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Editorial

Psychiatric Intensive Care – What's in a name?

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The United Kingdom (UK) Mental Health Services have recently engaged in a relatively large scale service redesign. This process has seen the creation of a number of community based teams with a specific remit for dealing with acute periods of crisis over relatively short episodes. There has also been the developing notion of 'home treatment' allowing for mental health staff to enter a patient's home to help support them through an acute period of crisis, sometimes for days at a time, diminishing the need for recourse to admission to hospital. The strategic direction for mental health services within the UK appears increasingly underpinned by the ethos of intense short periods of engagement at the point of acute clinical need. The skills of the expensive professional are increasingly required to be sharply focused on the period of acute crisis. Longer term social inclusion and other interventions well known to promote and sustain mental health are increasingly not being provided by health service organisations with their expensive professionals.

Editing the Journal of Psychiatric intensive care (JPI) has provided the editorial staff with an appetite for debate as to what Psychiatric Intensive Care really is. In the UK, and indeed around the developed world, the term Psychiatric Intensive Care has arguably become almost synonymous with the term Psychiatric Intensive Care Unit (PICU). For a decade the PICU has become a well understood entity whose characteristics have been well discussed in the literature and defined within national policy guidance. It also appears that the consciousness of the clinical community within the UK understands Psychiatric Intensive Care as a range of practice interventions enacted in a PICU. Thus Psychiatric Intensive Care may have become more associated with a building than with a set of clinical interventions. The direction of strategic Mental Health Policy within the United Kingdom and indeed the increasing knowledge base around intensive episodic interventions aimed at acute crisis may be challenging the current status of Psychiatric Intensive Care as a type of practice dependent upon a PICU. It is not difficult to advance a credible argument that Psychiatric Intensive Care is much better defined as a set of interventions aimed at acute disturbance and crisis, than it is as a place in which these interventions are traditionally enacted. More provocatively, do the regimes and the very nature of a PICU produce much of the hostility that the unit then aims to resolve? Much of the evidence base and discussion around Psychiatric Intensive Care is arguably concerned with factors such as complex interactions between neurochemistry, developmental psychology and support structures available to contain acute disturbance when it emerges. Progressive thinking within the field of Psychiatric Intensive Care can now be considered to be extending the practice area and need for underpinning evidence base to far beyond the traditional location of the PICU.

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In this edition of a Journal of Psychiatric Intensive Care, the burden experienced by family members who live with and apart from patients with severe mental health problems is discussed. Family pressures, dynamics and support have well described associations with acute mental health breakdown and disturbance. In addition, within these pages, there is an analysis of post traumatic stress in women who have previously suffered abuse. A group who, during periods of acute crisis and disturbance, also often find themselves grappling with the regime of the PICU or other controlled in-patient environment.

Few would argue that understanding the effects of recreational drugs on mental health and trying to mange their use in in-patient units has become one of the most important challenges to almost all modern in-patient hospitals. The Journal of Psychiatric Intensive Care is tackling these issues with an occasional series of papers. These papers will provide short expert commentary and review of the effects of common recreational drugs on mental health. They will also offer practical insight on how the modern in-patient unit can mange the issues.

The first of these papers deals with the use of cannabis, still often represented as amongst the most harmless of all recreational substances. Dr Dominic Beer deals head on with the question of how concerned mental health clinicians should be about the growing popularity of cannabis use?

An increasing understanding of causation factors of acute disturbance and the complex clinical terrain in which it manifests may be creating an alternative path from the PICU to a tool kit of interventions for engaging with acute disturbance wherever it occurs.

The Journal of Psychiatric Intensive Care aims to collect and disseminate as much evidence, wisdom and advice as possible in engaging successfully with those who suffer acute mental health disturbance. In addition, another often not highlighted although extremely important function of Journal of Psychiatric Intensive Care is to represent a resource for the so called Low Secure Services in which patients require intensive interventions over a much longer period (up two years) in order that they are able to re-engage with the broader community and rediscover living skills often severely eroded by the attrition of previous extended periods of acute disturbance and social exclusion.

It is the intention of the Journal of Psychiatric Intensive Care to include the evidence base judged relevant to the causation of and engagement with acute disturbance, which at the present time, is often although by no means always associated with the Psychiatric Intensive Care Unit. Psychiatric Intensive Care may be becoming much more than a place; it is a set of interventions which could be delivered in a variety of settings, including the patient's own home. Is it time for the PICU clinical community to find ways to translate their wisdom about managing acute crisis from the PICU into other settings, including the patients own home? Some would say it is far too early in the development and understanding of effective interventions for the practice of psychiatric intensive care for it to escape the safe and reassuring corridors of the unit. What do you think?

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