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Original Paper

Characteristics of low secure units in an English region: audit of twenty mental health and learning disabilities units for patients with severe challenging behaviour

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Abstract

Aim: To survey the twenty low secure mental health and learning disabilities units in the South Thames Region.
Method: Ward Managers were interviewed and data gathered on: (1) Buildings and security; (2) Beds; (3) Staffing; (4) Therapeutic activities; (5) Policies; (6) Issues of concern.
Results: Learning disabilities units tended to be smaller, older and not purpose built with more issues of security and observation. There was an under provision of Clinical Psychology, Occupational Therapy and Social Work staff.
Conclusion: Any issues of concern raised by staff tended to reflect any structural and staffing deficiencies.

Keywords:

Low secure units; challenging behaviour; low secure mental health units; low secure mild learning disabilities units; national service frameworks for mental health

INTRODUCTION

A number of surveys have been performed looking at medium secure mental health and learning disabilities units (e.g. Brooke, 1998). There is little, if anything, written about the characteristics of low secure learning disabilities units.

Beer et al. (1997) have surveyed psychiatric intensive care and low secure units in the United Kingdom. The current survey describes both the mental health and the learning disability low secure units in one English Regional Health Authority (South Thames). This paper describes the units themselves. Another paper looks at the characteristics of the two hundred patients with severe challenging behaviour in the twenty units identified (Beer et al., 2005).

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METHOD

All low secure mental health (MH) and learning disabilities (LD) units were identified in the South Thames Region, using Department of Health, Regional and Local Trust sources. Issues which had been identified from Beer et al. (1997) survey

and further examined in Beer et al. (1999) and Beer et al. (2001) were used to identify standards to be audited. A questionnaire based on these was developed to address standards in the following areas:

1. Physical environment – airlock entry; reinforced windows, alarms system.
2. Beds – single bedrooms, gender specific, out of area patients.
3. Staffing – multidisciplinary team, ethnic grouping, training.
4. Policies – admission and discharge, control and restraint, seclusion.
5. Therapeutic activities – gym, activities area, art.
6. Any issues of concern.

These standards have subsequently been formalised by the Department of Health (2002) but its publication antedated the date when this survey was conducted.

The questionnaire was conducted by PMcG with the Ward Manager of each unit.

RESULTS

Units

There were three differences between the MH and LD units. (1) The LD units tended to be older: Four out of nine (44%) were over ten years old in contrast to only one out of eleven (9%) of the MH units. (2) Nine out of eleven (82%) MH units had strengthened window frames whereas only two out of nine (22%) of the LD units did. (3) Seven out of eleven (64%) of mental health units were purpose built but only four out of nine (44%) of LD units.

The other characteristics were broadly similar across MH and LD units:

19 out of 20 (95%) were 'stand alone' units; 8 (40%) had an airlock entry system; 17 (85%) had secure windows; 18 (90%) had limited opening windows; 17 (85%) had reinforced glass; 18 (90%) had an alarm system; 8 (40%) had a seclusion room; 3 (15%) had an intensive care area; 18 (90%) had access to a garden; 10 managers (50%) expressed satisfaction with the unit's security.

Beds

There were three differences between the LD and MH units. (1) Five of the MH units (45%) had designated beds for women patients compared with one out of eight (12%) LD units. (2) The LD units tended to be smaller, with four out of nine (44%) having five to nine beds, compared with one out of eleven (9%) MH units. Most of the MH units – nine out of eleven (82%) had 10 to 15 beds whereas only four out of nine (44%) of the LD units had 10 to 15 beds. (3) Four out of nine (44%) LD units accepted out of area patients whereas only one out of eleven (9%) of the MH units did.

In other respects there was little difference between the two types of units:

Nineteen out of twenty (95%) had single bed rooms; seventeen out of twenty (85%) were mixed gender; bed occupancy was 100% in fourteen (70%) units and over 80% in all units. Patients were sent out of area from eleven out of twenty (55%) units.

Staffing

There were three differences between the LD and MH units. (1) Six out of eleven (55%) MH units had four or more sessions per week of Occupational Therapist's input, whereas only two out of nine (22%) of the LD units did. (2) On mixed wards the ratio of male to female staff exceeded 2:1 on five out of eleven (45%) of MH units but only one out of nine (11%) of LD units. (3) Six out of eleven (55%) MH units had a whole time Consultant Psychiatrist, whereas only three out of nine (33%) LD units did. This finding may reflect the fact that the LD units tended to have fewer beds.

Other findings were similar across units:

Thirteen out of twenty (65%) had a Specialist Registrar or Associate Specialist; fifteen (75%) had an SHO or Staff Grade; only two (10%) were run by a Consultant Psychiatrist only. Only six (30%) had four or more sessions per week from a Clinical Psychologist and seven (35%) four sessions per week from a Social Worker. Seventeen (85%) said they had recruitment and retention difficulties. Seventeen (85%) said their staff ethnic grouping satisfactorily reflected that of the patients. Eight (40%) said that nursing staff had supervision on a weekly basis.

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Training including in Control and Restraint was reported as occurring in 18/20 (90%) of units. The ability to attend relevant courses was reported as occurring in 17/20 (85%) of units.

Policies
Most of the units had policies on:

1. Admissions and discharges (18/20; 90%);
2. Control and Restraint (19/20; 95%);
3. Seclusion (15/15 who used seclusion; 100%);
4. Illicit drugs (18/20; 90%);
5. Neuroleptic drug use (14/20; 70% but only 5/9 (55%) LD units);
6. Searching of rooms and patients (18/20; 90%).

Therapeutic activities
17/20 (85%) had access to a gym; 8/20 (40%) of which was a regular activity; 19/20 (95%) had an activities area; 16/20 (80%) had access to art; 12/20 (60%) had a patient support group at least every fortnight.

Areas of concern expressed by unit managers
9/20 (45%) were concerned about lack of facilities for patients; 9/20 (45%) about the building making security or effective observation of patients difficult; 11/20 (53%) said recruitment and retention was an issue; inappropriate patient mix was rated as a problem in 10/20 (50%) units; lack of management support was only mentioned in 2/20 (10%) units.

DISCUSSION

Positive features of these units
Given that this is a challenging group of patients to manage, it is encouraging that most of the mental health units are purpose-built, have been open less than ten years and have adequate security. Single bed rooms are found in the vast majority of all units.

Medical staffing appears to be adequate. The ethnic grouping of nursing staff appears to reflect that of the patients. Staff have regular training e.g. in Control and Restraint and can attend courses. Supervision of nurses is occurring in a significant minority of units as frequently as every week. The vast majority of units had policies covering the main clinical risk areas.

Differences between MH and LD units
Although many of the characteristics are shared by both mental health and learning disability low secure units, there are some differences between the two:

LD units tended to be older and smaller in terms of bed numbers; LD units were less secure in terms of window frames; LD units did not designate beds for women patients; More LD units accepted out of area patients; LD units had less Occupational Therapy input and tended not to have a whole-time Consultant Psychiatrist, and LD units had higher female/male nursing staffing proportions.

Issues of concern
Staff raised a number of issues of concern, most of which were borne out by the results of the questionnaire. Security and ease of observation were considered to be issues by 9/20 (45%) and can probably be explained by only 11/20 (55%) units being purpose-built.

Inappropriate patient mix was considered to be an issue in 10/20 (50%) of units and these tended to be those units without beds designated for women though.

Lack of facilities for patients was mentioned in 9/20 (45%) units. Most units had access to a gym, a garden, an activities area and an art room. However, the relative lack of Occupational Therapists (only 8/20 40% had four or more sessions per week) means that the greater range of activities needed for this group is often lacking.

Recruitment and retention is a common problem mentioned (10/20 50% of units). Lack of management support was not a common problem expressed by Ward Managers. It is possible that this may have been an issue for other grades of staff but they were not the subjects of the interview.

A particular issue of staffing to be noted is the relative paucity of Clinical Psychology and Social Worker contribution to the multidisciplinary team. Given the complex nature of the patient's challenging behaviour and the difficulty in finding suitable placements after treatment in such units, these findings are of concern.

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Bed occupancy is very high which means that access to these units can rarely be obtained in an emergency.

CONCLUSION

There are many positive features in the construction, staffing and therapeutic activities of low secure units. Some of the learning disabilities units are older and not purpose-built which gives rise to difficulties with security and observation. Recruitment and retention of nursing staff is a concern; and the under-provision of Occupational Therapists, Clinical Psychologists and Social Workers has implications for therapeutic activities, behavioural programmes and finding after-care for this challenging group of patients.

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