Chapter 1

Psychiatric Intensive Care: Development and Definition

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Introduction

In this chapter, we outline the historical development of psychiatric intensive care as a specialty. Then, we present an overview of the current facilities and patients based on the most recent UK National Surveys and current admission criteria taken from national guidelines. Further, we discuss how psychiatric intensive care interfaces with general adult services, mental health secure estates, the criminal justice system and community mental health services. Finally, we present an outline of the future strategy for the development of the specialty.

Historical Development of PICU as a Specialty

The implication is that by reading this you have an interest in psychiatry, specifically psychiatric intensive care. There are chapters within this book that provide modern-day definitions and principles of practice which relate to illnesses, levels of disturbance, commissioning services and physical environments in which these services can be delivered. A question that you may wish to consider is 'how has this specialty evolved?' or even, 'has there always been a need for this type of care?'.

This chapter develops answers to these questions by reviewing the historical development of care provision for the seriously disturbed, mentally unwell individual. By reading it, you will have a better understanding of how and why such services have progressed into what we now understand as psychiatric intensive care. The chapter also looks to the future and reflects upon what it may bring to this specialty.

There are many books and articles that give a historical context to psychiatry. They may discuss specific diseases or symptoms, but few concentrate specifically on what we now understand to be psychiatric intensive care, a discipline that, although small, has given its expertise to the management of severely unwell people who pose risk to themselves and/or others.

Patterns of Care

Throughout history, there has been a cyclic pattern in the modes of care for people suffering from mental illness. Types of treatments have tended to be based on whether an individual's behaviour was considered normal or abnormal. This depended on the milieu within which the behaviour occurred and thus changed as a function of a particular time and culture. As such, uncommon behaviour or behaviour that deviated from sociocultural norms at that time has been used as a reason to control individuals. The more extreme the behaviour, the more significant the intervention. Turner (1996) wrote that historically, psychiatry has been judged by its management of the 'furiously mad'. Nearly 3,000 years ago the king of Babylon was put to pasture (literally) after he started to behave like a wild animal (Book of Daniel).

On the other hand, a less cultural relativist view of abnormal behaviour has focused on whether behaviour poses a threat to oneself or others or causes so much pain and suffering that it interferes with one's daily life and relationships, and treatment focused upon the level of threat.

Early History of Acute Mental Health Care

Cave art was found that originated from as early as 6500 BCE which depicted extreme sadness, and archaeologists have found skulls from around that time that display trephination (removal of sections within the skull). Some historians believe that this was a product of people who were experiencing

hallucinations or who were chronically depressed (Farreras, 2021). In ancient Egypt (around 3500 BCE), a person suffering from psychological distress would be sent to a sanatorium, a sleep temple dedicated to healing. In the sanatorium, they would enter a dark cell and prepare for a 'therapeutic dream'. A hypnotic sleep state was induced by lamps and burning perfumed wood. Priests interpreted the dreams and consulted the 'Egyptian Dream Book' to find cures. This is not unlike segregation found in prisons or high-dependency units/seclusion suites found in modern-day psychiatric facilities receiving rapid tranquilisation to induce a calming state.

Throughout early history, mental illness was ascribed to supernatural powers, evil spirits or the wrath of gods. In Greek and Roman times, those marked with mental illness were often 'shunned, locked up, or on rare occasions put to death' (Corrigan, 2002). Sufferers were confined so that they would not cause injury to themselves or others, or damage to property. Two thousand years ago we read in the New Testament of a wild man wandering naked amidst the tombs, having broken the chains that bound him.

The ancient Greek philosopher Plato progressed matters. He suggested that the human soul had three parts, each one having its own home within the body. He remarked in the Timaeus that the body moulds and informs all three parts, and that even the rational part, albeit immortal, is affected by physical illnesses because it is confined to the head. Despite this, he also wrote 'If a man is mad, he shall not be at large in the city, but his family shall keep him in any way they can' (Meyer, 2015).

One of Plato's contemporaries, Xenophon, went further when he claimed to cite the teachings of Plato. He suggested that restraining a mentally ill person can be beneficial, but that a clear distinction must be made between people who are actually mad and people who are ignorant and foolish yet amenable to education and reasoning (Bonnette, 1994).

Western European accounts from the early part of the Middle Ages often blamed mental disorders on demons, an attribution that has precedents in the New Testament. Witch hunting and subsequent execution secondary to demonic possession became commonplace. As this practice diminished, it again became the individual's family that was held responsible for the actions of the mentally unwell. This led to people being hidden from the public by their families, often in states of neglect.

More recognised forms of segregation, motivated by the Christian duty of charity, developed towards the end of the Middle Ages. Somewhat akin to the ancient Egyptian sanitorium, religious houses took in 'lunatics'. In London, St Mary of Bethlehem (lastingly known as the Bethlem) was housing the mentally unwell by the late fourteenth century. By that time, the northern Belgian village of Gheel, with the shrine of St Dymphna, had achieved fame as a healing centre for insane and mentally defective individuals who were disturbed (Porter, 2002).

'Enlightened' Care

Before 1800, there was no country in which medical supervision was required for such asylums. The Bethlem became the national hospital for the disturbed mentally ill 750 years ago. The patient's parish of origin would pay for a stay of usually up to a year. Medical involvement did not automatically lead to good care, as the Bethlem institution showed. For example, the Monro of Fyrish family, who were associated with Bethlem Hospital, produced a dynasty of physicians in London who provided medical care in the eighteenth and nineteenth centuries and who, some suggest, regarded the treatment of madness as a family business as a means of generating wealth and status in society. The institution soon became known as 'Bedlam' as its conditions and practices were revealed. Violent patients were put on display like sideshow freaks for the public to view for the price of one penny; calmer patients were put out on the streets to beg for charity (Butcher, 2007).

Other countries began to follow suit and founded their own mental health facilities. San Hipolito was built in Mexico in 1566 and claims the title of the first asylum in the Americas. La Maison de Chareton was the first mental facility in France, founded in 1641 in a suburb of Paris. Constructed in 1784, the Lunatics' Tower in Vienna became a showplace. Many asylums were staffed by untrained individuals in conditions akin to prisons. A case study describes a typical scene at La Bicetre, a hospital in Paris, starting with patients shackled to the wall in dark, cramped cells. Iron cuffs and collars permitted just enough movement to allow patients to feed themselves but not enough to lie down at night, so they were forced to sleep upright. There were no visitors to the cell except to deliver food, and the rooms were never cleaned. Patients had to make do with a little amount of straw to cover the floor and

were forced to be with their own excrement (Butcher, 2007).

'Treatment' followed practices typical of the time; purging and bloodletting being the most common. Other practices included drenching the patient in either hot or ice-cold water to shock them back into a normal state. The belief that patients needed to choose rationality over insanity led to techniques aiming to intimidate (Butcher, 2007): blistering, physical restraints, threats and straitjackets were employed to achieve this end. In the mid-1700s, Dr Boerhaave invented the 'gyrating chair', which became a popular tool in Europe and the United States. This 'was intended to shake up the blood and tissues of the body to restore equilibrium' but instead resulted in rendering the patient unconscious (Alexander and Selesnick, 1966).

Abuses, however, came to light; none better known than the case of William Norris in 1814, which prompted a parliamentary enquiry. This unfortunate American seaman had been admitted in 1800. In June 1804, he was permanently confined in an iron harness so that he could move no more than 12 inches. Ten years later he was still in the same spot. His isolation and constraints were described at the time as:

> a stout iron ring was rivetted round his neck, from which a short chain passed to a ring made to slide upwards or downwards on an upright massive iron bar, more than six feet high, inserted into the wall. Round his body a strong iron bar about two inches wide was rivetted; on each side of the bar was a circular projection, which being fashioned to and inclosing each of his arms, pinioned them close to his sides. This waist bar was secured by two similar bars which, passing over his shoulders, were rivetted to the waist bar both before and behind. The iron ring round his neck was connected to the bars on his shoulders, by a double link. From each of these bars another short chain passed to the ring on the upright iron bar. (Committee on Madhouses, 1815)

In the United Kingdom, under the 1828 Madhouse Act, the Metropolitan Commission in Lunacy was established. Several iterations of the Act ensued mainly dealing with the issue of management of pauper lunatics in Middlesex and surrounding areas, as no county asylum existed. Research by Argent (2023) suggests that in 1840 resident medical officers were required by law in houses with more than 100 patients.

Asylums were also established under religious auspices in eighteenth-century Liverpool, Manchester, Newcastle and York, and in 1845, the provision of county asylums was made mandatory. Up until then, affluence enabled segregation within 'private asylums' of all shapes and sizes as well as quality. The Lunacy Commission was a public body established by the Lunacy Act 1845 to oversee asylums and the welfare of mentally ill people in England and Wales. County lunatic asylums opened such as the ones found in Essex on 23 September 1853 with 450 beds. It had originally been planned to have 300 beds, but the Lunacy Commission felt this was inadequate. It was replaced by the still-utilised Goodmayes Hospital, London Borough of Redbridge, which opened in 1901 and still retains a psychiatric intensive care unit (PICU) called Pathways on Tagore for the most vulnerably mentally ill patients.

Evidence suggests that the abolition of mechanical restraints was 'a gradual process that occurred at the same time in a number of different institutions and that no single individual can be identified as the unequivocal initiator of this movement in the UK' (Haw and Yorston, 2004). Notable individuals include Robert Gardiner Hill, house surgeon, and Edward Charlesworth, physician and governor, at the Lincoln County Asylum in 1838, John Connolly at the Hanwell Asylum in 1839 and Thomas Prichard of the Northampton Asylum in 1857. However, Connolly, in his influential publication *Treatment of the Insane without Mechanical Restraints*, gave credit to Samuel Tuke of the Retreat at York and Phillipe Pinel at La Bicetre hospital in Paris as the 'men who led the way for the more complete system of non-restraint' (Connolly, 1856, p. 9). Despite his pleas for reform, Connolly remained in favour of seclusion: 'The great advantage of a padded room . . . . . is that it renders both mechanical restraints and muscular force unnecessary for the control of even the most violent patients' (Connolly, 1856 p. 44).

The Mental Treatment Act 1930 introduced the concept of informal admission of patients and by 1938 such patients constituted 35% of all admitted patients (Jones, 1993). The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954–7) stressed that patients should be treated informally where possible. The Mental Health Act 1959 confirmed this and enacted strict guidelines for involuntary patients.

In the late 1950s, there was another important development in the care of the mentally ill. This was the introduction of chlorpromazine, the first pharmacological treatment for psychotic illness. The potent combination of effective antipsychotic drugs along with the introduction of patients' rights led to the unlocking of many hospital wards. The promise of community care was outlined by Enoch Powell in his 'Water Towers' speech when he stated: 'A hospital plan makes no sense unless the medical profession outside the hospital service will be able progressively to accept responsibility for more and more of that care of patients which today is given inside the hospitals.' Perhaps this paved the way for PICUs, as the occurrence of disturbed behaviour associated with mental illness in a small minority seemed to have been overlooked by politicians in their optimism when viewing care provision for the majority. Thus, the PICU function probably evolved as a pragmatic solution to the patient management problems encountered on the open wards.

Secure Provision in the 1970s in the United Kingdom

By the early 1970s, each health region was being encouraged to develop services in district general hospitals. These facilities could not adequately manage difficult patients. The latter joined the mentally abnormal offenders in asylums, prison or special hospitals.

The Department of Health and Social Security set up a working party in 1971 to review the existing guidance on security in National Health Service (NHS) psychiatric hospitals and make recommendations on the need for security. Consequently, the Glancy Report (Revised Report of the Working Party on Security in NHS Psychiatric Hospitals) was published (Department of Health and Social Services, 1974). The Report noted the almost total lack of secure facilities and recommended 1,000 places for England and Wales.

Perhaps the origin of what we now recognise as a PICU came from a man named Graham Young, who in 1971 at the age of 24 was working as a general handyman at a photographic instrument company in Hertfordshire, UK. In June, the head storeman, Bob Egle, was hospitalised with diarrhoea, nausea and numbness in his fingertips, and eight days later he died in hospital, apparently of broncho-pneumonia and polyneuritis. Shortly afterwards, other employees at the company fell ill, apparently with food poisoning or what became known as the 'Bovingdon Bug'. After another man died, a meeting of management and staff at the company was addressed by a doctor who ruled out contamination by heavy metals (something the staff were worried about due to the chemicals at the company). But someone challenged him with a question: 'Do you not think that the symptoms are consistent with thallium poisoning?' The questioner was Graham Young. After speaking with him further, concerns grew regarding his apparent knowledge of toxicology and the police were subsequently called.

Following this, it was discovered that nine years previously, Graham Young had administered poison to his sister, father and a school friend, all of whom survived (he had also killed his stepmother by poisoning, which he later admitted, but for which he was never charged). Following this, at the age of 14, he was sent to Broadmoor (a high secure hospital) with a recommendation that he serve at least 15 years. Young spent eight years in Broadmoor before being discharged to community psychiatry services. He had applied for his job at the photographic instrument company stating that he had 'previously studied chemistry and toxicology'.

He was arrested, charged and subsequently convicted of two counts of murder, two counts of attempted murder and two counts of administering poison. Following this, the home secretary announced an immediate review of the control, treatment, assessment and release of mentally disordered offenders. The terms of reference of what became the Butler Committee were:

- To consider the criminal law in relation to mental disorder or abnormality and to recommend whether any changes in the powers and procedures were necessary.
- To recommend whether any changes were required in the provision of facilities and treatment for this group of patients.

The final report of the Butler Committee was presented to parliament in 1975 (Committee on Mentally Abnormal Offenders, 1975). It recommended the development of regional secure units (RSUs) (with central funding) in order to manage those mentally disordered offenders who do not need conditions of maximum security but cannot be managed by local psychiatric services. It suggested a figure of 2,000 secure beds. This was double the Glancy

figure, which was based on the need for security among general psychiatric patients. It was envisioned that patients would remain within these units for 12–18 months prior to being discharged. It expected that these services would also be crucial in supporting the general psychiatric hospital as well as relieving overcrowding in special hospitals and providing a service to courts and prisons.

The RSUs were to be 50- to 150-bedded units closer to major centres of population than the special hospitals. Although this report addressed those patients who have offended, it did not refer to those mentally ill individuals who have not offended but present acute risk to others due to current mental state. A particular point that was made regarding difficult long-stay patients was that the RSUs should not be allowed to become blocked with such patients. If they did, then the problem which they were supposed to address would recur; however, no clear alternative model of care was proposed for these cases.

Subsequent to the Butler report, the Department of Health and Social Security very quickly made money available for 1,000 beds to be provided in RSUs and in interim secure units (ISUs) whilst the former were being built. These ISUs were usually converted psychiatric wards; most had a double door 'airlock' system to enter the unit and secure external exercise areas, as well as unbreakable glass and alarm systems. Bluglass (1976) proposed that the admission criteria should include any acutely ill patient whose illness was accompanied by difficult and dangerous behaviour but should exclude wandering demented patients, the severely learning disabled and the difficult acute patients.

Thus, historically, the RSU network has been centrally planned and funded, whereas locked beds for acutely ill, non-offender patients have not.

Development of PICUs Worldwide

The first publications which described locked PICUs came from the United States. Rachlin (1973) stated that 'an open-door policy cannot provide adequately for the treatment needs of all psychiatric patients'. He described the establishment of a 'locked intensive care unit' serving the Bronx area of New York 'to treat several types of patients who did not respond on open wards' (p. 829).

Half were referred because they were absconders. Crain and Jordan (1979) also reported on a PICU in the Bronx which admitted mainly violent patients, 'who simply cannot be treated with an acceptable level of safety on a regular ward'. It also provided a more humane treatment setting, 'for such individuals whose behaviour ordinarily would provoke angry, punitive responses from the environment' (p. 197).

Other PICUs were described elsewhere in the world. Goldney et al. (1985) described a locked unit for acutely severely ill patients in Adelaide, Australia. Warneke (1986) described a PICU for acutely ill patients in a general medical hospital in Edmonton, Canada. The patients were mainly suicidal, and the unit was not locked, nor were the patients legally detained. Musisi et al. (1989) described a six-bedded unit in a provincial Toronto psychiatric hospital.

In England, the first designated PICU was opened in St James's Hospital, Portsmouth; Mounsey (1979) described the setting up of a twelve-bedded PICU in Salisbury. This was a lockable converted ward for disturbed patients referred from the rest of the psychiatric hospital.

In Scotland, Basson and Woodside (1981, p. 132) described the working of a mixed, 'secure/intensive care/forensic' ward and stated that, 'the pendulum has swung from "open door" hospitals back to a recognition for some security'.

Secure Provision in the United Kingdom in the 1980s and 1990s

The RSU model was first developed throughout England and Wales and then subsequently in Scotland. Several deficiencies of the RSU model have been noted. Snowden (1990) wrote that there is a group of patients who are not so dangerous that they require special hospital security but who are chronically ill or poor medication responders and who require a degree of security. Some of the more severely ill and disabled patients will not manage in the community and long-term care will not be available. The mentally ill who cannot manage in the community may become mentally ill offenders by default, and even if they do not, general psychiatric services could well put pressure on forensic services to take patients that would have been considered appropriate for RSU admission in the past.

In 1991, only 635 medium secure beds existed compared with 1,163 beds in 1986, according to the Reed Report; this review of health and social Services for mentally disordered offenders and others requiring

similar services (Reed, 1992) proposed that 1,500 beds were needed. It also proposed that, 'access to local intensive care and locked wards should be available more widely' and that 'secure provision should include provision for those who require long-term treatment and/or care'. The Reed Report again referred to the lack of service provision.

Many offenders needing in-patient care can be accommodated in ordinary psychiatric provision. Although many offenders can be managed satisfactorily in 'open' wards, there must be also better access to local intensive care and locked wards (Annex J (local services 5.16 Hospital Services, p. 19)). The Report recognised, 'the need for each Health District to ensure the availability of secure provision ... [which] should include provision for intensive care'. The Reed Report (Reed, 1992) referred to ICUs as low secure units (LSUs).

Smith et al. (1990) hypothesised that the role of the RSU was changing. They compared patients admitted to the Butler Clinic RSU in Southwest England in 1983 and 1989. In the 1983 population, there were significantly more patients who had been aggressive towards staff and had histories of absconding. The 1989 population was much more likely to have been referred from the criminal justice system. The authors speculated that the RSU was originally dealing with a 'backlog' of local hospital patients for whom there was no secure provision before the RSU opened.

A survey of RSU patient characteristics in 1994 confirmed that the RSU population had high levels of serious offending (McKenna, 1996) and warned that, 'The ability of the RSU to respond quickly, effectively or flexibly to acute difficulties in the services referring potential admissions must in turn be compromised.'

In order to respond quickly, NHS trusts have now used the low secure wards or PICUs to take up this demand for urgent forensic patients. Dix (1996) pointed out that this group does not necessarily present high levels of behavioural disturbance but requires a degree of security because of their charge or offence. James et al. (1996) also referred to a group of patients that had offended but did not require security. The suggestion is that local services should be able to provide low security in order to facilitate diversion of offenders from the criminal justice system and aid the rehabilitation of patients discharged from special hospitals.

As Dix (1996) writes, however, 'A significant number of PICUs do not consider themselves as "forensic units" and are reluctant to accept patients who, as a result of legal restrictions, cannot be discharged from the PICU when clinically indicated.' Cripps et al. (1995) describe a mixed PICU/forensic unit and discuss some of the advantages and disadvantages of this type of unit. Many would argue that the forensic role conflicts with the more dominant function of local LSUs, namely, the modus operandi outlined by Faulk (1995): 'The usual pattern is for the wards to accept the patient briefly, to get them over an acute disturbance, before returning them to the original ward.'

A third role which has been adopted by PICUs is the care of the chronically disturbed patient. Coid (1991a) noted that the private sector was being used increasingly for such patients because of the lack of NHS facilities and he also (Coid, 1991b) stated that 'the game of pass the parcel must stop' with reference to 'difficult to place patients'. The Mental Health Act Commission (1995) also reported on the lack of provision for patients who demonstrate longer-term behavioural problems.

The chief medical officer (CMO's Update, 1996) stated that the number of medium secure beds was planned to be 2,350 by the end of 1998 and that there was also a need for a greater diversity of secure beds, particularly those offering longer-term care at medium and low security levels. By 2001, there were some 2,000 beds (Sugarman, 2002).

PICUs in the United Kingdom in the 1990s

In the United Kingdom, PICUs have developed independently of the RSU network and have provided a range of services in line with local circumstances and needs. This development is wholly appropriate. Units may variably describe themselves as PICUs, extra care wards, intensive care, high dependency, special care, challenging behaviour, locked wards or LSUs. None of these terms have a universally agreed upon definition.

This was highlighted in a rather damming (but highly influential) paper by Zigmond (1995), who commented upon his personal experiences of such facilities in his role as a Mental Health Act commissioner and second opinion appointed doctor. He noted that the patients within such wards were different from those on open acute wards; they were amongst the sickest and displayed disturbed behaviour. Environments were usually poor, staff were isolated and unsupported with the development of a somewhat 'siege mentality'

and patients were subject to a somewhat overpowering and regimented regime. He suggested several methods to improve such wards from philosophical, staffing, managerial and clinical perspectives. This could be seen as providing impetus for the development of standards for service provision.

Subsequent to Zigmond's criticisms, shoots started growing out of what eventually became the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) (Dix et al., 1997). Whilst such services had developed independently, all attempted to provide a service to meet local needs. It seemed difficult to be prescriptive regarding the role of all these services. Perhaps it was better to focus on similarities, such as admission of patients too disturbed to be managed on acute wards due to aggression, self-harming behaviour or absconding. Despite this level of disturbance, patients were not under the purview of any criminal service and thus needed care within local psychiatric facilities. Secondary to their presentation, patients needed increased and intensive multiprofessional input as well as physical security. The initial definition of what we recognise as psychiatric intensive care was therefore conceived. Patients were generally too disturbed to be nursed on open wards (because of aggression, self-harming behaviour, unpredictability or absconding). There was, therefore, a need for increased nursing and multiprofessional input and perimeter security. Admissions and discharges were generally governed by symptoms and behaviour and not by the courts (Dix, 1996). In order to help patients served by and clinicians within this specialty, a group of like-minded psychiatric intensive care multidisciplinary clinicians formed NAPICU with the following aims:

- To advance psychiatric intensive care, low secure and other locked services
- To improve mechanisms for the delivery of emergency psychiatric intensive care
- To audit effectiveness and promote research
- To educate and develop best practice
- To raise awareness in the mental health and medical world about psychiatric intensive care.

PICU Developments Since the New Millennium

Within the United Kingdom, PICU National Minimum Standards were first published in 2002 and updated in 2014, recommending specific principles that should be adhered to when planning and managing psychiatric intensive care and low secure services (Pereira and Clinton, 2002; NAPICU, 2014). The objective of these standards is to provide users, clinicians, managers and commissioners with a dynamic framework for delivering high-quality services.

In 2012, NAPICU worked with the Department of Health to produce two draft good practice commissioning guides (Department of Health, 2012a, b) in the clinical areas of psychiatric intensive care and low secure care. This process highlighted a need to revise the clinical standards set in 2002 to reflect the current clinical processes in PICU and low secure care and to set the clinical framework for the coming decades in this challenging area.

The National Minimum Standards (NAPICU, 2014) looks at the clinical standards in PICU services. The project group was set up through the NAPICU executive, a group comprising multiple professional disciplines, patient and carer representatives and expertise in all types of PICU modality. The remit of the group was to revise the agreed-upon standards for psychiatric intensive care services and the general good practice guidance for each of these standards. The overall objective is to provide patients, carers, clinicians, managers and commissioners with a dynamic framework for delivering high-quality psychiatric intensive care services. These standards are derived from the clinical perspective, which in turn is driven by the achievement of a positive and empowering experience for patients in PICUS (these are further discussed elsewhere in this book).

Another important document regarding inpatient care, *Mental Health Policy Implementation Guide: Adult Acute Care Provision*, was published by the Department of Health in 2002. This guidance is addressed to all involved in acute mental health care and is useful to all who use, work in or commission these services. PICU practice is on the spectrum of inpatient care. It covers issues related to areas shown in Box 1.1.

The first textbook for psychiatric intensive care was published in 2001. It was authored and edited by multidisciplinary psychiatric care, low secure, forensic staff such as consultant psychiatrists, consultant nurses, nurse managers, charge nurses, staff nurses, therapy managers, nurse therapists, clinical psychologists and forensic psychologists, specialist registrars, occupational therapists, pharmacists and

Box 1.1 Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision

- Purpose and aim of adult acute inpatient care
- Integrating inpatient care within a whole systems approach
- Problems with current inpatient provision
- Reshaping the service
- Inpatient care staff
- Specific issues
- Commissioning future inpatient provision
- Developing and sustaining improvement
- This guidance also refers to psychiatric intensive care provision (in section 6.3 of Department of Health, 2002)

senior lecturers. It was the first evidence-based textbook to define the sub-specialty. The book was written by clinicians for clinicians. It was subsequently revised in 2009; you are currently reading the third revision.

In 2002, an innovative MSc programme in psychiatric intensive care was offered by London South Bank University; this is another milestone in the advancement of psychiatric intensive care. This programme was initiated and developed by Pathways Policy, Research and Development Group, Goodmayes Hospital, London Borough of Redbridge in collaboration with South Bank University, following a review of the training needs of PICU staff (Clinton et al., 2001). The programme aimed to examine a variety of frameworks for the delivery of safe and consistent approaches to psychiatric intensive care and provide practitioners with the necessary confidence to be fit for practice. The course covered in detail the assessment and management of clients in psychiatric intensive care settings together with the therapeutic interventions applied in such settings.

The MSc programme ran successfully for several years and is still being delivered as a short course in partnership with St George's University of London, covering key PICU-related topics such as risk management, mental health law, physical health, substance use, pharmacology, care involvement and restrictive practices (NAPICU, 2023).

In 2002, NAPICU produced a bulletin for its multidisciplinary membership in order to promote best practice and share information. This subsequently formed the basis for the development of the *Journal of Psychiatric Intensive Care*, which continues to disseminate research devoted to the specialty.

In 2004, a study was commissioned by the UK Department of Health to evaluate the costs of addressing physical environment deficits in PICUs and LSUs in England (Pereira et al., 2006c). The results showed that approximately 37% of these units did not fulfil the National Minimum Standards for design. This critical study laid the evidence base for the UK government to release £160 million to address places of safety and for upgrading PICUs and LSUs to meet the National Minimum Standards in England (Pereira and Clinton, 2002).

To monitor the development of implementation of the National Minimum Standards, a National PICU Governance Network was created in 2004 as a joint venture of the National Institute of Mental Health in England (NIMHE), North East London Mental Health Trust (NELMHT) and NAPICU (Dye et al., 2005). The main aim of this network was to encourage the PICUs to work collaboratively to improve service provision, with an objective measurement of the benefits demonstrated. The collaborative nature of this project enabled the different PICUs to share experiences and difficulties and plan improvements, drawing upon expertise from both within and outside the network.

In 2005, NAPICU collaborated with the National Institute for Clinical Excellence in producing the clinical guideline, Violence: Short-term Management for Over 16s in Psychiatric and Emergency Departments. This guideline has been updated and replaced with NG10, Violence and aggression: short-term management in mental health, health and community settings, which was published in 2015 (NICE, 2015)

NAPICU continued to hold annual national conferences and quarterly meetings since formation, and during these years and it has been estimated that more than 10,000 multidisciplinary PICU and low secure clinicians have been involved in activities for sharing best practice and updating knowledge within the specialty.

In 2015, the National Minimum Standards for Psychiatric Intensive Care for Young People were published to ensure best practice in provision for young people (NAPICU, 2015).

Between 2009 and 2017, an accreditation programme was set up in collaboration between the

Royal College of Psychiatrists and NAPICU (NAPICU, 2009). Accreditation Inpatient Mental Health Services (AIMS) is an accreditation scheme, working with inpatient mental health services to assure and improve the safety and quality of services and their environments. AIMS-PICU is specifically designed for PICUs. It engages staff and service users in a comprehensive process of review, through which good practice and high-quality care are recognised.

Services are supported to identify areas for improvement and set achievable targets for change. Services that are performing well are accredited, assuring staff, service users and carers, commissioners and regulators of the quality of the service being provided. AIMS is an initiative of the College Centre for Quality Improvement. It is a collaboration between the Royal College of Psychiatrists, the British Psychological Society, the College of Occupational Therapists, the Royal College of Nursing and NAPICU, which means that it is led by the professional bodies of those staff most involved in inpatient care.

AIMS accreditation helps units to:

- demonstrate the quality of care they provide including:
  - dedicated, trained, and committed staff;
  - dedicated time with patients;
  - activity and therapy provision;
  - involvement of service users and carers; and
  - communication between services.
- demonstrate that they meet national standards, in line with national policy and guidance from the Department of Health, National Institute for Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA)
- use the standards and assessment process as a framework to monitor contracts and develop service level agreements
- use information from the accreditation process in Trust Quality Accounts, as recommended by the National Quality Board

The accreditation process supports services to evaluate their performance and improve their practice through:

- Self-review of their service
- Peer-review identifying and discussing challenges with the visiting reviewers
- A detailed team report recognising areas of achievement and identifying areas for improvement
- Organised visits to other services supported by an experienced lead reviewer
- Report of national findings identifying trends and enabling benchmarking with other services
- Sharing good practice through newsletters, email discussion groups, annual conference and publication of resources
- Personal development through training in peer-reviewing and participation in the wider process
- Spread of learning beyond the participating unit to other services within the organisation

This is now being taken forward by the Royal College of Psychiatrists Centre for Quality Improvement.

In 2015, a position statement on seclusion was released entitled, 'NAPICU Seclusion position statement on the monitoring, regulation and recording of the extra care area, seclusion and long-term segregation use in the context of the Mental Health Act 1983: Code of Practice (2015)' (NAPICU, 2016).

Guidance was produced for commissioners in 2016 (NAPICU, 2016), closely followed by design guidance for the procurement of new builds to mitigate environmental risks associated with building design (NAPICU, 2017).

In 2018, a joint effort of the British Association of Psychopharmacology (BAP) and NAPICU produced Evidence-based Consensus Guidelines for the Clinical Management of Acute Disturbance: De-escalation and Rapid Tranquillisation (Patel et al., 2018), followed by COVID guidelines for safe management (NAPICU, 2020).

In summary, some of the major PICU developments of the modern era have included:

- Increased use of evidenced-based treatments. A greater emphasis has been placed on using treatments that are supported by research, and in the last 20 years has seen the publication of NICE guidelines for treatment and NICE technology appraisals suggesting the use of treatments as suggested by the National Minimum Standards (Pereira and Clinton, 2002; NAPICU, 2014) such as cognitive behaviour therapy, dialectical behaviour therapy and best practice in medication-assisted treatments

- A shift towards a more person-centered approach, with a focus on involving patients and carers in decision-making
- A shift towards single-sex units and away from mixed PICUs
- A focus on the design of the buildings to be safer and more therapeutic rather than containing, including the publication of national guidelines
- Improved staff training and safety measures. Staff training programmes have been developed to improve patient care and prevent burnout, including the AIMS PICU programme, and focusing on therapies such as the formation of a network of occupational therapists in PICUs (NAPICU, 2020)
- Focus on least restrictive practices
- Integration of technology. The use of technology such as remote consulting and electronic patient records has increased in PICUs, making it easier to monitor and treat patients and to coordinate care between different healthcare providers. Use of technology has also been utilised in PICUs, such as the introduction of sensory suites and some high-tech innovations in terms of digital walls in seclusion suites
- Expansion of community-based services, such as crisis/intensive/assertive outreach/home treatment and early intervention teams which have become more widely available, reducing the need for hospitalisation and allowing patients to receive care in a more community-based setting

Further developments in psychiatric intensive care include the Intensive Care in Special Hospitals (in press) and Prison Guidance endorsed by the Royal College of Psychiatrists (Dix and Woods, 2023).

Past and Present Surveys of Psychiatric Intensive Care

Although there was very little objective data concerning the service that these units provide, three surveys had been published prior to the development of NAPICU. Each of these surveys had a slightly different focus.

Ford and Whiffin (1991) surveyed the 169 health authorities in England and asked them 'about their units providing services to acutely ill clients who require close observation and frequent nursing observation' (p. 48). They identified 39 units in England which admitted in varying proportions those with acute or chronic problems such as aggression or self-harm (in the setting of mental illness) and those with a forensic history.

Mitchell (1992) surveyed psychiatric hospitals in Scotland to determine the numbers and characteristics of their patients. He identified 13 PICUs in Scotland with a total of 219 beds (3% of total inpatient psychiatric beds). Two-thirds of patients were compulsorily detained and half were younger than 30 years of age; schizophrenia was the most common diagnosis and comorbid substance abuse/personality disorder was present in 10% of patients younger than 30 years old.

Beer et al. (1997) identified 110 PICUs in the United Kingdom, 45 of which had been operational for less than three years. Eleven units were intensive care areas of four to five beds which formed part of acute admission wards; 18 units were mixed PICU/challenging behaviour or PICU/forensic. The remainder were dedicated PICUs. Bed occupancy rates were high at a level of 100%, particularly in the larger dedicated units.

There was a wide variation in the level of security provided, ranging from 11 units which were built to medium secure specifications to the 22 units which did not have permanently locked doors. Operational policies also differed widely, with many staff feeling that they might as well not have, for example, an admissions policy, because it was frequently overridden to accommodate difficult-to-manage patients who could not be placed elsewhere.

Units accepted patients from acute psychiatric wards, prisons, RSUs, special hospitals and the community in various combinations. Sixty-three units were willing to admit informal patients, and this was irrespective of whether the door was permanently locked. The terminology used to describe the patient group admitted was confusing. There was no accepted cut-off point between acute and chronic disturbance or between intensive care and challenging behaviour. The point at which a patient was described as 'forensic' is similarly blurred.

Medical staffing was also highly variable. Only 30 units had a dedicated consultant psychiatrist with no other inpatient beds. An equal number of units could be accessed by several consultants, none of whom had overall responsibility for the daily functioning of the unit. Junior doctor posts were not exclusively filled by experienced registrars; more than half the units accepted rotational senior house officers, often with no supervision from a more experienced staff grade doctor or senior registrar.