

## Editorial

### Behind the locked doors

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My friend and colleague Dr Dominic Beer has always been an enthusiastic student of the history of psychiatry. I too share his passion for helping the most challenging of psychiatric inpatients and with an open mind, interrogating the past in pursuit of wisdom for the future. Over a glass (or two) of wine, we would often debate late into the night as to what the history of psychiatry has taught us; or at least, what should have been learned from the decades past in the care and treatment of the most troubled of psychiatric inpatients. Dr Beer is one of the UK's leading thinkers and authors on the history of psychiatry and understanding challenging behavior. His insights and writings have been instrumental in shaping the current range of services and clinical approaches in use behind the locked doors of the UK's inpatient units.

His sad death this spring has resulted in considerable reflection within the clinical community. We can still refer to Dr Beer in the present tense, through the power of publication; his many papers (often in this journal), books and book chapters ensure his ability to communicate and inspire long into the future.

Some of these reflections are concerned with where we have been, where we are now and the direction in which we may be travelling in the practice of psychiatric intensive and low secure care.

For hundreds of years, what goes on behind the locked doors of mental institutions has produced a curious mix of fear and fascination



in popular society. As a child, I remember riding my bicycle past Coney Hill hospital, the Victorian mental asylum for Gloucestershire in the UK. In the twilight of a summer's evening on our way home, my friends and I would often pause for a while, leaning our bikes against the perimeter fence of the asylum. With our gaze, thoughts also crossed the grounds to the lights in the windows of imposing redbrick building. We wondered, what at that moment, could be going on behind those walls? A handful of years later, I worked my first shift as a nursing assistant. In the year 1984, finally, I knew.

Back then, the term 'psychiatric intensive care' had barely been uttered in the mental health services of the UK. What went on behind the then mostly open doors of the asylum, in my experience, was often based on pragmatism rather than evidence. This occurred within a strong sense of duty of care in the staff, often based on tradition rather than creativity. With 25 years of rapid development in the UK's inpatient services, now is a good time to reflect

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on where we may be in terms of what goes on behind the locked doors.

The term ‘psychiatric intensive care unit’ (PICU) is now very well understood in the UK and other parts of Europe. My recent visits to Norway, Belgium, The Netherlands and Iceland reveal a growing confidence in the purpose and practice of PICUs. From their conceptual birthplace in the United States in the 1970s, PICUs have migrated around the world and can now be found on all continents. In the UK, the low secure unit (LSU) has also become firmly established as a discrete service for those requiring similar approaches to the PICU although for much longer periods of time. Branching off from PICUs in the late 1990s and developing a focused skill set for recovery, rehabilitation and criminal justice, the LSU can no longer be confused with the PICU. As a clinical specialty, it stands distinct and mature; separate from the PICU. The LSU story in the UK does not end here however.

Over the last few years a new service type has emerged from perceived gaps between the PICU and the LSU, often referred to as ‘locked rehabilitation’; there’s a new kid on the block.

‘Locked rehabilitation’ has so far not been officially defined in the UK. So what may be reasonably deduced when we look closely at this new comer? Locked rehabilitation units seem to most often be stand-alone units located within the heart of communities. These facilities aim to offer an environment with the capacity to respond with a degree of physical, procedural and relational security to needs of patients as they strive towards community reintegration.

This has been a portion of clinical territory previously occupied by the LSU; territory that many LSU clinicians and patients have not yet surrendered. With the average cost of a night’s accommodation in an English LSU at £500 and a night in a locked rehabilitation unit at around £300, one could not be criticized for predicting changes in LSU provision.

The Center for Mental Health published a report (2011) which commented on the cost of the UK mental health secure inpatient estate.

At 1.2 billion pounds, 1 in every 5 pounds spent on all mental health in Britain goes to the secure mental health estate. The stakes are high and the challenge is clear: can this newcomer ‘locked rehab’ successfully occupy some of the traditional LSU territory for lower cost? If so, will this mean fewer LSUs are needed? How will locked rehabilitation shape up when profoundly tested in the arenas of engagement and risk? I suspect we shall have answers to all these questions in the next few years.

The PICU seems to have successfully distanced itself from the turf war between the LSU and locked rehabilitation. Having settled the battle of identity with the LSU over a decade ago, one could be inclined to think that the PICU can now be comfortable in both its role and identity.

Not so. Professor Len Bowers once again provokes thought on the purpose of a PICU. I urge you to read his commentary, *PICU possibilities*, in this issue (Bowers, 2013). For me, this article serves to confirm that providing the most effective inpatient care for the acutely disturbed is always a journey and never a destination. There is need for continual evaluation of what a PICU does or could do for the best benefit of patients. These contemplations will be well informed by reference to Professor Bowers’ paper.

Rapid tranquillisation, physical monitoring and measuring quality within the PICU are also covered within these pages (Innes & Sethi, 2012; Loynes et al. 2012; Schröder & Björk, 2012). These papers serve as a reminder that ‘locked door’ psychiatry, in all of its manifestations, often shares at least one key theme. In the name of health care, one group of people (the staff) has great power over, and therefore great responsibility for, another group of people (the patients).

The *Journal of Psychiatric Intensive Care*, your journal, is the place to learn and contribute your ideas. It is only through contemplating the results of scientific enquiry, exchanging ideas and engaging in debate can knowledge and experience be processed into wisdom.

Our modern world gives every one of us the opportunity to publish, to make our mark in the great adventure of trying to understand more, and for this understanding to change the present and shape the future. My first publication was motivated by the following words of Carl Sagan (1981):

‘But one glance at it and you’re inside the mind of another person, maybe somebody dead for thousands of years. Across the millennia, an author is speaking clearly and silently inside your head, directly to you. Writing is perhaps the greatest of human inventions, binding together people who never knew each other, citizens of distant epochs. Books break the shackles of time. A book is proof that humans are capable of working magic.’

I shall miss my discussions with Dr Beer. We have, all of us, lost a friend and mentor. No doubt Dr Beer would encourage us to continue the debate in his absence. I would encourage you to join in the conversations that are continuing, also to read this journal and the many papers that are published in the area of inpatient psychiatry. Publishing ensures that your ideas will be accessible to future generations, helping them develop the wisdom required to exercise our great responsibility for the care and

treatment for some of the most disadvantaged people in society. This will be our best insurance against history judging us too harshly when considering what went on behind the locked doors of the early twenty-first century.

## References

- Bowers, L.** (2013) PICU possibilities. *Journal of Psychiatric Intensive Care*. Published online May 2013. doi: 10.1017/S1742646413000071
- Centre for Mental Health** (2011) *Pathways to Unlocking Secure Mental Health Care*. London: Centre for Mental Health, 64 pp. [http://www.centreformentalhealth.org.uk/pdfs/Pathways\\_to\\_unlocking\\_secure\\_mental\\_health\\_care.pdf](http://www.centreformentalhealth.org.uk/pdfs/Pathways_to_unlocking_secure_mental_health_care.pdf)
- Innes, J. and Sethi, F.** (2012) Current rapid tranquillisation documents in the UK: a review of the drugs recommended, their routes of administration and clinical parameters influencing their use. *Journal of Psychiatric Intensive Care*. Published online 19 November 2012. doi: 10.1017/S174264641200026X
- Loynes, B, Innes, J. and Dye, S.** (2012) Assessment of physical monitoring following rapid tranquillisation: a national survey. *Journal of Psychiatric Intensive Care*. Published online 22 November 2012. doi: 10.1017/S1742646412000295
- Sagan, C.** (1981) *Cosmos: The Story of Cosmic Evolution, Science and Civilisation*. London: Macdonald Futura. 281 pp.
- Schröder, A. and Björk, T.** (2012) Patients’ judgements of quality of care in psychiatric observation and intensive in-patient care. *Journal of Psychiatric Intensive Care*. Published online 16 November 2012. doi: 10.1017/S1742646412000313