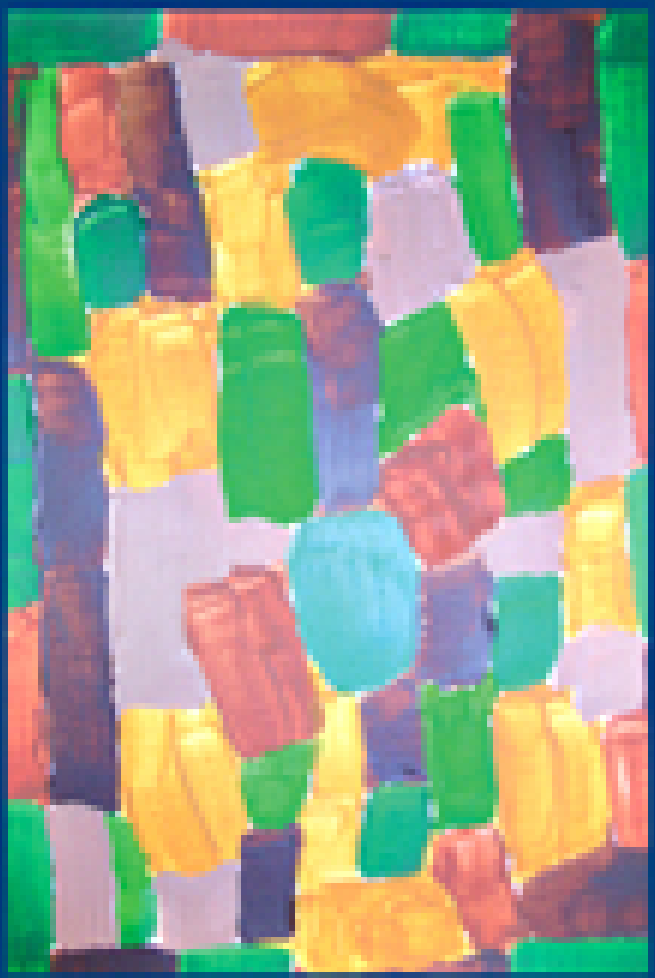
Psychiatric Intensive Care

Second Edition



Edited by
M. Dominic Beer
Stephen Pereira and
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Medicine

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Significantly expanded and updated from the first edition *Psychiatric Intensive Care* is essential reading for all healthcare professionals and managers involved in the care of the mentally ill patient, particularly in the intensive care and low secure environment. It provides practical and evidence-based advice on the management of disturbed and severely ill psychiatric patients in secure hospital settings. An expert team of contributors have refreshed and expanded the content focusing on how to manage patients, support staff, set up and run units, and provide the highest standards of care.

New chapters have been added emphasising the importance of multidisciplinary team working and of the interface of psychiatric intensive care with other mental health specialties.

This book should be read by all mental health team members working with disturbed psychiatric patients on an inpatient basis, as well as by management staff responsible for establishing and running these services.

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Preface to second edition

The first edition of this textbook was published in 2001 and its success surpassed our expectations. The editors have received many positive comments about the usefulness of the text and its relevance to everyday practice. The interest in the care of our most disturbed patients has been highlighted by both sales overseas and by the rapid translation of the text into Czech.

Since the publication of the first edition, the subspecialities of psychiatric intensive care and low secure care have grown from strength to strength. The Department of Health adopted standards developed by members of National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) that outline the care that should be delivered in Psychiatric Intensive Care and Low Secure Units (PICUs and LSUs). The publishers of this book have supported NAPICU to develop the first ever journal dedicated to this field: the *Journal of Psychiatric Intensive Care* (http://journals.cambridge.org/jid_JPI). The current chairman of NAPICU, Dr Stephen M. Pereira, played a central role in the development of the National Institute for Health and Clinical Excellence (NICE) guideline on the short-term management of violence; thus influencing the care of acutely disturbed patients beyond the speciality.

NAPICU continues to organise a successful annual national conference and quarterly regional mini-conferences. The majority of UK mental health trusts are now members of NAPICU, and in order to support the infrastructure of a growing organisation,

a permanent NAPICU office has been set up in Glasgow. NAPICU continues to produce a quarterly bulletin to keep members up to date with developments in the field. The development of a national clinical governance network, sponsored by the Department of Health, has also been supported and this has overseen clinical quality improvement projects in areas such as responding to emergencies, culture and diversity issues, and user and carer involvement. An award is given to the 'team of the year'. Each year, a travel bursary is awarded to fund a research, clinical audit or good practice project. A national audit of PICUs and LSUs conducted by Dr Pereira's team highlighted environmental issues that led to the Department of Health's investing capital monies to improve buildings.

This edition of the textbook has been expanded to include several new chapters. The interface between PICU/LSU and learning disabilities, child and adolescent psychiatry, general adult psychiatry and substance misuse are covered, as are multidisciplinary team working, the role of social work and user and carer involvement. All other chapters have been updated to include developments such as the publication of NICE guidelines. In the interests of space, the sample unit policies have been removed as most units have now developed their own, usually more comprehensive versions.

We hope that you find the additions to the textbook useful in your practice and look forward to further developments in the speciality of PICU/LSU care. Constructive comments on any aspect of the text are welcome and should be sent to the publisher.

Further details about NAPICU and its activities can be found on the official NAPICU website: www.napicu.org.uk.

The editors would like to thank Sarah Price (Copyeditor), and Jeanette Alfoldi and Chloe Wright from the Cambridge University Press Production team for all their help with the second edition.

M. Dominic Beer
Stephen Pereira
Carol Paton

Preface to first edition

'Why do we need a book about psychiatric intensive care?' 'What *IS* psychiatric intensive care?', 'Is there any difference between intensive care and general psychiatry?' 'Where is the distinction between forensic psychiatry and psychiatric intensive care?, 'What special skills do PICU staff require?' Our first attempt to address some of these questions came at the first national conference on psychiatric intensive care, held at Bexleyheath, England, in 1996. The enthusiasm of the delegates and their thirst for knowledge and networking has led to the publication of this book.

We, as editors, have attempted to cover as many elements of the psychiatric intensive care provision as is possible within one book. We are, however aware of certain deficiencies. Where there is an evidence-base, we have attempted to use it. Where there is not, we have used personal experience and the experience of others to guide us. We believe that psychiatric intensive care is at the heart of psychiatry and its good practice requires a full multidisciplinary team, strong leadership and effective managerial support. We have, therefore, included a wide variety of chapters, all written by professionals who have extensive expertise in this area of care. We have included examples of sample policies, which can be used as a guide, but these obviously need to be adapted and scrutinised for use locally. The editors would welcome any comments and suggestions on this work.

The first section addresses treatment issues. Effective treatment requires input from a wide variety of professionals. We have included contributions on the role of medication, psychological treatments,

therapeutic activities, and more controversially, the use of both restraint and seclusion. The development and definition of psychiatric intensive care and the management of the acutely disturbed patient and of the complex needs patient also warrant chapters in their own right.

The second section specifically addresses areas of risk and the interface with forensic services. Contributions from colleagues working in forensic services, we hope, will encourage the breaking down of unnecessary barriers between different services.

The third section addresses management issues such as how to set up and design a new psychiatric intensive care unit and how to manage such a unit effectively once it has been established.

We believe that this book will be of use to all disciplines working in, or interacting with, Psychiatric Intensive Care Units, and also to managers who have the responsibility for commissioning, providing and monitoring this high risk area of care. Although the emphasis is towards practice in the United Kingdom, the general principles should be relevant and applicable in any care setting where the disturbed psychiatric patient is managed.

We would like to thank all the contributors to the book; those who have assisted in the publishing, especially Geoff Nuttall, Nora Naughton, Kathleen Orr and Gavin Smith; our secretarial staff, Mrs Linda Wells, Mrs Lorraine Wright, Miss Michelle Gillham and Mrs Rosemary McCafferty for their considerable hard work; our patients and colleagues who have taught us much; and our families, especially Drs Naomi Beer and Preeti Pereira, for their support and patience through this project.

Dominic Beer
Stephen Pereira
Carol Paton

August, 2000

Foreword

I am delighted to be able to recommend this book to clinicians working at all levels of the multidisciplinary team in psychiatric intensive care, low secure, medium secure and general hospital psychiatry.

Psychiatric intensive care units (PICUs), have now been with us for some 20 years or more and, in that time, have refined and defined their role within the various levels of care offered by individual mental health care trusts. Most patients in the UK have access to intensive care and the importance of this area is emphasised by the continuance and strengthening of the National Association of Psychiatric Intensive Care Units (NAPICU) and the successful founding of the *International Journal of Psychiatric Intensive Care*. The editors of this edition have all been pivotally involved in these developments.

The PICU stands at the interface point between these different levels of care and is often the cornerstone of effective management of the most unwell and difficult to treat within the psychiatrically unwell population. All of those working within this field are consistently faced with complex issues that cut across ordinary boundaries of care. In addition, the biopsychosocial management of PICU patients, from the first break to the chronically treatment resistant, requires the individual practitioner to have access to, and knowledge of, the fullest therapeutic armamentarium.

The first edition of this book published in 2001, represented the 'first definitive and authoritive text in the subject (of PICUs)', and, covered, 'all aspects of the specialty from techniques for rapid tranquillisation through to physical, risk and management

issues, as well as interfaces with forensic services'. In the second edition the editors have again gathered and expanded their thoroughly inclusive, clinically experienced and scholarly panel of authors.

For this second edition, the authors and editors have revised, updated and supplemented the text recognising the rapid expansion in the evidence base impacting upon psychiatric intensive care. This includes the routine and rational use of the newer antipsychotics, the implementation of the NICE recommendations, the incorporation of a formal national guideline for PICUs, alterations in guidelines for physical restraint and seclusion, and finally the rapid expansion in forensic psychiatry services within the United Kingdom and the crucial interdependent relationship between these services and PICUs.

The popularity of the first edition of this book, will, I am sure be matched and surpassed by this edition. The authors and editors have produced another landmark publication, which stands at the forefront of the field. The challenges over the coming decade include the advent of new pathophysiologically based diagnoses and treatments for mental illness that will transcend the simple clinical descriptions and 'trial and error' treatments of the past. These developments will be incorporated within ICD-11 and DSM-V within the next 5–8 years. Other, more local, challenges include further changes in clinical service delivery and the implementation of the European Reform Treaty with its possible impact on human rights legislation.

The second edition of *Psychiatric Intensive Care*, will, in my opinion, prepare the reader to meet the existing and future challenges within this field.

On a final note, the pleasure of writing this foreword is, unfortunately, tinged with a certain sadness. Sadness, that Professor Robert W. Kerwin was unable to write this foreword himself, as he did the foreword for the first edition, due to his untimely death in February of this year. His legacy, however, lives on in the other clinicians and scientists he inspired, myself and several authors of this book included. In addition to projects, like this book, which he avidly supported, Professor Kerwin, though his editorship of the *Maudsley Prescribing Guidelines* and his numerous publications provided the tools for a generation of psychiatrists and mental health professionals to implement rational pharmacological and management strategies for their patients both within and without the PICU.

Rob would have enjoyed studying this book, as I am sure will you.

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PART I

Therapeutic interventions

1

Psychiatric intensive care – development and definition

M. Dominic Beer, Stephen M. Pereira and Carol Paton

Historical background

Throughout human history different cultures have had to manage their most behaviourally disturbed and mentally ill members. Turner (1996) has written that historically psychiatry has been judged by its management of the 'furiously mad'. Nearly three thousand years ago the King of Babylon was put to pasture (literally) after he started to behave like a wild animal (Book of Daniel). 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.

Seven hundred and fifty years ago the first 'asylum' for mental patients in England was formed at the Priory of St Mary of Bethlehem in London. 'Bethlem' became the national hospital for the disturbed mentally ill. The patient's parish of origin would pay for a stay of usually up to a year. Abuses however came to light, none better known than the case of William Norris in 1814, which prompted a parliamentary enquiry. The unfortunate man had been kept for seven years in a cell and restrained mechanically so that he could move no more than twelve inches.

Nineteenth century psychiatrists such as John Conolly then embraced 'non-restraint', but many hospitals remained locked. The Mental Treatment Act 1930 introduced the concept of patients being admitted informally and by 1938 such patients constituted 35% of the total (Jones 1993). The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954–57) stressed that patients should be treated informally where possible. The Mental Health Act 1959 confirmed this and laid down 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. By the early 1960s, only a handful of wards in our own hospital (the former Bexley Hospital, Kent) were still formally locked. Two of these wards housed a stable population of chronically disturbed patients. There was another transient group of acutely disturbed patients who were admitted for brief periods until their behaviour became containable on an open ward. Thus, the Psychiatric Intensive Care Unit (PICU or locked ward) function had evolved as a pragmatic solution to the patient management problems encountered on the open wards.

Secure provision in the 1970s in the UK

By the early 1970s each health region was being encouraged to develop services in district general

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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 1000 places for England and Wales.

The problem of the mentally abnormal offender was addressed by the Butler Committee which was formed after the case of Graham Young who was convicted of murder whilst on conditional discharge from Broadmoor.

The terms of reference 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 Butler Report (Home Office, Department of Health and Social Security 1975), and its interim version of 1974, advocated the development of forensic psychiatric services in the NHS and suggested a figure of 2000 secure beds. This was double the Glancy figure, which was based on the need for security among general psychiatric patients. It was proposed that regional secure units (RSUs) would 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. A particular point was made regarding difficult long-stay patients – 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; but no clear alternative model of care was proposed for them. The Department of Health and Social Security very quickly made money available for 1000 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 (Glancy) have not.

Development of psychiatric intensive care units world-wide

The first publications which described locked PICUs came from the USA. 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 UK 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 as compared with 1163 in 1986, according to the Reed Report; this review of Health and Social Services for mentally disordered offenders and others requiring similar services (Department of Health and Home Office 1992) proposed that 1500 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. But 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 (Department of Health and Home Office, 1992) referred to ICUs as low secure units.

Smith *et al*. (1990) hypothesised that the role of the RSU was changing. They compared patients admitted to the Butler Clinic RSU in South West 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 low secure units, 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 2350 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 2000 beds (Sugarman 2002).

Psychiatric Intensive Care Units in the UK in the 1990s

In the UK, 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 low secure units. None of these terms had a universally agreed definition.

Many PICUs operate in isolation not only from the main hospital wards, but also from other similar units. Zigmond (1995) commented upon his personal experiences of such facilities in his role as a Mental Health Act Commissioner and Second Opinion Appointed Doctor and described them as, 'Physically apart from other inpatient facilities, containing the most seriously disturbed, invariably detained patients who were cared for by staff who rarely rotated around other settings and became brutalised and dehumanised by the constantly high levels of disturbance and violence they faced'.

Psychiatric intensive care, as a specialty in its own right, is only beginning to have an identity. The National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) was formed as an organisation to provide guidance on PICU issues in the UK to overcome variability of practice and in response to concern of clinicians such as Zigmond (1995).

Aims of NAPICU

- To advance PICU/low secure service
- To discuss and improve mechanisms for the delivery of PICU/low secure care
- To encourage the support of staff working in PICU/low secure services
- To audit the effectiveness of the service provided
- To organise educational opportunities for staff

Unlike the standard services provided by the RSUs, PICUs had developed independently of each other. They sought to provide a service to fulfil local needs. It was therefore impossible to be prescriptive regarding the exact role of any individual PICU, although certain criteria were broadly filled. Patients were generally too disturbed to be nursed on open wards (because of aggression, self-harming

behaviour or absconding). There was, therefore, a need for increased nursing and multi-professional input and perimeter security. Admissions and discharges were generally governed by symptoms and behaviour and not by the courts (Dix 1996).

Although there were very few 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 thirty-nine 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, half were under 30 years of age; schizophrenia was the most common diagnosis and co-morbid substance abuse/personality disorder was present in 10% of the under 30s.

Beer *et al.* (1997) identified 110 PICUs in the UK, 45 of which had been operational for less than 3 years. Eleven units were intensive care areas of four to five beds which formed part of acute admission wards; eighteen units were mixed PICU/challenging behaviour or PICU/forensic. The remainder were dedicated PICUs. Bed occupancy rates were high: at the 100% level particularly in the larger dedicated units. There was a wide variation in the level of security provided, ranging from eleven units which were built to medium secure specifications or above through to the twenty-two 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 in order to accommodate difficult-to-manage patients who could not be placed elsewhere. Units accepted patients from acute psychiatric wards, prisons, RSUs and 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 or not. The terminology used to describe the patient group who were 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 thirty units had a dedicated consultant psychiatrist with no other inpatient beds. An equal number of units could be accessed by a number of consultants, none of whom had overall responsibility for the daily functioning of the unit. Junior doctors posts were not exclusively filled by experienced Registrars; over half the units accepted rotational Senior House Officers, often with no supervision from a more experienced staff grade doctor or Senior Registrar. Multidisciplinary team working was less developed than in general adult psychiatry and written guidelines or policies covering high-risk areas such as rapid tranquilisation, control and restraint and seclusion were often absent, confirming the informal observations of Zigmond (1995). The implications of these findings have been further developed by Pereira *et al.* (1999).

The most comprehensive national survey on the Psychiatric Intensive Care and Low Secure Services (Pereira *et al.* 2006a) identified 170 PICUs and 137 Low Secure Units (LSUs) in UK. This survey resulted in developing a national data set for PICUs and Low Secure Services together with a more comprehensive understanding of the service provision and patient characteristics (Pereira *et al.* 2006b) within these units. In addition, it also highlighted some of the differences between PICUs and LSUs. The national survey builds upon an earlier London-wide survey conducted on PICUs and LSUs, which described the service structure and functioning of PICUs and LSUs in London (Pereira *et al.* 2005a) along with the clinical characteristics of patients and the pathways

for admission and discharge in the London units (Pereira *et al.* 2005b).

The National Minimum Standards were produced in 2002, recommending specific principles that should be adhered to when planning and managing Psychiatric Intensive Care and Low Secure Services (Pereira and Clinton, 2002). The objective of these standards is to provide users, clinicians, managers and commissioners with a dynamic framework for delivering high-quality services. The standards cover the following core areas of PICU practice, as shown in the following box.

Box 1.1. Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments (Pereira and Clinton 2002)

- Admission criteria
- Core interventions
- Multidisciplinary team (MDT) working
- Physical environment
- Service structure – personnel
- User involvement
- Carer involvement
- Documentation
- Ethnicity, culture and gender
- Supervision
- Liaison with other agencies
- Policies and procedures
- Clinical audit and monitoring
- Staff training
- PICU/Low Secure Support Services

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 the following areas:

Box 1.2. Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision (DOH 2002)

- 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)

The innovative MSc Programme in Psychiatric Intensive Care offered by the London South Bank University from 2002 is another milestone in the advancement of psychiatric intensive care. This programme was initiated and developed by Pathways Policy, Research and Development Group in collaboration with South Bank University, following a review of the training needs of PICU staff (Clinton *et al.* 2001). This programme aims 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 covers in detail the assessment and management of clients in psychiatric intensive care settings together with the therapeutic interventions applied in such settings.

A study was commissioned by the 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 (Pereira *et al*. 2006c.) The main aim of this newly created network is to encourage the PICUs to work collaboratively in order to improve service provision, with an objective measurement of the benefits demonstrated. The collaborative nature of this project will enable the different PICUs to share experiences, difficulties and plan improvements drawing upon expertise from both within and outside the network. The Psychiatric Intensive Care Advisory Service (PICAS) was set up as a subsidiary of NAPICU and links with the PICU Governance Network. The main aim of PICAS is to support NHS Trusts/independent providers by providing expert advice and guidance in meeting the National Minimum Standards and to improve the standard and quality of care within the PICU and Low Secure environments across the country.

Definition of psychiatric intensive care

Three features should ideally be present in a PICU. Two of them have parallels with the general medicine ICU; one is unique to psychiatry.

1. 'Psychiatric intensive care is for patients compulsorily detained, usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward' (Pereira and Clinton 2002). PICUs may be permanently locked or just lockable, but they are not absolutely secure settings which can guarantee containment. Admissions from courts or prisons should not be considered if absconding carries serious risk to the public. Behaviours driven by symptoms of mental illness should govern admission, not a court's requirements for security. Such patients should generally be dealt with by the RSUs. There is a need for more facilities than on a general psychiatric ward. There are more facilities on a medical ICU and these are often 'high-tech'. On a PICU resources and facilities will be both environmental and human: more space, a garden, a quiet area, a seclusion suite, snoezelen area, activity and games room are all possible facilities. Just as the patient on a medical ICU is deemed to be in need of special care, so the psychiatric patient often has multiple and complex needs which require extra resources. In human resource terms there will be a need for a multidisciplinary team to address these needs.
2. 'Care and treatment offered must be patient centred, multidisciplinary, intensive, comprehensive, collaborative and have an immediacy of response to critical situations. Length of stay must be appropriate to clinical need and assessment of risk but would ordinarily not exceeed 8 weeks in duration' (Pereira & Clinton 2002). There is the 'intensive' level of care delivered by professionals. This results in both quantitative and qualitative differences from general psychiatric care. The need for increased speed of response is a key element. In terms of nursing, the nurse:patient ratios will be higher than on general wards because of the increased need for monitoring patients exhibiting increased levels of aggression or self-harm, and observing those on large amounts of medication, e.g. for side-effects. Medical staff will also need to be present more often than on general wards because of the need to assess patients rapidly and reach working diagnoses, to formulate and to monitor management plans and to prescribe and review medication. Qualitatively, nursing staff require special training in some areas of expertise such as the management of aggression. Medical staff will need training in the use of medication. The presence of a senior doctor (MRCPsych) on most days will be required to supervise trainees. This parallels the daily consultant ward round on a medical

ICU. Because patients are often locked in and disturbed, they will need more in terms of occupational input and therapeutic activity. Social needs require social workers. Psychological, emotional and behavioural concerns will require a clinical psychologist. Medication issues require the active participation of pharmacists. In addition, all team members need to meet regularly together to discuss all patients.

3. 'Psychiatric intensive care is delivered by qualified staff according to an agreed philosophy of unit operation underpinned by principles of risk assessment and management' (Pereira and Clinton 2002).

Definition of low secure

1. 'Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security' (Pereira and Clinton 2002).
2. 'This is according to an agreed philosophy of unit operation underpinned by the principles of rehabilitation and risk management. Such units aim to provide a homely secure environment, which has occupational and recreational opportunities and links with community facilities' (Pereira and Clinton 2002).
3. 'Patients will be detained under the Mental Health Act and may be restricted on legal grounds needing rehabilitation, usually for up to 2 years' (Pereira and Clinton 2002).

Conclusion

Psychiatric intensive and low secure care are at the cutting edge of clinical psychiatry. They are developing specialties. Patients in these units are often very unwell and behaviourally disturbed. This book seeks to address the principles and practice of meeting the needs of this group of patients.

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2

Management of acutely disturbed behaviour

M. Dominic Beer, Carol Paton and Stephen M. Pereira

Historically, psychiatry has been judged by its management of the 'furiously mad' (Turner 1996). In the current climate where inquiries into the care of patients are becoming increasingly common, considerable care has to be taken because of the risk of untoward incidents with acutely disturbed patients. On the one hand there is the necessity to protect the patient, their family, carers, the public and staff from the consequences of disturbed behaviour. On the other hand there is the risk that overzealous sedation with inappropriate medication regimens might lead to physical complications for the disturbed patient. Banerjee *et al.* (1995), reviewing eight cases of sudden death in detained patients, concluded that, 'the risk of sudden cardiotoxic collapse in response to neuroleptic medication given during a period of high physiological arousal should be widely publicised'.

There is some evidence to suggest that the level of violence in society is rising (College Research Unit 1998) and that this is reflected in the increasing number of assaults on hospital staff. Psychiatric Intensive Care Unit (PICU) staff are frequently called upon to manage patients who are violent or potentially violent. It is vital that staff work together in an informed and supported environment to minimise the potential risks to themselves and others.

Acute behavioural disturbance requires urgent intervention. It usually manifests with mood, thought or behavioural signs and symptoms and can be transient, episodic or long lasting. It can have either a medical or psychological aetiology and may reflect a person's limited capacity to cope with social, domestic or environmental stressors. The use of illicit substances or alcohol can accompany an episode of acute disturbance, or can be causative. The acute disturbance can involve: threatened or actual violence towards others, destruction of property, emotional upset, psychological distress, active self-harming behaviour, verbal abuse, hallucinatory behaviour, disinhibition, disorientation or confused behaviour and extreme physical overactivity – 'running amok'. More than one patient may be involved and everyday objects such as chairs, table knives or broken cups may be used to threaten or cause damage to others or to property.

Acutely disturbed behaviour can sometimes be anticipated: informing patients of their detention under the Mental Health Act, denial of requests to leave hospital or enforcing medication against a patient's will are all potentially provocative actions. Disturbance can also be unpredictable. A member of staff or another patient may say or do something that is misinterpreted by a paranoid patient who then lashes out. The underlying thought processes may not be obvious to others.

Disturbed behaviour is often transient and associated with the severity of the underlying psychiatric disorder. As the illness responds to treatment, so does the behaviour. Acute disturbance can also become chronic disturbance. Such patients are often

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described as exhibiting 'challenging behaviour' and may require longer admission and a wide range of pharmacological and psychological treatments. Some patients in this group have associated cognitive deficits (e.g. head injury) or severe problems with impulse control (e.g. borderline personality disorder).

The management of patients with acutely disturbed behaviour is a high-risk activity and it is essential that this risk is recognised and addressed throughout the management hierarchy of the hospital.

The following summarises the relevant issues in PICUs:

- PICU staff should be familiar with the procedures to be followed to facilitate the safe admission of an acutely disturbed patient.
- PICU staff should be trained in risk assessment and in the prediction, prevention and management of aggression.
- The PICU should have a written policy for the management of aggression. This should include advice on psychological and pharmacological interventions and when to involve the police.
- Ward policies on aggression should be communicated to patients as soon as is appropriate after admission.
- Incident forms should be completed after all aggressive incidents. These incident forms should be regularly reviewed and feedback provided to staff.
- Time and resources should be provided for formal debriefing after incidents. Specialist counselling may be required for victims of serious incidents.
- Sufficient appropriately staffed units to manage disturbed behaviour should be available across all levels of security.

Preparing the ward for the arrival of an acutely behaviourally disturbed patient

While many patients admitted to PICUs are already well known to the service, a significant proportion will be being admitted for the first time. A standard admissions procedure will help staff to feel more in control and reduce the variability in approaches that may be seen when less experienced staff or staff unfamiliar with the ward are on duty. Such a procedure could be written in bullet point format and displayed ideally in a prominent position in the nursing office. An example is shown below.

- Ideally, the patient should have been assessed prior to admission by PICU staff and a management plan should be in place.
- All PICU nursing staff should be alerted.
- If the patient is waiting in a police vehicle, he/she should remain there until the PICU is ready to receive him/her.
- If there is no dedicated 'reception suite', ensure that the unit is safe (e.g. lock the servery, TV room, etc.).
- Remove all other patients from the reception area.
- Ensure staff are prepared, e.g. that a control and restraint team is ready if required. Decide which member of staff will be talking to the patient.
- Inform medical staff and discuss any immediate requirement in advance if possible, e.g. a medical examination if the patient is already sedated or a rapid assessment if the patient is still very disturbed and requires sedation.

Nursing observations

Ideally, prior to admission, PICU staff should have assessed the patient and a clear nursing plan should be in place.

For new admissions unknown to staff, the level of nursing observations should be negotiated between the admitting doctor and the most senior nurse on duty.

The levels of observations are:

Level 1 Nominal supervision
Awareness of whereabouts of patient at all times

Level 2 Close attention
15-min checks plus awareness of whereabouts

Level 3 Constant care
Continual presence of nursing staff for observation, but privacy granted for bathing

Level 4 Intensive observations
Continual presence of nursing staff and constant direct visual observation

On admission, it is wise to be cautious. It is easier to reduce observation levels if the patient is more settled than anticipated than to deal with the consequences of inadequate observation.

The level of nursing supervision should be determined by the multidisciplinary team and reviewed at least once each nursing shift. Nurses trained in the appropriate techniques should carry out close observation. It should be recognised that special observation can exacerbate behavioural disturbance and unobtrusive monitoring can sometimes be used effectively. Episodes of continuous observation lasting less than 72 h have been shown to help two-thirds of patients (Shugar and Rehaluk 1990).

Mental Health Act status

Ideally the PICU should have a policy in place which clearly defines the legal status of patients who may be admitted. This should be subject to local agreement.

Some PICUs may process all Section 136 (police place of safety order) patients and some may accept prison transfers or even patients restricted by the Ministry of Justice. Informal patients may sometimes be admitted although this should be the exception rather than the rule (Department of Health 2002).

Although the Mental Health Act aims to facilitate care and not to be obstructive, it is a fact of life that PICU regimes may compromise basic human rights (Pereira *et al.* 1999) while informal status may compromise the ability of staff to provide optimal care.

In the UK if patients are resisting, aggressive and refusing treatment or threatening to leave the ward and their status is still informal then the appropriate Section-12-approved (approved as having specialist knowledge and experience in psychiatry) doctor (e.g. Consultant, Associate Specialist or Specialist Registrar) should be called to instigate formal detention under Sections 2 (assessment and treatment) or 3 (treatment) of the Mental Health Act.

If it is immediately necessary, for example to prevent serious injury, intramuscular medication can be given under common law (under the doctrine of necessity). Careful consideration needs to be given to this and clear documentation kept, because professionals may be open to prosecution for assault by an informal patient. Any doctor may use Section 5 (2) to detain a patient for up to 72 h or any registered mental health nurse can use Section 5 (4) to detain a patient for up to 6 h. However, medication cannot be given against the patient's will under Section 5 – but it can under Sections 2, 3 or 4 (as Section 2 but involving only one doctor: valid for up to 72 h). It would be considered good practice to audit the use of these sections in a PICU: they should never be relied upon for routine care.

For the use of control and restraint and for the use of seclusion please see Chapters 8 and 9.

Ensuring a safe environment

- There should be good visibility in all areas of the unit
- Alarms should be within easy reach at all times
- Staff response to alarms should be consistent
- Movable objects should be kept to a minimum; those that exist should be of safe size and construction
- Structured activities should be provided, e.g. gym, garden, games

For further information see Chapter 22 and the National Minimum Standards for General Adult Services in PICU and low secure environments (Department of Health 2002).

Assessment of the acutely disturbed patient

Staff safety

Staff on PICUs should be aware of the basic rules to be followed to reduce the risk to themselves. They should also ensure that other staff who may visit the ward on a sessional basis are aware of these rules.

- When interviewing a patient who has potential for aggressive behaviour always inform colleagues of your intentions and location.
- Try to conduct joint medical and nursing assessments to protect interviewers and to reduce stimulation to the patient.
- Ensure that there are alarms close by at all times. Consideration should be given to providing staff with personal alarms that have the facility to alert others to an emergency and its location.
- Sit at an angle to the patient at a safe distance away and in close proximity to the exit.
- Avoid interviewing with the patient between you and the door.
- Call the police if necessary.

Research performed in PICUs (Walker and Seifert 1994) has shown that a disproportionately high number of violent incidents are perpetrated by a few patients (two patients were responsible for fifteen of the thirty-seven violent incidents). Mortimer (1995) also showed that a few patients caused many incidents. As more staff were trained in control and restraint, the number of incidents fell. It is often very difficult to predict accurately who these patients will be but patients who score heavily from the factors in the lists below should be deemed as those most at risk of disturbed behaviour.

Important factors from the patient's history, which may indicate an increased risk of violence (Royal College of Psychiatrists 1995; College Research Unit 1998), include:

- Previous violence towards others or self
- Young male patients
- Previous forensic history
- Substance misuse
- Antisocial, explosive or impulsive personality traits
- Poor compliance with treatment or services
- Association with a subculture prone to violence
- Evidence of social restlessness or rootlessness
- Presence of precipitants, e.g. loss events
- Access to any named potential victims identified in mental state

The characteristics below have been identified as predicting the 'potential for immediate violence/aggression' (College Research Unit 1998).

Primary characteristics

- Previous history of aggression or violence, overtly aggressive acts, forensic history
- Hostile, threatening verbalisation, boasting of prior abuse
- Suspicious, paranoid ideation
- Delusions of control or hallucinations with violent content
- Poor impulse control
- Non-verbal expression of hostile intent such as increased motor activity, pacing, invading an other's personal space, angry facial expression
- Refusal to communicate
- Poor concentration or unclear thought processes
- Possession of a weapon

Secondary characteristics

- Fear, anger, anxiety and pain
- Inappropriate and unrealistic demands
- Exacerbation of psychotic illness particularly the changes in life events, low self-esteem, vulnerability to interpersonal stress
- Inability to verbalise feelings
- Previous substance abuse

Related factors and considerations

- Hypomanic excitement
- Confusional states
- Psychiatric or psychological motivation for problematic behaviour
- Goal structure for aggressive/problematic behaviour

There are also some behavioural clues which have been identified as being predictors of imminent violence (Wykes and Mezey 1994). These are mainly intuitive and include: dishevelled appearance, smell of alcohol, signs of increased physiological arousal, pacing, gesticulating and violent gestures, increased muscle tension such as clenched fists and teeth, flared nostrils, escalating volume of speech, swearing, direct threats, labile affect, and appearing frightened, confused and disorientated.

Precipitants of violent incidents on wards

- Enforcement of ward rules
- Denial of patient's requests
- Confrontational or irritable manner of staff

Staff factors related to incidents

- Staff stability
- Staff training (young untrained more likely to be victims)
- Poor leadership
- Inadequate staff resources

Older, more experienced staff (Hodgkinson *et al.* 1985; James *et al.* 1990; Carmel and Hunter 1991) and those that have been trained in the prevention and management of violence (Carmel and Hunter 1990) are less likely to be physically assaulted. Agency staff (James *et al.* 1990) are more likely to be assaulted, particularly when they are unfamiliar with ward routines (Katz and Kirkland 1990). Several studies support an association between aggression and overcrowding on wards (e.g. Palmstierna *et al.* 1991). Further information can be found in Chapter 12.

Milieu factors

- Access to weapons
- No fresh air
- Lack of privacy
- Environment that is too hot or too cold
- Uncared-for environment
- Lots of hidden corners in building
- Overcrowding
- Unclear staff functions
- Unpredictable routines and structure
- Overstimulation
- Authoritarian conditions

(Katz and Kirkland 1990; Palmstierna *et al.* 1991; College Research Unit 1998.)

Medical causes

Some medical or neurological conditions may present with disturbed behaviour and treatment of the underlying problem is vital. Such problems need to be excluded when accepting an unknown patient into the PICU. The exact screening tests required in any individual patient would depend, of course, on the clinical presentation.

Examples of medical conditions that can present in this way are:

- Head injury with vascular lesions, especially subdural haematoma
- Delirium tremens
- Intoxication with illicit drugs or alcohol
- Overdose with prescribed drugs, e.g. anticholinergics
- Meningitis
- Encephalitis
- Hypoglycaemia
- Diminished cerebral oxygenation of any aetiology, e.g. vascular, metabolic or endocrine
- Hypertensive encephalopathy
- Wernicke's encephalopathy
- Temporal lobe epilepsy
- Neoplastic conditions
- Dementia

On admission, or ideally prior to admission, a comprehensive history should be obtained from as many sources as possible. This may include the patient, family, police, general practitioner, social worker, community psychiatric nurse and previous notes.

Mental State Examination

Mental State Examination should cover the mental state factors known to be associated with violence. These are:

- Evidence of any 'threat/control override' symptoms especially persecutory delusions and delusions of passivity
- Emotions related to violence especially irritability, anger, hostility and suspiciousness
- Erotomania or morbid jealousy symptoms
- Misidentfication phenomena
- Command hallucinations

The severity and nature of the patient's symptoms in the acute situation often limit history taking and detailed examination of the mental state. However,

this should be carried out at the first available opportunity.

In the Mental State Examination, special attention should be paid to the level of consciousness, attention and concentration, memory, language abnormalities, mood and affect. Brief and quantifiable tests such as the Mini Mental State Examination can be useful for monitoring the progress of such patients (Folstein *et al.* 1975). Signs of acute organic brain syndrome (delirium) should be suspected until proven otherwise if the following are present:

- Disorientation (especially if worse at night)
- Clouding of consciousness
- Abnormal vital signs
- No previous psychiatric history (especially if over 40 years old)
- Visual hallucinations

Other signs and symptoms would include: an acute onset (hours to days), a reversed sleep–wake cycle, labile mood, shifting delusions, disjointed thoughts, poor attention and impaired memory.

Suicide risk

Some patients are admitted to PICUs because they pose a risk to themselves. The PICU does not offer significant advantages over open acute wards in the management of many suicidal patients. However, in those patients where absconding from the ward in order to self-harm is potentially problematic, then the locked door of the PICU confers additional protection. There are predictors of suicide specific to different diagnostic groups of patients, as follows.

Depression

- Male
- Older
- Single
- Separated
- Socially isolated
- Previous deliberate self-harm/suicide attempt
- Insomnia/hypersomnia
- Self-neglect
- Memory impairment
- Agitation
- Guilt
- Bleakness about the future
- Severe depression

Schizophrenia

- Male
- Younger
- Socially isolated
- Unemployed
- Previous deliberate self-harm/suicide attempt
- Depressive episode
- Severe and relapsing illness
- Insight and fear of deterioration in mental state

Alcohol problems

- Male
- Age 40–60 years
- Depression
- Previous deliberate self-harm/suicide attempt
- Bereavement
- Poor physical health

Management of acutely disturbed behaviour

Attempts should be made to prevent violence by using de-escalation techniques (see Chapter 3). The key points are (adapted from College Research Unit 1998):

- Stay a safe distance from the patient and within easy access to alarms and escape routes
- Stay calm, avoid sudden movements and explain your intentions clearly and confidently
- Engage the patient in conversation and try to reason
- If reasoning fails, consider other interventions depending on circumstances

Turner (1996) states that there is a, 'key need for much better audit and research of acute treatment approaches' in the management of acutely disturbed behaviour. All PICUs should have a written policy for the management of such patients. An example of such a policy is shown in Figure 2.1. The appropriate

MANAGEMENT OF ACUTELY DISTURBED BEHAVIOUR IN ADULTS: RAPID TRANQUILLISATION (RT)

The aims of RT are threefold:

1. To reduce suffering for the patient: psychological or physical (through self-harm or accidents)
2. To reduce risk of harm to others by managing a safe environment
3. To do no harm (by prescribing safe regimens and monitoring physical health)

Note: *Despite the need for rapid and effective treatment, concomitant use of two or more antipsychotics (antipsychotic polypharmacy) should be avoided on the basis of risk associated with QT prolongation (common to almost all antipsychotics). This is a particularly important consideration in RT where the patient's physical state predisposes to cardiac arrhythmia.*

In an emergency situation

Step	***Intervention***
1	De-escalation, time out, placement, etc., as appropriate
2	Offer **oral** treatment: **Haloperidol** 5 mg or **Olanzapine** 10 mg or **Risperidone** 1–2 mg With or without lorazepam 1–2 mg **If the patient is prescribed regular antipsychotics, lorazepam 1–2 mg alone avoids the risks associated with combining antipsychotics** Repeat every 45–60 min Go to step 3 if three doses fail or sooner if the patient is placing themselves or others at significant risk **Note that the SPC for haloperidol recommends:** **1. avoiding concomitant antipsychotics** **2. pre-treatment ECG**
3	Consider **IM treatment** From this point on: • Have flumazenil to hand in case of lorazepam induced respiratory depression. Consider • The patient's legal status. • Consulting a senior colleague. **Lorazepam** 2–4 mg or **Haloperidol** 5 mg or **Olanzapine** 5–10 mg IM olanzapine should not be combined with an IM benzodiazepine Monotherapy with buccal midazolam, 10–20 mg may offer a useful alternative. Note that this preparation is unlicensed **If haloperidol is used:** • **note the warnings above** • **ensure IM procyclidine is available (5–10 mg) in case of acute dystonia** Repeat after 30–60 min if insufficient effect **Promethazine** 50 mg IM is an alternative in benzodiazepine-tolerant patients
4	Seek expert advice from the consultant or pharmacist on call

Figure 2.1. Management of acutely disturbed behaviour in adults. From the Maudsley Prescribing Guidelines, 9th edn. (Taylor *et al.* 2005)

Guidelines for the use of Clopixol Acuphase

Acuphase should only be used after an acutely psychotic patient has required **repeated** injections of short-acting drugs such as haloperidol or olanzapine or sedative drugs such as lorazepam.
Acuphase should only be given when enough time has elapsed to assess the full reponse of previously injected drugs: allow 15 min after IV injections; 60 min after IM.

Acuphase should **never** be administered:
- In an attempt to 'hasten' the antipsychotic effect of other antipsychotic therapy
- For rapid tranquillisation
- At the same time as other parenteral antipsychotics
- Primarily as a 'test dose' for Clopixol injection
- To a patient who is struggling (risk of intravasation & oil emboli)

Acuphase should **never** be used for, or in, the following:
- Patients who accept oral medication
- Patients who are neuroleptic naive
- Patients who have an increased propensity to develop EPSEs
- Patients who are unconscious
- Patients who are pregnant
- Those with hepatitis or renal impairment
- Those with cardiac disease

Onset and duration of action
Sedative effects usually become apparent 2 h after injection and peak after 12 h.
The effects may last up to 72 h.

Dose
Acuphase should be administered in a dose of 50–150 mg, up to a maximum of 400 mg over a 2-week period. This maximum duration ensures that a treatment plan is put in place. It does not indicate that there are known harmful effects from more prolonged administration, although such use should be very exceptional. There is no such thing as a 'course of Acuphase'. The patient should be assessed before each administration.

Injections should be spaced at least 24 hours apart.

Figure 2.2. Guidelines for the use of Clopixol Acuphase (from Taylor *et al.* 2005)

use of Clopixol Acuphase is outlined in Figure 2.2. Monitoring requirements after rapid transquillisation are shown in Figure 2.3.

Detailed discussion of pharmacological management can be found in Chapter 5. Time out, seclusion and control and restraint are discussed in detail in Chapters 8 and 9.

Management after an aggressive incident/debriefing

After all aggressive incidents formal debriefing should be offered, focusing on practical and emotional issues at the time; although there is some controversy about the effectiveness of debriefing (Rick *et al.* 1998), victims need sympathy, support and reassurance. For professionals who are assaulted it is advisable for them to return to work as soon as possible to prevent 'the incubation of fear'. Usually the team working at the time of the incident is sufficient to deal with the debriefing. However, in the case of very serious incidents it may be useful to have an external person to ensure that sufficient counselling is provided, particularly to anyone who has sustained significant physical or emotional injury. At the time of a serious aggressive incident, immediate safety

(a)

Rapid tranquillisation: monitoring

After any parenteral drug administration monitor as follows:

Temperature
Pulse
Blood pressure
Respiratory rate

Every 5–10 min for 1 h, then half-hourly until patient is ambulatory.

If the patient is asleep or **unconscious**, the use of pulse oximetry to continuously measure oxygen saturation is desirable. A nurse should remain with the patient until they are ambulatory again.

ECG and haematological monitoring are also strongly recommended when parenteral antipsychotics are given, particularly when higher doses are used. Note that the Summary of Product Characteristics (SPC) for haloperidol recommends that all patients should have an ECG before haloperidol is prescribed (www.medicines.org.uk). Hypokalaemia, stress and agitation place the patient at risk of cardiac arrhythmias.

(b)

Remedial measures in rapid tranquillisation

Problem	**Remedial measures**
Acute dystonia	**Procyclidine** 5–10 mg IM or IV
Reduced respiratory rate (<10/min) or oxygen saturation (<90%)	Give **oxygen**, raise legs Ensure patient is not lying face down Give **flumazenil** (if benzo implicated) **Mechanical ventilation** (if other drug implicated)
Irregular or slow pulse (<50/min)	**Refer** to medical care immediately
Fall in blood pressure (>30 mmHg orthostatic drop or <50 mmHg diastolic)	**Lie patient flat** Tilt bed towards head
Increased temperature	**Withhold antipsychotics** Check CPK urgently

Figure 2.3. a, b. Monitoring requirements after rapid tranquillisation (from Taylor *et al.* 2005)

issues must take precedence over any investigation. The latter should attempt, as sensitively as possible, to compile detailed reports of the incident so as to understand its causes, context and consequences.

The investigation of serious incidents should use 'root cause analysis' where the aim is to identify all contributing factors. Many of these will be related to systems rather than individuals. The organisation has a duty to modify as many systems-related problems as possible (Neal *et al*. 2004; National Patient Safety Agency, Root cause analysis toolkit; available online at http://81.144.177.110/health/resources/root_cause_analysis/conditions).

The following may act as an aide-mémoire for those who are either directly involved in an aggressive incident or who may be required to support colleagues (for further reading, see Wykes and Mezey 1994).

Dealing with the aftermath of an incident if you are the victim

- Acknowledge that you may experience some symptoms of stress and be aware that these may be delayed for several hours
- Do not become helpless, be explicit about what you want or do not want in the way of support
- Do not blame yourself; try and learn from the experience
- Try to return to work soon
- Accept the necessary management investigations
- Follow procedures carefully
- Ensure that you get support, both formal and informal

What colleagues and friends can do

- At the time, give the victim unconditional reassurance
- Show that you are willing to talk at any time
- Reassure the victim's family and ensure that the victim is not left alone after work; for example, offer a lift home
- Help the victim to assimilate the experience and keep a sense of proportion, bearing in mind the nearly universal problem of unrealistic guilt
- Do not treat victims as if they have an infectious disease (they do report being ignored)

What teams and ward managers can do

- Consider the need both for support and debriefing
- Allow time to talk as a group
- Consider what worked well/went wrong and how to prevent/deal with similar incidents in the future
- Consider the feelings involved and make sure you have a chance to express them
- Act on any suggestions which come out of the post-incident debriefing, given the tendency of organisations to experience denial after traumatic events

Whether to charge a patient after an incident

This is often a very difficult decision and it may require considerable time and effort on the part of the clinical team to even persuade the local police service to interview the patient. It is essential for the multidisciplinary team to have a view on whether to press charges and there will be issues for the victim if he or she is part of the clinical team. He or she will need the support of colleagues because there may be emotions such as guilt, which need to be worked through. Factors that may influence the team's decision to press charges may include:

- The patient's mental state
- The capacity of the patient to form intent
- The degree of harm inflicted
- The likely effect on the patient
- Perceived need for more secure placement

Advantages of charges being pressed include

- The possible therapeutic effect for the patient who may understand the concept and value of boundaries
- The responsibility for managing difficult behaviour is shared with the Court/Criminal Justice System professionals