BH2I Behavioral Health Integration Initiative

Leadership Styles and Their Contribution to Integrated Care

Implementing effective integrated care (IC) can be difficult, time consuming, and often faced with challenges such as accessing electronic health records and staff resistance to change. Often it takes years to see measurable positive results (deGruy, 2015).

To bring about the positive benefits of IC, strong leadership is essential. However, medical clinics and behavioral health practices are complex, and providing IC services to American Indian/ Alaska Native (AI/AN) cultures can even be more complex, rendering leadership in IC in AI/AN communities a tremendous challenge.

The study of leadership as a broad concept is fraught with conjecture, theories, and models. Leadership in AI/AN settings has received little attention in literature, and writings specific to leadership styles in IC rarely apply to rural and reservation environments. So, how do we address the critical issue of leadership in AI/AN IC in rural and reservation environments?

One logical starting point is to assess who are the leaders in AI/AN IC? Leadership is interpreted differently by distinct groups within the organizational structure (Kezar, 2002). Positional leadership is leadership that is based on job titles and the formal authority that accompanies the title (Sanders, 2014). In IC settings, positional leadership might include positions such as the Medical Director and the Behavioral Health Director, depending upon where IC is located within the organization. In reviewing leadership failures in IC, traditional positional leadership and conventional structures were found to be less effective than communities of practice and mini-transformations that eventually impact system transformations (Nieuwboer, et al., 2019).

In IC leadership, influencers (those with little or no positional power, but tremendous social and contextual power) might be just as important in bringing about transformation as those with formal leadership roles. Examples of these leaders in IC include everyday leaders such as IC champions, advisory board members, front line IC workers, and traditional healers. Research shows that reliance on formal leadership stifles or inhibits the very goals the leaders hope to achieve regarding IC efforts (Sanders, 2014). Raney (2017) suggests that formal managerial leadership is necessary, but not sufficient for the implementation of IC. The author's rationale is that while managing ongoing processes can be accomplished by positional leaders, implementing IC is a change process, one that requires both managerial skills and leaders who can transform organizations. Management alone often leads to conflict, resistance to change, and a lack of buy-in (Raney, 2017). In short, leadership in IC requires both positional leadership (management) and influential leadership (informal).

What do we know about informal, influential leadership in AI/AN organizations? Truly little has been published on this subject, but Freeman (et al., 2019) conducted a qualitative study of AI/AN leaders working in system of care environments. The participants were carefully selected upon the basis of their success in leading change processes in AI/AN communities. The results of the study are depicted in Figure 1 (replicated with author permission).

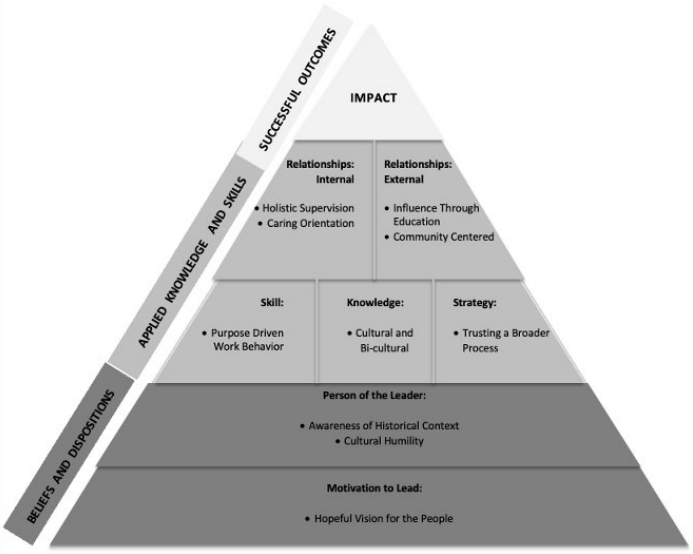

Figure 1: Conceptual model of AIAN behavioral health leadership.

Essentially, Freeman et al (2019). suggest that passion, motivation and enthusiasm for the outcome is critical, such as we might expect with an effective IC leader. The foundation of good leadership in this context is a deep and abiding belief that IC will improve services and access to care for the community. Built upon that commitment, findings of the qualitative study suggest that cultural humility and awareness of the multigenerational trauma experienced by the community are important traits. However, motivation and cultural humility are not enough to bring about the transformations needed to implement IC. Skills, knowledge, strategies, and (most important) relationship skills to collaborate with teams within the organization and build connections are necessary for effective formal or informal leadership.

In analyzing leadership in IC, deGruy (2015) proposes that the most effective leadership style is Complex Adaptive Leadership (CAL). This is an approach that encompasses administrative, adaptive, and enabling leadership styles that are essential for gathering resources for IC, leading visioning processes, and managing organizational structural changes. The CAL approach is often stimulated by informal leaders (e.g., advisory board members, traditional healers), who provide the input for positive adaptations. An example might be changing the IC coordinator schedules to better meet the needs of patients or adjusting the time of morning huddles so most staff can attend. Leadership utilizing CAL does not manage these changes, rather, the team acting with informal leadership brings about these positive mini-transformations. Adaptive leaders are the go-between in this system, much like cultural brokers. They keep administrative managers/leaders informed of mini-transformations and bring about a culture of team collaboration (deGruy, 2015).

We have a great deal to learn about effective leadership of IC in AI/AN communities, both in rural settings and urban clinics. Research and program evaluation of leadership styles in these settings is important to inform future leadership practices.

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