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## Correspondence

Page, M. J. (2010) Rediscovering our true purpose: principles in the competitive PICU market. *Journal of Psychiatric Intensive Care*. 6(1): 9–16.

It was with interest that I read the above Editorial which deals with some of the issues central to my experience as a senior clinician and manager within the UK independent PICU sector.

Page's insights describe the tension in the curious notion of detention in mental health services in the context of a competitive market. Indeed there is a challenge in introducing the Recovery model and principles into PICU and low secure care because fundamentally in the act of treating people for their mental illness the first thing we do is lock them up and deprive them of their choice to be free. This is not to say there is a better way but it sets the scene and automatically makes jailors of staff to an extent. Of course we know that the real skill of the psychiatric nurse is in building up a therapeutic relationship in order to engage and work with a patient and this can be done in a PICU setting even when one is caring for acutely unwell individuals. Putting the patient and their choices where feasible at the centre of care is not so difficult when they are with you physically and when you know that most individuals respond positively to personalised care that treats one with respect.

As a clinician first and foremost, I embrace the idea that whatever mental health setting one works in and for whichever organisation one works, the patient should always be at the centre of care. We should focus on the people first and design and run a service to meet their needs. A great idea and one which I'm sure no-one could disagree with in principle.

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I am, with no apologies, a manager also and have to manage within the resources I have at my disposal, given the occasional squeeze. I also have to manage within the resources outside my organisation and the political context. It is this that presents the bigger challenge. I can usually present a good clinical case for more resources or better management of the same within my own organisation and I know, having worked in the NHS and private sector that there is very little difference in this instance.

It is when the patient, service user or just person perhaps, in question is unknown to the team or panel deciding their future that they start to fall away from being at the centre of care. They can then become an object which is going to cost the purchaser a lot of money, especially in secure care, or increasingly nowadays a 'risk' to the extent that they become like a hot potato. We are expected to implement the Recovery model to achieve contract targets and in fact I don't know any clinician who thinks that this is not a good idea (the model not the targets) and is what we are already working towards.

Where I believe the real problem lies is that this model and the principles need to weave seamlessly through all aspects of a patient's care in the Health Service including when decisions are made about where they are placed. In fact the term 'placed' which is commonly used makes the patient sound like baggage.

I have experienced two recent examples where this has not been the case. The first was on a care programme that was engaging the patient in a programme with a goal in place to go to a less secure setting eventually. The patient responded positively to the programme and was rewarded with leave as per plan over several months.



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Unfortunately for the patient, the area from where he originated became what seemed to be risk averse which is not unusual from time to time depending on the political climate.

Suddenly, individuals from that area who did not know our patient particularly well became concerned about the 'risks' they posed and contra to our risk assessments and successful management the plan for him was changed to increase the level of detention in spite of the progress according to the known plan of care that had been in place for some months.

This was putting the political climate at the centre of the patient's care and people who had not had recent contact with this individual were making the decisions about that person's future. This is a challenge which is not impossible to take on and in fact eventually the patient was put back at the centre of care following much discussion and further assessment. It took some effort from all parties to really think about the patient and proportional risk as well as other considerations. It is not easy to detach from the political climate and nor should we completely nor blindly but we do need to keep coming back to focusing on people as individuals and their choices and hopes.

Another recent case is one where a patient had a care programme leading to a step down facility from a low secure setting. They chose to move from their place of origin and wanted to settle down elsewhere which requires being accepted by the services in that area. The plan was agreed and in place when at the last minute the funding was withdrawn for no clear reason and now there is wrangling over who will provide (pay for) the care. They have become a delayed discharge in our eyes which contrary to popular belief does really happen in the independent sector.

The patient is no longer at the centre of their care, finances are. This is happening increasingly in spite of the recommendations that are made to give patient choices and for them to be treated as close to their home as possible.

The challenge here, of course is for people with influence to advocate for the patient and to try and see them as a person who has worked hard towards their recovery and deserves the chance to continue in their pathway of choice.

These two examples are not isolated ones and I'm sure that as the Government's emergency budget goes out and resources become tighter there will be more wrangling over funding. Over the years, as a leader and manager in the health service I have experienced various meetings where decisions have been made about service users and their care where the most important consideration was cost. Decisions have been made to keep a patient in a home unit because an out of area placement is seen as cheaper, not that the patient's needs will be better met. Ironically of course how many times has that backfired due to using expensive agency staff to manage someone and the cost rockets! We can't ignore cost because as I acknowledge we all have resources to manage within. We can't ignore or get sloppy with risk assessment and management either as we do need to learn from our mistakes.

However, if we are to implement the Recovery Principles we all need to be working with them at the forefront of our decisions at every level of care. I present these challenges positively, because I know that there are enough individuals working in mental health who can advocate putting the patient at the centre of care. Many people are able to articulate the dangers of them slipping from the centre of care. They need not to be hidden or forgotten because they are locked up in secure care or worse considered permanently dangerous because they have been once when untreated. So, in spite of the challenges, or rather because of them, let us really work together in partnership within the Recovery principles and focus on the people we care for.

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