

EDITORIAL

The balance between clinical and administrative leadership in forensic psychiatry

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*The International Journal of Risk and Recovery, launched in January 2018, has as a stated goal a focus on not only addressing key forensic psychiatry issues but also on publishing articles pertinent to forensic psychiatry clinicians. The success of this goal, rooted in excellent research and effective knowledge translation, is dependent upon an infrastructure that promotes exploration and implementation, allowing evidence based concepts to not only survive but to flourish in professional practice and the provision of care. This may sound logical and reasonable; after all, who doesn't want the best and latest information to guide translation of research into professional practice? However, the reality of the healthcare environment is challenged by the convergence of increasing service demands, need for cost reductions, interprofessional tensions, pressures of technological changes, and demand for quality improvement, all of which can and do impact the broad hospital sector as well as specialized programs, such as psychiatry. With so much information to be digested and so many workplace technical requirements, there really isn't enough time to access this information. Healthcare is a business and by extension, forensic psychiatry programs need to operate as businesses in order to survive. It is therefore incumbent upon the *International Journal of Risk and Recovery* to explore not only*

the identification and mitigation of risk, and the components of recovery, but also the business underpinnings that make this work possible. Without a viable business, services collapse.

Key to the success of any business is the operational structure. For many years, hospitals and specialty programs within healthcare facilities functioned within 'psychic prisons'ⁱ where leaders identified strongly with an assigned mandate which was concretized in a way that stifled organizational learning, innovation, and the ability to adapt. Hospital and program administrators focused on the operational aspects of the business while physician leaders focused on the clinical and technical expertise that contributes to the provision of care. Operating in two solitudes, physicians and administrators defended their own perceptions of "clinical care versus business", resulting in continuation of the status quo. In recent years however, the focus, strategy, and structure of healthcare has evolved and there has been a clear departure from what was the traditional attitude of separating the business aspects from the clinical aspects of healthcare. Now physicians (and not just physician leaders), like other administrative leaders, must consider cost effectiveness, budgets, patient satisfaction, policy, and business strategy. Further, and perhaps less comfortably, administrative leaders must consider clinical and technical operations.

From a political perspective, organizations are ruled by whoever controls the fiscal, human and physical resources. They decide how resources are used to meet the established goals and interests. Given the evolution of healthcare facilities towards a more business focused model, one that

favours a shared model of physician and administrative leadership, it is essential that a balance be struck in all aspects, resulting in effective design, innovation, and responsiveness to challenges and change. When not balanced, the playing field can become a battleground for control, and the program can revert back to the “psychic prison”, and trapped by their own perceptions, there is no room for alternate viewpoints, and no capacity for growth and development.

Finding and maintaining the balance between clinical and administrative leadership is important in the operation of any healthcare program, but it is arguably essential with a forensic mental health setting. Rooted in concepts of detention with a mandate to protect public safety, forensic mental health is at significant risk of being another “psychic prison”, where the focus is on risk and containment, and concepts of hope and recovery are merely remote secondary considerations. History has recorded many examples of custodial care that focused on containment and lack of hope, and sadly, whispers of that history can and do quickly remerge in the face of tragic events that garner public attention. This is the challenge and the opportunity for shared leadership with forensic mental health settings.

The transition to a shared leadership model can be very difficult. As the model of shared leadership expands, both must break out of the individual expert mold and complement their clinical and administrative skills with a range of broader collaborative and relationship based skills. No longer can leaders only concern themselves with the divide between clinical and business, they must now each merge these two solitudes if they are to make a significant and sustained impact on programs they lead and the system they work within. It is difficult on a personal level to give up the perceived level of sole control, and even more difficult, yet essential, to form an alliance with someone with whom this control must now be shared. Leadership partnership are sometimes formed deliberately with forethought about shared vision, commonality, fit, or creative tension and sometimes formed without considera-

tion of the dynamic that will define the partnership, but regardless of the beginning, they are forged in experience.

So what makes for a successful shared leadership partnership in a forensic setting? It is tempting to answer this question by listing a range of qualities deemed to make for good leaders, but while important to have these attributes, they do not necessarily lead to a good shared leadership partnership. Experience suggests that good shared leadership partnerships require that each player must bring a range of skills in their area of expertise; however, that is not enough for the partnership to succeed. There are multiple examples of two highly skilled professions in their own right not being able to form the partnership required to successfully lead a program. So what is required? The two leaders who make up the shared leadership partnership do not have to agree; indeed, the discussion of areas of disagreement may fuel innovation and creativity as mutually acceptable solutions are identified and pursued. The two leaders who make up the shared leadership partnership do not have to have the same style; indeed, a difference in style may enhance their capacity for engagement of a broader range of stakeholders, with complementary styles of leadership. The two leaders who make up the shared leadership partnership do need to share the same high level vision for the program; however, differences of opinion on how to get there are not only healthy but necessary in preventing tunnel vision resulting in missing other opportunities. So what is the critical ingredient that makes it work? Experience suggests clinical and administrative leaders who share a compassion for and understanding of the population they serve, who respect and trust the capabilities and skills of each other, and who can challenge yet support each other may have a better chance of establishing and developing a strong, effective shared leadership partnership. This, however, requires further exploration to enhance our understanding of how leadership impacts and intersects with the academic aspects of forensic psychiatry.

The balance of risk and recovery is the business of forensic psychiatry. As this journal explores the business of forensic psychiatry, it is hoped that further exploration of the infrastructure that supports it will be undertaken.

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Note

ⁱ Organizational Metaphor developed by Dr. Gareth Morgan wherein organizations are ultimately created and sustained by conscious and unconscious processes, with the notion that people actually become imprisoned in or confined by images, ideas, thoughts, and actions