MEDICAL PRACTICE

Contemporary Themes

Area security unit in a psychiatric hospital

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Since 1974 a psychiatric hospital security unit, designed to serve the whole catchment area, has cared for mentally ill (mostly psychotic) patients with disturbed behaviour that cannot be managed in open wards. There are a few long-term dangerous patients but most stay only briefly. The admission of women to the unit was not followed by the expected reduction in violence. The unit has facilities for occupational therapy, physical recreation, work, and study, which are particularly important for those who are too dangerous to leave it. The unit's calming influence depends as much on the supportive effect of the high staff ratio as on the use of tranquillisers.

This type of unit is not suitable for patients with personality disturbances who "act out" or for mentally abnormal offenders; but it functions well as a crisis centre for the disturbed mentally ill, and there is an increasing demand for its services.

Introduction

Although regional secure units for mentally abnormal offenders have received plenty of attention,^{1,2} little has been written about secure accommodation for the disturbed mentally ill within our hospitals. We describe here a hospital security unit in Shenley Psychiatric Hospital that serves this hospital and the

two general hospitals, Northwick Park and Central Middlesex, of its catchment area (Brent and Harrow—population 523 000). It began in May 1974 as a 30-bed, locked male ward with a static population and has developed into a 48-bed unit of two locked wards with a considerable turnover of patients of both sexes.

The unit's object is to help the area's hospitals with the management of disturbed behaviour in the mentally ill. There are two categories of patients. Most are "nursed in," usually for a month or less—that is, they are cared for in the unit as an informal and temporary measure and remain on the books of their ward or hospital of origin. A few, however, are formally admitted, and these are mainly long-stay patients. All patients are screened in hospital first—no one is taken directly into the security unit.

Wards and staff

The two wards provide different degrees of security. One accommodates patients who are occasionally or unpredictably harmful or who would otherwise abscond from hospital. The other, having a higher ratio of nurses to patients, takes both patients with acute mental illness who have gross short-term behaviour problems and patients who are continually harmful to themselves or others for longer periods. At any given time eight to ten patients are confined within the unit, but most move in and out under varying supervision.

During the day there are nine full-time nurses, of both sexes. A consultant psychiatrist attends for two sessions a week and a senior registrar for five sessions. Occupational therapists, a social worker, and a psychologist attend as required.

The patients

Nearly all the unit's patients so far have come from Shenley itself. The formally admitted patients tend to be young, static, and long stay. On 1 November 1976 the 37 admitted patients ranged from 21 to 69 years (mean 38.5) and had been in Shenley for a mean of 10.8 years. The 11 "nursed-in" patients stayed in the unit between 1 and 115 days (mean 20.6; mode 24 hours). There has been a considerable

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Bed complement and movement of patients in and out of security unit

	Bed No	Temporarily nursed in the ward	Admitted formally to the ward*	Total movements in	Discharges†	Deaths‡	Total movements out
1974-5	25	60	11	67	16	1	70
1975-6	25	66	8	72	8	2	73
1976-7	48	106 { M 81 F 25	16 { M 5 F 11	122	23 { M 19 F 4	0	98

*Some patients were admitted after being "nursed in."

†Includes three patients transferred to Broadmoor.

‡Includes two suicides.

turnover since the unit opened (table) because the "nursed-in" patients, though a minority at any one time, tend to stay so briefly. A quarter of the patients had more than one spell there in the first two years.

Nearly all patients are psychotic, mostly schizophrenic. In 1976-7 73% had schizophrenia or other acute psychoses, 8% manic-depressive psychosis, 8% personality disorder, 7% alcoholism, 2% epilepsy, and 2% other conditions. In our experience patients who act out and manipulate the hospital environment do not do well in a locked ward as their destructive traits are reinforced by the attention they are given. This is the reason for the small number of patients with personality disturbances; the few we have had did not stay for long.

Patients are transferred to the unit usually because of behaviour disturbance that cannot be controlled by conventional measures in a normally staffed open psychiatric ward, where nurses need to be protected from unacceptable levels of violence. Mentally abnormal offenders and patients with a special status (detained under sections of the Mental Health Act, offered by special hospitals, or taken to a "place of safety" by a police constable) are not automatically accepted but may be treated on the same basis as any other patient.

Women have been taken into the unit since August 1976. Contrary to expectation, violent behaviour has not diminished—in fact, violent incidents increased slightly (though not significantly), being somewhat more frequent among the women than the men. On the other hand, the introduction of women has not led to sexual misdemeanours, as some feared.

The therapeutic milieu

The calming influence of the unit depends as much on the supportive effect of the high staff ratio as on tranquillising drugs. Causes of disturbance are analysed and remedies worked out, and patients of both sexes can vent their aggression in a controlled way—for example, by means of physical exercise (see below) or even the destruction of worthless articles like old magazines, in combination with psychotropic drugs. Group meetings are held in each ward to involve patients in their own care; these prevent withdrawal and isolation and create social awareness, responsibility, and group identity.

Apart from the few who are confined within the unit, patients take part in the hospital's activities and social clubs, supervised as necessary. Those who are too dangerous to leave it, however, need a comprehensive programme of occupational therapy, industrial rehabilitation, and physical recreation. The unit therefore provides facilities for painting, modelling, and crafts, and encourages physical exertion with such devices as punchball, a cycling machine, and gymnastic equipment; there is also table tennis and space for outdoor ball games. Vigorous physical activity is important as it relieves tension and reduces the need for tranquillisers.

Work is also important, and a few patients have jobs outside Shenley. Within the unit the staff attempt to reproduce normal work situations to assess physical skills, perseverance, concentration, and time-keeping. This helps the patients' rehabilitation and subsequent return to employment. They can also pursue courses of study in a quiet room.

A unit of this kind can easily lead to dependence. Patients are, however, returned to their own wards as soon as their behaviour has quietened down, before they become greatly dependent.

Conclusions

The work of the unit has increased considerably during its first three years. There is clearly a need for this kind of short-

term care, in a secure unit with a high staff ratio, for temporarily violent patients, and so far we have always been able to accept such patients—who may need several spells in the unit. As the service becomes better known in the area the demand is bound to increase. The system would, of course, cease to work if the unit became "silted up" with patients no longer in need of its special facilities; but most have rapidly returned to their ward of origin.

The formally admitted patients are increasing only slowly. They are, however, a young and static population and will take up a large proportion of the beds for a long time.

A security unit must have a particularly wide range of facilities and expertise. The collaboration of doctors, nurses, occupational therapists, social workers, psychologists, and industrial therapists is therefore essential to its success.

Because of its policy, its situation within a hospital with liberal traditions, and its limited resources, our unit cannot provide custody for mentally abnormal offenders—though it may on occasion give them short-term care. Thus it cannot serve as a regional security unit, a special hospital, or a forensic unit with respect to courts and assessment for reports, though we foster links with all such units. Its function is perhaps best described as a crisis centre for the disturbed mentally ill, and this it appears to be fulfilling with some success.

We wish to thank Mrs J C Smith for secretarial help.

References

- 1 Committee on Mentally Abnormal Offenders, *Interim Report*, Cmnd 5698, paras 20 and 21. London, HMSO, 1974.
- 2 DHSS Working Party on Security in NHS Psychiatric Hospitals, *Revised Report*, para 33. London, DHSS, 1974.
- 3 Department of Health and Social Security, *The Management of Violent or Potentially Violent Hospital Patients*, HC (76) 11.

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WORDS APOTHECARY is the earliest English term for those who prepare and sell drugs. It is now archaic except for its use by the Society of Apothecaries, a body of distinguished doctors who confer a licence to practise medicine, the LMSSA. The term is derived from *G apo*, away; *thesis*, put; *Apothēkē*, a place where things are put away, a storehouse. Apothec is obsolete in English, but foreign equivalents are used; Ger *Apotheke*; Scand *apoteke*; Dutch *apotheek*. The French *boutique*, a special kind of shop, and the Spanish *bodega*, a storeroom, hence a wine-cellar, also stem from *apothēkē*. CHEMIST, short for pharmaceutical chemist, was the term used until recently, and it is still so used by the general public. Chemist derives from alchemist, alchemy being the pursuit in the Middle Ages of the transmutation of base metals into gold. This in turn derived from the Arabic *al khimia*, of obscure meaning. PHARMACIST, a word of Greek derivation (*pharmakon*, a drug or poison), has been the preferred professional term since the 1940s, and similar terms are used in all Romance languages (*F pharmacien*). The Spaniards use both forms: *farmacia* and also *botica* and *boticario*; a *bodega* for drugs, as it were. DRUGGIST is of mainly Scottish and American usage. The word pharmacy has not caught on with the public. They still get their drugs—sorry, medicines—at the DISPENSARY in the hospital and at the CHEMIST's in the high street.