



editorial

Psychiatric Bulletin (2008), 32, 441–443. doi: 10.1192/pb.bp.108.019489

M. DOMINIC BEER

Psychiatric intensive care and low secure units: where are we now?

SUMMARY

The last decade has seen clinicians and policy makers develop psychiatric intensive care units and low secure units from the so-called 'special care wards' of the 1980s and 1990s. Psychiatric intensive care units are for short-term care, while low secure

units are for care for up to about 2 years. Department of Health standards have been set for these units. A national survey has shown that there are two main patient groups in the low secure units: patients on forensic sections coming down from medium secure units and

those on civil sections who are transferred from general psychiatric facilities. Recent clinical opinion has emphasised the important role both psychiatric intensive care units and low secure units play in providing a bridge between forensic and general mental health services.

When Zigmond (1995) asked 'Special care wards: are they special?', he described his experience as a Mental Health Act Commissioner visiting locked wards where staff were 'brutalised' and patients saw the unit as a 'punishment ward'. He wrote: 'Patients on special care wards are usually the sickest in the service. Surely they deserve the highest standard of care' (p. 312). How had this arisen? What has happened since then?

The Open Door policy of the 1960s and 1970s had led to most hitherto closed wards being unlocked. There still remained, however, patients who needed to be contained. The Glancy (1974) and Butler (1975) reports had led to the medium secure unit building programme of the 1980s. These units – initially often called interim secure units – were meant to manage three types of patients: those discharged from special hospitals, those transferred from prisons and those general psychiatric patients who were too disturbed for the local open wards. The last group were often in practice not admitted to these new, centrally funded units because there were too many patients referred from the other two services. These often chronically disturbed patients, therefore, had to be managed in locally planned units which were established in piecemeal fashion. The situation became more complicated after the Reed report (Department of Health & Home Office, 1993) encouraged a policy of diverting mentally disordered offenders from the courts and prisons. Because of a lack of space within medium secure units, the low secure wards admitted many of these patients, even though they may have committed serious offences such as grievous bodily harm. A survey in the late 1990s found that closed wards managed at least three types of patients – those diverted from prisons and courts, the acutely disturbed and those who required long-term care (Beer *et al*, 1997).

Some of the issues raised by Zigmond (1995) were addressed by Pereira *et al* (1999). The National Service Frameworks (Department of Health, 1999) recognised the need for psychiatric intensive and low secure units and national minimum standards for psychiatric intensive care units and low secure units were issued (Department of Health, 2002). Here, for the first time, two distinct units were recognised by the Department of Health: psychiatric intensive care units were designed for 'patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. . . Length of stay. . . would ordinarily not exceed 8 weeks in duration' (p. 3). Low secure units were for 'patients who demonstrate disturbed behaviour in the context of a serious mental disorder. . . and may be restricted on legal grounds needing rehabilitation usually for up to 2 years' (p. 4). A national survey (Pereira & Dalton, 2006) illustrated the types of patients admitted to low secure units. They were, first, chronically disturbed patients admitted from general adult wards on civil sections and second, patients transferred from medium secure units who may be on forensic sections, including restriction orders.

The National Minimum Standards (Department of Health, 2002) addressed among other things: layout of the buildings, multidisciplinary team working, therapeutic activities, patient and carer involvement, and clinical audit. Dye & Johnston (2005) and Dye *et al* (2005) described the way in which this guidance has become embedded in units around the country in practice. The Department of Health in a recent publication has re-emphasised these guidelines and recommends: 'a well-trained and well-motivated multidisciplinary workforce (including occupational therapy and clinical psychology); an ethos that is user and carer centred (and highly



responsive to feedback); good and consistent leadership exercised within a well-managed organisation; a physical environment that is modern, in good order and fit for purpose with regard to managing risk; clear lines of communication, in relation to the processing of referral and discharge, and widely accepted and adhered to criteria for admission and discharge' (Department of Health, 2008).

An inventory for psychiatric intensive care units and low secure buildings has been designed (Dix *et al* 2005). An audit of the proposed standards (Pereira *et al*, 2005) was conducted and it was estimated that about £140 million was required to meet these standards nationally. In fact, £160 million has subsequently been provided by the government (Appleby, 2007) to address these needs and to provide improved section 136 facilities (Mental Health Act 1983; Department of Health, 2007). Improvement within the units needs to be accompanied by effective interventions which they provide (Beer *et al*, 2007a). A strong multidisciplinary team is essential to provide consistent care required by patients on psychiatric intensive care and low secure units (McKenzie, 2001; Beer, 2006). Another specific issue is treatment with clozapine, as there is a large proportion of patients with treatment-resistant schizophrenia on such units. A significant reduction in violent and other incidents has been demonstrated following treatment with clozapine (Beer, 2006; Beer *et al*, 2007b). A follow-up of patients not treated with clozapine and discharged from a low secure unit found that improvement had been maintained, challenging behaviours had not recurred and there had been no re-offending (Akande *et al*, 2007).

Some have wondered whether the skills learnt by practitioners in this field can be transferred to other settings such as the accident and emergency department or even the community (Dix, 2007). In some settings, psychiatric intensive care unit staff may assist staff in accident and emergency departments; in others, a well-resourced psychiatric intensive care unit might be able to provide a 'flying squad' to help home treatment or crisis resolution staff de-escalate incidents involving potentially violent individuals in the community. A more likely situation would be that psychiatric intensive care unit staff would help train colleagues working in other parts of the mental health service.

The role of low secure units has recently been emphasised by Turner & Salter (2008) and O'Grady (2008), who concluded that these units were needed to address a number of areas: 'large-scale expansion of low secure, as opposed to psychiatric intensive care units, facilities for which both adult general and forensic teams would have carefully shared responsibilities' (Turner & Salter, p. 5). For 'patients with complex problems who cannot be managed without structure . . . and appropriate use of security . . . [there needs to be] a radical expansion of low secure provision' (O'Grady, p. 7). These views accord with the opinion of Pereira & Dalton (2006), who refer to psychiatric intensive care units and low secure units as 'bridges with other services and countries.'

The World Health Organization considers English mental health service the best in Europe, also referring to

the important role of psychiatric intensive care units (Appleby, 2007). Psychiatric intensive care units and low secure units in the UK can be a model for similar services in other countries. Both types of units are visited by psychiatric staff from all over the world and the UK-based National Association of Psychiatric Intensive Care Units (NAPICU, www.napicu.org.uk) receives enquiries from professionals working with highly disturbed patients in many countries. Clinicians and managers in psychiatric intensive care units and low secure units in the UK receive support from an advisory service founded by the Royal College of Psychiatrists' Training and Research Unit, and NAPICU (Dye *et al*, 2008).

Psychiatric intensive care units and low secure care have developed significantly in the past 10 years. There is still the need for resources to support further research, but standards have been established, the services are being audited, and clinicians and managers working in these units receive support. Much has been achieved in the decade or so since Zigmond (1995) described the many problems that he encountered on the 'special care' units.

Acknowledgements

I thank Dr Stephen Dye for his helpful comments on this article.

References

- AKANDE, E., BEER, M. D. & RATNAJOTHY, K. (2007) Outcome study of patients exhibiting challenging behaviours four years after discharge from a low secure mental health unit. *Journal of Psychiatric Intensive Care*, **3**, 21–27.
- APPLEBY, L. (2007) *Mental Health Ten Years On: Progress on Mental Health Care Reform*. Department of Health.
- BEER, M. D. (2006) Managing challenging behaviour. In *Enabling Recovery. The Principles and Practice of Rehabilitation Psychiatry* (eds G. Roberts, S. Davenport, F. Holloway, *et al*), pp. 211–228. Gaskell.
- BEER, M. D., PEREIRA, S. M. & PATON, C. (1997) Hot beds of general psychiatry. A national survey of psychiatric intensive care units. *Psychiatric Bulletin*, **21**, 142–144.
- BEER, M. D., TIGHE, J., RATNAJOTHY, K., *et al* (2007a) Predicting outcome in low secure environments: a case series from one low secure mental health unit. *Journal of Psychiatric Intensive Care*, **3**, 85–92.
- BEER, M. D., KHAN, A. A. & RATNAJOTHY, K. (2007b) The effect of clozapine on adverse incidents in a low secure challenging behaviour unit. *Journal of Psychiatric Intensive Care*, **2**, 65–70.
- DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health. Modern Standards and Service Models*. Department of Health.
- DEPARTMENT OF HEALTH (2002) *Mental Health Policy Implementation Guide. National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*. Department of Health.
- DEPARTMENT OF HEALTH (2007) *Mental Health Act 1983. TSO* (The Stationery Office).
- DEPARTMENT OF HEALTH (2008) *NHS Innovations Report on Psychiatric Intensive Care Units*. Department of Health.
- DEPARTMENT OF HEALTH & HOME OFFICE (1993) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services: Volume 2, Service Needs* (Reed report). HMSO.
- DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1974) *Revised Report of the Working Party on Security in NHS Psychiatric Hospitals* (Glancy Report). HMSO.
- DIX, R., PEREIRA, S. M., CHANDHRY, K., *et al* (2005) A PICU/LSU Environment Assessment Inventory. *Psychiatric Intensive Care*, **1**, 65–69.
- DIX, R. (2007) Psychiatric intensive care – what's in a name? *Journal of Psychiatric Intensive Care*, **3**, 1–2.
- DYE, S. & JOHNSTON, A. (2005) After the standards . . . a gaping cavity filled by Clinical Governance? *Journal of Psychiatric Intensive Care*, **1**, 3–6.

DYE, S., JOHNSTON, A. & PEREIRA, S. M. (2005) The National Psychiatric Intensive Care Governance Network 2004–2005. *Journal of Psychiatric Intensive Care*, **1**, 97–104.

DYE, S., JOHNSTON, A. & CHHINA, N. (2008) National standards and good practice. In *Psychiatric Intensive Care*, 2nd edn (eds M. D. Beer, S. M. Pereira & C. Paton). Cambridge University Press.

HOME OFFICE & DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1975) *Report of the Committee on Mentally*

Abnormal Offenders, CMND 6244 (Butler Report). HMSO.

McKENZIE, B. M. (2001) Psychological approaches to longer-term patients presenting with challenging behaviours. In *Psychiatric Intensive Care* (eds M. D. Beer, S. M. Pereira & C. Paton), pp. 93–106. Greenwich Medical Media.

O'GRADY, J. (2008) Time to talk. Commentary on . . . Forensic psychiatry and general psychiatry. *Psychiatric Bulletin*, **32**, 6–7.

PEREIRA, S. & DALTON, D. (2006) Integration and specialism: complementary not contradictory. *Journal of Psychiatric Intensive Care*, **2**, 1–5.

PEREIRA, S. M., BEER, M. D. & PATON, C. (1999) Good practice issues in psychiatric intensive care units. Findings from a national survey. *Psychiatric Bulletin*, **23**, 397–400.

PEREIRA, S., DAWSON, P. & SARSAM, M. (2006) The National Survey of PICU

and low secure services: 1. Patient characteristics. *Journal of Psychiatric Intensive Care*, **2**, 7–12.

TURNER, T. & SALTER, M. (2008) Forensic psychiatry and general psychiatry: re-examining the relationship. *Psychiatric Bulletin*, **32**, 2–6.

ZIGMOND, A. (1995) Special care wards: are they special? *Psychiatric Bulletin*, **19**, 310–312.

M. Dominic Beer Oxleas NHS Foundation Trust, Bracton Centre, Bracton Lane, Dartford, Kent DA2 7AF, email: dominic.beer@oxleas.nhs.uk



editorial