

Nursing Leadership for
Mental Health and Addictions Healthcare
Megan Delleman
Kwantlen Polytechnic University

Nursing Leadership for Mental Health and Addictions Healthcare

According to the Canadian Centre for Occupational Health and Safety (2018), “about one in five Canadians experience mental health issues at some point during their working years” (n.p.).

Furthermore, it is estimated that in Canada, costs associated with the provision of healthcare services, lost workdays, and work disruptions second to mental health challenges accrue to more than \$50 billion per year; figures that will continue to build and contribute to profound long-term economic impact (Mental Health Commission of Canada, 2016). These stark figures paired with concerns related to the growing national overdose injury and death public health crisis suggests both an acute failing of the current system and substantial opportunity for industry and healthcare leaders to work towards improving conditions for some of the country’s most vulnerable.

It is the intention that the findings articulated in the following will empower nurses and/or nursing students to utilize identified knowledge and strategies in order to mitigate the experience and/or propagation of stigmatization, conduct safe, trauma informed care, and remain active in their advocacy and client partnership. As stigma, cultural, legal, and ethical issues in mental health and addictions healthcare have the potential to create barriers between the nurse and client, subsequently propagating stigma, imposing harm, and poor health outcomes, maintaining a sound understanding of strategies for effective nurse leadership will work to combat these issues and shift this narrative in a positive way. This paper will investigate nursing leadership roles that contribute to harm reduction, the mitigation of stigma, and improved outcomes in the context of mental health and addictions healthcare in our current system. Three areas of nursing leadership for responsible mental health and addictions healthcare to be applied in a broad range of settings will be discussed in the following, and include: trauma informed practice as a form of leadership, educational leadership, and leadership through advocacy and partnership.

Trauma-Informed Practice as a Form of Leadership

Manderscheid (2009) notes that in recent years it has become increasingly apparent that “trauma is a major risk factor for the onset of mental and substance-use conditions... [and that] previous trauma, particularly physical or sexual abuse, is clearly implicated in subsequent mental health problems for many persons” (p.79). With this insight, the importance of trauma-informed care for the management and treatment of mental health and substance use disorders becomes starkly apparent. For the purposes of this review, *trauma* can be understood as “having three aspects: exposure to harmful and/or overwhelming event(s) or circumstances, the experience of these event(s) which will vary from individual to individual, and effects which may be adverse and long-lasting in nature” (British Columbia Ministry of Children and Family Development, 2016, p.4). From this definition of trauma, *trauma-informed practice* can then be understood as the consideration, integration and understanding of the effects of trauma “into all levels of care, system engagement, workforce development, agency policy and interagency work” (British Columbia Ministry of Children and Family Development, 2016, p.4).

Equipped with the understanding that trauma has the potential to be a major contributor to many of the mental health and substance use conditions we see permeating the Canadian healthcare system, trauma-informed leadership will be key not only in the context of education for nurses, students and the public, but in frontline work and client care in many capacities. Where continued stigmatization of mental health and addictions related issues continues to create barriers for healthcare access and equity in this regard, it is of key interest for trauma-informed nurse leaders to grow in both scope and numbers within current system, and aim to build capacity within individuals, communities, and institutions as a way of working to mitigate stigma, reduce harm, and improve client outcomes. It can be argued that these barriers to care associated with fear of judgment or stigmatization *themselves* can be traumatizing for an individual, population or community, perpetuating a vicious cycle of reduced “help-seeking”

behaviors and internal/self-stigmatization. Mildon (2017) proposes that key in addressing issues impacting the current system includes shifting focus towards trauma-informed, client centred, and barrier-breaking care, and that the integration of recovery, safety, and accountability narratives via nurse leaders is vital. With this, it is of critical importance that capacity is grown within the Canadian healthcare system through both education and informed utilization of identified effective strategies for trauma-informed care as we move forward.

It can be said that trauma informed practice as a form of leadership is essential in the successful reorientation of current maladaptive mental health and addictions healthcare narratives which contribute to the perpetuation of stigmatization and barriers to safe and equitable care. As relevant discussion in the world of mental healthcare “point to the central role that trauma plays in the development and course of mental illness” (Manderscheid, 2009, p.78), it is important for nurse leaders to equip themselves with the knowledge of what it takes to provide safe, compassionate, culturally competent care while recognizing the potential effects that trauma can have on the mental health of individual, populations and communities. Again, the British Columbia Ministry of Children and Family Development (2016) recognize that “a key aspect to trauma-informed practice is that it is delivered in a culturally safe manner to people from diverse backgrounds...[which] includes cultural sensitivity toward Aboriginal peoples, refugees, immigrants, and people of different religions, ethnicities and classes, and requires a commitment to ongoing professional development in cultural agility” (p.3). From this it can be gleaned that via trauma informed practice competency, mental healthcare inequity, stigmatization, and poor client outcomes can be addressed and combatted head on, and that progress can be made to improve conditions in the Canadian mental health and addictions healthcare system.

Educational Leadership

It may be argued that *educational leadership* can act as a backbone for growth and development towards improved outcomes in healthcare settings, the extenuation of stigma, and harm reduction in the Canadian mental healthcare system. According to Kelsey and Hayes (2012), the ability to critically reflect and achieve personal understanding lies at the heart of the forward thinking, motivated nurse leader, and that it is this self-awareness that is required in the “development of safe and effective practice teachers” (p.18) and educators. In the context of this paper, *educational leadership* can be regarded as “embedding notions of enhancement, innovation and change, with impact that extends beyond [a classroom or learning environment] (University of British Columbia, 2016, n.p.), and will be discussed in the following in two contexts: nursing education and education of the public.

Nursing Education

In both school-based and vocational learning environments, growth through education and the building of knowledge in the nurse or nursing student is often conspicuously propagated by a nurse leader, be it university faculty, nurse preceptors, unit managers, or nurse educators. In these educational contexts, it may be argued that in order to successfully build capacity in the learner, the nurse leader must employ strategies conducive to the effective mutual exchange of information and perspective between leader and learner. According to Choi, Kim & Kim (2018), leadership in the context of nursing education “is the interpersonal influence that leads to achievement of goals through *communication*... [and that the] leader's role in achieving organizational goals largely depends on how well they communicate” (p.102). It is further asserted by these authors that educational leadership is facilitative of the achievement of nursing unit goals and improved performance in nursing staff via this effective communication, which speaks to the profound potential impact that education through effective communication can have not only on the learner or team, but on the patient through improved care and outcomes on the unit. With this, goals for the development of future nursing educational leadership

should indeed focus on the building up and fostering of communication skills at postsecondary, undergraduate, and postgraduate levels.

Where communication lies at the heart of safe and effective educational leadership (Choi, Kim & Kim, 2018), current research has consistently focused on the many ways in which this form of leadership can impact how mental health and addictions healthcare is delivered in varying forms. For example, as emotional exhaustion and turnover have been shown to negatively impact client outcomes, contribute to higher costs, and negatively impact service quality (Green, Miller & Aarons, 2013), it can be argued that educational leadership to combat burnout is of great potential value in the context of mental health and addictions care settings. Within the provided definition of educational leadership lies “enhancement, innovation, and change,” terms which speak to the *transformational* nature of the work of the educational leader. Looking closely at the moderating nature of *transformational leadership* in relation to mental health provider burnout and subsequent potential workplace turnover, Green, et al. (2013) provide keen insight into how transformational leadership can be applied in an educational context, and maintain that the presence of a transformational leader – characterized by “idealized influence, inspirational motivation, intellectual stimulation, and individual consideration” (Green, et al., 2013, p.374) - acts as a defence against healthcare providers emotional exhaustion and risk for turnover. They further suggest that leadership in this form is key particularly in times of organizational change, and that propagation of leadership development programs is vital in the reduction of staff turnover and subsequent implications (Green, et al., 2013). As the perpetuation of institutional and systemic staff burnout has the acute potential to trickle down to those receiving care, maintaining an awareness of the positive impact that transformational nurse leadership can have on deterring or “buffering” emotional exhaustion through education is arguably of great value in the context of mental health and addictions healthcare.

Education and Engagement of the Public

While educational leadership efforts in the context of nursing or student nursing development is evidently essential to progress in mental health and addictions healthcare outcomes, harm reduction, and stigma reduction, the same might be said for educational leadership in the context of *education of the public*. Improved mental health literacy, prevention, early intervention, barrier reduction and “help-seeking behavior” promotion are recognized in relevant research as current priorities for growth within current systems (Bjørnsen, Eilertsen, Ringdal, Espnes & Moksnes, 2017; Lubman, Berridge, Blee, Jorm, Wilson, Allen & ... Wolfe, 2016), and can arguably be addressed by the educational nurse leader in clinical, community, public, and global health capacities. According to Lubman, et al. (2016), though policies and strategies to manage mental health related concerns have shifted from treatment to prevention, young people continue to “keep their problems to themselves or turn to their peers, with multiple barriers to help-seeking consistently identified among adolescents” (p.7). Furthermore, Speros (2009) recognizes that older adults are disproportionately represented in terms of inadequate health literacy, and that “multiple teaching strategies that are tailored to accommodate the cognitive, physical, and psychological changes associated with aging, such as clear communication that is purposeful...individualized and a patient-centered approach that demonstrates acceptance and respect, are actions that the nurse must take to promote health literacy in the older adult” (n.p.). This goes to show that there remains a conspicuous opportunity to address current system failings regarding public education through the action of the educational nurse leader in all healthcare contexts and for client demographics across the lifespan.

Advocating for policy change has been recognized as a strategy for evoking change on community, national or global scales, and is an approach that remains well within the scope of the nurse leader to pursue when looking to make changes within current mental health and addictions care

climates (Paluck, Williamson, Milligan and Frankish, 2001). According to Paluck, et al. (2001), “while regional health policy-making processes are influenced by a number of economic, political and social considerations, these processes are also increasingly being driven by a desire for evidence-based decisions” (p.19). With this, it could be the case that the nurse independently or within their community takes measures to become informed and knowledgeable about the range of considerations and processes acting as barriers for change, or which can help to promote positive change. This can be done through review of current and relevant research, the consultation of experts or industry officials, or through the independent development of research on the health topic or target audience at hand. It is from a sound base of knowledge and understanding of the target audience or health promotion topic that the nurse can effectively partner or collaborate with community groups or organizations with the goal of seeking change in current national or global healthcare environments through policy change. This notion is again solidified by authors Lalonde, Mendez and Perron (2010) who note within their study that by “possessing the knowledge, skills, and influence to positively impact practice at the service delivery level, [nurses] can also advocate for change at the policy level and lobby for higher priority and greater investment...at the national level” (p.2133). With this it can be said that the nurse is best able to engage within their given role in order to promote healthy lifestyles, health promotion, and disease control from a place of knowledge of key issues, target audiences, geopolitical or cultural strengths and barriers to health and healthcare equity, and current global health perspectives and established goals. Again, it is from a sound base of knowledge that the educational nurse leader is best able to educate and advocate for others, and that through the prioritization of life-long-learning and self-development that positive change can continue to be made over time by the individual.

Though *educational leadership* is discussed within this review in only a handful of contexts, it should be noted that nurses and/or student nurses can demonstrate educational leadership in *any* context.

Be it on an acute care psychiatric unit, in an outreach capacity in the community, or behind the scenes working to address issues that exist within current policy, the engaged, informed, and communicative nurse has the potential to take meaningful strides towards equitable, accessible, and effective healthcare for those living with mental illness or addictions related issues. Research consistently points to the idea that educational leadership contributes to sound professional practice in the context of improving client outcomes, reducing stigma, and mitigating harm in various mental health-addictions contexts. With this, it should be the case that educational nurse leaders develop in numbers to better address issues impacting healthcare systems and populations across the country.

Leadership Through Advocacy and Client Partnership

It can be argued that advocacy remains a critical component of safe, competent care within mental health and addictions healthcare, and is often based in education and support towards empowerment of individuals to participate in their own health and growth. Hughes (2008) argues that nursing leaders are those who show courage under duress by stepping up, are able to adapt and respond in the face of complex institutional and/or health challenges, face and embrace change, and acknowledge and address the needs of constituencies. It is through this courage and action that nurses are able to advocate for their clients in the most pressing of times or situations, and from which the potentially vulnerable and stigmatized are able to find voice in both institutional and community contexts. It may also be argued that it is via this “stepping up” that the nurse is able to equip the client with tools necessary for sustainable self-advocacy (i.e. via teaching and knowledge sharing, provision of harm reduction supplies, connection with community supports or allied health services, etc.). According to East and Roll (2015), self-advocacy has the potential to “create new processes or knowledge that others can use in advocating for themselves” (p.284) for growth beyond the therapeutic relationship. With this, the nurse may work to recognize where opportunities to nurture and support the client lie in order to

promote independence and autonomy in the client on an individual level. Collaborative care is a mutual process in which the nurse and client work collectively to meet the unique needs of the individual, and should be prioritized as a strategy for improving patient outcomes and mitigating both self and external stigmatization.

Conclusion

Through an evidence-based articulation of leadership roles for the mitigation of stigma, harm reduction, and improved client outcomes, this review found that trauma informed practice, educational leadership, advocacy and partnership can be employed to evoke positive change within the current Canadian mental health and addictions healthcare climate. It is through the integration of these leadership styles that the engaged nurse can take strides towards improving conditions for some of the country's most vulnerable. Through the propagation of leadership theory via educational institutions and/or workplace educational initiatives, the nurse may feel empowered to act in leadership within any nursing role, contributing in turn to harm reduction, the mitigation of stigma, and improved client outcomes. Furthermore, through education not only can harm reduction and strategies for reducing the prevalence of stigma be taught, but educational nurse leaders can grow in both scope and numbers, disseminating knowledge based on evidence and in turn improving client outcomes within various mental health and addiction care settings. It has been identified that through advocacy and client partnership the nurse can support the client in a range of capacities to feel empowered and an authority in their own care. Nurses and/or student nurses can demonstrate educational, trauma-informed, and advocacy leadership in *any* context, and the engaged, informed, and communicative nurse has the potential to take meaningful strides towards equitable, accessible, and effective healthcare for those living with mental illness or addictions related issues.

References

- Bjørnsen, H. N., Eilertsen, M. B., Ringdal, R., Espnes, G. A., & Moksnes, U. K. (2017). Positive mental health literacy: development and validation of a measure among Norwegian adolescents. *BMC Public Health*, 17(1), 1-10. doi:10.1186/s12889-017-4733-6
- British Columbia Ministry of Children and Family Development. (2016, Nov). *Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families*. Retrieved from https://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/trauma-informed_practice_guide.pdf
- Canadian Centre for Occupational Health and Safety. (2018). *Mental Health: Awareness*. Retrieved from https://ccohs.ca/products/courses/distributors/worksafe_sask/mh_awareness/?url=/products/courses/distributors/worksafe_sask/mh_awareness/
- Choi, E. H., Kim, E., & Kim, P. B. (2018). Effects of the Educational Leadership of Nursing Unit Managers on Team Effectiveness: Mediating Effects of Organizational Communication. *Asian Nursing Research*, 12(2), 99-105. doi:10.1016/j.anr.2018.03.001
- East, J. F., & Roll, S. J. (2015). Women, Poverty, and Trauma: An Empowerment Practice Approach. *Social Work*, 60(4), 279-286. doi:10.1093/sw/swv030
- Green, A., Miller, E., & Aarons, G. (2013). Transformational Leadership Moderates the Relationship Between Emotional Exhaustion and Turnover Intention Among Community Mental Health Providers. *Community Mental Health Journal*, 49(4), 373-379. doi:10.1007/s10597-011-9463-0
- Hughes, F. (2008). Leadership in mental health nursing. *Journal Of Psychosocial Nursing & Mental Health Services*, 46(9), 8-9.

- Kelsey, C., & Hayes, S. (2012). A Framework for Educational Leadership. *Primary Health Care*, 22(8), 16-19.
- Lalonde, A., Menendez, H., & Perron, L. (2010). The Role of Health Professional Associations in the Promotion of Global Women's Health. *Journal Of Women's Health (15409996)*, 19(11), 2133-2137. doi:10.1089/jwh.2010.2073
- Lubman, D. I., Berridge, B. J., Blee, F., Jorm, A. F., Wilson, C. J., Allen, N. B., & ... Wolfe, R. (2016). *A school-based health promotion programme to increase help-seeking for substance use and mental health problems: study protocol for a randomised controlled trial*. *Trials*, 171-10. doi:10.1186/s13063-016-1510-2
- Manderscheid, R. (2009). Trauma-informed leadership. *International Journal Of Mental Health*, 38(1), 78-86.
- Mental Health Commission of Canada. (2016). *Strengthening the Case for Investing – Background*. Retrieved from <https://mentalhealthcommission.ca/English/case-for-investing-background>.
- Mildon, B. (2017). Mental Health Nursing Practice -- Recovery, Safety and Accountability. *Nursing Leadership (1910-622X)*, 30(3), 9-12.
- Paluck, E., Williamson, D., Milligan, C., & Frankish, C. (2001). The use of population health and health promotion research by health regions in Canada. *Canadian Journal Of Public Health*, 92(1), 19-23.
- Speros, C. (2009). More than words: promoting health literacy in older adults. *Online Journal Of Issues In Nursing*, 14(3), 6.
- University of British Columbia. (2016). *An Educational Leadership Mapping (ELM) tool for teaching and educational leadership*. Retrieved from <https://ctl.ubc.ca/programs/all-our->

[programs/teaching-and-educational-leadership/an-educational-leadership-mapping-elm-tool-for-teaching-and-educational-leadership/](#)