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Providing Nursing Leadership in a Community Residential Mental Health Setting

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ABSTRACT

The worldwide burden of mental illness is increasing. Strong leadership is increasingly emerging as a core component of good mental health nursing. The aim of this article is to demonstrate the ways in which nurses can provide strong and consistent leadership in a values-based practice environment that embodies respect for individuals' dignity and self-determination within a community residential mental health service, which provides a structural foundation for effective action. This is accomplished through the presentation of two vignettes, which highlight how the seemingly impossible becomes possible when an economic paradigm such as agency theory is exchanged for a sociological and psychological paradigm found in leadership as stewardship at the point of service. It is through stronger nursing leadership in mental health that stigma and discrimination can be reduced and better access to treatments and services can be gained by those with mental illness. Nurse leadership in mental health services is not new, but it is still relatively uncommon to see residential services for "high needs" individuals being led by nurses. How nurses meet the challenges faced by mental health services are often at the heart of effective leadership skills and strategies.

With mental health being a critical area of health and disability around the globe and the growth in evidence surrounding the burden of disease and disparities of health status among those who have mental illness, it is important that nurses take a more active role in addressing this key health issue. Nurses are an important component of the workforce, and in many countries, they provide the bulk of care (World Health Organization [WHO], 2007). Thus, nurses are ideally placed to tackle the issues facing mental health consumers.

Mental health nursing combines professional therapeutic "people" skills with technical skills. This combination involves specialized, evidence-based knowledge, skills, and attitudes in patient observation, assessment, individual and group interventions, and care. Nurses also provide support to families within a therapeutic environment and work with other disciplines within a wider health care team.

MENTAL HEALTH NURSING LEADERSHIP

Strengthening mental health nursing leadership is imperative to tackling health and social issues for consumers. There is consensus that leadership is an essential practice, but it remains a concept that has different meanings depending on the particular nursing discipline in which one works. Effective nursing leadership is a critical part of the ways in which nurses address issues facing people with mental illness, as well as the ways mental health services are developed and delivered. It is central to how change is managed in our relationships with other health professionals, consumers and their families, the public, and the political system (Hughes, 2006). Demonstrating leadership as a nurse is not without challenges, but its contribution to informing the behavior of others allows visions to be realized and potential to be seen (Cook, 2001; Mahoney, 2001).

Leadership is not always associated with a formal title (e.g., manager) and can happen within or between services, between and among colleagues, and external to formal management or accountability structures. At its most narrow definition, *leadership* is reliant on formal hierarchical structures and provides little scope for the development of excellence. However, at its best, leadership has the potential to stimulate and maintain positive change and growth of individuals and services.

Nursing leadership is also contextual. The culture and formal structure within which leadership is exercised influences the leader's ability to be effective. Alignment with the mission, vision, and values of an organization is imperative for the collective well-being of those being served and the self-actualization of the leader. By creating environments that promote values-based practices, respect for the person's dignity, self-determination, fairness, and equity (Murphy & Roberts, 2008) are more likely to be realized.

A useful definition of leadership involves understanding that it is "a process ordinary people use when they are bringing forth the best from themselves and others" (Canadian Nurses Association [CNA], 2005). In this context, leadership is not reliant on formal structures but is based on a series of themes, including courage, change, vision and goal setting, enabling and inspiring, enlisting others to get things done, relationships, honesty and integrity, and fostering leadership in others (CNA, 2005).

With regard to mental health nursing, there is also a focus on recovery—one of the most important themes of leadership in mental health services. *Recovery* is defined as "the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience)" (Mental Health Commission, 2001, p. 1).

These principles are reflected in the stewardship paradigm, which has a strong focus on the individuals and environment external to the nurse (or other practitioner). This paradigm is not only attractive because it is able to draw on a range of strengths from all participants in the process of care, but it is able to be demonstrated as being effective. Such a demonstration is outlined in the vignettes described in this article.

Effective nursing leadership is a critical part of the ways in which nurses address issues facing people with mental illness, as well as the ways mental health services are developed and delivered.

MENTAL ILLNESS AND SERVICE USE

All around the globe, mental health services struggle to address

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the complex needs of those with mental illness. The worldwide burden of mental illness is increasing. Mental illness and neurological conditions account for 30.8% of years lived with disability, and depression is estimated to account for almost 12% of all disability (WHO, 2010). Mental illness affects millions of people, but although we have means of effective treatment, only a small minority receive even the most basic treatment (WHO, & World Organization of Family Doctors, 2008).

People who use mental health services—in particular those with a diagnosis of schizophrenia or bipolar disorder—are at increased risk for a range of physical illnesses and conditions, including coronary heart disease, diabetes, infections, respiratory disease, and greater levels of obesity (Department of Health, 2006). In many cases, weight gain is a clear side effect of medication (Department of Health, 2006). They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease (Department of Health, 2006).

People with mental health conditions are among the most marginalized and most vulnerable individuals. They often experience violations of their human rights, exclusion from social and economic activities, and are frequently denied opportunities for education and employment (WHO, 2010). This is despite the fact that tackling mental illness is cost effective—similar in impact to the provision of antiretroviral drugs and glycemic control of diabetes (WHO, 2010).

The evidence is now compelling for mental health nurses, as well as primary care nurses, to be skilled in providing choices and assessment, as well as supporting healthy options and interventions, when working with mental health consumers. However, there is a shortage of skilled health professionals, often in the poorest countries with the greatest burden of disease (WHO, 2006). Nurses are the core health care providers in the mental health area, an area often forgotten and neglected among health services (WHO, 2007).

As the largest professional workforce, nurses have a leadership role to play to fight stigma and discrimination and to provide care to those with mental illness. Articulate, informed nurse leaders can help raise issues of human rights, prevent inhumane practices, and galvanize communities to improve the rights of those with mental illness. Nurse leaders have a great deal to offer (Hughes, 2010).

LEADERSHIP IN COMMUNITY MENTAL HEALTH SERVICES

The "Cinderella status" (i.e., achieving recognition after a period of obscurity) of mental health services contributes to a lack of recognition of mental health nurses as leaders (Hughes, 2008). This is by no means an excuse for poor leadership, and it is despite this that mental health nurses are emerging as leaders in service provision, policy making, and education (Hughes, Duke, Bamford, & Moss, 2006).

A range of factors have led to this high standard of leadership in mental health nursing. Some of these factors are within nursing itself, while others reflect changes in the ways in which mental health services are provided. Mental health nurses have traditionally had to work extra hard to gain recognition and inclusion, resulting in one of two attitudes: (a) a defensive and entrenched position whereby nurses feel "the world is against us," or (b) a belief that mental health nurses need to be "out there" supporting their colleagues and seeking continuous improvement of services for mental health consumers. For the most part, mental health nurses take the latter view. This view fosters leadership and has resulted in the mental health nursing workforce developing a style of leadership that is often further developed than that of other nursing disciplines (Hughes, Grigg, Fritsch, & Calder, 2007).

However, mental health nurses are not always well recognized by other nurses. This is possibly a reflection of the deeply ingrained prejudices toward people with mental illness that includes those involved in their care or a reflection that general nurses are not well trained in mental health. There are a number of examples of this, from the policy level where mental health nurses were excluded from a working group on primary health (Bennis & Nanus, 1985) to inpatient surgical facilities where nursing staff feel incapable of "managing" a patient whose needs in that facility are surgical but who also has a mental illness (Hughes, 2008). These attitudes demand our response as mental health nurses. Although it might be argued that it is the responsibility of nursing leaders in those disciplines to show leadership, the very lack of such leadership requires us to take action.

In view of the factors influencing mental health nurse leadership, how best might mental health nurses promote and improve existing skills in this regard? Returning to the introduction of this article, it is critical to remember that true leadership occurs across, within, and between organizations, and is not necessarily dependent on hierarchy (although managers should,

VIGNETTE 1: MRS. T.

Mrs. T. has a long history of bipolar disorder and type 2 diabetes for which she is insulin dependent. She has lived at home with her family and in other residential care facilities; however, over the years the combination of managing her bipolar symptoms and diabetes has been challenging. She has had many different primary care providers, making management difficult. She continues to have a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Mrs. T. came into the mental health service 8 months ago with no permanent primary health provider. She was 25 kg (55 pounds) overweight and taking 56 units of insulin in the morning and 22 units in the evening. Her blood sugar average was 18.6 mm/L. Her mental state was labile and volatile, and she spent long periods of time in a distressed state. Her diet consisted largely of processed foods and soft drinks. She had a long history of using as-needed medication to manage her acute symptoms.

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On entry to the mental health service, the RN established, in consultation with Mrs. T., a lifestyle and care plan involving regular assessment and monitoring with the mental health team and her family. Mrs. T. enrolled with a local primary health care provider and had access to a diabetes nurse specialist and full physical reviews by her general practitioner. Day-to-day care involves RNs and community mental health support workers. As a result, Mrs. T. is now experiencing the benefits of integrated mental and physical health care. The principal challenge throughout Mrs. T.'s time with the service has been her everyday lifestyle choices, particularly related to diet, weight management, and exercise. This has been greatly helped by daily in-home support to assist her with lifestyle choices throughout her mental health recovery process.

Mrs. T. now lives in a house with three other women and from the day of arrival has experienced a change in her dietary regimen in being introduced to fresh foods. She has been encouraged to take responsibility for her diet by helping determine what to grow in the vegetable garden and by shopping with staff at the local market. Access to a wide variety of healthy food and increased exercise have been successful in stabilizing her diabetes. Within 6 weeks of her placement with the service, Mrs. T.'s insulin was reduced to 24 units in the morning and 10 units in the evening. Her blood sugar average is now 8.5 mm/L, and she successfully lost 10 kg (22 pounds) within 10 weeks. As a result of lowering her blood sugar, Mrs. T.'s mental state has improved and she has become less agitated, demanding, and aggressive in her engagement with others.

of course, be expected to exhibit leadership). The competencies for mental health nurses articulated by *Te Ao Maramatanga* (New Zealand College of Mental Health Nurses, 2004) reflect the themes of leadership listed above, thus strongly indicating that leadership is expected of all mental health nurses.

Having a clear understanding of leadership and formulating expectations of mental health nurses are important in developing services. However, there is a corresponding need to ensure that formal training is available to enable nurses to practice and take advantage of their leadership skills in the provision of independent mental health services (O'Neil & Morjikian, 2003).

Internationally and recently in New Zealand, moves toward enabling nurses to become independent nurse practitioners has been a significant contribution to the development of nurse-led services. The competencies for nurse practitioners set out by the Nursing Council of New Zealand (2008) include a specific focus on leadership and require nurse practitioners to "demonstrate nursing leadership that positively influences the health outcomes of client/population group and the profession of nursing" (p. 5). This clearly indicates the expectation that nurses can, and should, provide leadership, including in an independent practitioner role.

New Zealand has also responded to this need through the development of formally recognized training. For example, *Te Pou o Te Whakaaro Nui* (The National Centre of Mental Health Research, Information and Workforce Development) has delivered (2004-2007) the first national mental health leadership and management development programmed for District

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Health Board and nongovernment organization (NGO) managers, and clinical and service use leaders. Te Pou believes there are only two programs of this kind in the world—programs that see leaders who are service users and health professionals learning alongside each other.

Mental health nursing has come a long way, and the changes have been even more rapid in recent times. Mental health nurses now take an active role in service provision and continue to lead service development. The expansion of services in the community has both enabled and been enabled by nurses' ability to provide leadership in the care and recovery of people with mental illness. Mental health services are now predominantly provided in the community rather than inpatient settings, and nurses are often at the forefront of the delivery of these services. Such services range from clinic-based services (e.g., antipsychotic intramuscular injection) to the provision and management of residential services in the community. Of course, this is not unique to New Zealand, with nurse-led mental health services being provided in the United Kingdom, Canada, Australia, and increasingly in developing countries where there are few doctors.

At this juncture, it is useful to note that the focus of this article on nurse-led services is not intended to argue against a range of other services delivered by other providers, including service users/consumers. The focus on appropriate service delivery should ideally be sufficiently broad to ensure a range of services that meet the needs and wishes of all consumers.

The increased ability of NGOs to provide services in the community has also been a driving force in the development of nurse-led mental health services. An example of this kind of service is a residential mental health service in a community north of Wellington, New Zealand.

VIGNETTE 2: MR. X.

Mr. X., in his late 50s, has a long-standing forensic mental health history and treatment under different aspects of New Zealand's mental health legislation. He had previously been living in the community with 6 hours per day of support worker input but required more oversight and active support. His team was multidisciplinary, but no nurses were involved.

On Mr. X.'s arrival at the mental health service residence, his documents outlined his mental health support requirements and risk and relapse plan, but little information was included about his daily living needs and physical concerns. The RN discussed this with his prior care team and noted that the team was unclear about the mental and physical aspects of Mr. X.'s daily living. Despite his apparently having had very close supervision, Mr. X. arrived at the service in a physically neglected state. He had multiple fungal infections, calloused and infected feet, untreated infected burns, severe constipation, and high blood sugar. He had trouble walking, and his mental health appeared to be deteriorating.

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The RN worked with Mr. X. and other health providers to resolve his issues and established a supportive, supervised activities of daily living program. Mr. X. no longer needs his walking stick, no longer buys and applies his own enemas, receives regular input from podiatry professionals, enjoys trips into the community, and enjoys his meals. He recently commented that he had not had this kind of support before. His mental illness has stabilized to the point where he has been discharged from compulsory status under mental health legislation. This caused Mr. X. some anxiety about the possibility of losing his current residence and the care that has made such a profound difference in his quality of life. Regardless of his legal status, Mr. X. remains in the care of this service and will continue to require ongoing care and close supervision to retain his current level of mental and physical health.

A NURSE-LED RESIDENTIAL MENTAL HEALTH SERVICE

This service provides community support to 20 residents who have a combination of mental illness and intellectual disability. The multicultural residents' needs are high and complex, with the majority having enduring and severe mental illness. The facility consists of four residential dwellings, and residents are supported by a team of RNs, community mental health support workers, and other staff.

The service demonstrates effective nurse leadership in the delivery of a residential mental health service that is part of its community. A range of services are provided, including those related to acute recovery, and the service has been successful in transitioning residents back into their communities, without subsequent intervention from acute mental health services. The service has established extensive relationships with the surrounding community, the local Primary Health Organization, other mental health NGOs, the local mental health team, and the Regional Forensic Mental Health Service.

The residents of this service come from many sources, including other NGO providers for which residents were no longer suitable, forensic medium-secure units, and acute inpatient units. This means that the service is experienced in supporting and managing residents with complex needs, including people who (a) have compulsory treatment orders under the Mental Health (Compulsory Assessment and Treatment) Act 1992, (b) have complex physical and aged-related conditions, and (c) are dying and chose to stay in familiar surroundings (with the support of district nurses). Although the residence was originally an all-male facility, it now includes five women. Residents are a mixture of cultures—Eastern Bloc European, British, Irish, and New Zealand European and Maori.

The vignettes provided in the **Sidebars** on pages 38 and 39 demonstrate how nurses can provide strong and consistent leadership in a values-based practice environment. These vignettes clearly demonstrate the contrasting paradigms of the *agent* versus the *stewardship* style of leadership. They also show how the concept of leadership in mental health includes a strong focus on recovery and, as part of that, there is a need to constantly advocate that all residents be respected and treated fairly. Both vignettes provide an accurate reflection of the concept of recovery; that is, both residents are able to live well in the presence of mental illness.

Recovery principles are apparent in that service residents have few admissions to inpatient mental health. For example, in August 2006, five residents were welcomed to the service from their previous accommodation that had its license revoked. All of these residents were successfully transitioned into the service and have not needed intervention from the acute mental health services since that time.

The expansion of services in the community has both enabled and been enabled by nurses' ability to provide leadership in the care and recovery of people with mental illness.

Sadly, there are also instances that provide stark contrast between the leadership demonstrated by many mental health nurses and those working in other services. There are many examples of how other health services can fail to meet the needs of people with mental illness (Hughes, 2008). How can this be? One explanation could be a difference in the philosophical underpinnings of the governance and leadership approach in these services. For some, care provision is seen as purely a business, and managers act as agents trying to maximize their utility, which can be at the expense of the consumer when consumers are not seen as people but rather as economic units. Agency theory tends to depict people as "individualistic and utility maximizers" (Davis, Schoorman, & Donaldson, 1997, p. 38), whereas stewardship theory depicts people as "collective self actualizers who achieve utility through organizational achievement" (Davis et al., 1997, p. 38). This demonstrates the extent to which those working in mental health services have an obligation to continually extend our leadership as stewards into other services.

The vignettes described here clearly demonstrate how nurses can provide strong and consistent leadership within a community-based, high-needs mental health service when the leadership is underpinned by the stewardship model and serves to restore the dignity and self-determination of the people in that service. Both Mrs. T. and Mr. X. had been cared for by other community teams but both were physically and mentally at risk of further serious illness.

The focus on leadership at this service includes continuous quality improvement, designed to enhance the lives of staff and residents. This involves strong clinical support and supervision for residents and a proactive approach to all health-related areas of residents' lives—screening, monitoring, and early intervention. Furthermore, it involves a belief that its residents should

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live well and walk tall in the wider community.

CONTINUING TO DEVELOP LEADERSHIP AMONG MENTAL HEALTH NURSES

Having determined the value and active presence of strong leadership among mental health nurses, it is equally as important to ensure such leadership continues to grow and develop (CNA, 2005). One of the strengths of effective leadership is its ability to identify and respond to challenges. It is tempting to perceive *challenges* as being negative and requiring some sort of struggle to overcome. Rather, challenges are inevitable and may be positive in nature, for example, the availability of a new medication, preparing a service user for transition into a new environment, and taking on a new role or establishing a new service. The emergence of a robust mental health consumer movement in New Zealand is a challenge and a delight—and has resulted in better services. The strength of mental health nurses as leaders is reflected by our ability to adapt to change and to foster leadership in others.

As noted in the preceding discussion, there is a need for formal training and recognition of leadership, as well as a common understanding of its principles and purpose. There is also a need for leadership to be an active process. Part of the role of nursing leaders and service providers is to continue the debate on leadership and to articulate what we expect from those involved in establishing training policy, competencies, and standards (Hughes, Duke, et al, 2006).

In terms of developing nurse-led services, nurses who are prepared to understand the business aspect of health services and who have a sense of entrepreneurship are necessary. Perhaps this is yet a further theme that can be added to those outlined previously.

CONCLUSION

The continuing development of strong and effective leadership by mental health nurses is a critical factor in the emerging provision of nurse-led services, including an increasing number and range of residential services for people with mental illness. Mental health nurses can exhibit the skills needed to lead within mental health services; these skills are not only valuable, but are critical in ensuring that services (including health, disability, and social services) meet the needs of the people using them. Effective leadership also ensures that staff are well supported and able to participate as leaders in their own right, regardless of their job title or position within an organization.

This article highlights some of the ways in which a nurse-led mental health service can provide effective residential services for people with long-term mental health and disability issues. The WHO (2010) specifically recognizes that people with mental illness are a vulnerable population and notes that people who are vulnerable due to other causes (e.g., illness, disability, poverty) are at increased risk for mental illness. Nurses have the opportunity to use their skills to build the strength and resilience of those who are vulnerable. Leadership within this context is not solely about management or ownership; rather, it is about enabling other people to perform at their best, toward common goals in a practice environment that respects the dignity of each person and offers the opportunity for self-actualization. Furthermore, it includes advocacy and the courage to tackle discrimination and stigma—both of which are often well entrenched in other health services. Goodwin and Happell (2006) recognized that social stigma attached to mental illness is often more debilitating than the illness itself.

As leaders, nurses working in mental health must have the courage to respond to such challenges and build the resilience

KEYPOINTS

Hughes, F.A., & Bamford, A. (2011). **Providing Nursing Leadership in a Community Residential Mental Health Setting.** *Journal of Psychosocial Nursing and Mental Health Services, 49*(7), 35-42.

1. Strengthening mental health nursing leadership is imperative to tackling health and social issues for consumers.
2. True leadership occurs across, within, and between organizations, and is not necessarily dependent on hierarchy.
3. The service described in this article demonstrates effective nurse leadership in the delivery of a residential mental health service that is part of its community.
4. Leadership in mental health nursing is about enabling other people to perform at their best, toward common goals in a practice environment that respects the dignity of each person and offers the opportunity for self-actualization.

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needed to ensure timely and appropriate responses. Challenges can arise at all levels—policy, legislation, service delivery, and through relationships with clients and various communities. Nurses should be prepared to address these many challenges, have sufficient strength to welcome them, the honesty and integrity to face them, and the courage to address them.

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