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## Editorial

# What are PICUs for?

Len Bowers

*Professor of Psychiatric Nursing, Institute of Psychiatry, Kings College London*

It is probably true to say that the traditional PICU, the type that provides a service to acute wards by taking their most risky and disturbed patients, is under threat. Or at least, that the role of PICUs within a standard psychiatric service is showing signs of significant change. The pressures giving rise to this are, I believe, threefold. Firstly significant numbers of mentally ill people are being transferred from prisons into PICU care, reducing the available beds PICUs have to accept transfers from acute wards. Secondly, the majority of UK acute psychiatric wards are now permanently locked. As many transfers used to be justified by the risks of absconding, and locking wards is perceived as an effective way to abolish absconding, the need for PICU support may have declined. Thirdly, many hospitals are now opting for a service configuration based on a triage ward (as an intake for all admissions) coupled with slightly longer term treatment wards that take those not discharged promptly from the triage ward. As the triage wards have higher nurse staffing ratios, smaller bed numbers, etc., it is easy to see how they could, with some adjustments, replace the necessity for having a PICU support service at all.

Setting aside judging any one of these pressures, whether they are right or wrong, whether they represent a good or a bad thing, it is legitimate to ask what the outcomes are of the traditional PICU support role to acute wards? Do PICUs work? Are they effective? Are they cost efficient? The evidence from my research group published in this issue suggests not (Bowers et al. 2012). Acute wards in hospitals that have no, or a restricted level of, PICU support do not experience higher levels of disturbed behaviour, controlling for all other factors. These findings have made me rethink completely what PICUs as a support service to acute wards may be for, what their purpose is. Because settling this question has to come before trying to gather evidence on whether that purpose is achieved successfully. As I began to think through this issue again, a number of new thoughts started to emerge.

Up to this point, my assumption had been that the primary purpose of PICU care was the suppression of aggression, and therefore

Correspondence to: Professor Len Bowers, PO Box 30, David Goldberg Building, Institute of Psychiatry, Health Service and Population Research, De Crespigny Park, Denmark Hill, London SE5 8AF. E-mail: len.bowers@kcl.ac.uk
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that transferring potentially aggressive patients from acute wards to a PICU was an endeavour to prevent the aggression from occurring at all. The mechanisms underlying this were, I thought, the greater observation leading to faster intervention from staff, the larger numbers of staff making patients less likely to attempt the aggression for fear of rapid intervention, and the highly structured milieu of the PICU producing more organised behaviour from patients. Hence a legitimate outcome measure for PICU efficacy would be an overall reduction in violent incidents and through the removal of patients most likely to be violent, more peaceful acute wards. Yet this impact was not demonstrated by our research. Violent incidents on acute wards with good PICU access were not less frequent. Our research is, of course, only one study, with a sample of only 136 wards, and with many potential methodological deficits; and one study alone never proves anything for certain, replication is required. Nevertheless, this was an uncomfortable and unwanted finding from my point of view, and I would have been far happier if I could report that PICU provision was associated with very real reductions in aggressive behaviour on affiliated acute wards.

While numbers of incidents might not decrease substantially, transfers to the PICU might move the most risky patients to an area where early and robust intervention makes injuries to other patients and staff less likely. Thus the primary outcome to assess would be the number and severity of injuries, rather than the number of violent incidents per se. We did not have this data for analysis in our study, and we recommend that future studies make sure that they do.

Alternatively, the purpose of PICU care might be construed as the delivery of more intensive treatment to those in most need. Thus the most acutely psychotic and disturbed patients are transferred so as to benefit from a richer skill mix of staff, with more time for individual patients and more opportunity for therapeutic intervention. The outcome measure for PICU care would then be more rapid treatment gains for PICU patients, a speedier and more extensive recovery and rehabilitation of the patient. I would be more persuaded of this if I had seen more UK PICUs that had rigorous, detailed and intensive therapeutic programmes extending beyond the mere pharmaceutical. Things like complex behaviour modification programmes, detailed behavioural analysis, cognitive behavioural work, individualised activity programmes, anger management programmes, social skills training and rehabilitation activities with rigorously measured outcomes, and a range of other individual and group psychotherapeutic interventions, etc. I deeply wish I would see such things more often, and not just on PICUs. Nevertheless, the purpose of the PICU could be construed as more effective and efficient treatment.

Yet another way to regard the service a PICU provides is to see it as a more secure care area than the acute ward; in other words that the purpose of the PICU is to prevent absconding by more risky patients. Although increasing numbers of acute wards are becoming permanently locked, their level of security remains lower than that of acute wards (Nijman et al. 2011), and high staffing ratios increase the intensity of supervision on the PICU. Acute wards have high numbers of forensic patients, with about a third having a previous conviction for assault and two thirds a criminal record (Hodgins et al. 2007). Coupled with the increasing number of transfers from prisons to PICUs, this might begin to indicate that the acute inpatient care system is more than ever a branch of forensic psychiatry, and that PICUs actually represent a higher security category of ward equivalent to a higher category of prison. Higher physical security is related to lower absconding rates (Bowers et al. 2008; Stewart & Bowers, 2011), however in our report in this issue, although transfers to PICU care were associated with absconding, PICU provision was not associated with reduced rates (Bowers et al. 2012).

It may be the case that PICUs do not reduce violent incident numbers on acute wards, and it remains an open question as to whether they reduce the risk of staff and patient injuries. Yet they might still have other beneficial impacts



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on the acute ward that transfers disturbed patients out. For example, the sustained, complete and utter mayhem a manic patient can cause on an ordinary acute ward has to be seen and experienced to be believed. The transfer of such a patient may have a dramatic impact on the ward atmosphere for the remaining patients. They might feel safer (even if, in reality, the chances of an assault had not substantially diminished). Treatment and activity programmes might run more effectively and efficiently. The stress on the remaining patients may well diminish, and the connection between stress and symptoms is well established. The purpose of the PICU might thus be construed as improvements to the comfort and effective treatment of the patients left behind on the acute ward. Once again, further research is needed to assess whether these potential benefits are actually delivered in the real clinical world.

However there is another less comfortable and more difficult to express potential function of the PICU. It may exist to bolster the moral order of the hospital, in that it allows sanctions or consequences for bad behaviour. The purpose of PICUs might thus be to produce justice, and it is perhaps no coincidence that almost universally, whatever hospital you go to, in patient parlance the PICU is referred to as 'the punishment block' where you get sent if you do 'something bad'. Where a PICU transfer is possible, a patient who has seriously assaulted a fellow patient or nurse can be removed from immediate contact with the victim and those who may have been seriously frightened. The continuing presence of such a patient on the ward where the assault occurred is exceptionally difficult for everyone to manage, due to the residual feelings of anger and fear, coupled with the perception that there have been no consequences for the patient. The situation generates a certain degree of natural outrage that is resolved when the perpetrator is transferred. There is a huge sense that 'something has to be done', and transfer to PICU can be that something.

It would seem that even though we work within a psychiatric system that accepts patients are found not guilty of crimes due to mental illness, when it comes to the hospital and regulating patient behaviour, we are unable to let go of the moral order. All patients are held to account by staff, they are told not to damage hospital property, for example, and if they do we remonstrate with them about how wrong it is, and many staff would like to see patients pay for the damage they cause. Many hospitals promote policies that seek the prosecution of patients who assault others. So it is plainly visible that to some degree we struggle with believing the morality of the very psychiatric system we work within. Perhaps this also somewhat explains the complex relationship between seclusion and PICU care we describe in our paper, as both are based on the exclusion of patients from the acute psychiatric ward. If this is how the purpose of PICUs is to be construed, very different outcome measures would apply to its evaluation. The most important of these might be the perceived legitimacy of the authority of the hospital and the professionals within it. However, my own previous research would imply that perceived legitimacy results in reduced violence. If PICUs enhance perceived legitimacy, we failed to find that beneficial outcome in that research.

If PICUs are to be construed as bolstering the moral order, we could choose two different roads. We could go along with supporting the moral order in a more thoroughgoing way. It has been suggested that wards could set up some form of informal tribunal or court (Crichton, 1997; Alexander & Bowers, 2004). Difficult behaviour on wards, particularly rule breaking, might be better managed by setting up hearings in front of staff and patient representatives, where patients who had broken the rules could be held to account and required to explain their actions. Such a process would certainly make explicit the moral order, and would be rather similar to what has operated in many therapeutic communities.

Alternatively, we could choose to make a full commitment to our therapeutic ideology. Let go of moral judgments of patients, instead seeing all their behaviour as the working out of their internal pathology and something to be worked with therapeutically. Thus, after



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any assault, the correct response would be in depth discussions with the patient to work through with them why they did what they did, how they perceived the incident, how other people perceived them and their behaviour, what the consequences of that were for them and how other people treated them, how that would work outside in the real world, exploring with the patient how they could change and grow. This is, after all, what should happen in a post incident debrief of the patient, and yet I have never yet heard of it happening within the context of a busy and frenetic acute psychiatric ward. This might even be the most efficacious way forward, as it would seem that 'punishment' and 'consequences' do not often work really well to change future behaviour. Either approach might significantly reduce the necessity for PICU care if, in fact, justice was a PICU's main purpose.

None of the potential purposes of PICUs that I have outlined above are mutually incompatible. PICUs might actually fulfil any or all of these roles to some degree, and future evaluative research needs to take this into account. Perhaps it is not possible to determine with complete certainty what the purpose of a PICU actually is. Instead this might be something that we have to choose through how we use them, who is transferred to them in what circumstances, and how we choose to talk about them.

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