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Guest Editorial
Australasian Psychiatry
June 2016 themed issue on 'Psychiatric Leadership'

Expert leadership – why psychiatrists should lead mental health services

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In most Anglosphere nations, managers have replaced doctors in the executive suites of the health sector. Managers were expected to be more efficient, effective and responsive. However, with many health services in disarray, it is fair to ask whether the switch from doctors to managers could be partly to blame?

In this special international issue, we hear from medical experts and management scholars. The President of the World Psychiatric Association, Professor Dinesh Bhugra has helped define the field of psychiatric leadership.[1] In his current article, he introduces the concept of expert leadership, and the requirement that expert leaders combine knowledge, experience and technical competence with innate ability and leadership training, in order to meet the challenges of changing times.[2]

Goodall (2016) presents a theory of expert leadership (TEL) in psychiatry that raises testable hypotheses about how psychiatrist-leaders might improve organisational performance.[3] She suggests that psychiatrist-executives are viewed as more credible by their peers. Because they have the same Fellowship training, they are also more likely to understand the motivations of other psychiatrists, and therefore set appropriate goals, evaluate and support their colleagues. We are currently investigating TEL in psychiatry in a collaboration between Cass Business School, City University London, and Flinders University in Adelaide.

Doctors were trained as '*heroic lone healers*', but training programs now emphasise doctors as multidisciplinary leaders. The USA has a mature culture of physician leadership. The Cleveland Clinic provides an outstanding example. It is a prominent U.S. healthcare provider in Cleveland Ohio, which has been physician-led since its foundation in 1921. In the current issue, Christensen and Stoller (2016) review their medical leadership programs.[4] One specific program, which emphases emotional intelligence, is also reviewed by Farver et al. (2016).[5]

In the United Kingdom (U.K.), the National Health Service (NHS) has been going through one of the hardest periods in its history. Leadership and management failures are widely reported; money is tight, staff morale is low, and junior doctors have been on strike for the first time in 40 years. Linked to these difficulties, and possibly as a result of the ensuing crises, medical leadership and management have been gaining ground. In 2011, the twenty-one U.K. Royal Colleges created the Faculty of Medical Leadership and Management, with aims to improve patient care through better leadership. Kyratsis et al. (2016) describe, in this issue, the former decline of medical leadership, and its impending rise in the British context.[6]

Australian mental health services are experiencing similar problems with deteriorating services and industrial disputation. We spend proportionally less on mental healthcare than the U.K., and the Australian sector has reached a tipping point.[7] In South Australia (S.A.), psychiatric bed occupancy was effectively above 100% in 2014, and patients faced excessive waiting times in hospital emergency departments (EDs). Despite these difficulties, further bed closures were planned, even though psychiatrists warned about the untoward effects for patients.

This clinical issue escalated into a leadership dispute before the S.A. Industrial Relations Tribunal. After a protracted negotiation, clinical directors (not service managers) were recognised as being responsible for the '*total management*' of regional mental health services, with accountability for strategy, clinical services, consumer flows, consumer outcomes and efficiency of the mental health service.[8] In effect, these tough negotiations enabled the return of psychiatric leadership to S.A. In this issue, Long and Allison (2016) describe the impact of these events on statewide eating disorder services.[9]

The change to psychiatric leadership has been associated with improved care for patients within the S.A. mental health system. ED waiting times were halved from an average of 15.7 hours (October 2014) to 8.0 hours (December 2015).[7, 8] The positive results of expert leadership might have implications for other jurisdictions.

Psychotherapy is being brought to patients in the ED frontline. The Foundation Professor of Psychiatry at Flinders University, Ross Kalucy began an innovative academic unit in the busy ED of an acute hospital, and Dr Paul Cammell has extended his work. In this issue, Cammell, et al. (2016) call for psychotherapeutic leadership across the public sector.

To consolidate these changes, we argue for academic clinicians to return to all levels of public mental health services. Historically, academic clinicians led the tripartite mission of research, teaching and clinical excellence, which drove the advances of modern medicine.[4] This vital structure was lost in S.A., but after the industrial dispute, the Flinders University Professor of Psychiatry, Malcolm Battersby was appointed as executive leader of the regional mental health service in 2015. The links between the return of academic leadership and clinical excellence are being evaluated.[7, 9]

To conclude, the motivation for the themed issue is neatly summarised by Kyratsis et al. (2016): '*As management academics and clinical leads passionate about medical leadership, we share a desire to unlock doctors' potential, to improve health care and create social value for both patients and... (health services)*'.[6] These goals require an active research agenda on the contributions of medical leadership to clinical excellence.

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