

Commentary

Psychiatric intensive care units in Belgium: a new mental health service provision meriting research?

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Abstract

Belgium has a large capacity of psychiatric beds as compared to most other European countries and is on the verge of reducing this capacity. An accompanying augmentation of assertive community treatment strategies alongside acute crisis resolution has already begun. The latter function has been implemented in recently developed psychiatric intensive care units. Whether this development will result in improved care for psychiatric patients and in a reduction in cost for the government remains unanswered. Outcomes research in psychiatric intensive care is ongoing in the United Kingdom but this is not the case in Belgium. In this commentary we suggest that this moment of change is a perfect time for initiating research on psychiatric intensive care units in Belgium preferably in close collaboration with experienced staff in the United Kingdom.

Keywords

Psychiatric intensive care; change; mental health organization

INTRODUCTION

The Belgian mental health care system is built around institutional care, provided in psychiatric hospitals as well as in psychiatric wards in general hospitals. Institutional care in Belgium is densely bedded with a total number of psychiatric beds of 22 per 10 000 inhabitants. Eight countries have more than 10 beds per 10 000 inhabitants: Belgium, the Czech Republic, Estonia, France, Latvia, Luxembourg, Malta and the Netherlands. Only four countries (Cyprus, Italy, Spain and the United Kingdom) have less than 6 beds per 10 000 inhabitants. The mean number of psychiatric beds in the world is 4.36 per 10 000 inhabitants (World

Health Organization, 2005). In this WHO report, Belgium thus ranked first in a comparison of 27 EU member states.

A direct effect of this situation in Belgium is that specialized psychiatric care is almost exclusively delivered to inpatients, increasing patient's direct health care costs and social isolation. From earlier research it is known that direct healthcare costs for inpatients with schizophrenia are significantly higher in Belgium than in other European countries (De Hert et al. 1998). Moreover, patients in a prolonged full-time hospitalization are more prone to social rejection and stigma (Verhaeghe et al. 2008) thus leading to a significant disadvantage in their efforts in revalidation and social integration. Hence, the current mental health care organization in Belgium diverges from the

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principles of ‘balanced care’ and ‘stepped care’ (Thornicroft & Tansella, 2004).

Between 1970 and 2009, the Belgian government prepared a policy of transforming the existing overcapacity in psychiatric beds to a more efficient organization that was able to provide the adequate mental health care in the best context for a patient. The actual transformation started in May 2010 and is supposed to lead to a mental health organization with two pillars: first, acute psychiatric treatment, aimed at crisis resolution and second, long-term treatment and care. The latter pillar, comprising an assertive community treatment paradigm, serves as the basis for a significant psychiatric bed reduction over the forthcoming five to ten years, thus bringing Belgium into the group of European member states with lower bed density (Belgian government, 2010: <http://www.psy107.be/>).

In this article, we will describe how changes in Belgian society brought about a renewed need for locked acute wards providing crisis resolution treatment, which in a second phase embraced the model of psychiatric intensive care (Beer et al. 2001) and are intended to operate in close collaboration with the newly founded assertive community treatment teams. Secondly, we argue that this evolution should lead to research initiatives on treatment efficacy and on health economic aspects of this new approach.

THE PATH TO LOCKED WARDS FOR CRISIS RESOLUTION

At some point during the history of institutional care in Belgium a tendency developed towards changing from locked to open wards in psychiatric hospitals. This evolution was first caused by the evolving notion of destigmatizing patients in psychiatric facilities as well as a growing awareness of the emotional consequences for patients of being admitted to locked psychiatric wards. However, it became a problem to manage patients with complex needs who were admitted to these open long-stay wards as well as the same type of patients admitted to open acute units. At the same time an increase was seen in involuntarily admitted patients to these open wards (Servaes

& Van Eekert, unpub. report 2007¹) with direct effects on the safety of them and of their environments. A similar evolution was described in the United Kingdom (Brown & Bass, 2004; Yasir Kasmi, 2007). As a result of the developing safety problem with absconding patients the criticism of police forces and the judiciary grew, initiating a reverse movement with the reappearance of locked wards for acute crisis resolution.

The emphasis in these wards was on the symptomatic stabilization of aggression, psychosis and agitation. These new wards have been organized with the same characteristics as the ‘classical’ wards in a psychiatric hospital, meaning that they do not differ from the latter in patient/staff ratio, in staff education or in design of the ward.

This evolution brought up the situation that in Belgian psychiatric hospitals at the beginning of the 21st century there was a coexistence of wards with very different characteristics (open vs. locked, acute vs. chronic, (psycho)therapeutic vs. rehabilitation, short-term vs. long-term), within the same hospital. A distinct referral pathway for admission of the severely and acutely ill psychiatric patient did not exist. This made patients vulnerable to not receiving the right care at the right moment with a risk of a prolonged and complicated hospital stay. Moreover, these different and specialized units tended to deliver crisis resolution services to acutely ill patients in line with their theoretical (psycho)therapeutic protocol and thus without any standardization and without having evidence based treatments for this type of patients.

DEVELOPMENT OF SPECIFIC PSYCHIATRIC INTENSIVE CARE SERVICES

In 2005, this situation was acknowledged by a few psychiatric hospitals in Flanders. They started with the implementation of pathways of care with ‘stepped care’ and ‘balanced care’ as guiding principles (Thornicroft & Tansella, 2004). The clinical functioning was based on

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the work of Beer et al., which provided a clear basis for the psychiatric intensive care provisions (Beer et al. 2001; Beer et al. 2008). Hospital management invested in building new wards or renovating older wards and training programs for conflict de-escalation were established. Patient referral pathways and treatment policies were developed in close collaboration with emergency departments (psychiatric and other), other acute and chronic wards in the psychiatric hospital and in general hospitals.

However, because of the short time that has elapsed since 2005 these local initiatives have not yet attained acknowledgement from the Belgian authorities. The main reason for this is that wards, converting to psychiatric intensive care units (PICUs), delivered their services within the above described Belgian mental health system lacking formal referral procedures between services and thus precluding research on several outcome variables and patient or ward characteristics. International data could not be used because evidence produced was scarce or inconclusive. In spite of the fact that, in the United Kingdom, PICUs are a standard and integrated part of mental health services, hard evidence that they offer a superior treatment model when compared to conventional acute wards is still lacking (Brown et al. 2008). Moreover, in an earlier study, it was demonstrated that the opening of a PICU appeared to have little long term effect on the clinical activity of the other hospital wards (Brown & Langrish, 2006).

Without further and fundamental changes in the Belgian mental health system this would lead to a standstill, resulting in the existence of locally relevant but not generalizable, thus not scientifically comparable, intensive care service provisions.

THE IMMINENT CHANGE IN MENTAL HEALTH CARE ORGANIZATION AND THE RELEVANCE FOR BELGIAN PICUS

As described above, a PICU in Belgium is now operating with the same staff/patient ratio and the same level of training for staff as found in

other acute wards in the psychiatric hospital. Moreover, architectural guidelines are not adapted to the new type of approach to the acute patient in need of intensive treatment oriented at symptomatic stabilization and the shortest possible period of stay. Although these scarce new units demonstrate good and innovative practice in crisis resolution and operate within local initiatives providing transparent referral pathways for acutely ill patients, most of the regionally based networks of mental health systems in Belgium still lack clear criteria for admission and discharge for severely and acutely ill patients.

It will be interesting to assess if, and how, the new PICUs in Belgium will benefit from the upcoming mental health care transformation, aiming at lowering the capacity of beds and changing them for more assertive community treatment teams. New projects are committed to link crisis resolution with assertive community treatment in a clear referral pathway if they wish to be accredited by the authorities. In this way, after a first wave (between 2005 and 2009) of locally implementing the model of psychiatric intensive care to locked wards, a second wave (from 2010, in alignment with the bed reduction policy) is coming up allowing for good benchmarking and outcomes research on therapeutic interventions in PICUs in Belgium. A similar evolution was seen in the Netherlands with the planning of the ASAP-II study (Koppelmans et al. 2009). This study aims at comparing different Dutch PICUs on, amongst others, treatment aspects, outcome variables and rates of coercive actions. Results of this study, together with data from the United Kingdom, will be very relevant to the Belgian mental health system because they provide a good basis for research planning on outcome measures, treatment policies and cost effectiveness of these new PICUs.

SUMMARY AND CONCLUSIONS

Belgium is facing a significant transformation in its mental health services. In the years prior to this transformation PICUs had already developed within the system but it was up until

now impossible to answer the question of whether they were really providing better care than ‘classical wards’. Starting this process of transformation in 2010 creates opportunities to conduct research on this evolution and establish whether the Belgian mental health system is really in need of services providing psychiatric intensive care. This research should be conducted in close collaboration with countries (e.g. United Kingdom) that already have established standards of care and of research methodology in this area.

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