# The Psychiatric Intensive Care Unit
# &
# Personality Disorder

BIGSPD Annual Conference
April 2019

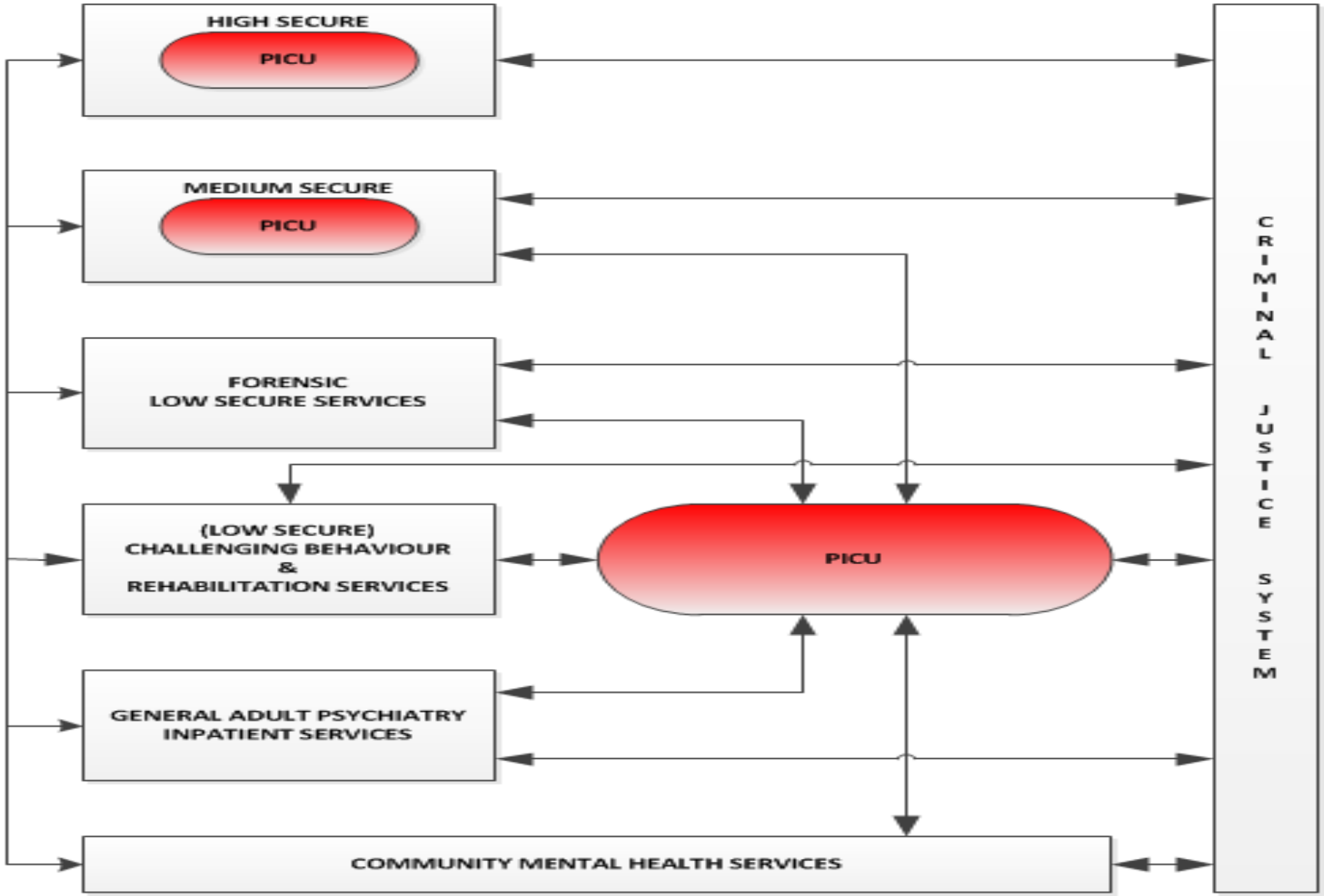
Durham, United Kingdom

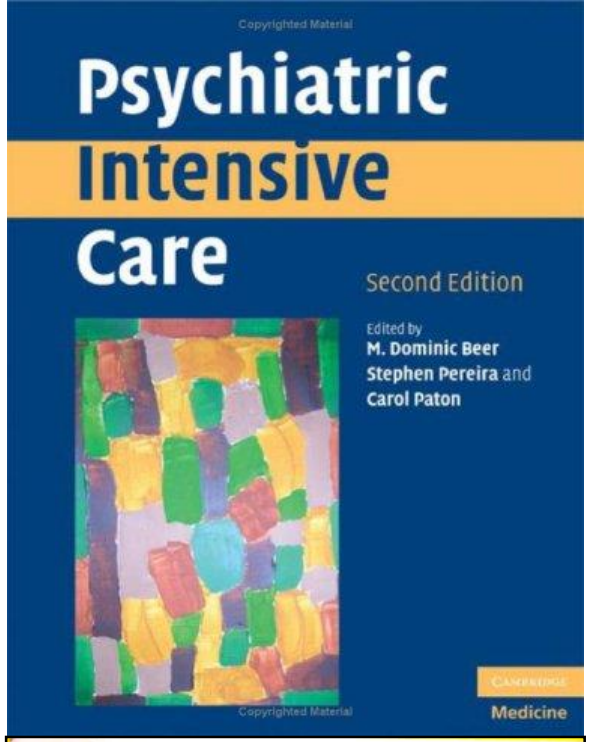
Dr Faisil Sethi

# Psychiatric Intensive Care (PICU)

- **Psychiatric intensive care is for patients who are in an acutely disturbed phase of a serious mental disorder.**
- **There is 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 less acute or less secure inpatient ward.**
- **Care and treatment must be patient-centred, multidisciplinary, intensive, and have an immediacy of response to critical clinical and risk situations.**
- **Patients are usually detained compulsorily under the appropriate mental health legislative framework, and the clinical and risk profile of the service user usually requires an associated level of security.**
- **Psychiatric intensive care is delivered by qualified and suitably trained clinicians according to an agreed philosophy of unit operation underpinned by the principles of acute and dynamic clinically focussed risk management.**
- **Length of stay must be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks in duration.**

# META-PATHWAY: ADULT MENTAL HEALTH SERVICE STRUCTURE (NAPICU 2012)

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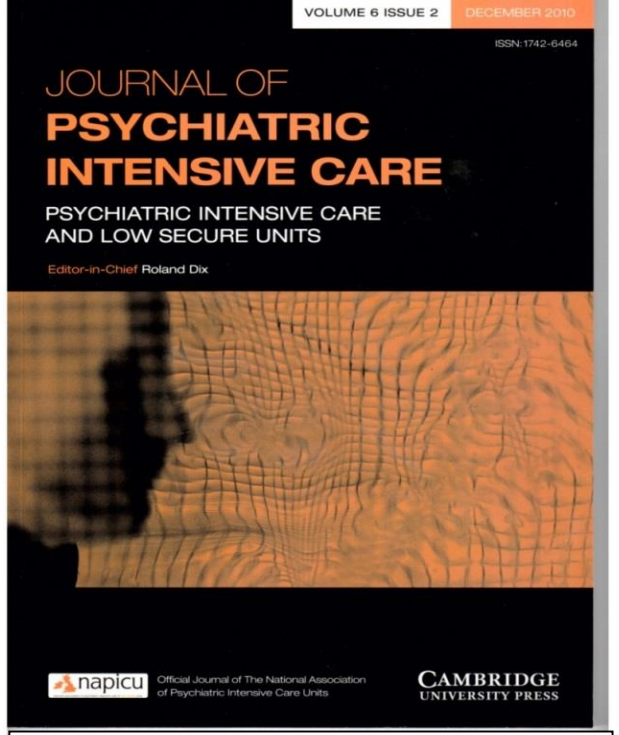
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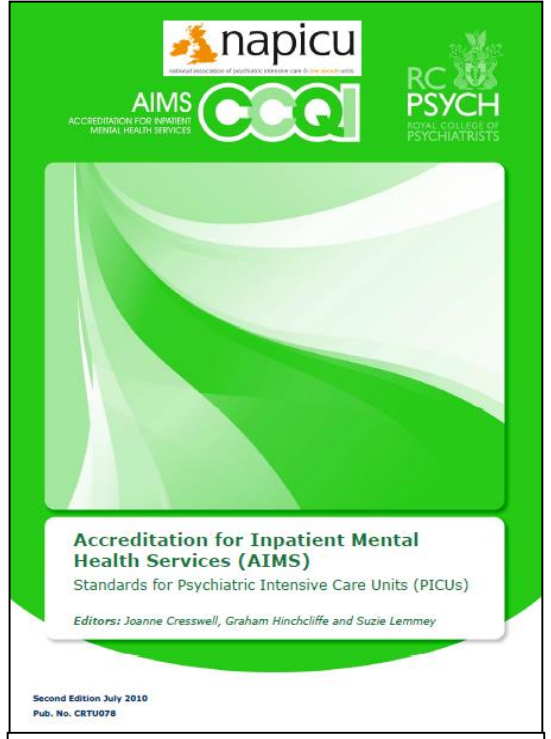
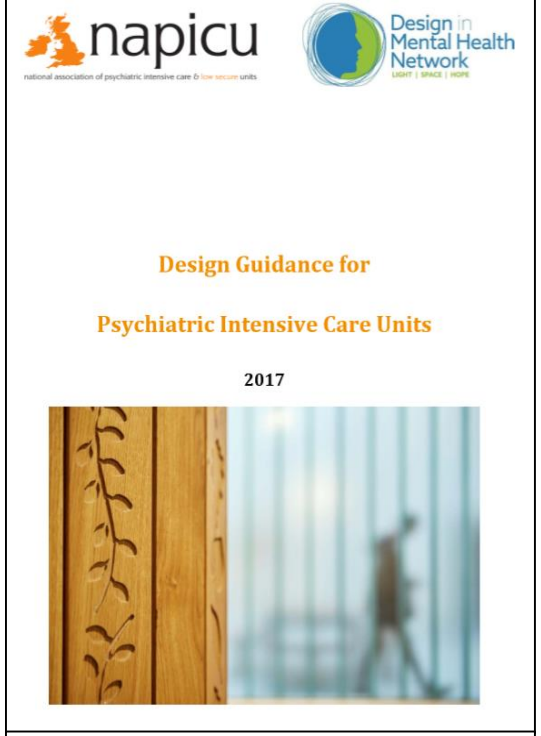
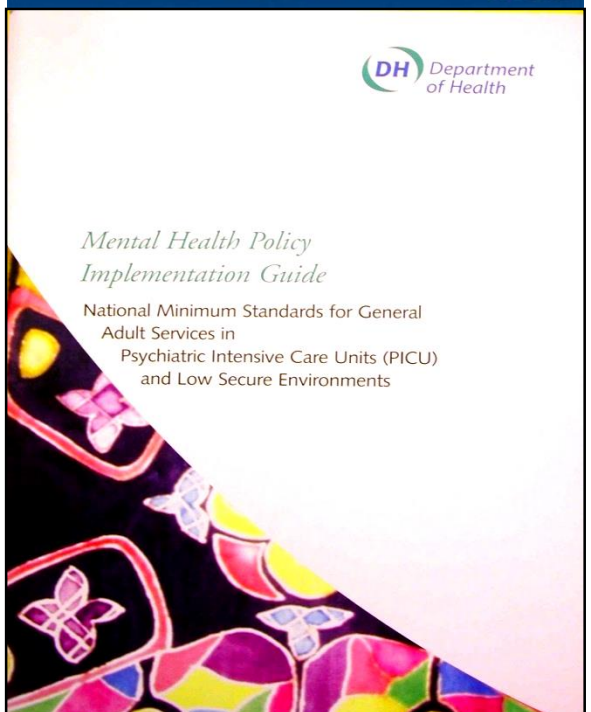
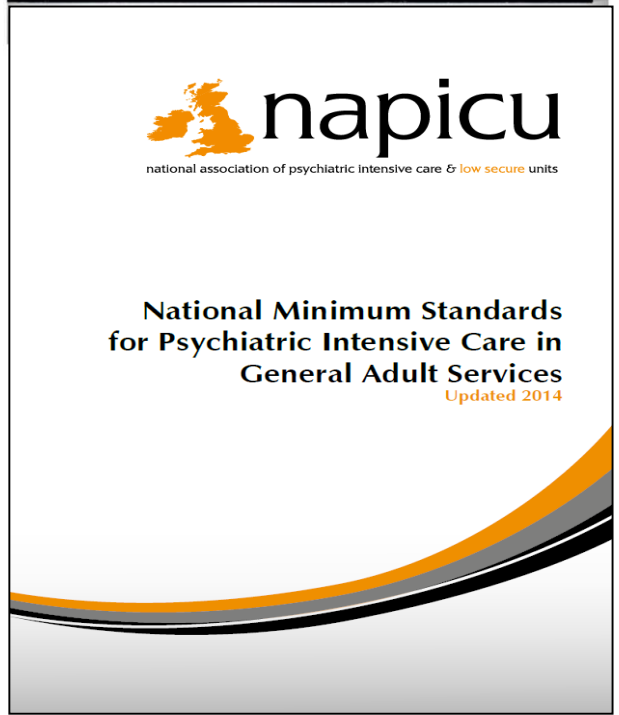
PSYCHIATRIC INTENSIVE CARE AND LOW SECURE UNITS
Editor-in-Chief Roland Dix
napicu
Official Journal of The National Association of Psychiatric Intensive Care Units
CAMBRIDGE UNIVERSITY PRESS


napicu
AIMS
ACCREDITATION FOR INPATIENT MENTAL HEALTH SERVICES
RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS
Accreditation for Inpatient Mental Health Services (AIMS)
Standards for Psychiatric Intensive Care Units (PICUs)
Editors: Joanne Cresswell, Graham Hinchcliffe and Suzie Lemmey
Second Edition July 2010
Pub. No. CRTU078


napicu
national association of psychiatric intensive care & low secure units
Design in Mental Health Network
LIGHT | SPACE | HOPE
Design Guidance for
Psychiatric Intensive Care Units
2017


DH Department of Health
Mental Health Policy Implementation Guide
National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments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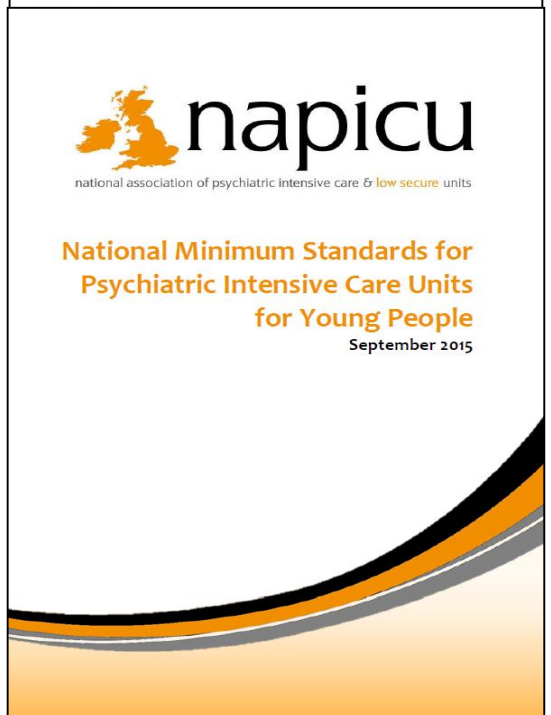
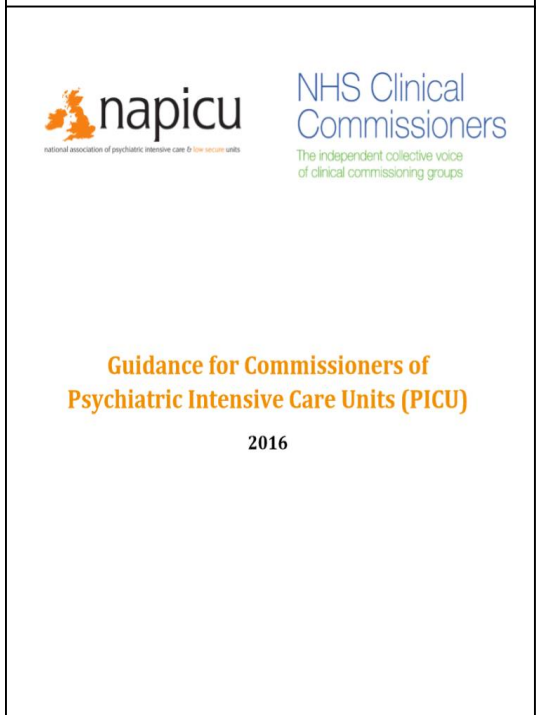
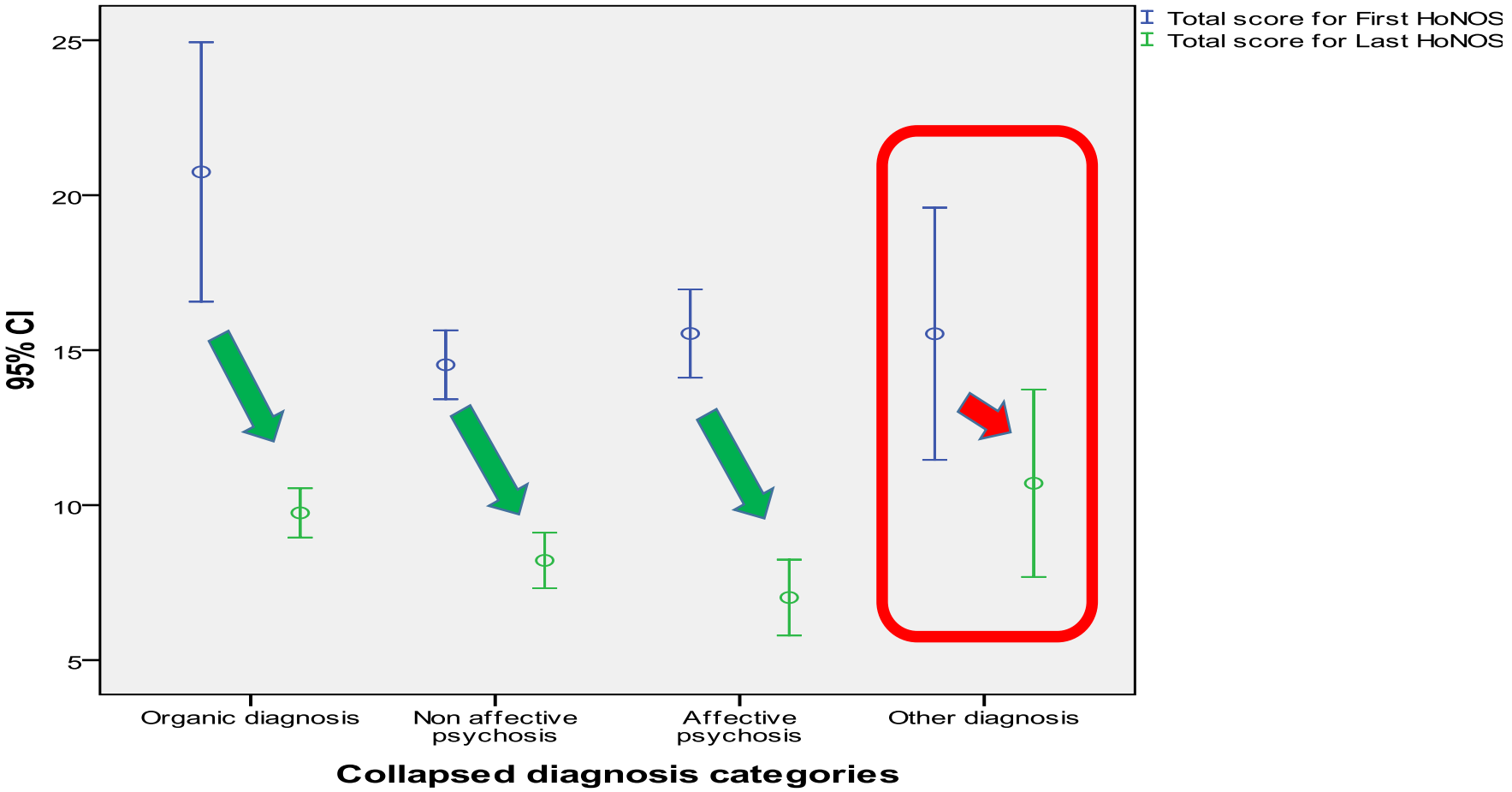
national association of psychiatric intensive care & low secure units
National Minimum Standards for Psychiatric Intensive Care in General Adult Services
Updated 2014


napicu
national association of psychiatric intensive care & low secure units
National Minimum Standards for Psychiatric Intensive Care Units for Young People
September 2015

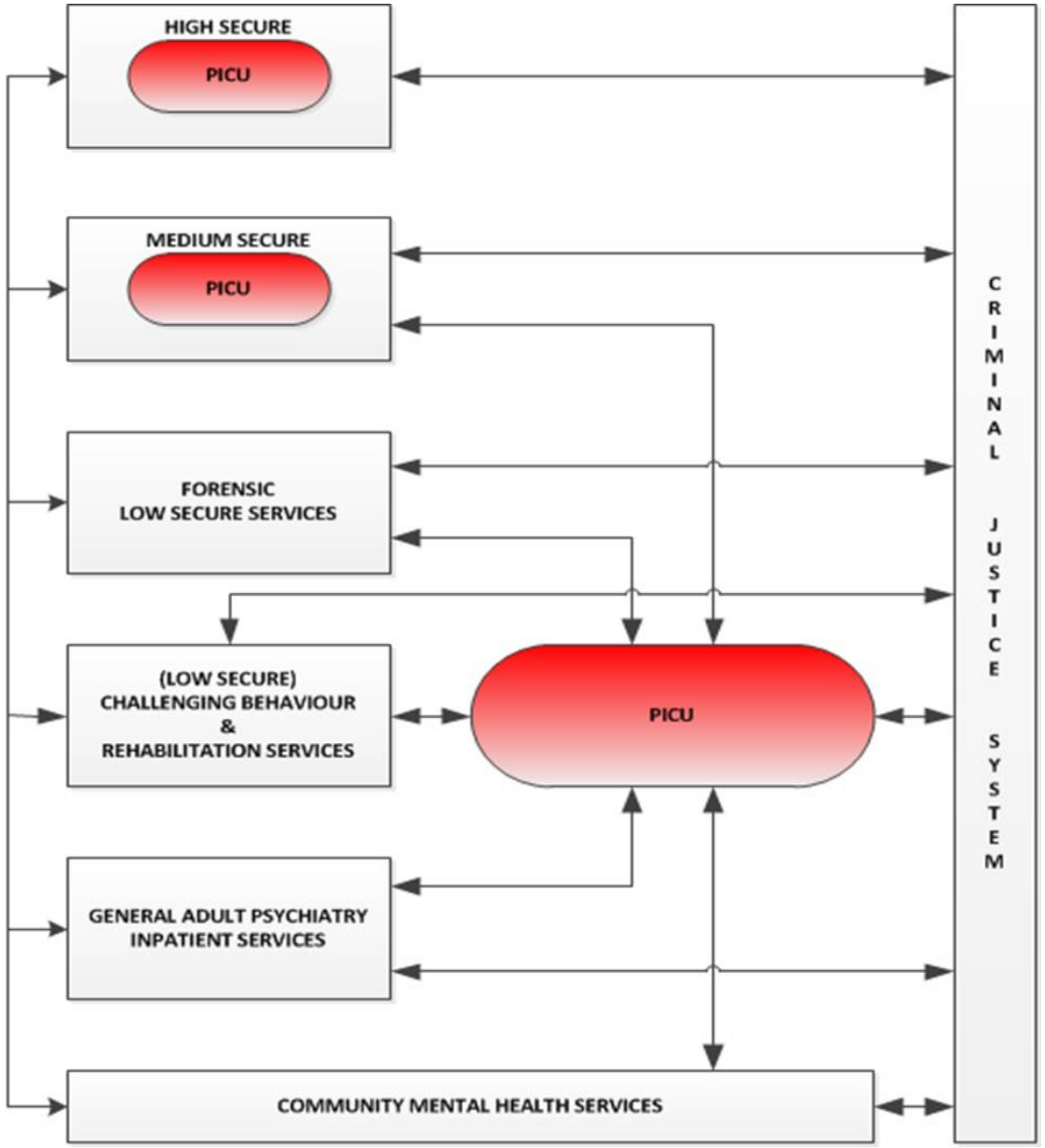

napicu
national association of psychiatric intensive care & low secure units
NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups
Guidance for Commissioners of Psychiatric Intensive Care Units (PICU)
2016

| HEALTH OF THE NATION OUTCOME SCALES (HONOS) ITEMS | | SEVERITY RANGE |
|---|---|---|
| **BEH**<br>Aggression: Overactive, Aggressive, Disruptive or Agitated Behaviour | | 0<br>NO PROBLEM |
| **DSH**<br>Self-harm; Non-accidental Self-injury | | |
| **SUBS**<br>Drug/Alcohol Problems: Problem Drinking or Drug Taking | | 1<br>MINOR PROBLEM REQUIRING NO ACTION |
| **COG**<br>Cognitive Impairment/Problems | | |
| **DIS**<br>Physical Illness or Disability Problems | | 2<br>MILD PROBLEM BUT DEFINITELY PRESENT |
| **HAL**<br>Hallucinations/ Delusions | | |
| **DEP**<br>Depressed Mood | | 3<br>MODERATELY SEVERE PROBLEM |
| **OTH**<br>Other Psychological (mental & behavioural) Symptoms | | |
| **RELS**<br>(Social) Relationships | | 4<br>SEVERE TO VERY SEVERE PROBLEM |
| **ADL**<br>Activities of Daily Living | | |
| **LIVC**<br>Accommodation Problems (Living Conditions) | | MAXIMUM TOTAL SCORE = 12 x 4 = 48 |
| **OCC**<br>Employment/Leisure Problems (Occupation and Activities) | | |

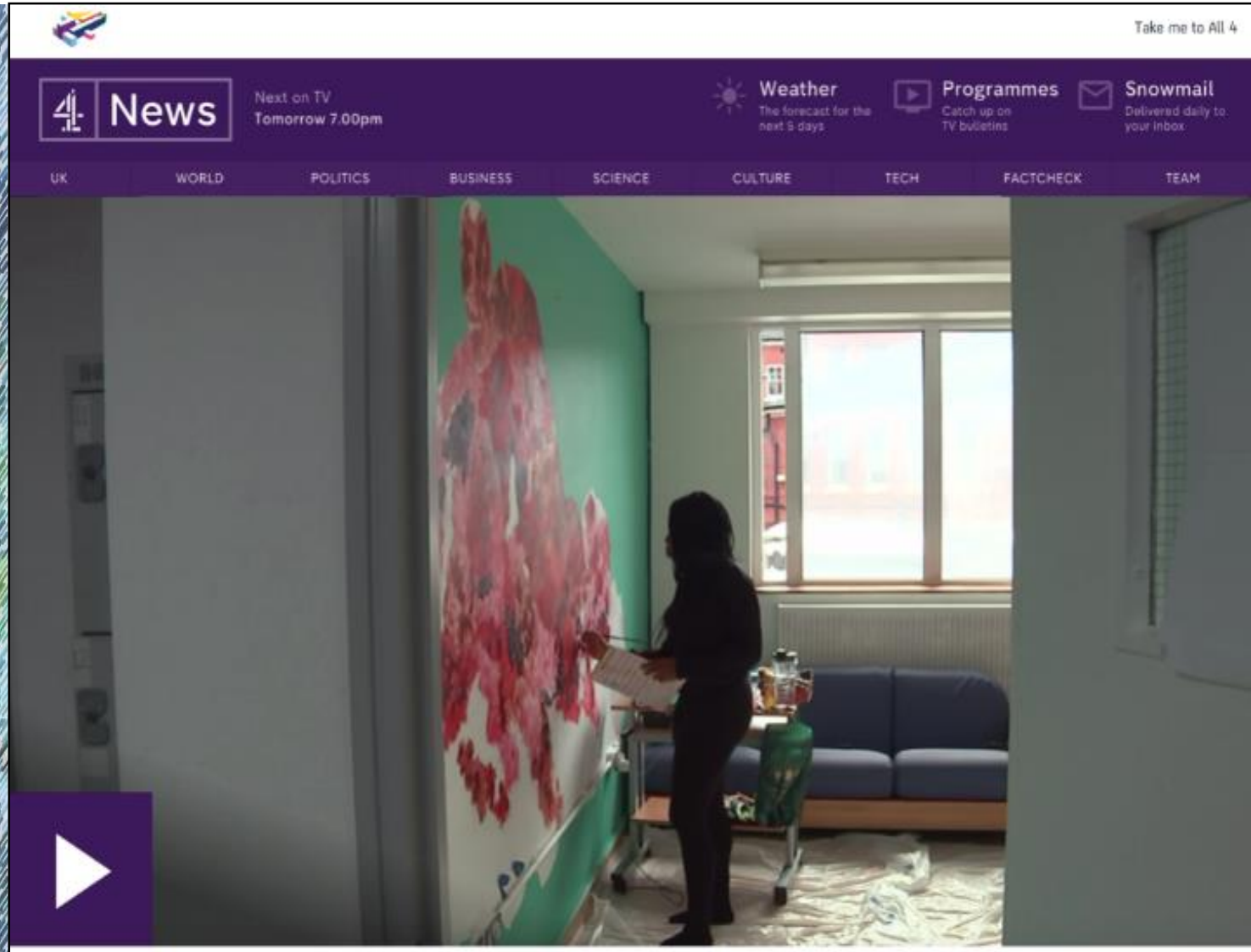

Total score for First HoNOS
Total score for Last HoNOS
95% CI
25
20
15
10
5
Organic diagnosis
Non affective psychosis
Affective psychosis
Other diagnosis
Collapsed diagnosis categories

# The Essence of PICUs

- Fast paced and high intensity.
- Immediacy of response.
- Acute disturbance of multiple aetiology.
- Multidisciplinary.
- Dynamic.
- Leadership at all levels.
- Treatment interventions reduce risk and improve clinical state.
- **Innovative in approach.**



# Art & Mental Health in the Women's PICU




Charity transforms mental health units with art

Tamsin Relly - Main Sitting Area

Julian Opie - Corridors

**Paresha Amin - Interview Room**

Harold Offeh - TV Room

**Aimee Mullins**
**Seating Area**

**Nengi Omuku - Family Room**

# Sensory Rooms & Sensory Based OT Treatments (De-escalation)

- Specially designed environment that offers a unique sensory experience
- Calming, de-escalating spaces but can also be immersive, interactive spaces
- Traditionally used in paediatric and learning disabilities
- Used more often in adult psychiatric settings as an alternative method of de-escalation
- Sensory modulation can support the rapid building of trust and rapport between staff and patients (*Sutton and Nicholson, 2011*)
- Support patients to improve skills in self-regulation of behaviour
- To potentially see a reduction in the use of restrictive interventions

# Summary

- Evidence is emerging that sensory rooms can reduce agitation and distress for patients experiencing acute disturbance

- Sensory rooms can improve the therapeutic atmosphere on the ward and make patients and staff feel more valued

# BPD & Sensory Processing Impairment

- SPD may have a role to play in BPD
- Both SPD and BPD: impulsivity, affect dysregulation, problems with arousal.
- Sensory processing approaches could potentially be integrated into the creative arts psychotherapies, DBT and CBT.
- May reduce dependence on acute services, reduce self-harm and improve symptoms.

# Restraint:
# Psychiatric Perspectives

BJPsych | The British Journal of Psychiatry (2018)
Page 1 of 5. doi: 10.1192/bjp.2017.31

Analysis

## Restraint in mental health settings: is it time to declare a position?

Faisil Sethi, John Parkes, Eric Baskind, Brodie Paterson and Aileen O'Brien

# THEMES

- Awareness of factors complicating restraint.
- Awareness of the complications of restraint.
- More emphasis on psychological, psychodynamic and relational aspects.
- Alternatives to restraint.

- Impact on Patients.

# The Multidisciplinary Management of Acute Disturbance

## AIM: To review evidence and provide recommendations on de-escalation and medication

Article

## Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation

Maxine X Patel[1]*, Faisil N Sethi[2]*, Thomas RE Barnes[3], Roland Dix[4], Luiz Dratcu[5], Bernard Fox[6], Marina Garriga[7], Julie C Haste[8], Kai G Kahl[9], Anne Lingford-Hughes[10], Hamish McAllister-Williams[11,12], Aileen O'Brien[13], Caroline Parker[14], Brodie Paterson[15], Carol Paton[16], Sotiris Posporelis[17], David M Taylor[18], Eduard Vieta[7], Birgit Völlm[19], Charlotte Wilson-Jones[20] and Laura Woods[21]

Psychopharm

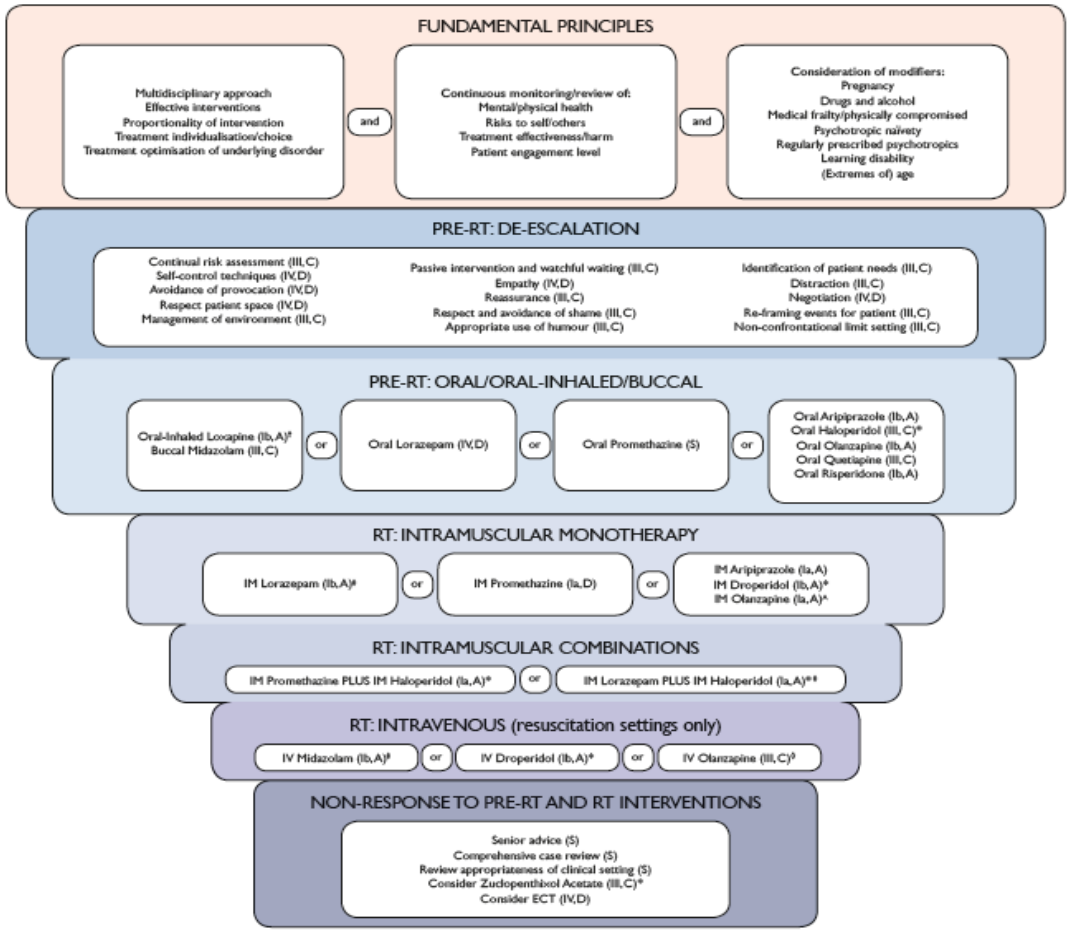
*Journal of Psychopharmacology*
1–38

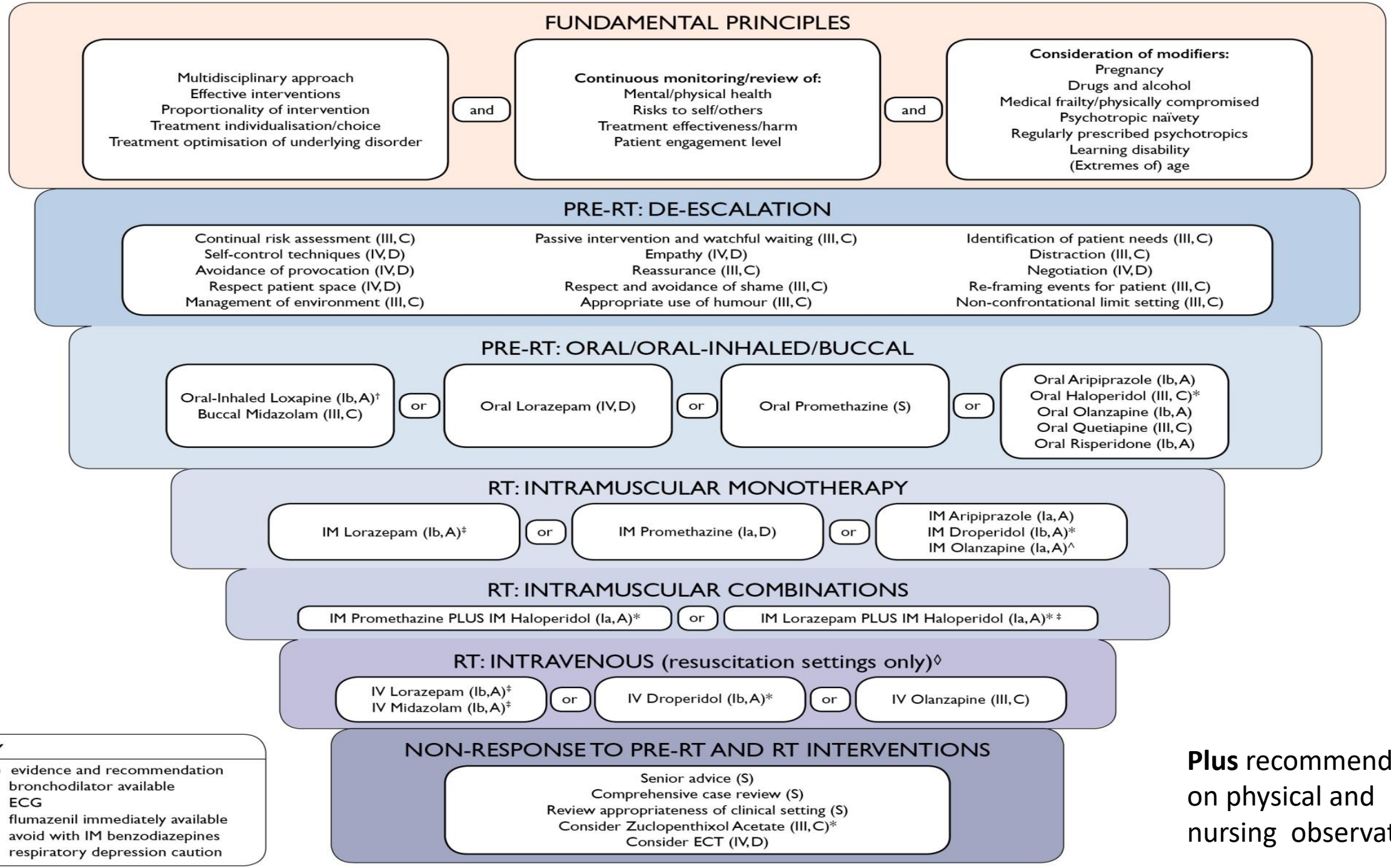
DOI: 10.1177/0269881118776738
journals.sagepub.com/home/jop
SAGE

BAP British Association for Psychopharmacology

napicu national association of psychiatric intensive care & low secure units

### AN ALGORITHM FOR THE MANAGEMENT OF ACUTE DISTURBANCE






**Plus** recommendations on physical and nursing observations

European Neuropsychopharmacology (2019) 29, 122–126

www.elsevier.com/locate/euroneuro

# Inhaled loxapine for agitation in patients with personality disorder: an initial approach

Barbara Patrizi[a,*], María V Navarro-Haro[b], Miquel Gasol[b]

Table 2 ACES values at each assessment and comparisons by time ($n=41$).

| | Basal | 10 minutes | 20 minutes |
|---|---|---|---|
| ACES(mean(SD)) | 1.80(0.49) | 3.75(1.49) | 4.53(1.05) |
| Comparisons ACES by time | | | |
| | | $p$ | |
| Basal vs 10 minutes | | .000 | |
| Basal vs 20 minutes | | .000 | |
| 10 vs 20 minutes | | .000 | |

ACES, Agitation-calmness Evaluation Scale; SD, Standard Deviation.

Table 3 PANSS-EC values at each assessment and comparisons by time ($n=41$).

| | Basal | 10 minutes | 20 minutes |
|---|---|---|---|
| PANSS-EC (mean(SD)) | 22.78(4.39) | 16.2(4.93)* | 11.14(4.17)*, ** |
| Comparisons PEC by time | | | |
| | Mean differences | | CI 95% |
| Basal vs 10 minutes | −6.49 | | −8.91, −4.07 |
| Basal vs 20 minutes | −11.63 | | −14.05, −9.22 |
| 10 vs 20 minutes | −5.15 | | −7.56, −2,73 |

PANSS-EC, Excitement Component of Positive and Negative Scale;
* $p < 0{,}001$ versus basal;
** $p < 0{,}001$ between 10 min and 20 min.

## PRE-RT: DE-ESCALATION

| | | |
|---|---|---|
| Continual risk assessment (III, C) | Passive intervention and watchful waiting (III, C) | Identification of patient needs (III, C) |
| Self-control techniques (IV, D) | Empathy (IV, D) | Distraction (III, C) |
| Avoidance of provocation (IV, D) | Reassurance (III, C) | Negotiation (IV, D) |
| Respect patient space (IV, D) | Respect and avoidance of shame (III, C) | Re-framing events for patient (III, C) |
| Management of environment (III, C) | Appropriate use of humour (III, C) | Non-confrontational limit setting (III, C) |

- The following de-escalation components *are* effective:
  - Continual risk assessment
  - Management of environment
  - Passive intervention and watchful waiting
  - Reassurance
  - Respect and avoidance of shame
  - Appropriate use of humour
  - Identification of patient needs
  - Distraction
  - Reframing events for patient
  - Non-confrontational limit setting

**WHAT DOES THIS MEAN FOR PATIENTS WITH BPD IN CRISIS IN THE PICU?**

# Aspects of DBT/MI/PST useful in (PICU) ED

**Dialectical Behavioural Therapy (DBT)**

**Motivational Interviewing (MI)**

**Problem-Solving Treatment (PST)**

| | | |
|---|---|---|
| **BASIC VALIDATING TECHNIQUES** | Open-ended Questions | Engagement<br>&<br>Problem Clarification |
| Listening & Observing<br>Reflections<br>Interpretations | Affirmations | Solution Generation |
| **PARADOXICAL INTERVENTIONS** | Reflections | Select Mutually Agreed Plan |
| Extending<br>Devil's Advocate<br>Irreverent Communication | Summary Statements | Implement Plan |

*The Diagnosis and Management of Agitation. Edited by Scott Zeller et al. Publ. Cambridge University Press 2017. Chapter 8: Psychiatric Causes of Agitation: Exacerbation of Personality Disorders. P104-125.*

# ACUTE AND PICU SETTINGS?

## Women in acute psychiatric units, their characteristics and needs: a review

Michaela Archer,[1] Yasmine Lau,[1] Faisil Sethi[2]

BJPsych Bulletin (2016), **40**, 266–272, doi: 10.1192/pb.bp.115.051573

**Aims and method** Recent policy guidelines published by the Department of Health highlight the need to develop gender-sensitive psychiatric services. However, very little is currently known about the specific characteristics and needs of female patients entering acute psychiatric wards, particularly psychiatric intensive care units. This article aims to review the current literature on what is known about this group of patients. PubMed, Embase and PsycINFO were systematically searched using a number of key terms.

**Results** A total of 27 articles were obtained. The findings were divided into four categories: admission characteristics, treatment needs, risk management and outcomes after discharge. Gender differences were found in diagnosis and presentation.

# Some Conclusions from the Review

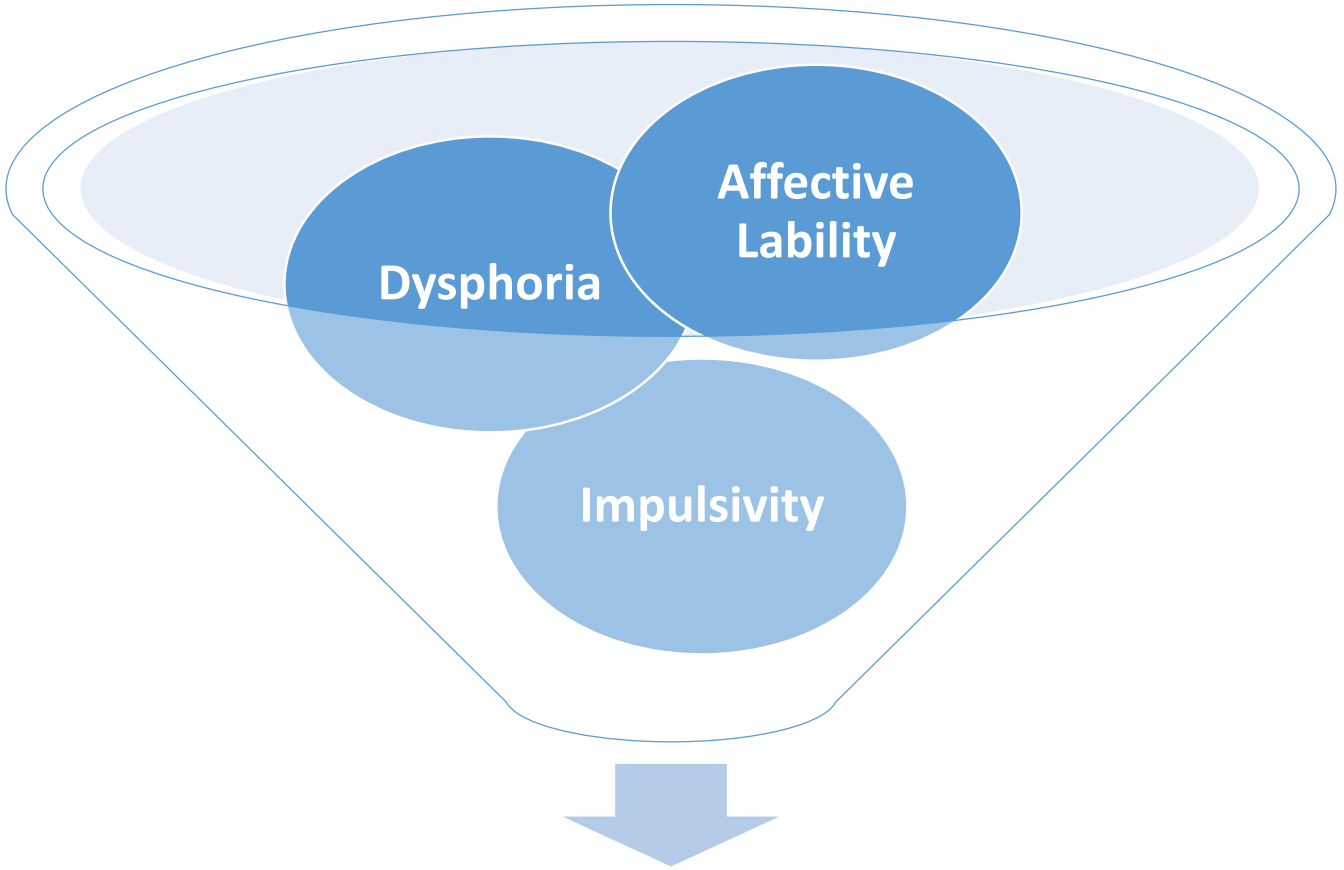
- **Need for good interpersonal relationships with staff! Awareness of attachment difficulties, and linked with safer ward environment.**
- **Higher rates of comorbidities with other mental health problems (e.g. personality disorders and anxiety disorders), also histories of abuse or trauma and self harm more common.**
- **Complex factors linked with poorer outcomes.**
- **Importance of providing high level of staff support, training and supervision – able to safely contain and manage complexity.**
- **Providing gender-informed training – can greatly improve experience and recovery for patients.**

*Other Areas …*

- Women, medication & psychopharmacology

- Women in prison & forensic psychiatry

# Comorbidity & Diagnostic Uncertainty




**BPD or Bipolar II Disorder**

# Treatment Resistance in BPD (not reluctance!)

**Unconscious Resistance**

+

**Ineffective Treatment**

- Psychotherapy
- Medication
- Clinical Model/Setting
- People

➡

**Treatment Resistance**

# HELP?

| Principles of Management for Patients with BPD in PICU/ Acute Inpatient Units. |
| --- |
| Maintain Flexibility |
| Establish Conditions That Keep Patient Psychologically and Physically Safe |
| Tolerate Intense Anger, Aggression and Hate |
| Promote Reflection |
| Set Necessary Limits |
| Establish, Review and Maintain the Therapeutic Alliance |
| Avoid Splitting Between Psychotherapy and Pharmacotherapy |
| Understand the Splitting Between Team Members and Beyond |
| Monitor Counter-transference |

*Management of Personality Disorders in Acute Inpatient Settings by Leonard Fagin (Advances in Psychiatric Treatment (2004).*

# Where Next?

**Women's PICU and BPD:**

**Clinical Model**

**&**

**Service Model**

- Pharmacological Management in the Immediate/Short-term Phase of PD Crisis
- Psychological & Psychotherapeutic Interventions in the Management of PD Crisis
- Acute Disturbance Guideline on PD
- Restrictive Interventions and PD
- Sensory Interventions in PD Management
- Team Approaches to Managing Severe PD in the Acute Inpatient Setting