leadership is more than a set of competencies. The goals of leaders are to "achieve the mission and take care of people." Leadership needs to have a recovery orientation, support cultural competence, eliminate discrimination and stigma, utilize technology, be consumer and family driven, and facilitate evidence-based treatment and supports. She believes in transformational leaders who

- externalize strongly held values to shape and articulate a unifying vision for the future
- inspire others to see their place in that future
- motivate others to look beyond their own interests to achieve group goals
- act as role models
- develop others to higher levels of ability and potential
- encourage collective decision making
- create energizing environments that incubate ideas, actions, and other leaders, and
- think and plan backward from an envisioned future to take action.

They follow the "Four Is of Transformational Leadership:"
- idealized influence-role modeling
- inspirational motivation
- intellectual stimulation-new ways, and
- individualized consideration.

They build momentum for change, make the change, sustain the change, balance risk with courage, and enable people to stand up and pull the rest of us over the horizon.

Leadership competencies are summarized in The Transformation Leadership Competencies Wheel (Figure 8) (SAMHSA (May/June 2005, 2; *www.samhsa.gov/matrix_mh.aspx*)

Figure 8: The Transformation Leadership Competencies Wheel

The American College of Healthcare Executives (ACHE) defines three types of leadership competencies: system competencies, personal leadership competencies, and leadership competency knowledge areas (Ross et al, 2002):

System competencies, also called organizational competencies, are the competencies of the organization as it relates to its environment, its competitors, and its constituencies (physicians, patients, the community, payers, employers, and the government). Organizational core competencies define the organization's culture – how things are done. The leader can affect he culture over time, but at any point in time the organization's core competencies provide the framework within which the leader exercises his or her leadership competencies (41).

They are:

- Governance
- Strategy development
- Physician relationships
- Ethics and values
- Quality and value enhancement
- Public health and community involvement
- Health policy and law, and
- Alternative, complementary, and integrative medicine (41).

There are many personal leadership competencies. Those of particular value during volatile times are:
- Decision making
- Risk taking
- Team building
- Evaluation
- Managing conflict
- Professional mentoring, and
- Career management (225).

"Ten specific areas leaders must have knowledge of to effectively guide their organizations" are:

1. Governance and organizational dynamics
2. Human resources
3. Financial management and economics
4. Strategic planning and marketing
5. Information and information systems
6. Communications and public relations
7. Community health and managerial epidemiology
8. Quantitative analysis and modeling
9. Legal and ethical issues, and
10. Organizational and healthcare policy (297).

ACHE has an annual conference on healthcare leadership training with many seminars and courses (50th annual in New Orleans in March 2007) and offers many self-study courses including ones on leadership topics, and on-line seminars including "Exceptional Leadership" and "An Executive Skills Primer in Healthcare Management" (*www.ache.org*).

NCLH & ACMHA. The basis of much current health leadership training in the United States is the model developed by the National Center for Healthcare Leadership (NCHL, 2005; *www.nchl.org/ns/documents/CompetencyModel*). A benchmarked, researched, and validated model, NCHL 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. Its three domains and the supporting competencies (Figure 9) are:

Figure 9: NCHL Competency Model

The NCHL model provides breakthrough research and a comprehensive database for defining the competencies required for outstanding healthcare leadership for the future.

TRANSFORMATION
• Achievement Orientation
• Analytical Thinking
• Community Orientation
• Financial Skills
• Information Seeking
• Innovative Thinking
• Strategic Orientation

HEALTH LEADERSHIP

EDUCATION
• Accountability
• Change Leadership
• Collaboration
• Communication Skills
• Impact and Influence
• Information Technology Management
• Initiative
• Organisational Awareness
• Performance Measurement
• Process Management/Organisational Design
• Project Management

PEOPLE
• Human Resources Management
• Interpersonal Understanding
• Professionalism
• Relationship Building
• Self Confidence
• Self Development
• Talent Development
• Team Leadership

NCHL and the GE Institute for Transformational Leadership offer a variety of programs for leaders at different levels of organizations as well as other training and coaching options:

• Front line managers: Essentials of Leadership Excellence
• Managers of managers: Effective Executive Leadership, Manager of Managers, Strategic HR Leadership
• Senior Executives: CAP for Leaders, Executive Working Session, Advanced Leadership Development Program.

In August 2006, the American College of Mental Health Administration (ACMHA) launched the first Behavioral Health Leadership Excellence Network (LENS) (www.acmha.org/news/leadership) in partnership with NCHL and held its first meeting in September. The partnership with NCLH is focused "on developing leadership competencies through the formation of a behavioral healthcare LENS (Leadership Excellence Networks) using the NCHL model. We are not adapting the competencies themselves, but rather are using them for the first time in a behavioral healthcare setting." This first behavioral health LENS provides opportunity for teams of senior and emerging leaders from four provider organizations to come together and learn from each other about leadership development successes and challenges, in addition to the development work they address in their individual organizations. LENS participants are from organizations across the country and are beta sites for future behavioral health Leadership Excellence Networks.

In addition to the focus on leadership development in the LENS, which addresses components from succession planning to the training of emerging leaders, the ACMHA LENS model is also focused on the question "Leadership for what?" As behavioral health systems attempt to create new service models, enhance existing practices, and infuse treatment with belief in resilience and recovery, some fundamental principles have emerged. First, services can only be as good as the agencies and staff that deliver them. Second, organizational competence is a critical ingredient in the provision of effective services and, third, competent organizations are guided by inspired, creative leaders. Even behavioral health systems with an embarrassment of riches are unable to initiate and sustain change in the absence of strong, progressive leadership that creates healthy organizations. Exceptional leaders support high performing organizations whose results reflect the leaders' passion for excellence and produce positive outcomes for clients, families and communities.

Why is effective leadership so critically important for today's behavioral health services? The current demands of behavioral health are daunting. Treatment is much more complex and, like recovery, is not

linear. Services must be provided as a collaborative venture in which the client is the managing partner of his/her treatment and recovery plan. Services must be structured so that they support recovery and facilitate wellness and do not create dependency on the behavioral health system. "Creating community" for consumers outside treatment is as important as the therapeutic alliances within treatment.

High performing behavioral health organizations are consumer and quality-driven, recovery infused, and outcome-oriented and are guided by exceptional leaders. Effective leaders create a balance between social mission and business aims and keep the bottom line in correct perspective. They understand how to satisfy customers and purchasers and communicate that understanding to staff and board. They embrace evidence-based and emerging best practices and create their own practice-based evidence. They create and empower teams whose work advances the organization's response to clients and keeps change alive.

Other Initiatives: Another important mental health training initiative is two programs offered at sites around the country by the National Council for Community Behavioral Healthcare and Slayton Consulting (*www.nccbh.org/SERVICE/Leadership-Academy*). The Leadership Academy is a three day training program for upper management based on research by the Center for Creative Leadership. Its core leadership skills are leadership practices, coaching for commitment, performance management and accountability, and resource management – time, people, and money. Its core competencies are managing self: communication skills, conflict management, time management; managing others: recruiting staff, delegating, evaluating and disciplining, managing for peak performance; managing for results: goal setting, financial management, project management; and: leading for the future: negotiation/influence skills, strategic thinking, managing change.

The Middle Management Academy, four days, teaches the following management tools:

- Leadership approaches and situational leadership
- Team building and effective work group practices
- Using financial reports, managing budgets
- Developing and using practical performance measures
- Using data to guide decisions and operations
- Human resource issues: coaching discipline, managing conflict, effective communication, performance appraisal, giving feedback, building team morale
- Delegation and monitoring
- Effective meetings
- Middle management resources and supports, and
- Personal awareness and effectiveness.

Its competencies are:

- Alignment of unit and organizational goals
- Budget, finance
- Change management
- Client satisfaction data and use
- Organizational communication plans
- Complaints
- Conflict
- Culture
- Customer service
- Data for management
- Delegating
- Differences/diverse approaches
- Goal setting
- Managing up
- Meetings
- Performance indicators
- Performance management
- Planning

- Productivity
- Project management
- Supervisory, and
- Team building.

State mental health groups are starting to provide leadership training. For example, Arkansas offers a fifteen month Leadership Development Initiative covering budget and legislative process, communication, diversity, habits of highly effective people, managing human resources, mediation and facilitation skills, mentoring, and planning and project management.

The California Healthcare Foundation (*www.cimh.org*) has a healthcare leadership development program provided by the Center for Health Professions at the University of California San Francisco (*http://futurehealth. ucsf.edu/Program/chcf*). It is a two year fellowship including six, five day seminars. Subjects include building and handling teams, giving and receiving feedback, managing change, managing human resources, applying new technologies and information systems, understanding and using financial tools, applying economic principles to healthcare, developing organizational strategies and goals, balancing personal and professional life, communicating within and outside of an organization, and understanding emerging trends such as consumerism and changing demographics.

The California Institute for Mental Health Leadership Institute in 2006-2007 is four modules and nine days of training (*www.cimh.org*). Two institutes, one for new California county mental health directors and one for developing directors, are being planned. The curriculum includes

- 1
    - > Leadership effectiveness: service focused team leaders
    - > Leading others in teams
    - > Outcomes and strategy mapping
    - > Communication (verbal) and coaching
    - > Politics: county process

- 2
    - > Managing organizational change
    - > Handling crisis
    - > Policy windows/the policy process
    - > State policy and legislative process
    - > Mental health policy

- 3
    - > Inter-organizational networks
    - > Successful collaboration with consumers and family members
    - > How to work effectively with the media
    - > Essentials for culturally competent leaders
    - > Organizational culture including changing it

- 4
    - > Taking charge: leading through influence
    - > Facilitative leadership, social value model, negotiation

- 5
    - > Best practices in mental health leadership
    - > Work preferences and high performing teams
    - > Developing outstanding service.

In the 1990s, William Anthony, Executive Director of the Center for Psychiatric Rehabilitation at Boston University designed a course in mental health leadership and invited sixteen leaders from around the country to present. Since then, with Kevin Ann Huckshorn, he has conducted extensive interviews with forty leaders selected for their ability to create significant organizational change toward a consumer-centered, noncoercive, accountable system of care that facilitates recovery for persons with severe mental illness. Based on these interviews, the Eight Principles below and 8-10 tasks associated with them were created.

These are the foundation of their newly published book, **Principled Leadership**. Anthony and Huckshorn also argue that leadership style is linked to organizational setting – situation or context can affect, cause substitution, neutralize, or enhance the effects of leader behavior; that leaders' actions are often based on the situations in which they find themselves (*www.bu.edu/cpr/ressources/newsletter/leadership*; Anthony and Huckshorn, 2008)

- *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 and them.
- *Principle 5:* Leaders ensure that staff are trained in a human technology that can 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.

The Massachusetts Health Leadership College is sponsored by the Massachusetts Hospital Association and is nine two day modules, one each month beginning in September and ending in May:

1. Intentional Leadership Style and Substance
2. Fine-tuning Your Leadership Skills
3. Building a High-Performing Team
4. Employee Engagement
5. Managing Transitions (change management)
6. Attracting and Retaining Top Talent
7. Coaching
8. Innovation
9. MHLC Transition-Graduation including a Personal Development Plan

In Ohio, the Ohio L2000+ Leadership Academy through the Ohio State John Glenn Institute for Public Policy is continuing. It is a year long mental health certificate program teaching personal attributes, ethics, leadership skills, setting individual goals, integrating diversity, mentoring and coaching, and applying technology (*www.partnersforrecovery.samhsa.gov/doccs/NASADAD_Leadership_and_Management_ Development. ppt* – Text Version). Also in Ohio, the Case Western Reserve University, Case Weatherhead School of Management offers the Robert T. Kauer Mental Health Executive Leadership Program (MHRLP) (*http://weatherhead.case.edu*). It is intended for clinicians and directors in the mental health delivery system. Over eight months there are eight, day long sessions covering

- Basic Finance, Budgeting, and Fiscal Controls in Health Organizations
- Basic Marketing for Health Care Organizations
- Legal and Political Issues in Behavioral Health Business Planning
- Planning and Implementation of Performance Management Systems, and
- Four business planning sessions.

The Mental Health Association of Virginia is offering Consumer Empowerment and Leadership Training (*www.mhav.org/celt*), four day trainings designed to give mental health consumers tools for successful leadership. Topics include organizing consumer advocacy groups, monitoring and reporting issues, identifying issues, developing goals and select plans of action, conducting effective meetings, identifying specific group needs, and power and control in organizations

Other organizations are developing national leadership competencies and training. For example, the American Association of Community Psychiatrists is revisiting its Guidelines for Psychiatric Practice in Community Mental Health Centers. In addition to clinical responsibilities of the Medical Director, other leadership responsibilities include

- Job descriptions, recruiting, staffing, and human resource tasks
- Staff training and supervision

- Quality Assurance and outcomes evaluation
- Developing practice and other standards including medical records standards
- Program budgeting, planning, development
- Work with Board of Directors
- Liaisons with private and public payers and community persons and agencies (American Association of Community Psychiatrists, November 20, 2006).

The ATTC of New England Center for Alcohol and Addiction Studies Leadership Institute for Addictions Professionals (*www.nattc.org/leaderInst*) trains clinical leaders in a program that includes formal assessment, a five day immersion training, and experiential learning. The Institutes are offered in all of the regions of the ATTC. It also sponsors a leadership training with the Southeast Conference on Addictive Disorders.

Open Minds, a national behavioral health research and management consulting firm, offers a wide variety of 2-5 day Executive Education and leadership programs (*www.openminds.com*). They include

- Leading Through Constant Change
- Executive Leadership Institute
- Understanding Your Leadership Style & Building Your Skills
- Building Your Team's Management Competencies
- Strategic Planning
- Managing Change as a Leader's Challenge
- How to Link Your Technology Plan to Your Strategic Plan
- Marketing Diagnostics
- Developing a Winning Marketing Plan
- The 2007 Innovation Institute
- Planning for Your IT Staff
- The Future of Technology in Behavioral Health
- Turning Around Your Lagging Software Implementation
- Tools for Strategic Planning and Effective Management
- Building Your Executive Leadership Team, and
- Managing Care Across the Continuum.

Partners for Recovery, an initiative sponsored by SAMHSA's Center for Substance Abuse Treatment, provides technical resources to those who deliver services for the prevention and treatment for substance abuse and mental health disorders. Its regional Leadership Institutes develop leadership at all levels (*http://partnersforrecovery.samhsa.gov/leadership_institutes*).

Some private behavioral health providers are conducting leadership training for their staff. Most notable is that of Don Jordan at the Seven Hills Foundation, Worcester, MA. (*Jordan, 2006; www.sevenhills.org*). In his paper intended for his staff at all levels, after a very nice literature review including different leadership paradigms, Jordan bases his leadership model on Burns' model of transactional and transforming leadership and creates the concept of a "Triarchic Leadership Model."

- Transactional (Self-Embeddedness)
- Transformational (Mutual Enhancement)
- Transcending (Self-Transcendence).

He presents the "Seven Hills Leadership Framework":

- Who Leaders Are/Leadership "Characteristics"
  1. emotional intelligence
  2. determined resolve
  3. "other" interest before self-interest
  4. a desire to nurture/develop others
  5. a passion of ideals
  6. vision
  7. systems thinker

- How Leaders Act/Leadership "Behaviors & Actions"
  1. leads by example

2. exhibits moral/ethical behavior
3. acts with humility
4. listens intently to others
5. maintains a positive attitude
6. honest with self and others
7. empowers others

- What Leaders Do/Leadership "Skills and Competencies"
  1. coaching and mentoring
  2. an ability to manage change
  3. effective communication
  4. conceptual skills
  5. analytical skills
  6. ability to motivate others
  7. self-reflection.

He ends his paper with seven principles of leadership:

1. A leader is first a servant.
2. Deeply held core values are what directs and sustains a leader.
3. Our character – how we exhibit our values – is our lasting legacy.
4. To envision and pursue with enthusiasm a yet unrealized future is the essence of the "art of leadership."
5. Leadership is fundamentally about relationships.
6. Our actions - be they ethical or self-serving - serve as our life's signature.
7. Self-reflection and awareness are crucible disciplines for a leader. Each invariably leads to humility.

Leadership training is also offered by health organizations that are not specifically focused on mental health. The Leadership Competency Framework was developed by the National Public Health Leadership Development Network (NLN) (Wright et al, 2000; *www.heartlandcenters.slu.edu/nln*), a consortium of organizations and individuals founded in 1994 to support the growth of public health leadership institutes and expand collaboration among academic and other institutions. Public health leadership institutes are offered in many states, some regions, the CDC Leadership and Management Institute, the National Public Health Institute, the Public Health Leadership Society, internationally (Saskatchewan Institute of Health Leadership, National Public Health Leadership Programme in England, The Institute of Public Health in Ireland), and in sessions at the Annual Meeting of the American Public Health Association. The framework is being used by network members to develop and refine program competency lists and content; to compare programs; to develop needs assessments, baseline measures, and performance standards; and to evaluate educational outcomes. It is a working document, to be continually refined and evaluated to ensure its continued relevance to performance in practice. Its core competencies are

- Transformational Competencies
  > Visionary Leadership
  > Sense of Mission
  > Effective Change Agent

- Political Competencies
  > Political Processes
  > Negotiation and Mediation
  > Ethics and Power
  > Marketing and Education

- Transorganizational Competencies
  > Organizational Capacity and Dynamics
  > Trans-Organizational Capacity and Collaboration
  > Social Forecasting and Marketing

- Team Building Competencies
  > Team Structures and Systems
  > Team Development

> Facilitation and Mediation
> Effective Role Model.

The Collaborative Leadership Web site (*www.collaborativeleadership.org*) maintained by NLN offers a variety of on-line public health leadership training tools and other leadership resources.

Management Sciences for Health (MSH) (*www.msh.org*) is working in over 100 countries to develop the next generation of public health leaders. The Center for Leadership and Management at MSH works with a broad range of partners to build human capacity, strong governance, and effective health systems to foster sustainable health improvements in developing countries. It offers an array of learning programs and resources in multiple formats and languages including its Virtual Leadership Development Program (web-based content with face-to-face meetings), LeaderNet (a web based community of practice), Health Manager's Toolkit (over 35 web-based tools to support leaders), and The Manager and e-Manager (print and electronic periodical). **Managers Who Lead** (2005) is a handbook and CD-ROM that contains leadership models and practices. It is based on fundamental principles:

* Focus on health outcomes
* Practice leadership at all levels
* You can learn to lead
* Leadership is learned over time
* Sustain progress through management systems.

In addition to a toolkit and annotated bibliography, its chapters are

1. Leading and managing to achieve results
2. Leading teams to face challenges
3. Improving work climate to strengthen performance
4. Moving up the leadership ladder
5. Reorienting roles in the health system
6. Leading change for better health.

The Leading and Managing Framework are practices that enable work groups and organizations to face challenges and achieve results:

* Leading
  > Scanning
  > Focusing
  > Aligning/Mobilizing
  > Inspiring

* Managing
  > Planning
  > Organizing
  > Implementing
  > Monitoring and evaluating.

These lead to improved work climate, improved management systems, improved capacity to respond to change, improved services, and improved health outcomes. They shift perspective from

* Individual heroics to collaborative actions
* Despair and cynicism to hope and possibility
* Blaming others for problems to taking responsibility for challenges
* Scattered, disconnected activities to purposeful, interconnected actions, and
* Self-absorption to generosity and concern for the common good.

The Global Health Leadership Forum (*http://ahlf.berkeley.edu*) is "an international program to rethink health policy and systems change." An offering of the University of California Berkeley School of Public Health in conjunction with Cambridge (England) Judge Business School and Universitat Pompeu Febra, it is two, week long seminars in San Francisco and Cambridge with participants working during the six months between each session on a real world country or problem issue. Sample curriculum issues include

- Workshops on leadership and evidence-based management
- Effective policy implementation and strategies for health systems change
- How to ensure quality
- Public vs. private insurance mix and innovations in payer and health delivery connections
- Lessons learned from managed care/innovative budgeting
- Defining benefit packages
- Pharmaceutical innovation and regulation
- The new consumerism
- Infectious disease preparedness and health care ethics
- IT and care management systems.

The W.K. Kellogg Foundation sponsors a number of leadership training programs (www.wkkf.org). The Building Bridges between Practice and Knowledge in Nonprofit Management Education Initiative develops more comprehensive educational programs that respond to the wide range of management and leadership needs of nonprofit leaders. The Community Health Scholars is a one to two year fellowship for scholars who will be appointed to teach in health profession schools, especially schools of public health. The Institute for Diversity in Health Management is a residency program for recent master – degreed graduates which places fellows with top level executives.

Leadership for Community Change (KLCC) focuses on the development of shared leadership in a community setting. It engages communities and develops the shared leadership expertise needed to work across a range of backgrounds and perspectives. The hope is that KLCC will yield leadership models that are appropriate to the challenges and opportunities of the 21st century. The program's framework has four stages each with four elements:

Four Stages/ Four Elements	Build Trust	Co-Construct Purpose and Strategic Plan	Act Together	Deepen, Sustain, Make Work a Way of Life
Know Community	Be grounded in your place	Learn from community	Make allies	Work becomes part of the community fabric
Build a Strong Team	Know the others	Create shared purpose	Collective action	Include new partners
Develop the Individual	Know your own story and values	Name your passion	Contribute your gifts	Help develop others
Make the Change	Define the work	Make a plan	Implement the plan	Sustain the work

According to Kellogg, leadership development, both current and future, is based on the following assumptions:

1. The primary focus of leadership development at the Kellogg Foundation is to build institutional and community capacity to lead social, cultural, and economic change efforts that improve the social and economic well-being of people and their communities.
2. Leadership development is strategically integrated throughout all programming goals, objectives, and priorities in order to realize greater impact, leverage new knowledge, promote sustainability, and have a positive influence on the transformation of individuals, communities, and institutions, through capacity building and public policy change.

In the context of current social and economic trends, the leadership skills and characteristics necessary for influencing future change in the 21st century will be the ability to

- Bring people together being as inclusive as possible around a common agenda for collective action;
- Demonstrate collaborative and inclusive decision making in a community setting;
- Be flexible and responsive in the face of change;
- Engage in continuous learning and improvement;
- Create trusting relationships in a team environment;

- Communicate a compelling set of visions, purposes, and values;
- Be willing to develop, nurture, and create space for others to lead;
- Possess a global perspective and understand its impact on local communities;
- Use imagination and creativity in the solution of difficult problems;
- Be open to new and different ideas;
- Operate from a systems orientation; and
- Be capable of informing and influencing policy change.

The American College of Physician Executives (*www.acpe.org*) has a Physician Management Seminar that covers finance, influence, management, marketing, negotiation, and communication. The organization offers other seminars including Leading Beyond the Bottom Line, and Leadership and Management for Group Practice Department Chairs, on-line short seminars and courses, and Masters degrees in Medical Management from four colleges either on-line or in a blended program.

The Institute for Healthcare Improvement (*www.ihi.org*) offers many seminars as well as other on-site and web-based services to improve the quality of health care. Among them is the Executive Quality Academy, three intensive days designed to "dramatically increase the capacity of senior executives to lead improvement… Senior executive teams will identify their primary quality-related leadership challenge; articulate a bold, system-level aim that addresses the challenge; and create a detailed plan to move forward with system level improvement based on a dynamic leadership leverage framework."

The U.S. Department of Health and Human Services Emerging Leaders Program is a two year program for persons interested in working for HHS (*www.hhs.gov/careers/elp*)

Many medical schools and schools of social work, psychology, psychiatry, and public health offer management and leadership training, often in collaboration with their business schools and frequently as joint degrees.

Public Administration Leadership Trainings: The American Management Association offers three day seminars, covering understanding today's leadership expectations; strategic elements of leadership (defining mission, vision, values; culture, planning, envisioning the future, personal vision statement); situational leadership (feedback, teams, coaching); culture, values, ethics; and emotional intelligence (*www.amanet.org/seminars*). Among them are Developing Executive Leadership, Developing Executive Leadership in a Government Environment, Stepping Up to Leadership, Leadership Skills for Supervisors, Preparing for Leadership, Leadership and Team Development, Leading with Emotional Intelligence, and The Voice of Leadership: How Leaders Inspire, Influence, and Achieve Results.

The Center for Creative Leadership (*www.ccl.org*), founded in 1970, is a leading nonprofit institution dedicated exclusively to leadership. The Center conducts research, publishes many books on leadership, and provides research, training, coaching, 360 degree assessments, virtual learning and many on-line resources at five campuses and 16 network associates in the United States and around the world. Its open enrollment programs are in four areas: Individual Leader Development (e.g., Leadership at the Peak, Foundations of Leadership), Groups, Teams, and Organizations (e.g., Advancing Global Leadership, Developing the Strategic Leader, Leadership and High-Performance Teams, Specialized Topics (e.g., The African-American Leadership Program, The Woman's Leadership Program), and Human Resource Development and Talent Management.

The United States Office of Personnel Management, The Federal Executive Institute and the Management Development Centers (*www.leadership.opmgov/programs/Executive-Leadership-Development*) offer seminars on hundreds of topics including at least twenty on leadership development among them Leadership Assessment Program (5 day), Leadership Foundations Seminar (5 day), Leadership Potential Seminar (5day), Contemporary Leadership Issues (3 day), Developing and Communicating Your Leadership Competencies (5 day), Power Thinking for Leaders (2 day), Executive Communications Workshop (1 week), Executive Development Seminar: Leading Change (1 week), Executive Development Blended Course, Leadership for a Democratic Society/Leading Public Sector Transformation (2 weeks), Emotional Competencies, Understanding The 360-Degree Leader, The ABCs of Effective Relationships, Collaborating Across Organizational Boundaries, Leading Across Generations, Leading in a Virtual Workplace, The Aspen Executive Seminar, Strategic Leadership: Leading Culture Change, Bridging

Organizational Culture, Building A Great Place for People to Work: A Blueprint for Successful Human Capital Leadership, Coaching Skills, and Leaders Growing Leaders.

Many universities offer leadership training programs. While their primary focus is not on mental health or health, their generic institutes are excellent training opportunities, they frequently provide customized training to these organizations, their publications can be very informative, and they can be useful consultants and resources for our field. The University of Delaware School of Urban Affairs ran a major conference, "Leading the Future of the Public Sector, The Third Transatlantic Dialogue" in May 2007 in which leadership training was a major topic (contact Jeffrey Raffel at *Raffel@udel.edu*), a book, **Public Sector Leadership: International Challenges and Perspectives** based on the conference is due out in 2009, and the University's Institute for Public Administration runs a Woman's Leadership Program. Harvard's Kennedy School (*www.ksgexecprogram.harvard.edu*) offers week long executive education courses: Leadership for the 21st Century: Chaos, Conflict, and Courage; Leadership in Crises: Preparation and Performance; and Women and Power: Leadership in a New World, as well as its Senior Executive Fellows program. Indiana State University Leadership Development Institute (*www.indstate.edu/leadersh*), the Ohio State University Leadership Center (*http://leadershipcenter.osu.edu*), and The James McGregor Burns Academy of Leadership at the University of Maryland (*http://www.academy,umd.edu*) are other leading examples.

The Burns Center in 2007 began a three year project, The Leadership for Transformation Project, funded by The Fetzer Institute. It emerged from their conviction "that efforts to address the world's critical issues must go beyond political, social, and economic strategies to their psychological and spiritual roots." The project had dialogue meetings on The Practice of Transformational Leadership (spring 2008) and The Practice of Transformational Leaders in Action (fall 2008). A third session in spring 2009 will focus on The Nature and Dynamics of Transformational Leadership, while the fourth in spring 2010 will bring together sessions leaders to write two edited books on transformational leadership focusing on theory and practice. In fall 2009 the group will host an international conference in Prague (*www.academy.umd.edu/Research _ Centers/TLC/transformationalleadproj.html*).

Leadership and the competencies of this paper are taught in many courses in our Suffolk University Masters in Public Administration (MPA) and Masters in Health Administration (MHA) degrees and the issues in this paper are explored in more depth in a course, Leadership for An Inter-connected World (*www.suffolk.edu/mpa*).

Business Schools: While this paper does not intend to cover business school offerings in executive leadership education, we do have much to learn from their many certificate and degree programs. Some of these programs focus on audiences of this paper, e.g. non-profit organizations, health and managed care, and women. Others may be suitable for people in mental health and health desiring strong leadership training. Mazade (January 26, 2005) surveyed programs offered by the top eleven business schools in the United States. The profiles describe their programs and curriculum foci, their audiences, and their teaching approaches, but generally do not cover specific leadership competencies. However, a review of the titles and sessions gives a useful view of transformational leadership areas deemed important by business. Some such as "credit risk" and "corporate governance" are most applicable to business. Many are similar to those reviewed in this paper. Among them are:

- Leadership and strategy, innovation, managing change, vision
- Global leadership
- Organizational design, managing culture
- Financial management
- Human relations management, leading and managing people and teams
- Working with diversity
- Negotiation
- Operations management
- Performance management and measurement, management information systems and technology
- Marketing
- Stakeholder and political management
- Personal awareness, emotional intelligence, stress management, promoting continuous learning.

Mazade (February 21, 2005) also reviewed "selected non-university training venue" offerings in transformational leadership. The wide variety included U.S. Department of Defense programs, the CIA and the FBI and many other United States government departments, the Council of State governments, a mountain leadership program, several religious seminaries, and the Brookings Institute. As with the business schools, he found a large number of common topics and competencies.

This paper also reviewed accrediting organizations, especially those related to healthcare. These include the Commission on Accreditation of Healthcare Management Education (CAHME), the National Center for Healthcare Leadership (NCHL), and the Association of Behavioral Healthcare Management (ABHM) that has a Certified Behavioral Healthcare Executive program.

WALES (UNITED KINGDOM). The National Leadership and Innovation Agency for Healthcare (NLIAH) is in its fourth year as a resource to support NHS Wales. With the support of NHS Wales and The Welsh NHS Confederation, it sponsors Care to Lead, an academic programme designed to affect change at the individual, team, organizational, and patient level.

The Care to Lead Learning Program Framework is:

- E-learning: web-based learning and e-classrooms, e-mentorship (Peer e – mentoring), and bulletin board based communication to access wide sources of information including the Harvard University ManageMentor system, with 37 Management topics, horizon stretch, cross discipline working, and a learning log to develop reflective practice
- Diagnostic: Activities to understand current individual needs, using PDP, LQF 360, and other tools through a Development Centre
- Developmental work experiences: PDP and diagnostic feedback, mentor influenced, access through a talent pipeline
- An action learning impact project, and
- Post-programmatic activities including resources, help as alumni, local problem solving, and learning roll out.

Its academic programme has nine two day modules:

- Introductory: The Strategic Context
- Hospital in the Community-Leading an Integrated Future
- Professions, Power, and Finance
- Leading a Diverse Workforce and Understanding the HR Context for Leaders
- Modern Governance- Getting Beyond the Documentation
- Leading and Delivering Through Teams
- Leading Complex Change
- Leading @ the Future, and
- Improvement Sciences for Leaders.

Participants who complete the programme receive a Certificate of Graduate Study (*www.wales.nhs.uk/ sites3/Documents/484*)

The organization also sponsors a variety of other leadership training and support programmes. Leading Professionals is a leadership development programme for allied health professionals, psychologists, and healthcare scientists. Run over 12-18 months, its eight two day modules are

- Introductory (primarily policy)
- Hospital in the Community-Leading an Integrated Future
- Politics, Power, and Finance
- Leading a Diverse Workforce and the HR Challenge
- Modern Governance-Getting Beyond the Documentation
- Leadership and Teams
- Leading Complex Change
- Leading @ the Future.

Leading to Deliver supports and enables General Managers and Directorate Managers. It begins with

participants identifying a key area of action, service change, or improvement that they are responsible for. A one day Introductory Workshop clarifies goals and objectives, decides on important work, develops personal development plans based on the 360 Leadership Qualities feedback, and looks at desired outcomes. This is followed by the five day "Quick Start Intensive Development:"

1. Mapping the What, Where, How, When, Who
2. Strategies, Relationships, & Influence
3. Mobilizing Your People, Skills, Objectives, Deadlines
4. Dealing with Resources, Finance, Estates, Workforce
5. Rigorous Thinking & Innovation, Measurement, Creativity.

Each session has two components: Tools, Skills, & Knowledge and Management & Leadership Skills & Qualities. There is also ongoing coaching support and co-consulting, Gaining Commitment (team) workshops, ongoing Peer and Action Learning Review, ongoing Context Specific Mentor Support, a two day Results and Mainstreaming Workshop, and a final one day of presentations and celebrations.

The Top Leaders Development Experience is a two day experience with a one day prior briefing for a cohort of twelve Chief Executives. Modeled on the TV show, the Apprentice, the group works on a real healthcare scenario using a number of assessment tools and resources with one to one coaching. It is filmed and participants receive a personalized DVD that showcases their behaviors. Members have the option of taking the Care to Lead academic programme, as well as a post-event co-consulting challenge with Chief Executives from England, Scotland, and Northern Ireland working across country and organizational boundaries on critical strategic challenges.

Other leadership programmes sponsored by the group include

- Chairs development
- Board development
- NOMS & BEDS
- OD Practitioners Network
- Executive Coaching'
- 360 degree feedback
- Gateway to Leadership for new senior managers, and
- Gateway to NHS Wales for new graduate entry management trainees, E-mentoring.

OUR LEADERSHIP COMPETENCIES & PROGRAMS' PRIORITIES

The NHCL leadership model competencies are being used by many healthcare groups in the United States as a basis for assessing and creating health and now behavioral health curricula and training. Our initial plan two years ago was to use these as the basis for comparing competencies in our listed programs. However, we quickly found that we did not have enough detail in our descriptions, that nearly every program had its own way of organizing its content, and that most could not neatly fit into the NCLH model.

Instead, building on NHCL, we created five areas that nearly all of the mental health, health, and public administration articles, books, reports, and programs that we reviewed covered, whether in one course or in a group of courses. We went through these and culled out the competencies from each. We realized that in some cases competencies could and should be in more than one group. We also found that in doing so we fell into the distinctions of the first section; we reiterate our belief that all of these areas of knowledge are necessary to be an effective leader depending upon the situation. Our objective was not to debate the organization of these areas, but to be sure that we created a comprehensive list.

Our five leadership competency areas are

- Personal Skills and Knowledge
- Interpersonal (People) Skills
- Transactional (Execution, Management) Skills
- Transformational Skills, and
- Policy and Program Knowledge.

Having completed our listing and ordering the competencies, we then asked which were the most taught in the programs described in this paper. In other words, what were the priority training competency areas of those who responded to us? Since no program can teach everything, what are the areas that we might target in training with limited time and other constraints?

Using our competency list, we went back and reviewed the programs and counted the number of times each of these competencies appeared. We excluded anything such as the first part of this paper, books and articles, and speeches such as Kathryn Power's that were not direct training. We found five programs in New Zealand that we had enough information to analyze, three in Scotland, three in the United Kingdom, and fourteen in the United States, a total of twenty-five programs, No programs in Australia, Canada, Ireland, or Northern Ireland had enough detail at that time to assess. The number of programs that were examined was too small to break down the competency areas by particular country. I recognize that because our information on any program may be incomplete or lack detail, our findings are not exact. However, I do have enough information to gain an overall picture of the field.

This report includes a number of additional programs. In reviewing them, they confirm the core competencies of this model. Where enough detail is present to analyze, most cover at least to some degree the five areas. Areas that appear to be more commonplace than those listed below include human relations and diversity, coaching and co-counseling skills, board governance, use of diagnostic tools such as the LQF and 360, community building, consumer involvement, information technology, and marketing.

The full list of competencies and the number of programs that appeared to train people in them are contained in the following tables. They are arranged in order of the most common to least common competencies found in the identified programs. The number to the right of the competency indicates the number of programs that teach that particular competency.

PERSONAL SKILLS AND KNOWLEDGE	
Competency	Number of Programs
Emotional intelligence (self-awareness, personal reflection, personal style, conscious use of self)	11
Leader's values and beliefs (honesty/integrity, respect for others, courage, humility/ generosity/empathy/caring, showing genuine concern)	9
Ethics, morality, respect for human rights	8
Adaptability, creativity, flexibility, situational awareness	5
Intelligence, knowledge, competence	5
Being responsible	5
Confidence	4
Reflective thinking and practicing, challenging thinking	4
Critical thinking	4
Being decisive, taking responsibility, determination	3
Customer orientation	3
Self-care, work-life balance, stress management	3
Personal development plan	3
Being accessible, collegial, open-minded	2
Passion	2
Conceptual thinking	2
Perseverance	2
Recovery orientation	2
Professionalism	2
Listening	2
Positive attitude	1
Time management	1
Judgment	1

INTERPERSONAL (PEOPLE) SKILLS	
Competency	Number of Programs
Communicating (written, verbal including listening, presenting)	16
Teamwork and small group skills, collaboration, meeting management	15
Coaching, mentoring, development, personal growth, enabling and building leadership skills in others	15
Negotiating, resolving conflict, facilitating, agreement building, mediation	12
Working with people of other cultures, promoting diversity	9
Motivating, inspiring, energizing, empowering others	8
Supporting recovery, working with stakeholders, inclusion and empowerment of stakeholders including consumers, families, and providers	7
Managing others, holding others accountable, disciplining and supervision	6
Networking	5
Building trust	5
Trusting others, delegating and sharing tasks	4
Ability to lead teams	2
Affirming and regenerating values	1

TRANSACTIONAL (EXECUTION, MANAGEMENT) SKILLS	
Competency	Number of Programs
Quality management (CQI), accountability, measuring, monitoring and reporting, evaluation, outcomes, performance assessment, data use, evidence-based practices	15
Human resource management, staffing, recruiting	12
Finance, budgeting, and funding, health economics	11
Organizational theory and design	9
Information systems and technology, software and data base management, applying technology	9
Project planning and management	8
Planning and priority setting, agenda setting, decision making	6
Problem solving and decision making, analytical models and skills, task management	6
Business acumen: business plan development, business-to-business models	6
Marketing	6
Service and systems design and improvement, operations management, managing service improvements and patient care	5
Keeping the system functioning, maintaining the institution, building the organization	4
Contracting management, performance contracting	3
Legal	3
Working with the media	3

TRANSACTIONAL (EXECUTION, MANAGEMENT) SKILLS - *continued*	
Competency	Number of Programs
Process improvement	2
Risk management	2
Resource management	2
Governance	1
Research methods and data collection	1
Developing partnerships	1
Use of best practices	1
Crisis management	1

TRANSFORMATIONAL SKILLS	
Competency	Number of Programs
Visioning and setting shared strategic vision and mission, strategic thinking and planning, innovative strategic thinking, broad scanning, anticipating trends, future thinking and positioning, systems thinking	20
Managing of complex organizational change, renewing, leading innovation, being a catalyst	14
Goal setting, setting direction, alignment, driving for results, leading through influence	10
Mobilizing support, influencing, inspiring and motivating others, creating energizing environments, being a conductor	7
Working across complex inter-organizational systems, external relationships, working collaboratively	7
Political astuteness and awareness, skills, and management	5
Creating and empowering the organizational culture	4
Role modeling, leading by example	4
Policy development	3
Community development, capacity building	3
Support of lifelong and continuous learning	2

POLICY AND PROGRAM KNOWLEDGE: UNDERSTANDING	
Competency	Number of Programs
Local, state, and Federal government and policies; political knowledge	5
Recovery principles and experience and, in health, "patient centered care"	3
The policy formation process/policy development	2
History, organization, funding, policies, and legislation of the mental health, substance use, and health systems in one's country and globally	2
Discrimination, stigma, racism, social inclusion, users' rights	2
Clinical and service areas	1
Issues in medical ethics	1

The overall findings in this updated report are the same as those in the original report. A wide variety of transactional skills are taught in the studied programs. The most common are quality management and assessment, human resource management, finance and budgeting, organizational theory and design, information systems, and project planning and management.

Interpersonal skills are honed in many of the studied programs. Written and verbal communicating, teamwork, coaching and enabling others, and negotiating and facilitating are particularly important. Working with people of other cultures and with stakeholders and empowering others are also viewed as valuable skills.

Visioning and strategic planning is the skill most taught in the programs that we found. Other frequently offered transformational training is catalyzing change and innovation and goal setting.

The personal skills that programs indicate they foster are emotional intelligence (self-awareness), values and beliefs, and ethical behavior.

Relatively few programs show that they teach policy and program knowledge. This may be an artifact of their descriptions; these areas are core subjects in training but are not explicitly listed in program descriptions. Alternatively, the field may believe that experienced people already know much about the mental health or health field or that honing basic transferable skills is more important that learning about particular policies.

DISCUSSION

This project began as a narrow effort to identify mental health leadership competencies in the IIMHL countries. I quickly found that to do so I had to identify the programs in each country. As I found a limited number of mental health leadership training programs, I also had to expand this report to include health and other leadership training programs, as well as some discussion of the theory underlying leadership and competencies.

My search has shown that all of the countries that I was able to contact strongly believe that leadership development is a critical challenge that needs to be addressed not just for mental health and substance use but for health as well as more generally public administration. My research shows that there is much theory and sometimes debate on the subject, and that many people and organizations are devoted to defining models and competencies.

One of our questions was whether leadership competencies for mental health were different from those in health or public administration and whether these competencies differed depending upon the country in which they were used. In our first four areas, I find that 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. It is striking that many leadership programs say that teach generic skills, and few list policies among their learning objectives. They may assume that their participants already understand these issues. Or, these areas may be discussed in their courses, but are not listed in their descriptions. Alternatively, the sponsoring organizations may not feel that these topics are important to spend time on in leadership training and should instead be the focus of other seminars on these types of issues.

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 this 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. It also becomes clear that 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. Another is to strengthen one's capabilities through continuing learning, training, and introspection – self renewal (Gardner, 1965).

Similarly, a full leadership training program will cover all of these areas, just as Skills for Health lays out the full range of leadership competencies. 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. Organizations such as Open Minds and the Office of Personnel Management in the United States take such an approach.

Many leadership training programs are being offered locally, regionally, and to a lesser degree nationally in the studied countries. The programs are often based on solid research and theory including needs surveys, and are usually targeted to particular identified needs. While their design is not the focus of

this paper, they appear to be creative in their scheduling and use of multiple approaches to teaching and learning.

The problem is that in most countries that I have studied, the United States being a prime example, leadership training is scattered and only partially covers many of these 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. This problem was quite evident in my research. I have spent many hours searching the literature and the internet and contacting many helpful people in order to compile what I know is still a very incomplete list. In some countries, I have 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. I appreciate that even now they continue to network, find, and send me more information as word of this project and drafts of this paper are shared. If I have had such difficulty, imagine the challenge facing a middle manager searching for a place to strengthen his or her leadership skills.

This also raises questions about recommendations such as those of the Annapolis Coalition to develop a more comprehensive review of available leadership programs than is contained in the report, to evaluate more thoroughly the skills in these programs, or to assess their effectiveness. While we need to move in this direction, it will be hindered as I have found by the lack of programs and information on them. The first priority needs to be to create programs and give people access to them.

A major barrier to this is funding. At least 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. The current recession is already leading to major cutbacks in mental health services in the United States, and leadership training will probably be an even lower priority than saving critical clinical services.

Yet as IIMHL and many leaders in its countries recognize, we face a crisis in leadership. Only 7.5% of the United States Federal workforce is under age 30, while over 40% is over age 50. By 2006, about 31% of Federal employees will be eligible for retirement. Fifteen percent overall and as many as 50% of workers in some agencies will actually retire. As of 2004, more than 7 out of 10 top Federal government managers could claim their pensions. The situation is similar in other public fields. In the United States, and probably the IIMHL countries, as many as 40% of senior managers at all levels of government, health, local agencies, and advocacy organizations will retire within the next five years (Broder, 2001; Civil Service Subcommittee, 2003; GAO, 2001; Spors and Fialka, 2002; Wamunyu, 2003). Many of these people received leadership and management training when funded programs were more available. 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.

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. Despite unipolar major depression being the leading cause of global disability losses and four of the top ten DALYs being unipolar major depression (1), alcohol use disorders (3), schizophrenia (5), and bipolar disorders (7) (Merson, Black, and Mills, 2006, 32), 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 a chronic disease that will need capable leadership if it is ever to be addressed.

NEXT STEPS

This self-funded report is a solid but insufficient start at pulling together the global knowledge about mental health (and health) leadership training. We need to do (and hopefully fund) more.

The needed next steps are the same now as in the first report and include the following:

- Continue to expand, update, and publish the lists of leadership programs in these eight IIMHL countries.

- Use the IIMHL forums and other meetings as venues for continued discussion of this report and issues. For example, in addition to presenting this at the IIMHL meeting in Canada in August 2007, this paper or variants of it were scientific presentations at the American Society of Public Administration in March 2007 and the American Public Health Association in November 2007 and October 2008.

- Create a central web-based directory of programs and/or directories of programs in each country with links to each other.

- Build on our simple e-mail list of people interested in mental health and health leadership that continues to grow with this project and turn it into a list serve or web site where information can be shared and dialogue about best practices and theory can be discussed.

- Expand this study to European and other developing countries in the world.

- Study the methods by which these programs are taught and the most effective ways for people to learn and improve their leadership competencies. The Annapolis Coalition is very critical of the way that most continuing education programs are taught and is hopefully stimulating a discussion on how to do a better job. Many of the programs described in this paper use very creative learning approaches.

- Most important, countries should fund, develop and link mental health and health leadership training programs at all levels. In the United States, the recommendations of the Annapolis Coalition report should be seriously considered.

I close with further thanks to the many people who have joined with me on this project. I look forward to continuing information sharing, dialogue, development, and collaboration on this important subject.

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APPENDICES

APPENDIX 1. KEY CHALLENGES FACING CLINICAL LEADERS AND DESCRIPTORS OF LEADERSHIP QUALITIES
(DELIVERING THE FUTURE, p.11)

- Clarifying clinical leadership and establishing it as a legitimate career path

- Managing tensions between strategic leadership role and operational management/clinical service delivery role

- Aligning professional and organizational agendas

- Balancing the need for transactional management with transformational leadership

- Breaking down organizational silos, both vertical and horizontal

- Consistency of leadership behaviours, being corporate

- Developing self awareness and self management strategies

- Managing complex change

- Resolving conflict, negotiation, and mediation

- Working in virtual teams across professions and across organizations

- Strategic influencing and influencing at all levels (360 degree influencing)

- Understanding high level political processes and political service interface

- Managing local politics

- Shaping clinical strategy and redesigning services to improve health and healthcare delivery

- Engaging in policy formulation

- Leading cultural change

- Meaningful patient focus and public involvement including consulting with communities

- Clarifying accountabilities and ensuring processes are in place to effect real change for patients

- Opportunities for sustained development programmes.

The 'Leadership for Health Improvement Programme' Framework

SUCCESSFUL HEALTH IMPROVEMENT SYSTEMS ...

- Promote and protect the population's health and well-being
- Develop health programmes and services and reduce inequalities
- Protectively build on surveillance and assessment of the populations health and well-being
- Systematically implement evidence based practice
- Create seamless-working across boundaries for the benefit of communities and staff
- Earn and retain the confidence of politicians and the public

- Prioritise and focus on the key issues and leverage points in the health improvement system
- Continuously increas capacity to deliver the health improvement agenda (e.g. through training and development)
- Engage operational staff and others in actively delivering health improvement
- Develop organisational cultures that are receptive and positive environments for change.

Health Improvement System

Leadership and Health Improvement

Leadership

Important Knowledge and Skills

Leadership for Improvement
Improvement of Leadership

A SUCCESSFUL LEADER ...

- Communicates a clear (shared) vision direction and roles
- Strategically influences and engages others
- Challenges thinking and encourages flexibility and innovation
- Drives for results and improvement
- Builds leadership skills in others
- Practices political astuteness
- Displays self-awareness and emotional intelligence
- Builds relationships and works collaboratively
- Nurtures a culture in which leadership can be developed and enabled
- Demonstrates mastery of management skills
- Ethically manages self, people and resources
- Commits with passion to values and misson.

A SUCCESSFUL IMPROVEMENT LEADER ...

- Sees whole systems and any counter-intuitive linkages within them
- Brings inthe experiences and voice of the community and staff.
- Seeks to create new evidence and to translate evidence into practice
- Exposes processes to mapping, analysis and redesign
- Applies engineering concepts of flow, capacity, demand and waste-reduction
- Encouragesflexiable, innovative rethinking of processes and systems
- Facilitates reflective practice
- Sets up measurement to demonstrate impact and gain insight into variation
- Develops quality and risk management within an evaluation culture
- Works constructively with the human dimension (psychology) of change
- Sustains past improvement and drives for continuous improvement
- Spreads improvement ideas and knoeledge widely and quickly.

APPENDIX 3. SKILLS FOR HEALTH

Units. Each includes unit summary, outcomes of effective performance, behaviours which underpin effective performance, knowledge and understanding.

A. Managing self and personal skills

    A1. Manage your own resources (knowledge, understanding, skills, time). Skills include setting objectives, communicating, planning, time management, evaluating, reviewing, learning, obtaining feedback, self-assessment. For team leaders.

    A2. Manage your own resources and personal development. Skills as A1 plus stress management, reflecting, prioritizing. For first line, middle, and senior managers.

    A3. Develop your personal networks. People in and outside your organisation. Skills: communicating, setting objectives, questioning, time management, information management, presenting information, influencing and persuading, reflecting, learning, evaluating, risk management. For middle and senior managers.

B. Providing direction

    B1. Develop and implement operational plans. For middle managers
    B2. Map the environment in which your organization operates
    B3. Develop a strategic business plan
    B4. Put the business plan into action
    B5. Provide leadership for your team
    B6. Provide leadership in your area of responsibility
    B7. Provide leadership for your organization
    B8. Ensure compliance with legal, regulatory, ethical, and social requirements
    B9. Develop the culture of your organization
    B10. Manage risk
    B11. Promote equality of opportunity and diversity in your area of responsibility
    B12. Promote equality of opportunity and diversity in your organization

C. Facilitating change

    C1. Encourage innovation in your team
    C2. Encourage innovation in your area of responsibility
    C3. Encourage innovation in your organization
    C4. Lead change
    C5. Plan change
    C6. Implement change

D. Working with people

    D1. Develop productive working relationships with colleagues
    D2. Develop productive working relationships with colleagues and stakeholders
    D3. Recruit, select, and keep colleagues
    D4. Plan the workforce
    D5. Allocate and check work on your team
    D6. Allocate and monitor the progress of work in your area of responsibility
    D7. Provide learning opportunities for colleagues

E. Using resources

    E1. Manage a budget
    E2. Manage finance
    E3. Obtain additional finance for the organization
    E4. Promote the use of technology within your organization
    E5. Ensure your own actions reduce risks to health and safety
    E6. Ensure healthcare safety requirements are met
    E7. Ensure an effective organizational approach to health and safety

F. Achieving results
   F1. Manage a project
   F2. Manage a programme of complementary projects
   F3. Manage business processes
   F4. Develop and review a framework for marketing
   F5. Resolve customer service problems
   F6. Monitor and solve customer service problems
   F7. Support customer service improvements
   F8. Work with others to improve customer service
   F9. Build your organisation's understanding of the market and its customers
   F10. Develop a customer focused organization
   F11. Manage the achievement of customer satisfaction
   F12. Improve organizational performance

SKILLS		
setting objectives	communicating	planning
time management	evaluating	reviewing
learning	obtaining feedback	providing feedback
self-assessment	stress management	reflecting
prioritizing	questioning	information management
presenting information	risk management	delegating
networking	involving others	innovating
consulting	monitoring	building consensus
thinking strategically	analyzing	decision making
scenario building	leadership	balancing competing needs and interests
influencing and persuading		problem solving
leading by example	motivating	valuing and supporting others
managing conflict	following	empowering
coaching	mentoring	inspiring
reporting	contingency planning	thinking systemically
benchmarking	thinking creatively	reflecting
team building	negotiating	assessing
empathizing	stress management	demonstrating
acting assertively	questioning	forecasting
thinking with a focus on customers		