

Nursing Leadership: Making a Difference in Mental Health and Addictions

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Mental health – or the lack of it – is one of the most serious challenges facing the healthcare system. The scope of the problem is staggering. According to the Canadian Mental Health Association (CMHA), by age 40 about 50% of Canadians will have or have had a mental illness. Suicide accounts for 24% of all deaths among 15- to 24-year-olds and 16% among 25- to 44-year-olds – making it one of the leading causes of death from adolescence to middle age. Almost half of those who feel they have suffered from depression or anxiety have never seen a health-care provider or received treatment (CMHA 2017). Yet, a study by the Mental Health Commission of Canada (MHCC) estimated that in 2011 \$42.3 billion was spent on treatment, care and support services for those who did seek help. The Commission further estimated that these costs would exceed \$2.3 trillion within 30 years (MHCC 2013).

The costs to the economy are also significant. The Conference Board of Canada reported in 2012 that mental illnesses were costing the national economy about \$20.7 billion annually because of the reduced number of people in the workforce. It projected that this cost is growing at a rate of approximately 1.95% every year and would rise to \$29.1 billion annually by 2030 (CBC 2012).

In addition, issues such as the toll of mental illness on individuals, their caregivers and communities, negative media coverage, access to care – particularly for children and youth – further compound a difficult situation.

In the face of this, is there an opportunity for nurse leaders to make a difference? Are there areas in which nurses can have a unique impact? When the editorial team at the *Canadian Journal of Nursing Leadership* was considering questions like this, we went to five nurse leaders currently engaged in this sector. Each leader identified an area in which they see significant opportunity for nurses to provide leadership: nursing practice, continuity of care, technology and innovation,

stigma and patient partnerships. Over the next few pages, you will read their insights and perspectives on why these five areas are particularly important and what they believe is the opportunity for nurses to make a difference.

We encourage readers to think of this as a call for action, and to consider areas in which you can show leadership in making a difference in mental health.

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Mental Health Nursing Practice – Recovery, Safety and Accountability

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Psychiatric and mental health nursing is well established as a specialty practice in Canada through the Canadian Nurses Association's national certification program. Standards of Psychiatric-Mental Health Nursing are developed and published by the Canadian Federation of Mental Health Nurses (CFMHN) to inform and direct expert practice. Now in the fourth edition (McInnis-Perry et al. 2014), the introduction to the Standards emphasizes the need for psychiatric-mental health nursing to remain “contemporary, relevant and responsive” (p. 3). Keeping current with psychiatric-mental health nursing today includes (but is not limited to) integrating recovery-oriented practices into one's nursing care; implementing quality care standards; monitoring and taking action as indicated to improve outcome and/or performance metrics; understanding and incorporating approaches that optimize personal, team and environmental safety; relentlessly working to prevent the use of seclusion and restraint; facilitating seamless patient transitions through the health and social care systems; adopting co-design principles and being an advocate for the continued destigmatization of mental illness. These imperatives demonstrate today's psychiatric-mental health nursing to be a highly complex and challenging practice! Accordingly, a further explanation of each is warranted.

Recovery-Oriented Practice

The intent of establishing Recovery as both a goal and an approach to mental healthcare has taken root globally since approximately 2000. The Recovery model is based on a shared decision-making process between client and healthcare provider (Caldwell et al. 2010) in which the definition of Recovery encompasses healing, transformation and the ability to live a meaningful life while striving to realize one's full potential (McLoughlin et al. 2013). Recovery as both a goal and an approach to care is advanced and enabled by the patient's plan of care. However, a 2016 audit of Ontario's four specialty mental health hospitals by the Office of the Auditor General found low rates of completion for care plans, admission assessments and discharge planning – findings that prompted several key recommendations (Office of Auditor General of Ontario, 2016). Eliciting and documenting the "Patient Story" has emerged as a best practice in Recovery-oriented practice and is increasingly accommodated in both electronic and paper-based medical records. Nonetheless, one specialty mental health hospital found that only 36% of medical records contained a fully completed Patient Story. Co-design has more recently been highlighted as a best practice in mental health. The term refers to a partnership, or collaboration with patients/service users to co-design services (Larkin et al. 2015). The co-design approach reflects a "patients first" focus that is increasingly being emphasized by stakeholders and funders including Accreditation Canada. Understanding and implementing co-design is an emerging priority for mental health nurses that is synergistic with Recovery-oriented practice. Opportunities for nurses to learn about Recovery and co-design must be made available and a study by McLoughlin et al. (2013) called on employers to provide Recovery education to clinicians and to measure the degree to which Recovery-oriented practices were in place. Prioritizing implementation of those actions would strongly advance realization of Recovery-oriented care.

Equally as important as Recovery-oriented care in mental health nursing today is understanding and compliance with quality standards of care such as those recently mandated in Ontario by Health Quality Ontario and the Ministry of Health and Long-Term Care. The first of the standards were introduced in 2016–2017 and include Dementia, Schizophrenia and Depression (Health Quality Ontario 2017). Outcomes for these quality standards will be tracked and reported as a mechanism by which to standardize and optimize care for those complex diseases. Additional quality standards for mental health care are currently in development. Standardization of treatment and care in mental health is another trend unfolding as manualized therapies for conditions such as Borderline Personality Disorder and Post Traumatic Stress Disorder become increasingly established. These evidence-based, prescribed approaches to care enable both length of stay and clinician time to be predicted while demonstrating very positive outcomes for patients. Accordingly, they are an important tool to reduce long wait times for patients and enhance access to care.

The use of seclusion and/or mechanical restraint (S/R) in mental health nursing is now widely recognized as highly traumatizing to patients, especially if prolonged. While controversial, it has been suggested that the use of S/R represents a failure of care – moreover, because it is nurses that most often initiate S/R they must be the leaders in efforts to reduce or prevent such practices. It has been said that “what gets measured gets managed” and in Ontario, the group of four psychiatric specialty hospitals publicly report metrics related to restraint or seclusion utilization as a mechanism to promote accountability and ultimately achieve zero utilization (Ontario Shores 2017). Given the complexity and highly relationship-based care that characterizes mental health nursing, it is imperative that mental health nurses today are supported to learn about and integrate into their practice research-informed approaches such as Trauma-Informed Care, Safewards and Relationship-Based Care. These frameworks have been shown through research to enhance care and outcomes for both nurses and patients.

Safety in mental health nursing

Promoting safety for nurses and other healthcare team members is another imperative in today’s practice settings. Achieving safe environments requires focused effort that cascades throughout the organization, from the senior management team to the staff members providing the care. In addition to statutory requirements including the Joint Occupational Health Committee, it is important to mobilize other departments and services to create a robust approach to safety. Security personnel play a role in working with teams and patients and of course in responding to codes or personal safety device alarms. A dedicated violence prevention committee offers insight and ideas regarding trends or needs. Employee Assistance Programs can be accessed to provide timely debriefing to staff members after a critical incident. The senior management team’s regular review of safety-related metrics and associated responses further contributes to promotion of safety. Professional practice is a key partner in providing or overseeing safety training upon hire, annually and as needed. Furthermore, professional practice along with clinical educators, clinical nurse specialists are linchpins in providing education to staff on the patient care frameworks noted above. Clinicians themselves are central players in promoting safety. Implementing the patient care approaches associated with those frameworks into practice has been shown to promote safety by giving clinicians tools and knowledge to provide patient-centred care that can, for example, avoid triggers and/or effectively de-escalate a patient’s rising anxiety or distress. Reviewing and eliminating “norms or rules” within care units is another strategy the healthcare team can use to reduce tensions that can escalate into unsafe situations, for example, the times at which telephones or computers are available; when food is available or where it can be consumed; lights out policies, etc. Applying a “one size fits all” approach in patient care does not allow clinicians to use their clinical judgment in their patient care and undermines efforts to provide effective patient-centred care.

In closing

This brief overview has attempted to portray the complexity and emerging imperatives for contemporary psychiatric-mental health nursing. It will be important for these trends to be incorporated into the curriculum for both undergraduate and graduate education programs and for employers to support nurses in continually adapting their practice. Ideally, the development of a Nurse Practitioner-Mental Health designation will also emerge in the next few years. Hope is at the heart of recovery-oriented mental health nursing practice and it is nurses who often hold that hope for their patients until Recovery is achieved. Guiding patients towards the restoration of hope and Recovery, along with a practice that is dynamic and complex continues to make psychiatric-mental health nursing a meaningful and rewarding practice.

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Continuity of Care in Mental Health Services: A Critical Role for Nurses

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The concepts of transfer, transition and continuity of care are distinct, yet often not fully understood. This brief will define these concepts, place them within the current literature and public discourse, and argue that stronger continuity of care is vital to improving health outcomes. Furthermore, nurses have an important role in this process, particularly within mental health services.

Transfer is the termination of care in one service and re-establishment of care in another program or service (Paul et al. 2013) while transition aims to ensure continuity of care through a planned healthcare process that addresses personalized therapeutic and developmental needs (Blum et al. 1993). Continuity of care in Canada is defined by: (a) how a patient experiences care over time and (b) how care is received by a patient (Reid et al. 2002). It is when patients experience transfers in healthcare as connected, coordinated and meeting their care needs (Accreditation Canada 2013; Jeffs et al. 2013). Continuity of care must be coherent and linked as a result of good information flow, interpersonal and readiness skills and coordination of care (Reid et al. 2002).

Poorly coordinated transitions create unnecessary safety risks for patients, can delay treatment and unnecessarily increase costs to the healthcare system (Accreditation Canada 2013). On the other hand, in mental healthcare, better continuity of care has been associated with improved functioning, reduced healthcare costs, decreased mortality, improved patient satisfaction and improved quality of life (Adair et al. 2005; Puntis et al. 2015).

Ensuring effective mental health service transitions has been cited as a priority provincially and nationally in Canada. It was recently designated a priority action area in Ontario's Policy Framework for Child and Youth Mental Health (MCYS 2006), in Ontario's Mental Health and Addiction Strategy (MOHLTC 2010), and more recently by the Health Ministers of Canada, who specifically highlighted the importance of improving continuity of care particularly for young people who outgrow child mental health services (Canadian Intergovernmental Conference Secretariat 2016).

Designing more effective models of care, increasing interprofessional collaboration across child, adult and community mental health services and engaging patients and their families to develop care pathways will likely translate into a greater proportion experiencing continuity of mental healthcare. Nurses and nurse leaders are uniquely positioned across the continuum of healthcare in Canada to improve transitions and ensure continuity of care.

Given care transitions is a required operating procedure for Accreditation Canada (2013), it is likely that nursing leaders have been involved in tracers, quality of care and quality improvement initiatives in their organization to ensure patients are not falling through the cracks of our healthcare system. In addition, in collaboration with our interprofessional colleagues and patients, nurse leaders and researchers have an important role in developing, refining and prioritizing quality and process indicators to assess the effectiveness of current transition protocols and interventions (Cleverley et al. 2016; Jeffs et al. 2013). I believe nurses are not

just important players in this process, but nurses can demonstrate a leadership role within the healthcare system.

Resources available to support nurses in this work include the RNAO BPG on Care Transitions (RNAO 2014), Health Quality Ontario's transitional care planning document (HQO n.d.) and the Transition Clinical Practice Guideline developed by BC Children's Hospital for transitions from child to adult physical healthcare (BC Children's Hospital 2015).

As a profession, let's move together and lead the charge in ensuring stronger continuity of care in the Canadian healthcare system.

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Technology and Innovation in Mental Health

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Within Canadian mental health and addictions settings, there are a number of opportunities to leverage information and communication technologies (ICTs) to improve both access to services and outcomes. The Mental Health Commission of Canada (2014) reports that “technology in this area (mental health and addictions) is not as widely used or invested in, due to significant resistance and misunderstanding” (p. 1). Nursing leaders play an important role in the increase and successful utilization of ICTs in mental health and addictions settings. Namely, nursing leaders are well situated to identify contexts where ICTs may be used to address gaps in mental health and addictions services, advocate for the partnering and/or co-design of health ICTs with patients, support efforts that improve adoption amongst health professionals and ensure the ongoing efficacy and/or evaluation of these technologies. Nursing leaders should also consider advocating for those who require mental health and addictions services, but cannot or do not want to use health ICTs because of a number of reasons. Despite the tremendous value that these technologies may bring for some, when an individual does not use or have access to a health ICT, further marginalization could ensue and could lead to health disparities (McAuley 2014). Nursing leaders can play an important role in ensuring that no one is left behind as Canadian mental health and addictions care contexts are digitally transformed.

Across Canada, there have been a number of examples of uses of ICTs to support mental health and addictions care delivery; however, much progress is still to be made. Electronic health records (EHRs) have been adopted in a number of mental health and addictions settings in an effort to improve information quality and processes used to make decisions and deliver care. In some of these organizations patient portals have also been developed, where patients may have

access to parts of their EHR. In Ontario, more than 100,000 people are seen through *Telepsychiatry* annually, therefore improving access to mental health care in situations where travel or wait times present challenges (OTN 2017). As well, mobile applications are available to support individuals with a number of aspects of mental health including anxiety management, the reduction of distressing emotions, sleep hygiene, relaxation, symptoms of post-traumatic stress disorder, medication reminders and others. Given the number of applications currently available, Dr. Kendall Ho from the University of British Columbia developed *health-e-apps* to support health professional and consumer decision-making regarding the appropriate selection of health-related mobile applications (University of British Columbia 2013).

Despite these examples, progress still needs to occur before ICTs will be able to effectively support person-centred mental health and addictions care. To do so, more organizations will need to adopt technologies that offer patients the opportunity to engage in their own health decision-making, self-management and care, e.g., through comprehensive patient portals linked to organizational EHRs. These efforts will need to be done in a coordinated interoperable fashion, where data obtained from patients can be used in combination with health-professional generated data from multiple sites and sources. Although in its early stages of development, translational bioinformatics (clinical data from EHRs combined with genomic data) within the mental health and addictions context may allow for the prediction and prevention of certain conditions, and may support personalized medicine and care (Tenenbaum 2016). This is one of a number of very promising and meaningful future uses of ICT within the mental health and addictions context. However, for these and other ICTs to be successfully implemented and used, nursing leaders will need to be actively involved in their selection, design, deployment and evaluation (CNA 2006)

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Challenging Stigma in Mental Health and Addictions and Nursing

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I am pleased to see a focused issue of the CJNL on *Nursing Leadership: Making a Difference in Mental Health and Addictions*. Through this issue, we hope to highlight the importance of addressing challenges in mental health for society, put a spotlight on innovations and opportunities for mental health nursing and at the same time illuminate the challenges that continue to exist, albeit in the shadows, to improve care outcomes for patients and families. Stigma has long been recognized as a key challenge associated with mental illness. In recent years while there has been a notable shift in our social conversations about mental illness, the assumption that stigma is decreasing is not true. In fact, some would argue that the stigma has actually increased (Mental Health Commission of Canada 2012). For many people, the stigma they face as a result of their (or their family member's) mental illness is often worse than the illness itself (Mental Health Commission of Canada 2012). Thus, the need to understand and successfully address the negative impact of stigma remains paramount.

What is stigma? Stigma can be defined as “a mark of disgrace ... a stain or reproach on one's reputation” (Dictionary.com n.d.). In mental health literature, stigma is often described as a “negative stereotype” that leads to “intersecting layers of discrimination.” The impact of stigma is pervasive. It is the context in which help is sought (or not); quality care is received (or not) and recovery and wellness is sustained (or not). This is further compounded by the intersection of culture and stigma. As the cultural diversity of the population increases, healthcare practitioners need to understand the cultural context in which stigma is experienced. For many cultural communities, a diagnosis (actual or potential) of mental illness is equivalent to a black mark, a “kalanka” for individuals and families (Sapkota 2012). These communities are particularly vulnerable as they are often simultaneously navigating complexities of re-settlement and facing discrimination on the basis of race, religion and ethnicity.

Stigma is not limited to patients; it extends to families seeking help as well as providers of mental healthcare. Psychiatrists, mental health nurses and others are at risk for stigma and discrimination by association. The notion of “courtesy stigma” has been explored in the medical and nursing literature (Delaney 2012; Morgan 2010). While mental healthcare has moved to general hospitals and primary care, the world of mental health is often seen as “strange, a bit deviant, weird, exotic” (Morgan 2010). Rarely are our best and brightest encouraged to choose mental health and when they do, there is often an implied sense that the

work is somehow “less than” what is expected in other sectors of healthcare. New nurses are often discouraged from choosing mental health so they can “build up their skills” before coming to this field.

To address the devastating impact of stigma, in all forms, there must be recognition that successful challenge will require a shift from changing attitudes to changing behavior. Because stigma is pervasive and multi-layered, it is often hidden and invisible. To effectively confront this multilayered discrimination, leaders and clinicians must educate themselves to recognize discriminatory practices, develop the wisdom to identify these practices and the skills to effectively challenge the negative stereotypes across all aspects of healthcare. Mental health nurses are leading the way in many innovations to improve the health of society as a whole. Challenging stigma is a call to action for all nurse leaders!

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Patient Partnership: Does it Matter?

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Patient partnership has become a central element of healthcare delivery in many countries. The concept has specific relevance in mental health, as it is a critical enabler of recovery and healing (Bailey and Williams 2014). Patient partnership implies active engagement of patients in shaping decisions at the direct care, organizational and system level (Bate and Robert 2006; Hayward 2013; Health Quality Ontario 2017).

The concept of patient partnership emerges from a patient-centred approach that aims to personalize care according to individual patient needs and preferences,

and positions patients as full-fledged partners in their own care (Adams et al. 2014; Baker et al. 2016; Barello et al. 2012; Barry and Edgman-Levitan 2012; Delbanco et al. 2001; Choudhry et al. 2005; Hibbard and Mahoney 2010; James (2013); Pomey et al. 2015). The concept of patient partnership has specific relevance in chronic conditions such as mental illness where patients are expected to bring forward their experiential knowledge and to actively engage in the management of their conditions (NHS 2001; Pomey et al. 2015; Tattersall 2002). The therapeutic alliance between the patient and professional is the basis of all mental health interventions; this alliance is enabled by authentic engagement of the patient in bringing forward their lived experience, and further by ensuring that the care plan fits their values, beliefs and life patterns (Bailey and Williams 2014; Dziopa and Ahern 2014).

Patient partnership as a key element of mental health and recovery acknowledges that peoples' lived experiences are assets in shaping their health and well-being (Pomey et al. 2015). A significant number of studies illustrate the positive relationship between patient experience and clinical outcomes (Bauman et al. 2003; Choudhry et al. 2005, Doyle et al. 2013; Isaac et al. 2010; Laurence et al. 2014; Manary et al. 2013; Robert Wood Johnson Foundation 2012, 2013; Stewart et al. 2000; Weingart 2011) such as prevention, self-rated and objectively measured health outcomes; adherence to recommended care, adverse events and resource utilization.

In mental health nursing, the interpersonal interaction is the core of practice. Dziopa and Ahern (2013) uncovered the nine constructs of a therapeutic relationship in mental health nursing, namely, conveying understanding and empathy, accepting individuality, providing support, being there/being available, being genuine, promoting equality, demonstrating respect, maintaining clear boundaries and having self-awareness. In fact, these constructs exemplify the fact that establishing genuine partnership with patients is an essential and core element of mental health practice. Therapeutic relationships based on alignment and co-production illustrates how best scientific and clinical knowledge can be better combined with the expertise and commitment of patients to drive recovery outcomes (Bowers 2014).

The notion of “patients as partners” has been embraced at all levels at Ontario Shores Centre for Mental Health Sciences, located in Ontario, Canada. This public hospital provides a range of specialized mental health services to those living with complex and serious mental illness. Interprofessional teams provide care through evidence-based approaches where successful outcomes are achieved using best clinical practices and the latest advances in research. Patients benefit from a recovery-oriented environment of care built on compassion, inspiration and hope (Ontario Shores 2017). Ontario Shores is a champion of patient- and

family-centred care – working “with” patients and families rather than just doing “to” or “for” them (Institute for Patient and Family Centered Care 2016).

As we describe elsewhere in this issue (Velji et al. 2017), Ontario Shores has embraced the patient engagement framework from Health Quality Ontario (2017). The framework builds on both the Carman et al. (2013) Framework developed by the American Institute for Research and the International Association for Public Participation (2017) and recognizes that the practice of patient partnership is on a continuum. The framework demonstrates:

- Three stages of engagement across the continuum horizontally.
- Highlights that they can live at all three levels of the organization vertically.
- Highlights a promise to the patient at each point across the continuum.

Building on the far end of the continuum with its deep focus on collaboration, Ontario Shores has partnered with patients and families in a process of co-design that is applied at all three levels of the organization with demonstrable results at each level. There have been positive measureable changes in safety and quality trends. Our patient experience metrics are highest among the four free standing mental health hospitals in the province of Ontario – we believe this is an outcome of our commitment to authentic relationship-based care.

People who live with all mental health conditions should be central to the planning and delivery of their care: Unleashing the power and wisdom of patients has enormous potential to reset the bar on patient experience.

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