Journal of Psychiatric Intensive Care

Journal of Psychiatric Intensive Care
Vol.9 No.2:68–71
doi:10.1017/S1742646413000071
©NAPICU 2013

Commentary

PICU possibilities

Len Bowers

Professor of Psychiatric Nursing, Institute of Psychiatry, Kings College London

Keywords

Innovation; utilisation; application; therapy; expertise; specialism

Late last year I was invited to address the NAPICU quarterly meeting hosted by the South London and Maudsley NHS Foundation Trust. I was to take as my topic 'the future of PICUs'. The talk stimulated a lot of thoughts for me. To my delight, it also stimulated others, and I have been encouraged to share my thoughts with a wider audience. So here, for 2013, are 13 ideas about what PICUs (and their staff) could do and provide in the future. Whilst they are of varying degrees of novelty, creativity, and no doubt usefulness too, I offer them for consideration.

1. PICUS AS SPECIALIST WARDS IN RAPID, RELIABLE, VALID ASSESSMENT

PICU staff would need to build on their expertise and knowledge of psychotic symptoms and cognitive deficits, enough so that these can be recognised and accommodated during ordinary daily life on the ward. Staff teams should also be able to use a variety of rigorous structured interviews to assess mental state, psycho-neurological status, social and self-care abilities, risk and other areas. Given the PICU setting, such assessments could be carried out rapidly, with a staff team able to make clear, accurate summaries. Such a staff group would be highly skilled in communicating such assessment and formulating realistic service user care plans.

Correspondence to: Professor Len Bowers, PO Box 30, David Goldberg Building, Institute of Psychiatry, Health Service and Population Research, De Crespigny Park, Denmark Hill, London SE5 8AF. E-mail: len.bowers@kcl.ac.uk

2. EXPERTS IN INDIVIDUAL SERVICE USERS

In the 1960s, Sheppard Kellam (1961) described staff teams that were able to formulate bespoke assessment scales for individual service users, given their intimate knowledge of said service users. Similarly, PICU staff should be experts not only in symptoms and conditions, but also in John Smith and Fred Bloggs – their service users. We could help staff to develop their in depth knowledge of individuals, their: histories; families; social networks; problems; interests; preferences; peculiarities; accomplishments; failures; strengths; weaknesses; and what works for them in terms of: medical; nursing; occupational; psychological and physical care. In other words, develop a full knowledge of our service users in all their glorious individuality.

In order to do this we would need to source, discover, unearth and use previously accrued knowledge which is in the heads of our experienced staff who have known the service user for a long time, augmented by what is in our records and files. These staff members will not just be on the PICU, but also in the community and other parts of the system. Do not assume that this information is already in the system. In fact we often have a rather superficial personal knowledge of service users backed up by repetition over admissions. As part of a research project, we recently had the opportunity to administer the five minute speech sample test to many inpatient nurses (Moore & Kuipers, 1999).

https://doi.org/10.1017/S1742646413000071 Published online by Cambridge University Press

In this assessment the subject is asked to talk about a randomly selected service user, what they are like as a service user and how they get on with them. Many of the participants were themselves shocked at how little they knew about their service users with most struggling to fill the full five minutes of the test.

3. SPECIALISTS IN BEHAVIOURAL ENGINEERING

It is now 54 years since Ayllon & Michael (1959) published their paper proposing nurses as behavioural engineers. To date PICUs have still not used these strong, effective, evidence based interventions to manage and reduce the challenging behaviours of service users. Yet these very behaviours result in a service user's admission to PICU in the first place. In order to apply these properly, staff teams need to become experts in behavioural assessment, being able to utilise structured interviews; rating scales; ABC charts; scatter plots; setting-event questionnaires; structured partial-interval records; structured real-time record with sequential analysis; etc. This has to be backed up by intensive, perspicacious, knowledgeable, expert, unrelentingly rigorous and accurately recorded, detailed and insightful observation for the functional analysis of behaviour (Emerson & Einfeld 2011). We then need to know how to apply behavioural methods such as modifying idiosyncratic setting events; non-contingent exercise; interspersed requests; neutralising routines; activity scheduling; stimulus fading; functional displacement; differential reinforcement; etc. Most challenging of all for the nursing team, and where such approaches are most likely to fail, is the need to be rigorous, disciplined, constant, absolutely consistent behavioural responders to service users. These behaviour therapy methods really do hold great promise for truly helping service users.

4. PLACES OF MAXIMUM THERAPEUTIC INTENSITY

In many PICUs, there is scope to move from a position of drugs and diversional activity to one that is much more therapeutically intense. However, this requires flexibility of scheduling so that interventions can be individual to the service user, rather than group based. In addition, they should be flexibly timed to those moments when people are less psychotic and more lucid. They can't be put in a timetable, in other words, but introduced when they have the greatest chance of reception. Moreover we need to cast our net wide to usefully borrow from other psychiatric specialities to find things that we can apply to benefit service users. Things that come to my mind include adult education, life long learning, rehabilitation in self-care skills, micro social skills training and anger management. We can take offender assessment and rehabilitation programs dealing with criminogenic need borrowed from forensic psychiatry. We can adapt reality orientation and reminiscence borrowed from old age psychiatry. There are surely many more therapeutic approaches that we can implement to maximise the therapeutic intensity of the ward.

5. RESERVOIRS OF NURSING KNOWLEDGE

In nursing there may be a great deal of tacit knowledge and expertise that has accumulated by experience. Traditional approaches probably exist, both locally and nationally, that are absent from the text books. One possibility for the PICU is that this is consciously surfaced, known, discussed, used and shared to produce an extensive reservoir of service user management methods. I have in mind an encyclopaedic knowledge of stuff to try with service users: a Hitchhikers' Guide to the Mental Health Universe. If we accumulated this knowledge, maybe we would have a choice of at least 20 methods for tackling each of the many diverse problems we encounter. Potentially, what is a unique problem for the acute ward nurse could be problem solving meat and drink for the PICU nurse.

6. SYMPTOMATIC RECOVERY SCIENTISTS

It may surprise you to know that little is known about how people actually recover from a psychotic episode. There is little collated on

https://doi.org/10.1017/S1742646413000071 Published online by Cambridge University Press

what the pattern or fluctuation of psychiatric symptoms looks like across an admission. What research has been done dates back a long time, and different authors propose different stages through which psychosis resolves. But a PICU is all about such symptomatic recovery. Through careful structured observation and the use of clinical rating scales such as the NOIIS (Bowers et al. 2011), PICUs could accumulate this missing knowledge and generate new ideas about how to speed the recovery and discharge of service users.

7. LEADING PARTICIPANTS IN TRANS-ADMISSION AND FULL TRAJECTORY TREATMENT

As clinicians on the PICU, our sights are generally set on working towards our service users' discharge from PICU care, with interventions based upon that target. Things could be very different. Many of our service users are repeat admissions, and we could focus our perspective on results achievable after several PICU admissions. Let's call this a 'trans-admission treatment perspective'. Thus behavioural goals could be targeted and readdressed across multiple PICU admissions. In fact, psychological interventions could continue across the PICU – admission ward boundary, with acute ward staff taking up where PICUs left off, and vice versa, dependent on the service user's journey. More challenging still, we could lodge our perspective across several admissions to hospital, with treatments continuing in the community as well as in hospital. Thus, resolving a service user's propensity to be aggressive whilst ill and in hospital might be addressed (at least in part) by therapy, in the community, while they are relatively well. Problems difficult to resolve in the community alone (e.g. physical health assessments and treatments) can be started during an inpatient stay and continued in the community. Thus the questions we would address at ward rounds on the PICU would be what are our combined one year goals (multidisciplinary, inpatient, community, nursing, medical, occupational therapy, psychology, carer, client own etc.) for this service user? Our five year goals? Our lifetime goals?

8. HUBS OF BOUNDARY BLURRING OR MELDING

To date the traditional place for the blurring of professional boundaries has been in community teams, in particular community mental health teams. Here there have been cases where psychologists, social workers and community psychiatric nurses have carried out very similar roles. However there is no reason why PICUs should not take up this baton and see what they can do to build up mutual respect between disciplines and blur boundaries between professional roles. The goal here is to borrow and use each others strengths, professionally and individually. Such a cohesive team can (and does) work powerfully to the service users' benefit.

9. TESTING CENTRES FOR NEW MODELS OF PICU SUPPORT

There is no need to be stuck in a single operating model for PICUs, with support to the acute wards being based on transfers of service users for days and weeks following assessment by PICU staff on the acute ward. Other models exist or can be considered. What about 'transfer on demand' of the acute ward staff, for a shift, for a day, or just overnight? What about day programmes on the PICU attended by acute ward service users? What about outreach services, with PICU staff spending time on the acute wards demonstrating service user management techniques? What about 'inreach', with acute ward staff having short placements on the PICU for advanced development and training?

10. EARLY TECHNOLOGY ADOPTION NUCLEI

Another role the PICU could play would be as first adopters and appliers of new technology. There are such a wide range of new things that can be taken and applied to the care of service users, including: the integration of CCTV in care; communication technologies for the staff team; computer mediated learning for service users and staff; computer based therapy for service users; entry and exit control; identity

https://doi.org/10.1017/S1742646413000071 Published online by Cambridge University Press

based systems (facial, thumbprint, iris); tagging (and other GPS based applications); remote physiological monitoring; service user handheld recording for mental states and symptoms. Few of these have yet been exploited to the maximum.

11. CENTRES OF COMMUNICATION RESEARCH APPLICATION

There is a body of research work on the verbal and nonverbal communication deficits of people with schizophrenia. New research has shown that people with schizophrenia use fewer hand gestures, that service users with negative symptoms nod less but gesture more. Recognition of facial expression is also affected. Coupled with these communication deficits are cognitive deficits in memory and executive function. This adds up to service users having learning, communication, and memory difficulties that are frequently not identified, observed or taken into account. Were we to do so, our whole approach to dealing with certain service user problems might be different.

12. LOCATIONS OF COMMUNICATIVE EXPERTISE

Expert nurses have a huge number of communication strategies they use with acutely psychotic service users, and yet these are not often formally identified, shared or taught. We have described and detailed some of these techniques (Bowers et al. 2009), and they could be used and expanded upon by staff of all disciplines working within the PICU environment.

13. PROVIDERS OF MAXIMALLY EFFICIENT CASE MANAGEMENT

And finally, PICUs could be wards where the staff hold the most comprehensive knowledge of the whole psychiatric system. They could be places where staff teams nurture the best contacts spanning other wards and all the community teams. Coupled with speedy, efficient and accurate processing, accessing of other services, realistic expectations and regular updates direct to service users, the PICU could become known by service users as 'the ward that gets things done'.

IN CONCLUSION

Cumulatively, all these things mean that a PICU has the potential to be the engine room for a whole unit or location. It could influence the philosophy of care by the methods, theories and assumptions it promulgates. By offering qualified staff placements on PICU as post graduate training experiences with clear goals and outcomes, its influence could be extended to other wards. By becoming the top place to work on the unit, the PICU could then truly strengthen, support and energise the acute wards.

These thirteen ideas summarise what I think PICUs could be and the role they could play in the future. Some of them are more feasible than others, doubtless some more attractive than others, and maybe some are utterly useless. However you too will have your own ideas about how PICUs could develop and contribute to service user care. Many of them will be better than mine because as a researcher I am somewhat distant from clinical services. I shall look forward to seeing, in the years to come, what we can collectively make of psychiatric intensive care.

References

Ayllon, T. and Michael, M. (1959) The psychiatric nurse as a behavioural engineer. *Journal of the Experimental Analysis of Behaviour.* 1959(2): 323–334.

Bowers, L., Brennan, G., Winship, G. and Theodoridou, C. (2009) *Talking with acutely psychotic people: communication skills for nurses and others spending time with people who are very mentally ill.* London: City University, 74pp http://www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/l_436_Talking.pdf

Bowers, L., Brennan, G., Ransom, S., Winship, G. and Theodoridou, C. (2011) The Nursing Observed Illness Intensity Scale. *Journal of Psychiatric and Mental Health Nursing.* 18: 28–34.

Emerson, E. and Einfeld, S.L. (2011) *Challenging Behaviour*, 3rd ed. Cambridge University Press, 224pp.

Kellam, S.G. (1961) A method for assessing social contact: its application during a rehabilitation program on a psychiatric ward. *Journal of Nervous and Mental Disease.* 132: 277–288.

Moore, E. and Kuipers, E. (1999) The measurement of expressed emotion in relationships between staff and service users: the use of short speech samples. *British Journal of Clinical Psychology.* 38: 345–356.

https://doi.org/10.1017/S1742646413000071 Published online by Cambridge University Press