skills have been overlooked and there has been stereotyping of attitudes within the ward team towards occupational therapy as the provider of a basket making 'Butlin's' approach of keeping everyone happy and busy. It would be a great pity if the same were to happen in the community and such skills already available were not fully utilised.

Within the present drive to create a more effective and efficient NHS, more and more professionals are being asked to determine their value and state their 'core skills'. This accounting for oneself can produce anxiety, frustration and uncertainty in all professions, who feel their role is being eroded and perhaps others will be identified as more effective or cheaper alternatives. It is essential to the effective functioning of the multidisciplinary team that there exists a respect for each profession and the skills they have to offer. It is hoped that such a respect may develop for occupational therapists who have a useful range of skills to offer in the provision of a wide ranging comprehensive community mental health service and that it may no longer be the forgotten speciality in psychiatry.

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Psychiatric intensive care after two years

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The following is a descriptive study of Willoughby Ward, a psychiatric intensive care unit, opened in Parkside Hospital, Macclesfield, in July 1986. It provides a moderately secure facility for the treatment of psychiatric patients within both Crewe and Macclesfield Health Authorities. The unit has 15 beds, of which two are funded and used by Crewe area, where, unlike Macclesfield, the psychiatric unit is located in the district general hospital. Managed as a locked ward, the patients are admitted under the provisions of the Mental Health Act 1983. As well as being mentally ill as defined in the Act, the patients were disturbed to a degree as to be unmanageable in open conditions.

The unit has a high nursing staff to patient ratio, with at least one nurse to every 2.5 to 3 patients, there being always at least four nursing staff present during the day, and three at night. Treatment programmes were tailored to the individual needs of the patients, and their progress regularly monitored.

The unit was funded by the Regional Health Authority, the total ward budget being £202,386 per annum, including funds from Crewe area for two beds. This budget covered all ward expenditure.

In the two years studied, there were 40 admissions, of which 80% were single, almost 70% male, and 90% unemployed. The mean age was 37.5 years, with a range from 18 to 61 years. Forty-five per cent were admitted under Section 3 of the Mental Health Act, 22% under Section 2, 16% under Section 37, 8% under Section 35, and 6% informally. There were none admitted with a restriction on discharge, unlike those admitted to the Interim Secure Unit at Rainhill Hospital, which reflects their differing functions (Higgins, 1979). Willoughby Ward copes primarily with those who are difficult to manage, and the interim secure unit caters for patients who are a serious immediate danger to the public (Basson & Woodside, 1981; Higgins, 1981).

NHS hospitals accounted for 67% of referrals, with 22% from the penal system, 8% from special hospitals, and 3% from community agencies.

Of our patients, 57% were schizophrenic, 22% had organic psychosis, 16% were personality disordered and 5% had bipolar affective disorders. The high rate of organic psychosis was because the David Lewis Centre for Epileptics, a national centre for epileptics, was within the catchment area, and referred

some patients to the unit. The diagnostic categories were similar to those found in the interim secure unit, and it appears that it is the severity rather than the nature of the illness that determined to which unit the patient was referred (Higgins, 1979; 1981).

Of those admitted, 57% had a history of previous convictions, and in 62% it was the precipitating cause of the admission. Of these, 27% had a history of destructive behaviour, 13.5% of moderately violent crime, 13.5% of minor offences and 11% of arson. Of those with a history of psychosis, 50% had previous convictions, while of the 18% with a primary diagnosis of personality disorder 80% had previous convictions (Bluglass, 1978; Basson & Woodside, 1981).

During the period studied the discharge rate was 70%, the majority being transferred directly to the community (46%), or to other hospital beds in less secure settings (46%). There were no referrals from the catchment area during this period to the more secure units of the region.

The mean length of stay on the unit was 27 weeks, those with a diagnosis of mental illness spending on average ten weeks less than those with personality disorders, and offenders spending about one month longer than their non-offending counterpart. Of those admitted from the Macclesfield area, 50% were discharged home, while of those from Crewe the rate was less than 20%. At the time of writing, Crewe patients accounted for 39% of those on the unit, while funding was for 13%. Their average duration is two weeks longer, 20% are re-admitted, and at present 50% of all their referrals remain on the unit, which is probably due to the lack of long-stay facilities in that area.

Comments

The experience that we gained may be helpful to other hospitals attempting to establish similar units. Our approach to the management of this rather difficult group of patients has allowed an unobtrusive integration of a unit with secure facilities into an open psychiatric hospital, local community and forensic psychiatric services. We have not had many of the problems reported by others, such as difficulty with staff recruitment, security problems, or increases in absconding.

The annual funding of £202,386 includes funding for two beds (13%) by the Crewe district. However, as they occupy 40% of the total beds this source of funding must be increased to a realistic level covering five beds, a figure which is likely to increase in the future because of their lack of long-stay facilities.

The unit's function is to deal with difficult patients – either in a short or longer term basis. This costs £13,500 per patient per year, contrasting with £4,700 on admission wards, or £3,000 on long-stay wards (assuming 100% bed occupancy). The differences are misleading, as intensive observation of disturbed patients on acute wards has decreased, reducing their total budget. Accepting this, the difference remains considerable. However, the alternatives of transferring such patients to units of higher security would be inappropriate and more expensive, while reducing the budget would result in a reduction in staffing levels with a return to custodial type care, creating more long-term problems, by decreasing the discharge rates.

In view of the current political climate with plans to close long-stay mental hospitals and to integrate the psychiatric services into the district general hospitals, we feel that given our discharge rates and destinations the future of our unit is guaranteed. Even with very extensive programmes there will always be a small number of patients for whom long-stay hospital care is the only solution. In the scheme of placing patients in district general hospital psychiatric units there has been a total failure to recognise this fact, with the result that ordinary long-stay patients are becoming artificially 'forensified'. Should this continue, then the demand for units such as ours can but increase.

Although this is an expensive method of management of difficult patients, it seems the most cost-effective solution offered. We expect that, given the nationwide policy to close down mental institutions, the need for units such as ours will increase, as will the need for long-stay back-up facilities. Without such facilities, in the current political climate, there is likely to be an upsurge of inappropriate referrals to both interim and regional secure units, as well as to the penal systems.

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