Hot beds of general psychiatry

A national survey of psychiatric intensive care units

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Little is known of the facilities available nationally to treat the most disturbed patients. A postal survey sent to all pharmacists in the UK known to have a special interest in psychiatry identified 110 psychiatric intensive care units. They varied in size from four to 30 beds, with the small units having low and the larger units very high occupancy levels. Many units accepted a mixture of informal patients directly from the community, detained patients and referrals from the prison service. Medical cover was variable, multidisciplinary team-working poor, and the existence of written policies unsatisfactory. Staff often felt undervalued with little control over admissions and discharges. There is currently no national or local support network for these units.

Much energy, both political and clinical, has been devoted to the reprovision of services from large psychiatric hospitals and the associated developments in community care. At the other end of the spectrum there is a paucity of research aimed at identifying the service provision needs of the most disturbed of our patients. The old Victorian water tower hospitals traditionally included a locked ward, and Zigmond (1995) commented upon his personal experiences of such facilities in his role as a Mental Health Act Commissioner and second opinion doctor. He described these locked wards as physically apart from other in-patient facilities, containing the most seriously disturbed, invariably detained patients 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. Zigmond commented that these units often operated in isolation. A major problem identified by the current authors was the lack of a national register. Therefore it is not surprising that there is no networking between these units and almost no objective data concerning the services they provide.

The study

Questionnaires were sent to 397 pharmacists whose names were on the mailing list of the UK Psychiatric Pharmacists Group. They were asked to identify their local psychiatric intensive care/locked ward and to answer questions about its admission criteria, date of opening, level of security, number and percentage occupancy of its beds, male:female ratio of its patients, sources of referral, medical staffing, multidisciplinary team working, and the existence of written policies. Those pharmacists who did not have detailed knowledge were asked to supply a contact name. All incomplete questionnaires were followed up by telephone.

Findings

Three hundred and thirty-two (84%) questionnaires were returned and a total of 110 units identified.

The units

Eighty-nine accepted mental illness patients only, one learning disability (ALD) patients only and 20 would accept ALD if the current management problem was due to mental illness. Forty-five units had been open for less than 3 years, 35 units for 3–9 years, and 26 for 10 years or more.

Eleven units (one prison, two special hospitals, eight mixed forensic/intensive care wards) were built to medium secure specifications or above. The remaining 99 described themselves as low security, with 22 of these units only locking their doors when necessary.

Eleven units contained 4–5 beds (intensive care areas (ICAs) off acute admission wards) and 18 units contained 6–9 beds (within a 15–20 bedded facility, the remaining beds being forensic or challenging behaviour). A further 47 units contained 10–15 beds and the remaining 34 units 16 beds or more. Half of the 4–5 bed units had occupancies of less than 60%, half of the 6–9 bed units 100% occupancy, and over 60% of the units containing 10 beds or more had occupancies of 100%.

The patients

One hundred and seven units accepted referrals from other wards in their own trust (the

https://doi.org/10.1192/pb.21.3.142 Published online by Cambridge University Press

remaining units being prisons or private facilities), and 63 units contracted with other trusts. Eighty-nine units accepted patients from the Prison Service, 21 from Courts, 24 from Regional Secure Units (RSUs) and Special Hospitals and 13 from the police (all Section 136). Eighty-four units accepted patients directly from the community, one directly from social workers and seven commented that 'anyone could get a patient admitted if they made enough fuss'. Forty-seven units would accept only detained patients and the remaining 63 informal patients also 'if appropriate'. Thirty-eight units would not admit/keep 'long stay' patients (defined by these units as meaning anything from a two week to a six month stay). Twenty-nine units would not admit 'forensic' patients. Almost half the units had a male: female ratio of 4:1 and a further quarter 5:1 or more.

The staff

Eighty-one units were looked after by a single consultant psychiatrist, although in 51 the consultant had other in-patient (usually acute admission) beds. In the remaining units, the patient's own consultant continued care and there was no overall medical responsibility for the unit. Forty-five units had a senior registrar and 10 a doctor of staff grade. Fourteen units had no junior doctor at all, 18 had a senior house officer (SHO) and 40 a SHO/registrar (variable). The remaining units were covered by a registrar. Nursing staff did not rotate in 91 units and 37 (mostly inner city units) had difficulty recruiting. Spontaneous staff comments are shown in Table 1.

The multidisciplinary team

Seventy-eight units had occupational therapy time allocated to them, 64 pharmacy, 60 clinical psychology, 59 social work and 12 art therapy.

Written policies

Seventy-six units had no policy for the use of high dose neuroleptics either as rapid tranquillisation or longer-term in 'treatment resistant' patients, 22 no policy for control and restraint, and 15 no seclusion policy (a further 47 units did not use seclusion at all). Twenty units had no admissions and exclusions policy and 32 no search policy.

Comment

This is the most complete national survey to date of psychiatric intensive care units, although the authors acknowledge that some units may not have been identified. Previous studies by Ford & Whiffen (1991) and Mitchell (1992) identified 39 and 13 units respectively. The focus of these studies differed making their findings impossible to compare. The 110 units identified in our survey had almost as many differences as similarities. The terminology used caused further confusion with units describing themselves as being extra care wards, intensive care, high dependency, special care, psychiatric intensive care, locked wards and low secure units. The two themes common to all units were the need for intensive nursing input (at a level higher than could be provided on an admission ward) and the ability to provide perimeter security, although this was also very variable with some units frequently having open doors and others being built to RSU specifications.

The terminology used to describe the patient group added further confusion; when does acute disturbance become chronic disturbance, intensive care become challenging behaviour, and when does a patient become 'forensic'? This confusion is mirrored in the structure and functioning of many of the units, with staff often feeling that they are expected to be 'all things to all people' and not feeling in control of who is admitted and how long they stay. This perceived lack of control and the associated frustration it

Table 1. Examples of spontaneous comments made by PICU staff

"Good afternoon, lock-up ward, Dave speaking".
"No we don't take forensic, they have more than enough money to look after their own".
"Yes, we have an admissions policy, it hangs on the wall, that's about all it does though".
"Yes we have a mix of patients here; about half are ICU and as for the rest, you might as well throw away the key".
"This ward is a dumping ground for the patients that no-one else wants".
"About half of our patients are forensic, but that ward is full. There's no recognition though, we just have to get on with it".
"Staff get burnt out, but there is no management support, they just don't want to know us or the patients".
"Anyone can admit someone here if they shout loudly enough".
"Everyone moans when there are no beds to admit, but no-one will take back their chronic patients. We could use bunk beds and still not please everybody".
"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 it's like!"

https://doi.org/10.1192/pb.21.3.142 Published online by Cambridge University Press

produces is a common theme which runs through many of the comments in Table 1.

Units varied in size from 4 bed ICA areas off admission wards to 30 bed dedicated units. While ICAs may be suitable for containing patients for 24–48 hours, longer stays become increasingly problematic in such constrained spaces. The fabric of these units also tends to be poor and a combination of these factors may explain their low occupancy levels. In contrast, the larger dedicated units have dangerously high occupancy levels with many patients being discharged before they are ready in order that a bed is made available at short notice for someone even more disturbed. The burden of daily care falls onto nursing staff yet the great majority of units do not rotate their nurses and a significant proportion have difficulty recruiting. While specialist nursing skills are required to manage such constantly high levels of disturbance, there is a need to balance the requirement for such skills against staff burn out.

The skills of other professional groups are also required to manage this challenging group of patients but this tends not to be reflected in multidisciplinary team working which is the norm in general psychiatry. When other professionals are involved, their input may often be more reactive than proactive as illustrated by the large percentage of units which have a pharmacist involved but no policy for rapid tranquillisation (RT) or the use of long-term high dose neuroleptics. This particular omission becomes even more unacceptable when considered in terms of the frequency at which RT is used on these units and the fact that a high proportion have either no dedicated junior doctor or a potentially very inexperienced SHO. This is at best unfair and at worst unsafe. Significant concern should also be raised by the fact that a quarter of the units which practised seclusion had no written policy. This is the stuff enquiries are made of.

This study has provided the first step towards identifying current psychiatric intensive care provision. It is hoped that the data collected will act as a springboard for the development of both local and national networking between these units.

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https://doi.org/10.1192/pb.21.3.142 Published online by Cambridge University Press