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A new specialty of acute in-patient psychiatry?†

Luiz Dratcu makes a case for a new specialty of acute in-patient psychiatry; Frank Holloway argues otherwise. In neither instance are the arguments at all surprising, and in both they are eloquently expressed. The case for a new specialty is based upon recognition of a continuing need for acute psychiatric in-patient services, and recognition that these services require particular skills and facilities which are likely to be most efficiently and effectively provided when interests and activities are focused upon them. The case against does not deny the need for attention to widely acknowledged shortcomings of many acute psychiatric in-patient services, but it does ask the questions 'what should constitute a specialty?' and 'what benefit would flow from having a specialty and for whom?'

Thus, both authors acknowledge a need to attend to the acute in-patient setting. Recent years have seen a whole series of publications drawing attention to shortcomings of acute psychiatric in-patient services (e.g. Sainsbury Centre for Mental Health, 1998; Department of Health, 2002; Rix & Sheppard, 2003; Garcia *et al*, 2005; Mental Health Act Commission, 2005; Braithwaite, 2006). Recurrent issues are: poor communications with community staff; service users' experiences of an unsafe, threatening environment; social and geographic isolation; lack of clarity of purpose around the admission and its context; and processes of management decision-making that are highly dependent upon ward rounds.

This chorus of discontent is not a response to sudden, recent deterioration in the quality of service on offer; rather, it reflects a timely and appropriate rise in the level of expectations. The most recent (11th) biennial report of the Mental Health Act Commission (2003–2005) is probably the most critical to date. This is not because matters have worsened significantly since publication of the 10th report. Recent years have seen long overdue attention paid to matters such as human rights, gender and racially sensitive characteristics and power relations within mental health settings. These are all particularly pertinent and challenging when considered alongside traditional acute psychiatric in-patient practices.

In October 2005 the outcome of consultations about the role of the consultant psychiatrist was published (Royal College of Psychiatrists & National Institute for Mental Health in England, 2005). The publication draws attention to the multidisciplinary nature of mental health services and the activities that they support. Conclusions include the view that it is no longer tenable for the consultant psychiatrist to assume full responsibility for, and influence over, all aspects of care provided to community-based recipients of complex systems of care. It is the need to consider the implications of this upon the consultant's contribution to the acute psychiatric in-patient unit that prompts the current debate. It has acquired relevance through the development of a national acute in-patient mental health project board, which is acting as a formal reference group for the Health Care Commission, setting standards against which to audit acute psychiatric in-patient care.

In addition to the now well-established and respected pioneering work at Guy's Hospital (Dratcu *et al*, 2003), a number of other units have experimented with, or considered developing, consultant roles that are either exclusively in-patient or exclusively community based. Detailed feedback is being assembled. Initial reflections have indicated that the journey has not been an easy one for everyone. However, even where this approach is felt to have contributed improvements in service and working life, there is no clarity about whether or not this is dependent upon, or could be enhanced by, according the activity specialist status.

In many ways, pitching a debate such as this around interpretations of an arbitrary term such as 'specialist' distracts from other more pressing concerns. Recurrent criticisms of the quality and nature of acute in-patient services are not specifically directed against the consultant. They are much more holistic, and refer to the extent to which a period of acute psychiatric in-patient treatment constitutes and is experienced as part of a journey through a larger system of care, ways in which power is experienced and exercised within what is very often a coercive environment, and the physical characteristics of the facilities within which acute in-patient care is practised. None of these are likely to be usefully addressed simply by defining another set of sub-specialist competencies of relevance to only one of the several contributing professions. All are likely to be responsive to clarity of purpose, commitment and leadership among those involved. Furthermore, contexts differ and

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solutions appropriate to one setting are by no means necessarily applicable to another. What might be an entirely appropriate *modus operandi* in central London may not be applicable to a rural setting. Could the same flexibility apply to a professional accreditation?

Attention to emergent shortcomings of acute psychiatric in-patient services requires change, and there are signs that policy makers are prepared to motivate National Health Service provider organisations accordingly. At the same time, there are open reflections upon the contributions the consultant psychiatrist (and by implication, psychiatry as a professional discipline) makes to a multidisciplinary mental health service. Change in services requires leadership, creativity and commitment. These might well be supplied by a consultant psychiatrist who happens to have appropriate personal qualities, but they are not likely to arise simply because an individual has captured a further set of professional qualifications. Consideration of the part played by the psychiatrist in acute in-patient settings has to include honest reflection upon whether or not traditional practices invariably support patients' experiences of a whole system of care, from community setting through the in-patient unit and out again. Particular concerns are the pros and cons of medical or crisis team 'gate-keeping', the value, status and conduct of the 'ward round', the pros and cons of 'continuity of care', which can result in ward staff having to relate to multiple medical teams, and the development of non-medical prescribing.

Answers to these concerns are likely to differ from place to place and from team to team. In seeking a solution it might be more appropriate to focus upon how best to provide a smooth and appropriate 'patient journey' within a defined setting and with the individuals available, than to attempt to define an organisational structure that all patients and professionals are then expected to conform to. Where there is a consultant psychiatrist keen to take the lead on developing acute psychiatric in-patient services, then that person might be the most appropriate to do just that. This should not prevent capable leaders from other backgrounds coming forward when they might be more appropriate, just because there is a notion that each acute psychiatric in-patient unit should be led by a specialist acute in-patient psychiatrist.

Declaration of interest

H.M. is a member of the National Institute for Mental Health in England/Care Services Improvement Partnership Acute Care Steering Group and a contributor to New Ways of Working for Psychiatrists.

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