Psychiatric intensive care: a developing specialty

Care of acutely ill psychiatric patients is a problematic area for the NHS. This article charts the development of the specialty of psychiatric intensive care and discusses the major issues for staff and patients.

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Psychiatric intensive care units (PICUs) fulfil a role analogous to the intensive care/intensive therapy units familiar in general hospitals. Lehane and Rees (1995), Saverimutlu (1996) and Ford and Whiffin (1991) described the establishment of PICUs, where patients who are severely unwell or who present severe management problems can be nursed in safety.

PICUs provide a service to acutely ill patients who, for brief periods, require a level of staff observation and intervention beyond that which can reasonably be provided on busy general psychiatric acute admission wards. The basic function of the PICU is to stabilise these patients so that they can return to, and be safely managed in, normal open acute admission wards.

The PICU is characterised by a high staff-patient ratio and by a degree of security. Windows and doors are usually locked (Dix 1995, Hyde and Harrower-Wilson 1994), and access to potential weapons and other harmful items, such as illicit drugs, plastic bags and belts, is restricted. However, PICUs are low-security units and usually do not have the perimeter fences and other features which characterise medium secure units.

The physical environment of purpose-built psychiatric intensive care units is designed to maximise the safety of disturbed patients and not just prevent them absconding. This is accomplished by, for example, enclosing pipework so that patients cannot hang themselves, and by ensuring that while patients can achieve some degree of privacy from one another, they can also easily be observed by staff. In practical terms this means that PICUs tend to be compact wards, built on a single level (usually on the ground floor) with rooms which radiate out from a central nursing office.

RISK ASSESSMENT
Risk assessment is a core skill for PICU staff. Patients are admitted and discharged on the basis of assessments about the risk that they pose to themselves and others. Many PICU teams also offer a consultative risk assessment service to clinicians in other elements of their local psychiatric services. Patients from the community or from open wards are sometimes placed in a PICU because of concerns about their potential danger to themselves and others. If these concerns are substantiated, the patients concerned may be referred to a forensic unit for longer-term treatment in a secure environment.

Staff in specialist PICUs care for patients who are violent, actively suicidal or at high risk of absconding. They seek to help these patients solve their problems and cope with their symptoms. Staff offer patients this assistance in a quiet, therapeutic environment, away from the hustle and bustle of the busy admission ward. Control of noise and activity is important; evidence suggests that quieter environments with high staffing ratios may reduce the level of frustration felt by patients, reducing the incidence of aggression (Berkowitz 1965, Buss 1961).

STAFF ATTITUDES TO PICUs
PICU staff sometimes experience mixed reactions from their nursing peers. On the positive side, many psychiatric nurses value the role of the PICU in caring for acutely disturbed and ‘difficult’ patients. Staff are often aware that a few very disturbed patients consume disproportionately large amounts of time and attention. They recognise that the resources used in caring for these one or two patients may well affect the standard of care that can be offered to the remaining 23 or 24 patients on the typical admission ward. They also recognise that the environment of the admission ward may also be far from optimal for the safety and well being of very disturbed patients. The problem lies in deciding when patients are ‘very disturbed’ and appropriately managed in the PICU and when they are not (Dix 1995).

Problems of de-skilling Psychiatric acute admission ward staff have varying levels of skill and experience in managing disturbed patients. Some of these nurses feel that establishing specialist units for the management of disturbed behaviour is unnecessary and may de-skill staff in acute admission wards. De-skilling is not a trivial issue – if the staff of general admission wards feel...
Mental Health

de-skilled they may find themselves unable or unwilling to cope with patients who present with disturbed, aggressive or difficult behaviour. This could lead to a situation in which their 'threshold for coping' falls and patients who would previously have been adequately and safely managed on open wards are refused admission and are instead referred to locked wards such as the PICU.

This problem can be overcome in two ways:

- By establishing explicit criteria for admission to the PICU so that both PICU staff and the staff of other wards have a standard against which to measure the suitability of referrals (Dix 1995)
- By rotating staff from admission wards through the PICU so that they maintain and develop their skills in working with very disturbed patients who are difficult to manage.

Misconceptions

The authors have also heard concerns expressed that the PICU may be the 'punishment block' of the modern psychiatric service. We have heard anecdotal reports of PICU referral being used as a threat. Threatening patients in this way is clear misconduct and if substantiated would call for firm managerial action. This type of attitude may stem from fears that behind closed doors PICU staff may employ ethically dubious approaches to the care and management of patients.

Similarly, some staff may suspect that the PICU and other controlled environments attract nurses with a particularly authoritarian approach to patient care. This may be a source for some concern but, to date, there is no published research on the type of people who are entering the emerging specialty of psychiatric intensive care nursing. Some published reports suggest that the adoption of authoritarian approaches to patient care may actually increase the level of violence in psychiatric units (Brailsford and Stevenson 1973, Geen 1990, Lancee et al 1995, Owens and Bagshaw 1985).

Whittington and Wykes (1996) reported that interactions with staff which patients experience as aversive are frequent precipitants of violence in the psychiatric hospital. However, the level of violence in PICUs is generally quite low. If psychiatric intensive care staff did routinely browbeat and bully patients then the authors of these reports cited above would predict that these units were characterised by high levels of violence and aggression.

Training

Precise figures are hard to come by, but the trend in the UK seems to be towards an expansion in the numbers of psychiatric intensive care units. Currently there are no specialist ENB courses designed to train staff for this emerging specialty. The authors have been unable to find any other courses which specifically cover the short-term nursing care and management of severely disturbed and/or violent patients outside the forensic setting. Psychiatric intensive care remains a little known and poorly understood concept, even within psychiatric nursing, despite a growing body of literature demonstrating the positive therapeutic and organisational value of these units.

Staff Issues

In general, in well run units, the level of violence which staff encounter will be fairly low, but stress and frustration arise from many other factors besides violence and aggression.

Staffing levels

In controlled environments there are always conflicts between security needs and the demands of therapy. PICUs are not immune to the staffing crisis that affects other psychiatric specialties. When staffing levels fall, care may become secondary to custody (Gentle 1996). However, in the PICU, the low-level physical security largely relieves nurses of what Montgomery and Johnson (1996) described as 'the necessity of intensive one-to-one vigilance' to prevent disturbed patients absconding and possibly harming themselves or others.

Decision Making

In managing very disturbed patients, staff members often have to make decisions on the spot with relatively little opportunity to think through a range of options. Staff in the PICU work with some of the most disturbed and challenging patients within the psychiatric system. On bad days, staff may feel that the PICU is simply a dumping ground for the most difficult patients (Gentle 1996). This intense interaction and contact with disturbed patients can be very draining and stressful for the individuals concerned.

Staff Support

The importance of training, preparation and good staff support should not be underestimated. Debriefing after incidents may help to maintain morale. However, staff may sometimes avoid post-incident discussion and reviews because these sessions can arouse strong emotions and conflict between staff members. In small units such as the typical PICU, effective clinical supervision is vital in resolving these tensions and preventing burnout.

Patient Care

Given the very brief length of stay in many units, PICU staff may feel that they are working on a production line. Staff work hard to stabilise a patient, then transfer that patient to an open ward, and immediately admit yet another disturbed patient (or sometimes rapidly re-admit the same patient). The severe national shortage of acute psychiatric admission beds, also sometimes results in patients being admitted inappropriately to the PICU.

Patients who need inpatient psychiatric care but who do not need the specialist skills

Mental Health

REFERENCES


and environment of the PICU may sometimes be admitted there because there are no locally available acute psychiatric admission beds.

**Patient and staff satisfaction**

Many patients appreciate the care offered by the PICU. They find the high levels of staffing calming and supportive (Carney and Nolan 1975). They also often feel reassured that their distress can be contained (Goldney et al 1985). For staff there can be considerable satisfaction in giving ‘intensive care’ to patients, using advanced skills and in seeing disturbed patients improve over the space of a few days (Musisi et al 1989). PICU nurses are often very aware of the positive therapeutic effects of a controlled environment and close patient contact (Montgomery and Johnson 1996).

However, a small number of patients are distressed by being placed in the PICU (or ‘locked up’ as they see it) and require repeated reassurance from staff that they have done nothing wrong, and that the PICU is a specialist therapeutic unit and not there to punish them. For staff with a strong therapeutic ethos, it can be distressing to be perceived as a gaoler.

**PATIENT ISSUES**

**Readmission**

Many of the patients of the modern PICU have recurrent or relapsing psychotic illnesses with relapses characterised by disturbed and aggressive behaviour (Citrome et al 1994). These patients often have repeated admissions to hospital. In 1979, Crain and Jordan reported that over a six-year period, 40 per cent of patients were readmitted to their PICU. More recently, Citrome et al (1994) reported a recidivism rate of 35 per cent over an eight-year study period. As well as readmission with successive relapses, it is not uncommon for patients who have been stabilised in the PICU to be referred back to the PICU within 48 hours of transfer to an open ward. This suggests that many of the factors which influence aggressive and other ‘difficult-to-manage’ behaviours may be at least partly of environmental origin (Drinkwater 1982).

This is also evidence that symptomatic improvements in the PICU must in part be due to the intensive nursing care of patients, coupled with the effects of a carefully managed ward environment – and not just to the effects of medication. The authors also have experience of former patients requesting readmission to the PICU when they recognise that their symptoms are growing out of control and they fear being unable to resist dangerous or suicidal impulses.

**Transfer**

Patients are often disrupted and frightened by transfers between wards. Armond (1982) reported that transfers may unsettle patients and lead to escalation in violent behaviour. Relocation may be very stressful for patients. They have been in a ward with only three or four other patients, locked doors and largely one-to-one nursing, with the opportunity for privacy. Then they are moved to a busy ward, with many people coming and going, open doors, few staff, and usually 20-30 other patients. They need psychological preparation to reduce the risks of rapid loss of control and deterioration in mental state. This preparation may include:

- Escorted walks
- Familiarisation visits to the destination ward before transfer
- Beginning occupational therapy away from the PICU.

**CONCLUSION**

There are three urgent needs in this specialty:

- PICU nurses must network more effectively
- More research and publication in this area of growing importance in the field of mental health nursing.

Teamwork, good leadership and strong team cohesion are paramount for the PICU to work effectively. Adequate funding is vital, as is the maintenance of an appropriate skill-mix, since violent incidents may occur with little warning and there may be no time to meet as a team, discuss alternative courses of action and plan interventions. A cohesive, practised and mutually supportive team can achieve a high level of anticipatory co-operation. In the new psychiatric intensive care units described by Lehane and Rees (1995) and Saverimuttu (1996), time and money have been invested in team building and in agreeing internal policies, philosophy, standards and procedures. Gentle (1996) gives a good illustration of the problems with morale that can arise through poor planning and preparation.

Team building helps staff gain better knowledge and appreciation of each other’s strengths and weaknesses. This is valuable in promoting the development of individual and group coping strategies and ways of dealing with incidents. The development of good non-verbal communication can make a real difference to the occurrence of injuries when confronted by violent patients. In such an environment it is important that staff consensus is achieved, as far as possible, in the planning and delivery of care. Team building may also help PICU staff to overcome feelings of isolation from professional peers that can arise for nurses working in a small – and often poorly understood – specialty area (Montgomery and Johnson 1996).

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