Correspondence

The doctor and seclusion

Sir: I was saddened by the innocence and ignorance shown by Drs Okhai and McLaren in claiming that the supervision of seclusion of patients should be no part of a trainee psychiatrist's job (*Psychiatric Bulletin*, April 1997, **21**, 227). Are they not concerned with the general well-being of their patients as well as with specific mental illnesses? If one of their patients suddenly appeared with two black eyes would they not think that they ought at least to ask why? Are they really so unaware of all the abuses, physical, emotional and sexual, sometimes suffered by vulnerable patients, children and old people, in homes and hostels as well as in psychiatric and even general wards? The newspapers today sometimes tell us about such matters, and the history of psychiatry in the 19th and 20th century is full of scandals, public enquiries and regulations and laws passed to try to prevent their recurrence.

Seclusion (equals imprisonment without trial) should not be simply a way of doing without staff, or of satisfying a private grudge; it must be openly justified; it must only be for a limited prescribed period; it must not be easily repeated; and there must be frequent, regular checks on the secluded person's well-being in the cell. It will not always be carried out properly unless it is inspected and written down in the case record for evidence. External inspection is essential, because nurses are loyal to their colleagues and will not report against them, doctors too are loyal to their fellows, while administrators want things hushed up. Often no-one knows quite how to deal with abusers if they are discovered.

Physical and mental abuse seems to be a disease of institutions rather than the acts of one or two individuals unsuited to their work (paedophile in a children's ward, sadistic psychiatric nurse, etc.,). It tends to be a reflection of poor staff morale; overwork and long hours with low pay; an administration ignoring complaints and offering no support, particularly with overcrowding; lack of job satisfaction; and patients who are sectioned, irritating, perverse or obstructive. Any of us is a potential abuser if the environment is bad enough.

The trainee needs to be involved in seclusion, not because it is therapy (which it is not) but to prevent it becoming anti-therapy, and to use the opportunity to get to know (and support) nursing colleagues. A team pulls together, it is not a set of individuals each doing their own thing.

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Authors' reply: John Crammer's letter suggests he has missed the point of our paper. His letter belies an ambivalent attitude towards psychiatric nurses, as on the one hand he recommends that trainees should 'get to know and support nursing colleagues' while on the other he views them as potential 'abusers' likely to cover for each other's malpractice. The physical abuse of patients has been, and can only be, addressed by increasing the professionalism of psychiatric nursing. Comments such as those made by Dr Crammer undermine this process. Seclusion is a nursing intervention and responsibility for documentating and monitoring its use should reside within that profession.

If monitoring by one professional group of another's practice is required, and our view is that it is not, is it appropriate to ask junior psychiatrists, who may be in their first psychiatric post, to oversee the actions of experienced nursing staff? If Dr Crammer is serious in his concerns should he not be advocating that consultants be responsible for 'external inspection'?

We agree with Dr Crammer that the therapeutic effects of seclusion are uncertain. Psychiatrists should be working with nursing colleagues, through clinical audit, to minimise its use. We are still of the view that the current involvement of trainee psychiatrists is inappropriate and needs to be reconsidered.

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National survey of psychiatric intensive care units

Sir: Beer *et al* (*Psychiatric Bulletin*, March 1997, **21**, 142–144) report the results of a postal survey sent to pharmacists who were asked to comment upon the characteristics of their local psychiatric intensive care units (PICUs). The questions asked of these pharmacists are not included in

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their report, and some of the information obtained may be of questionable value.

It is not immediately apparent why pharmacists were believed to be the most appropriate source of some of the data acquired. Pharmacists may not be expected to be fully cognisant of admission criteria, levels of security, sources of referral, medical staffing issues and recruitment difficulties. If they are not formally aware of these issues then their 'opinions' may be little more than the distillation of hearsay (the same would apply to other disciplines asked to comment outside their area of expertise).

The point is made apparent by the inclusion of a table (Table 1) bearing little relationship to the text of the paper, and listing verbatim comments made by staff. Quite how these comments were recorded, by whom, and of whom is not clear. Neither is their status as fact. What is the status of the first and last comments listed?: "Good afternoon, lock-up ward, Dave speaking"; "We have 15 beds and 11 consultants who could potentially admit to them. They look after their own patients when they are here – you can imagine what that's like!"

The authors repeatedly refer to 'confusion' existing within these (PICU) units, yet at no point is it clear that this 'confusion' exists in these units rather than in the respondents to the postal survey. There are 'confusions' over the names of the units, the structure and functioning of many, and we are told that the staff feel that they have no control over who is admitted and the duration of their admission. But perhaps it is not surprising that pharmacists are not determining the admissions policies of these units and if the 'staff' referred to are not pharmacists but members of other disciplines then who is reporting their 'feelings' and how have they accessed them?

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Authors' reply: There have been previous surveys of PICUs; one by Ford & Whiffin (1991), who contacted 169 District Health Authorities and received 65 replies, identifying 39 units, and the other by Mitchell (1992), identifying 13 units in Scotland. These numbers are low and we required a methodology which had the best chance of accessing the majority of units. The options included writing to all College members (impractical) or Trusts (difficult to identify Mental Health Trusts). We decided to approach pharmacists with a special interest in psychiatry. Our rationale was as follows; all PICUs use drugs and therefore a pharmacy somewhere serves them. In the UK there is a special interest group of pharmacists working in psychiatry. The pharmacists in this group were approached as a means of identifying the units. Our method clearly stated that pharmacists who did not have detailed knowledge of their PICU were simply asked to supply a contact name: many did. Eighty-four per cent is a high response rate, which is likely to have picked up the majority of units.

In our paper the questions posed were broadly described as space did not allow a full reproduction of the questionnaire. In respect of pharmacists' detailed knowledge of the workings of the local PICU, although the questions posed were not difficult to answer for anyone who is a fully participating member of the mandatory drugs test, the responding staff were in the main a mixture of consultant psychiatrists and ward managers. With regard to admission policies there is no suggestion that pharmacists either do or should determine policies for these units. The salient point from the survey is that often no-one else does.

'Confusion' can only reflect staffs understanding of the system in which they work. Table 1 aimed to highlight this issue by incorporating spontaneous comments made by PICU staff, as stated in the table heading. They were either written on the questionnaire or made during completion of the questionnaire by phone. None originated from pharmacists.

The principal aim of the study was to identify PICUs and broadly describe them with the ultimate aim of providing a network of support, education, training and improved service provision. To this end, the first national conference occurred in March 1996 where the findings of this study were presented. Over 200 people attended and the overwhelming feeling was of enthusiasm for open discussion of the issues raised by the study. Many identified with the comments made and the discussion afterwards echoed this. Such was the enthusiasm to improve practice that a national multi-disciplinary committee has been set up and has met quarterly in order to take the pertinent issues forward.

FORD, I. & WHIFFIN, M. (1991) The role of the psychiatric ICU. *Nursing Times*, **87**, 47–49.

MITCHELL, G. D. (1992) A survey of psychiatric intensive care units in Scotland. *Health Bulletin*, **50**, 228–232.

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