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Editorial

Acute mental health care; lessons from opera and Iceland

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Last summer, I had the privilege of working with the mental health services based in Reykjavik, Iceland. At the request of Dr Pall Matthiasson (Chief Executive of Icelandic Mental Health Services) I was invited, with colleagues, to assist in the development of Iceland's first psychiatric intensive care unit (PICU).

Iceland's Mental Health Services had taken the decision to modify and develop the architecture of a pre-existing acute ward to the standards of a PICU. A team of staff had been identified, having applied for positions within the new PICU service due to become operational in the early Autumn of 2013.

As guests, our role was to offer reference points based on our experience of working with PICU services in the UK and elsewhere. We saw ourselves not as exporters of a particular brand of PICU, or as in possession of definitive wisdom, but as collaborators in the production of a unique home-grown brand of Icelandic PICU.

I had never visited Iceland before. Whenever assisting teams and services towards developing their own brand of new PICU, I always experience a sense of healthy anxiety. Would the assistance I may have to offer easily fit with the specific cultures and expectations of the local PICU services? These services need to reflect the towns, cities, cultures and communities that they serve.

This healthy anxiety was born from my experience of developing PICU services in the

UK in particular. All too often I have faced big challenges in trying to navigate the pre-imposed norms, rules, policies and complexities of the accepted frameworks defining UK mental health services. Although very often nothing to do with patients, their needs, clinical interventions or the staff, these challenges seemed never the less always to punctuate the mission course of developing a new service.

My anxiety sat with me in my seat as we cruised at 30 000 feet heading north from London towards Reykjavik. As I pored over the papers and revisited the presentations that we had prepared for the week long programme we were facilitating in Reykjavik, I subconsciously searched our prepared material for reassurance and positive omens that our efforts would be well received. We would need to succeed in meeting the expectations of the brand new PICU team who were looking forward to occupying a newly converted unit approximately eight weeks after the policy development and induction programme that we were about to facilitate.

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Struggling to find anything deeply reassuring in the pre-prepared material I glanced up from my laptop and looked out of the window of the Icelandair Boeing 757 and was immediately struck by a strange sight.

We had taken off from Heathrow Airport in total darkness and through the window I observed that we were flying into a bright white light which haloed the horizon. I was overcome with the feeling that we were, indeed, heading somewhere special – somewhere different. Maybe we were leaving behind the clutter and dark closeness of a large, complex and highly populated hive of activity towards a bright horizon beyond which anything might be possible. Eagerness rather than apprehension now sat with me in the aircraft. In my mind at least, the first omens for the brand new Icelandic PICU Services were good.

We were about to embark on an adventure. As in all good operas, the essential characters needed to play out the drama of developing a new complex PICU service would be required to remain passionate, reflective, analytical and inquisitive. There was no universal PICU service blueprint that could be simply followed to assemble a functioning and successful service. There could be no guarantee of a winning script. We would need good reliable evidence and creative thinking in equal measure.

During the car journey from Reykjavik Airport to our hotel, we travelled across the breath-taking landscape in broad daylight even though it was well after midnight. Talking to Dr Matthiasson about the forthcoming week, it was clear that we were not in the UK or indeed anywhere in Western Europe. We were, in fact, somewhere else.

Dr Matthiasson told us that there was a new team ready to take part in the induction and policy development programme. Also, that there was a willingness and enthusiasm to embrace new ways of working and to develop a particular brand of PICU suitable to the unique identity of Icelandic Services.

Over the following week we engaged in an intensive programme starting early in the morning and often progressing into the evening. We covered issues such as admission criteria, care plans and engagement, transfer criteria and mechanisms for decision making. The team of around 25 people included the nursing staff, senior medical staff, occupational therapists, psychology staff and managers. All assembled with a single goal of defining and agreeing the best way to organise Iceland's first PICU service to serve the country's population and become a respected member of the global PICU community.

One of the most striking features of my experience in Iceland was that the light that bathed the breath-taking landscape almost 24 hours a day, also seemed to illuminate the terrain we needed to navigate for the development of philosophy, policy and procedure for the service. What I had previously thought of as inevitable non-clinical bureaucracy and service politics appeared absent – or at least, not in the way of people's ideas for implementing the best solutions.

The team readily agreed a policy of goal orientated admission requiring an agreement between referrer and PICU staff as to the goals for the admission of each patient before they were received into the PICU. The establishment of an expected date of transfer back to general adult services or discharge from hospital was also deemed necessary at the point of admission to the PICU. The idea being that all admissions would be for specific and agreed purposes with an expected timeframe which was understood and shared by patients and staff alike. During the remainder of the week, an activity programme for the unit was agreed, standard operating procedures developed and new practices proposed.

During the course of the week there was often spontaneous and passionate debate amongst practitioners within the team as to how best to take particular facets of the policy forward. Much of this debate was in Icelandic which, although I did not understand, I found myself engrossed in the energy of the conversations, sometimes even nodding with agreement even though I was clueless as to what people were actually saying until the conversation again morphed back into English.

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A month later, we returned to Iceland for another part of the induction programme just days before the unit was to become operational.

Why do I tell this story? What could this event developing PICU services in Reykjavik have to offer the global PICU community? Well, here are some possibilities.

Iceland's close-knit community, relatively small population and sophisticated infrastructure seemed to allow for a 'blank sheet' when considering the best way to develop PICU services. I was struck by the apparent absence of bureaucracy hindering what were universally agreed to be good ideas. There was an open mindedness and willingness to take the shortest route to the best solution, which appeared unfettered in comparison to many of the experiences I had had in the UK of developing and delivering PICU services.

I was struck by a particular conversation with some senior managers. There was a proposal that maybe one of the best ways to organise admission policy to the PICU would be to change some of the existing procedures associated with admissions to the acute wards. All were agreed that while this probably offered the best longer term chance for success, it represented a significant policy change that would affect a relatively large number of people across the service, and that there would be many stakeholders to consult and persuade for a trial policy to be initiated. I suggested that it would obviously take quite some time to develop and initiate and, based on my experience in the UK, I enquired how long it might take to instigate such a significant policy change. I was told that we from England needed to appreciate that this was indeed quite a complicated proposed change and therefore others would need to be brought on board. With this in mind, I was told cautiously that the trial policy could not be agreed until at least next Tuesday! I stood in silence, trying to conceal the fact that I was expecting, based on my UK experience, to be told at least 12 months.

In the evenings, there was time for analysis and reflection, to stand back from the mission at hand and indulge in the narrative of the humanity of acute mental health care.

Maybe one core lesson is that it is possible for those who stand united towards a single cause to make changes and develop practice with surprising efficiency. It is also possible for a coalition of the willing to embrace new ideas and manufacture an approach to PICU orientated to their specific population unfettered by the usual expectations of bureaucracy and endless committee meetings. An absence of the all too familiar imposition of considerations often unrelated to the realities of PICU care delivery at the point of patient contact. The best interests of patients, the best clinical evidence available and the most efficient solutions can and should represent the stage and script for planning and operating services.

All mental health inpatient teams share a common bond of collective effort towards a single purpose of assisting the most troubled of mental health inpatients often, at the point of their greatest need. For this to be achieved in the most engaging and successful way, one must be prepared to throw off the shackles of tradition, bureaucracy and be prepared to translate the best evidence for acute care and PICU services into a discreet language. This allows for the particular communities the PICU serves to experience a sense of connectivity to the service and feel that they are being cared for by people who understand them at a critical time. Maybe, achieving this is best served by practitioners, managers and patients allowing themselves space to reflect, discuss and most importantly listen to themselves.

With this in mind I would draw your attention to Henck van Bilsen's paper 'Lessons we can learn from opera' in this issue (van Bilsen, 2013). For some, this may be an unusual paper to see occupying the pages of a scientific journal. Reading Henck van Bilsen's paper I was reminded of my experience in Iceland. The ability to stand back from the complexity and traditions of PICU/inpatient care and to identify the intricate patterns and stories sometimes hidden from those without time or space to analyse and reflect.

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At times it may be best to leave the stage and observe from the balcony in order to be able recognise where the best harmonies are to be found. Clinical experience, evidence and practice rather than comforting bureaucracy should be our guide.

No doubt we will hear more from Iceland in the pages of the *Journal of Psychiatric Intensive Care*; they should of course, let us know how they are getting on. Moreover, all of us within the global PICU and LSU clinical community have a responsibility to remain curious, tell our stories and share our insights. We at the *Journal of Psychiatric Intensive Care*, look forward to hearing from you.

Reference

van Bilsen, H.P.J.G. (2013) Lessons we can learn from opera. *Journal of Psychiatric Intensive Care*. Published online 19 September 2013, doi: 10.1017/S1742646413000228.