PROGRAMS THAT WORK: ISSUES OF LEADERSHIP

by William A. Anthony, Ph.D.

Did you ever wonder why some programs seem to work better than others? Why these settings seem so "user friendly"? Why these programs have better outcomes? I have. And I think I'm learning some more answers.

When Dan Weisburd invited me to visit and to write about the Village for The JOURNAL it was an easy invitation to accept. It was a chance to become re-acquainted with Martha Long and to meet the Village staff and clients. I told Dan that I would like to focus my visit on the staff that make the program work and not the program structure itself. You see, I think we know enough about what programs need to do to improve their process and their outcomes. The Center for Psychiatric Rehabilitation is now well into its second decade of assisting programs to change their operations based on state-of-the-art knowledge, philosophy and technology. What interests me now is why some programs try to use what the field knows while others seem to be stuck in the past?

I was able to meet with Martha and her staff at the Village and over dinner, attend a team meeting and a student training seminar, participate in an organizational strategic planning meeting, and observe staff and clients interact in the course of the Village's daily life. I was trying to understand what leadership strategies might contribute to the Village's success.

One of the first things I learned was that staff had struggled to develop a mission statement that reflected staff and member consensus. It was important to note that the mission statement which emerged was brief and stated what ***consumer outcomes*** were trying to be achieved, rather than the typical platitudes. Mission statements of this type seem to me to characterize programs that work. ***Leadership insures that all staff and recipients of service know what the intended outcomes of the program are.*** Less successful leaders seem to write long-winded mission statements which no one can remember and which focus on process rather than outcome. These non-memorable mission statements include descriptions of services, settings, staff, etc. but no mention of consumer outcomes. In contrast to these purposeless mission statements is the Village mission statement: ***"The mission is to encourage the empowerment of adults with psychiatric disabilities to successfully live, socialize, learn and work in the community."***

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The Village leadership is big on consensus management. But not so big that consensus cannot give way to specific leadership direction. Martha believes that it is now time for the Village to make a concerted effort toward more work placements in the community. While many of her staff probably agree with this direction this is a decision for which Martha did not seek out consensus. Some leadership decisions stem from the leader's unique perspective. ***Programs that work have***

WILLIAM A. ANTHONY, Ph.D. is Executive Director of Boston University's Center for Psychiatric Rehabilitation and is Professor in the Sargent College of Allied Health Professions at Boston University.

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leaders who can discriminate when consensus is and is not necessary.

As a principle, the Village leadership attempts to empower its staff. It is difficult to encourage consumer empowerment when the staff is burdened by regulations and procedures which are themselves disempowering. *Staff disempowerment* is often one of the biggest obstacles to consumer empowerment in traditional inpatient and outpatient settings. Each team at the Village is empowered by a knowledge of the consumer-based mission and by having responsibility for their own budget and their own priorities about how to spend their budgeted dollars. In this way staff experience the consequences of their own program priorities. ***Leaders in programs that work have a strong, consumer-based mission statement that is central to the whole organization, while at the same time the day-to-day operations are decentralized to individual program units.***

Programs that work seem to have leaders who can easily articulate the organization's most critical values. Staff at all levels of the Village respond to questions about values with such phrases as "member centered," "consumer choice," "no-reject," "continuity of care", and "consumer work opportunities." In effective programs values do not just serve as written pap for the agency brochure. Different decisions are measured with respect to their consistency with the program's values. Sometimes values themselves conflict and Village staff must reprioritize their values. I saw a team struggle with a member's choice not to work that particular day for what the staff considered to be a very poor reason. Do staff, in this instance, respect the member's choice or consider the importance of the member developing a worker identity? In this instance a majority of team members voted to send someone to the member's home to convince him to come to work. ***In programs that work empowered staff make decisions based on explicit agency values rather than on implicit psychiatric theories.***

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Interestingly, in a capitated funding program such as the Village, cost containment is a major value, which at first glance might seem to conflict with such agency values of choice, client centeredness, and the like. Leadership, however, has accepted the notion that these apparently conflicting values of cost-containment and quality outcomes can co-exist. Staff and members seem to understand that neither staff nor members can have everything they want, but must make decisions within a budget where every service has a cost to the program. The predicted clash between the program's consumer based values and the system's cost containment values has not undermined program quality. By empowering each team to make its own team's budget decisions, the program and system leadership is not seen as making the service decision based only on cost. Team members themselves are empowered to deal directly with situations in which the values of cost and quality may be in conflict. Interestingly, the purchase of private psychotherapy, while never a large part of the budget, has decreased over time to near zero. Another indication of the teams' cooperative effort in managing costs is their joint initiative in developing a "catastrophe fund," as protection against unplanned, unavoidble and extensive treatment expenses.

The Village, like other programs that work, is constantly planning for change. Agency focused strategic planning, which I witnessed, as well as program specific changes about which I was informed, seems to be a constant.

Programs which are in the business of changing people must be constantly in the business of changing themselves. As an organization, the Village is investigating new opportunities – such as expanding its member base, training and dissemination functions, and upgrading the expertise of its staff. In particular, the upgrading of staff is especially critical at this period in the Village's development in order to avoid program stagnation and calcification. When an innovative program such as the Village is rushed to begin its operations, most of the initial energy is focused on program design, and on developing basic program policies and procedures. Staff are recruited and selected based on attitudinal compatibility, energy level and credentials. These characteristics, combined with an innovative program structure, ensure initial program success. ***However, at some point if a program seeks to move to even more effective levels of services then the agency emphasis must not only be on program development but also on staff development.*** The Village is currently exploring staff development possibilities as they move to a more intensive emphasis on supported work.

As I reviewed the identification of Village leadership strategies on my plane ride back to Boston I was struck by how attainable they are: developing a consumer based mission statement, discriminating when consensus based management is and is not necessary, empowering line staff, specifying explicit values, accepting cost containment as a legitimate value, planning for change, and ongoing staff development activities.

The question with which I began this paper has been replaced by new questions. Who is training this generation of leaders to run our next generation of programs? **Will our universities be as remiss in this function as they have been with respect to training practitioners to staff these innovative programs?** I think so. Faculty interest and expertise in training mental health leaders currently ***does not exist*** on the campus.

It is up to public mental health leaders and consumer and family organizations to pressure universities to hire agency leaders such as Martha Long to train mental health leaders in their university training programs. The philosophy, technology and knowledge base is strong enough to make model programs mainstream programs. The question remains – is the leadership? ■