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Editorial

Responding to acute crisis: ways and means

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During the winter of 2007, the *Journal of Psychiatric Intensive Care* published a series of editorials questioning the role and future of psychiatric intensive care units (PICUs; Dix, 2007). Within the context of the care pathway, these papers reflected on the ways and means by which a modern mental health system may best respond to acute crises.

At that time, the UK's Mental Health Services were rapidly evolving towards services that were specialised, more specifically focused and often delivering time limited interventions. A significant objective for redesigning services was to increase effectiveness for engaging and resolving acute crises. This period in history was marked by many questions around the use of expensive mental health professionals and the rationale for the often expensive in-patient clinical environments in which they operated. The PICU of course, could not escape this scrutiny.

More recently, the Centre for Mental Health (2011) published a report pointing out the huge expense of the mental health secure estate. For every five pounds spent on adult mental health care, one pound goes to funding the secure mental health services. Once again profound questions are being raised as to the purpose and outcomes expected from PICUs which are one of the most expensive facets of mental health care.

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The *Journal of Psychiatric Intensive Care* is very pleased to publish a paper by Professor Len Bowers on the characteristics of acute wards in the presence or absence of a PICU (Bowers, 2012; this issue). In this paper, profound questions are raised as to what the purpose of a PICU is and how effective it is in meeting that purpose. This is an important paper for the psychiatric intensive care constituency and I urge readers to reflect on it carefully. Professor Bowers asks us to consider what it is that we expect from a PICU. Once we have answered that question there is also a challenge of how we measure effectively the extent to which, if at all, this purpose is being fulfilled.

In the editorial that follows, Professor Bowers extends to debating the measure of success (or lack of it) that PICUs have in arguably one of the speciality's core purposes: reducing the level and intensity of aggression within the facilities making referrals to the PICU. The arguments go further. Professor Bowers also suggests that

if the PICU is not significantly making a difference to the amount of aggression experienced in referring units, then what other purpose could it be serving? The suggestion is made that possibly the PICU is fulfilling a function similar to that of a 'punishment block'. This proposition is not new. Ingrained in my memory from the spring of 1994, was the need for sustained efforts to convince the rest of my hospital that the setting up of our first PICU was not for reasons of punishment and retribution for those who challenged the hospital rules.

In his editorial, Professor Bowers challenges us further. There is a suggestion that if the PICU serves some purpose in redressing those who breach rules or the regime of the hospital, then maybe this function could be better served by the installation of a form of hospital tribunal to which rule breakers could be referred and have their cases heard with appropriate action decided. These are challenging ideas indeed and I would urge that they receive objective and evidence based analysis from PICU practitioners and activists.

For me, Professor Bowers raises another profound issue about the nature and practice of psychiatric intensive care. Should every patient admitted to a PICU be beyond responsibility for their actions on the basis that they are assumed to be acutely mentally ill to the extent that would justify this ethos? The point here is that if there was a paradigm shift from judging of a patient's behaviour and the ways in which the services should reasonably respond – more towards solely therapeutic engagement – would the purpose and effectiveness of the PICU be strengthened? The PICU as a place in which all patients by definition are assumed unable to be responsible for their behaviour may well be met with profound unease amongst many PICU practitioners. Could there be a bigger point to be made here?

At the present time, many PICUs are required to deliver a curious and often complex mix of containment, treatment, therapy and reaction to those who some way have breached the expectations of a wider hospital community. The measure or manner in which the PICU should provide for each or a combination of these things is ill defined. The true nature of a PICU regime may often be arbitrarily created primarily on the basis of the expectations of distant organisational executives or the personalities of the staff operating the unit.

In his speculations, Professor Bowers puts forward another idea that should be more universally accepted by the PICU clinical community. PICUs should be profoundly therapeutic places in which a number of supportative interventions are employed, far beyond the traditional bastions of PICU care involving pharmacology, containment and coercive techniques. There should be a clear and creative therapeutic programme forming the central pillar of the PICU's core purpose, around which all other considerations should revolve. Some of the issues that would help or hinder such a central therapeutic purpose are also covered in this issue of JPI with papers considering the beliefs in dealing with threatening patients (Evans & Petter, 2012; this issue) and the effects of counter-transference within the complex environment of PICU (Jagarlamudi et al. 2012; this issue).

With ever increasing focus on the cost of inpatient mental health care in particular PICUs, there is no better time to establish the core purpose of a PICU and set about measuring its achievement or otherwise.

For many stakeholders, the PICU may prove to be elusive in terms of clear empirical interrogation towards purpose and outcome. It is difficult to avoid the feeling that a well run PICU with its central pillar of creative engagement fully supporting the basis on which the unit is defined, will be producing benefits that are difficult to scrutinise through the lens of reductionism. Possibly, there is a quality to the effect of a PICU which emerges from more than the sum of its parts. If this is true, then the challenge is clearly articulated by Professor Bowers that the PICU constituency needs to urgently define its purpose and demonstrate its worth. In my discussions with him, Professor Bowers is the first to concede that he is not a PICU clinician and that there are undoubtedly

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many more considerations to the PICU debate than those that he has proposed. Many of those issues have in the past, and will in the future, occupy the pages of the *Journal of Psychiatric Intensive Care*. Like all leading scientists, Professor Bowers finds being proved wrong as rewarding as the alternative.

I hope you find the editorial that follows constructively provocative and at the same time inspirational, resulting in stakeholders being compelled to join this debate. Whatever one makes of the various points of view advanced about the purpose and outcome of PICU, one thing is for sure. In order to drive the continuing improvement of the quality of care provided by PICUs, or indeed for them to have a secure place in the future of mental health care, silence amongst the PICU clinical community is not an option.

The *Journal of Psychiatric Intensive Care* would be very pleased to hear from you.

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