Journal of Psychiatric Intensive Care

Journal of Psychiatric Intensive Care
Vol.3 No.2:63–65
doi:10.1017/S1742646408001209

Editorial

Care pathways to acute care and the future of Psychiatric Intensive Care Units – How the dominos line up and what makes them fall

Roland Dix

Editor-in-Chief

'Care pathway' (CP) has become a very familiar phrase which seems to emerge in virtually every discussion, in every meeting concerning the operation of mental health services. What does CP really mean? How do you know when you have a CP? On what basis are they really defined?

In this editorial, and in the series of four editorials that follow, the *Journal of Psychiatric Intensive Care* (JPI) will deal head on with these questions. For many service managers and clinicians, the answer to the first question may seem straight forward. 'A care pathway is a flow chart – we have lots of them'. The natural logic that seems innate to the concept of a care pathway is that it is indeed a series of steps by which a person enters and leaves different aspects of mental health care. It is also very useful to express these steps in neat boxes, often positioned artistically with colour in a flow chart. In terms of acute care, the Psychiatric Intensive Care Unit (PICU) will often occupy about box (4) in the CP flow chart. In box (1) the patient is first engaged by the community primary care mental health team. Box (2) is the intervention of the Community Crisis and Home Treatment Team (CCHTT). On to box (3) the in-patient acute wards and then box (4) the PICU. A long enough stay in the PICU and the contents of box (5) could well be the Low Secure rehabilitation Unit (LSU). Each box is connected to the other like a line of dominos, the right conditions will cause one to trigger the next allowing a momentum through the pathway, taking a patient in and out of acute care services. If only it were that simple.

In this and the series of four editorials that follow, we dig beneath the flow chart and unearth the complex factors that are really involved in a patient's progression through the seemingly very simple care pathway involving the PICU. This will prove to be an often complicated, difficult, messy and at times deeply uncomfortable excavation.

PICUs are now well understood for their primary purpose of engaging acutely disturbed and challenging behaviour. On the way into and out of the PICU, other mental health teams will very often engage the patient. For a variety of reasons the patients' needs and the inability of other services to meet those needs will be deemed to require the involvement of a PICU. On this basis, individual PICUs and the very concept of acute care will often vary dramatically from place to place. With the following editorials as my inspiration, I make the contention here that the PICU and approaches

Correspondence to: Roland Dix, Montpellier Unit, Wotton Lawn Hospital, Horton Road, Gloucester, GL1 3WL.

to acute care will ultimately be defined by the interaction between teams, the success of which is profoundly dependent upon the philosophy and values of the professionals within them. The nature and content of PICUs may be an emergent entity, the characteristics of which are defined by the surrounding mental health services, their attempted interventions and all the associated personalities, strengths and weaknesses of those involved. This may represent a very different lens through which to scrutinise the PICU than the traditional view.

Traditionally, the need for psychiatric intensive care and the PICU, have been defined by the mental and behavioural pathology of the patients who are deemed to require them. In future, a much clearer focus on the true nature of the need for psychiatric intensive care may be achieved by considering the PICU as just one option for the engagement of perceived acute disturbance. The range of options and the appropriate order for deployment of each of those options being defined by much more complex considerations than the traditional approach of diagnosis, treatment and prognosis.

In the first editorial that follows, *Taking the drama out of crisis*, my colleague Dr Chris Fear explores the concept and function of the UK's relatively new Crisis and Home Treatment Teams (CHTT). These teams are often judged to have been created specifically to reduce the need for hospital admission, and resolve disturbed behaviour in the community setting. In Dr Fear's account, the engagement of CHTTs may ultimately result in the patients who go on to require treatment in hospital being much more acutely unwell – possibly providing the catalyst for what we now know as acute wards to metamorphose into what we now understand as PICUs and the PICUs in turn to evolve into, well – something else.

Other crucial issues in dealing with acute disturbance are raised in Dr Fear's editorial – do some patients at times simply need to leave their home environment and others within it, to provide the opportunity for breathing space. The implication of this point, for me, raises the first of many profound and challenging issues contained within this series of editorials. How so? Because the conceptual basis for the practice of western psychiatry is still strongly rooted in the medical approach requiring diagnosis, the application of treatment with consideration towards prognosis as the highest of all considerations. Dr Fear raises the issue, as indeed do all the editorials that follow, that the patients mental and behavioural pathology may just be one factor – very often not even the most important factor – that defines the way in which acute crisis is engaged, including the decision to admit a person to the PICU.

In his editorial C*hanging the script* Professor Smyth offers further analysis of the issues raised by Dr Fear. It should be said that Professor Smyth's editorial was informed by the benefit of an advance review of Dr Fear's account. In Professor Smyth's editorial, a call is made for a complete paradigm shift in how efficacy is considered for acute treatment methods and the basis on which they are considered to have succeeded or failed. The point is made that if a CHTT attempts to engage an individual in the community, who ultimately requires hospital or even PICU admission, then this is not failure – it is a preferable alternative. The contention here is that new approaches may result in more or fewer PICUs, although not no PICUs.

We have seen that the journey to becoming a PICU patient is very complicated which, in my opinion, is being increasingly understood to depend on many factors far beyond purely the mental and behavioural pathology of the patient. Is this opinion being supported by the first of the two editorials that follow?

Marion Janner, the architect of the hugely celebrated 'Star Wards' programme deals with the issue of what actually happens in hospital wards and more importantly, what helps resolve disturbance, promote recovery and shorten length of stay in in-patient wards and PICUs. Her editorial *From the inside out* contains first hand experience in living in a modern in-patient ward and again raises hugely profound issues about what really works in reducing disturbance in in-patient units. Again, the

https://doi.org/10.1017/S1742646408001209 Published online by Cambridge University Press

gauntlet is laid down that diagnosis, medication and assessment of psycho-pathology are only one category of considerations in engaging with acute disturbance and very often may not even be amongst the most important of considerations. Ms Janner's account of what works in in-patient wards challenges us, as professionals, to look closely at ourselves and the commonly held wisdom that we have kept so dear about how to view acute disturbance.

At the invitation of Professor Valentina Iversen, I recently visited the in-patient services at St Olav's University Hospital in Trondheim, Norway. Following a dinner at which the importance of diagnosis and medication in the treatment of acutely disturbed patients was discussed, I was struck by how ward culture, levels of activity and relationships were being increasingly accepted as equally important as the medical issues. I came away truly inspired by Professor Iversen's determination to do away with the use of mechanical restraint by introducing a philosophy very similar to that so convincingly advanced by Ms Janner in her editorial.

Another profound challenge raised in this series of editorials is represented by the introduction of market forces to mental health care in general and to PICU/ LSU services in particular. My colleague Mathew Page in his editorial *Supply versus demand* guides us through his first hand experience of operating an LSU in the new business culture of the UK NHS. This is where our dig down into the future issues of acute care has the potential to become messy and uncomfortable. Page warns the PICU/ LSU clinical community of the need to spend time reflecting on the ethical challenges of profits from illness and detention. In future, will accountants become as important as clinicians in deciding who is admitted and discharged from services? This editorial also challenges the NHS traditionalists to examine the true nature of the units they operate, many of which may be lacking efficiency, innovation and quality initiatives; the very things that the new business culture will claim as its strength.

What will be the effect of the hard business minds that will be shaping the future PICU/ LSU services on the common problem of delayed discharges? Perhaps the possibilities are opposites. Greater efficiency is required to win contracts therefore length of stay is reduced. Where discharge accommodation is lacking it must be found or even commissioned. On the other hand, once a patient is in the LSU, it could be good business to keep them there.

Future concepts in acute mental health care are diversifying and developing so quickly. For those of us working in the speciality, these are indeed exciting times. In this issue of the JPI the series of editorials that follow track the care pathway associated within PICUs. Along that journey, there is an exploration of the topical up to the minute issues associated with community treatment, acute wards, PICUs and discharge in the context of the business culture. Readers of the JPI will be well equipped to enter the debate. We have seen that issues of assessment for admission, discharge and the approaches to care in-between, are starting to emerge as incalculably more sophisticated than our traditional bed rock of diagnosis, medication and prognosis. In every stop on this journey through all the configurations of teams and approaches to acute care, no one has yet even suggested that we can do without PICUs. Come and add your voice to the debate, JPI would be very pleased to hear from you.

https://doi.org/10.1017/S1742646408001209 Published online by Cambridge University Press