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EDITORIAL

PICU and prison

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Over the years, the extent to which general adult psychiatric intensive care units (PICUs) should be able to accommodate prisoners, if at all, has remained a familiar theme. Since the publication of the Reed Report (Reed 1992) it has long been acknowledged that mental health inpatient services require appropriate provision for people who have committed criminal offences.

Beginning with the Butler Report (Committee on Mentally Abnormal Offenders 1974) the medium secure estate within the United Kingdom has been increasingly developed. The last decade has seen the 'low secure unit' joining the secure estate as a mature member of inpatient secure services that are also now considered unequivocally 'forensic'.

Within the UK, criteria for admission to the secure estate include a 'grave and immediate risk' to the community for high secure, a 'serious risk' for medium secure and a 'significant risk' warranting low secure. The longstanding debate continues as to what is actually meant by a 'forensic patient' or a 'forensic service'. It feels that by now, we all should share a collective understanding. Closer inspection of these issues suggests that debate and confusion still remain.

In preparation for this editorial, even after decades working in a secure unit as well as a PICU, I found myself needing once again to review contemporary wisdom in terms of the definition of 'forensic psychiatric' services. This activity first took me to a basic Google search and visits to the British Royal College of Psychiatrists website and other arguably authoritative sources.

Wherever one chooses to look, themes such as the interface between psychiatry and the law, mental health and criminology, and understanding the mental health of those who have committed offences, seem consistently advanced as the central pillar around which the notion of 'forensic services' revolves.

That said, it is difficult to describe a person who has

made it into the prison system and also requires mental health care as anything else other than a 'forensic patient'. By definition, their journey has caused them to be arrested by the police, appropriately interviewed and charged with an offence. This must then have progressed to presentation before a Court, which for whatever reasons governed by the law, has decided that bail was not appropriate and therefore imprisonment followed.

In the case of imprisonment, society's safeguards had been visited and processed to the conclusion that a person required removal from society because of the nature of the offence for which they were remanded or convicted. In contrast, the psychiatric intensive care unit revolves around a very different central pillar.

The PICU can be said to follow the principles of intensive care as it exists in general medicine. Put simply, an acute health condition requiring intensive short-term treatment, beyond the level offered by a standard ward. For mental health, the basic premise involves a condition or illness, the symptoms of which are

directly resulting in disturbance and an inability to regulate the patient's normal behavioural responses. The PICU scientific literature, now dating back more than a quarter of a century, has discussed, described and confirmed the PICU as an acute treatment centre of short duration with the sole purpose of alleviating acute mental distress and its associated risks. The vast majority of the general adult PICU population has been admitted from less controlled acute mental health wards or the community. At the conclusion of a period of acute treatment, the return of the patient to the less intense ward or the community is the expected pathway. The vast majority of PICU patients in the UK do not have criminal offences related to their admission to hospital. Many also do not have profound criminal justice previous engagement and there is no legal restriction beyond civil mental health legislation for their transfer or discharge following the successful treatment of their acute condition.

It is true that patients within PICUs are periodically referred for secure mental health care because of their risk profile. It is also true that some people who find themselves in prison are only there because of behaviour that occurred as a direct consequence of an acute mental disorder.

On this theme, the UK has pursued a longstanding agenda of diversion from the criminal justice system into the mental health system wherever this is deemed to be appropriate. This is based on the premise that the prison system has a large number of inmates who should always have been patients. The extent to which this premise is true has also been rigorously debated over many years. If substance misuse and personality disorder are included in the considerations of inmates in the prison system, then some surveys have shown that up to 90% of prisoners in the UK have a 'mental disorder'. The true number of people who find themselves prisoners simply because of untreated mental illness remains difficult to establish. Most would agree that wherever mental health problems are identified, there ought to be appropriate treatment available in whichever setting this takes place.

Previous editorials in this journal have charted the development of mental health inpatient services within the UK and have told the story of how services have come to be what they are (Dix 2013). Mental health care over the last century has shown a continuing development with new services, ideas and means of meeting mental health needs punctuating its history. Current service arrangements and methods of treatment can never be considered a destination. Current services mark just a single point in time within a long and continuing journey.

Within the UK, there may be a renewed effort to call upon the PICU once again to widen its remit to include more prisoners in place of the traditional general adult inpatient population. Talking to colleagues, there are mixed opinions about this proposition. There are those who believe that this is appropriate and necessary work for the PICU. There may be a greater sense that the secure and prison estate should be developing its approach to be able to help those with mental health needs for whom society has deemed imprisonment necessary.

In this edition of the *Journal of Psychiatric Intensive Care*, Ward & Prasad (2021) compare the characteristics of patients admitted to a PICU to those of a general adult acute ward. This aims to provide insight into the nature and needs of patients admitted to a PICU and papers of this type are of interest to those trying to understand where the PICU may fit into the wider effort to meet needs of patients who present degrees of disturbance.

Prisoners within the UK and elsewhere around the world can be considered to be a generally very disadvantaged group. Add to this mental health needs, then indeed those within the prison population who experience acute mental illness may legitimately lay claim to the services of a PICU, as would be the case for any other member of society.

There is also the question of whether general adult PICUs are able to accommodate prisoners. My personal experience suggests that alternative arrangements are probably required for these patients. After all, many PICU services around the UK are already at full capacity and need to commission the equivalent of another whole unit elsewhere to fulfil the demand for beds.

I am struck by the longstanding challenge for the PICU of trying to be all things to all people and as result struggling to adequately meet the needs of anyone. Indeed, it is well rehearsed throughout the literature and clinical experience that PICUs struggle to maintain clarity in respect of those they are most able to help and where the limits of this are reached. Many PICUs have often found themselves trying hard to work with people with a variety of complex needs including adolescence, learning disability, mixed gender units and people with significant personality issues.

The suggestion that PICUs should more readily accommodate prisoners is credible. Further debate requires reference to evidence as well as established clinical models. It cannot be acceptable that too often prisoners are experiencing acute mental health pathology with seemingly great difficulty in finding appropriate treatment. That said, an equal or possibly more credible argument can be advanced that PICUs are not well placed to meet this need and attention needs once again to be turned to implementing further developments in the secure or prison estate. It must be accepted that a credible argument for wider access to the PICU estate can be advanced and reasoned analysis informed by evidence is required to enter the discussion.

The Editorial Board would be very interested to hear your views and opinions on the PICU and prison issue. NAPICU is currently working on guidance to further assist at the interface between the prison system, the secure mental health estate and PICUs. If your patients, services or staff have views on this area, please don't keep them to yourselves. We would be very keen to hear from you.

In an important final note, NAPICU would like to thank Mr S. Ouzounian for his very kind donation to further the work of association.

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