

Psychosocial support on the paediatric intensive care unit: A UK survey

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The results of a UK survey of levels of psychosocial staffing on PICUs and the mechanisms available for addressing psychological needs of families and staff show that the majority of units are regularly involving psychosocial personnel in patient care, although fewer than 20% have a regular psychosocial meeting. The provision of feedback to bereaved parents is routine but subsequent follow-up is more patchy, and staff debriefing after a death is provided in fewer than half the units.

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contacted by telephone to ensure that the data were representative.

INTRODUCTION

Patients on a paediatric intensive care unit (PICU) and their families are clearly a needy group from a psychological point of view. They are theoretically at an increased risk of developing post traumatic stress disorder symptomatology, since by definition they will have experienced an event that is both life threatening and outside normal experience¹. However, the literature on psychological adjustment to an intensive care admission is relatively sparse, which has led commentators such as Lloyd² to call for more research in this area and longer term follow-up of patients and their families. Such research as there is reports clinically significant levels of irritability and sleep disruption in parents, three months after their child's discharge³ but very little is known about the child's experience, although they are acknowledged to have a number of special needs relevant to their stay⁴.

In recognition of these issues the British Paediatric Association has, in a recent report⁵, recommended that, along with the provision of specialist paediatric nurses, units employ the services of psychosocial personnel to help address the needs of patients, relatives and staff. In this paper the results are presented of a UK survey into the present position regarding levels of psychosocial staffing on PICUs and the mechanisms available for addressing psychological needs both of families and healthcare workers.

METHODS

A brief questionnaire (TABLE 1) requesting details of the level of psychosocial support available was sent to all 26 PICUs in existence in the UK in June 1996, according to the records of the Paediatric Intensive Care Society.

The questionnaire addressed four specific areas:

1. Accessibility of psychosocial staff.
2. The degree to which units set time aside to discuss psychosocial needs of patients and their families and also whether they referred them on for these needs.
3. Staff support arrangements.
4. Follow-up arrangements in the event of bereavement.

The questionnaire was sent out in three waves over a three month period. Those units which had not replied were later

RESULTS

Questionnaire response rates

The initial response to the postal questionnaire was good with 19 units responding (65%). The response rate increased to 88% by the third wave which left only three units to contact by telephone. Eventually information was gathered from all units and can therefore be assumed to provide an accurate picture of the situation regarding psychosocial support on PICUs in 1996.

Psychosocial staffing

In total, 21 out of 26 units (81%) had at least one formally attached member of their team with specific responsibility for psychosocial aspects of care. This was most commonly a social worker, formally attached in 14 units (54%). A psychologist was formally attached in 8 cases (31%) whereas only 1 unit had a formally attached psychiatrist, although 15 units (58%) were confident that a psychiatrist was easily available if needed. In seven units (27%) there was a play therapist attached, but a further 11 units (42%) were able to get hold of a play therapist when necessary. In five units psychological liaison was seen as the role of a specifically appointed liaison nurse (FIGURE 1).

More generally, in terms of the facilities available to families, 21 units reported that they had space on or near the ward for siblings to play safely (81%) and all units stated that they had space available to talk privately with families.

Psychosocial meeting

Units were asked whether they regularly set time aside to discuss the psychosocial needs of patients and their families (TABLE 2). Significantly three of the five units which had no formal time set aside to discuss psychosocial aspects had a liaison nurse formally allocated. Part of the job description included keeping regularly updated on relevant psychosocial issues, commonly by daily bedside visits, arguably rendering a more formal meeting unnecessary. Of the 21 units that reported that they did make time available on a regular basis to discuss psychosocial issues, the majority did this within the

PSYCHOSOCIAL SUPPORT ON THE PICU

1. PSYCHOSOCIAL STAFFING

A. Please indicate whether any of the following psychosocial staff are attached or, if not, easily accessible to your unit

	Psychologist	Psychiatrist	Social Worker	Play Therapist	Bereavement Counsellor	Other (Please specify)
Formally attached						
Easily accessible (please tick)						

2. CHILD AND FAMILY NEEDS

A. Do you set time aside on a regular basis to discuss the psychosocial needs of patients and their families? Y/N
If Yes, please indicate how:

Within ward round	<input type="checkbox"/>	At a regular psychosocial ward round	<input type="checkbox"/>	Via occasional special meeting	<input type="checkbox"/>
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B. In the last year, has the ward made a referral to any of the following psychosocial staff?: (please tick)

	Psychiatrist	Psychologist	Social Worker	Play Therapist	Bereavement Counsellor	Other (Please specify)
For sick children						
For family						

C. Are there facilities on or near the ward for siblings to play safely? Y/N

D. Is there space on the ward to talk to parents in privacy? Y/N

3. STAFF SUPPORT

A. Do you have regular staff support groups? Y/N

If yes, which topic(s) would these address?
(please tick)

Bereavement	<input type="checkbox"/>
Work related stress	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>

Also, who would normally attend?

Nurses only	<input type="checkbox"/>
Doctors only	<input type="checkbox"/>
Nurses and Doctors	<input type="checkbox"/>
Other Please specify	<input type="checkbox"/>

B. Are staff offered debriefing after a child dies? Y/N

If yes,	Routinely	<input type="checkbox"/>
	Occasionally	<input type="checkbox"/>

And, who would normally provide this?

4. BEREAVEMENT

A. Are families offered a follow-up appointment after the death of a child?

Never	<input type="checkbox"/>
Occasionally	<input type="checkbox"/>
Routinely	<input type="checkbox"/>

If yes, how long after the death would this typically take place?

Who would normally attend? (please tick all that apply)

Nurse	<input type="checkbox"/>
Doctor	<input type="checkbox"/>
Psychosocial Staff (please specify)	<input type="checkbox"/>

B. Is further bereavement counselling support:

Not offered by hospital	<input type="checkbox"/>
Not offered but information given re services outside hospital	<input type="checkbox"/>
Available through the hospital if necessary	<input type="checkbox"/>
Routinely provided through the hospital	<input type="checkbox"/>

C. Does the hospital run a support group for parents after the death of a child? Y/N

If yes, how frequently does the group meet?

Any further comments on psychosocial support are welcome

TABLE 1. Questionnaire to determine the level of psychosocial support in PICUs.

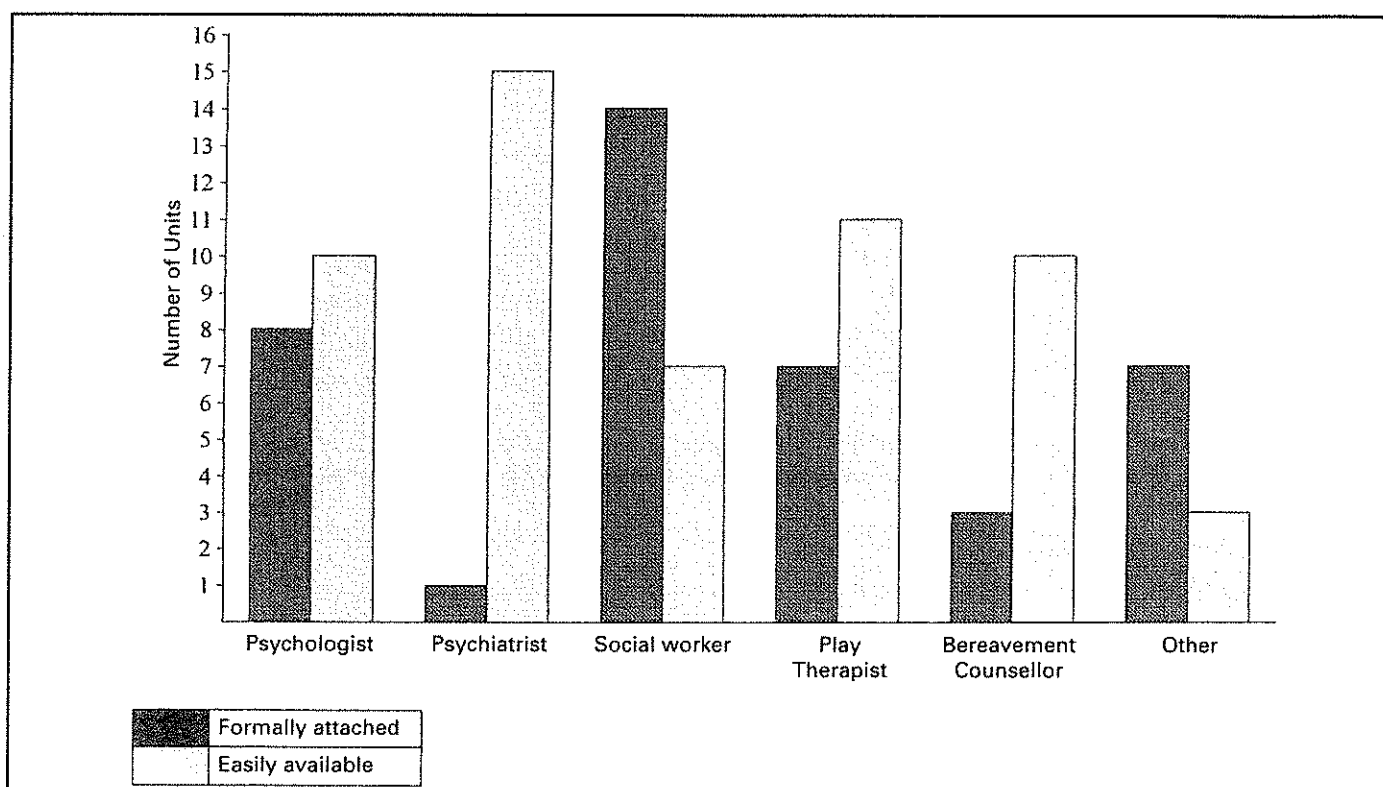


FIGURE 1. Psychosocial staffing levels on PICUs in the UK (n=26).

Type of discussion	No of PICUs
Regular psychosocial meeting	5 (19%)
Within ward round	8 (31%)
Occasional special meeting	4 (15%)
Combination of within ward round and occasional special meeting	4 (15%)
No regular time set aside	5 (19%)

TABLE 2. Regularity and format of discussion Re: psychosocial aspects of care on PICU (n=26).

Professional consulted	No. of PICUs referring	
	For child	For family
Psychologist	13 (50%)	10 (38%)
Psychiatrist	13 (50%)	12 (46%)
Social Worker	13 (50%)	20 (77%)
Play Therapist	17 (65%)	8 (31%)
Bereavement Counsellor	4 (15%)	10 (38%)

N.B: Data available for 24/26 PICUs

TABLE 3. Referrals to psychosocial staff over previous year.

medical ward round, sometimes in combination with occasional special meetings in particular cases.

Referrals to psychosocial staff

Units were asked whether they had referred either the sick child or a member of the child's family to a psychosocial professional in the previous year. The data available (which was for 24 out of 26 units) show that the vast majority (92%) had made a referral for a child in their care, and that all units had referred a family for further help. The profession most commonly referred to on the child's behalf was play therapy, with 17 units (65%) making such a referral, but around half of all units also reported referring children to a psychologist or psychiatrist. Of all professional groups, the social workers were the most likely to be contacted regarding family support, with 20 out of 24 units making such a referral over the past year. A smaller number of referrals were made, both on the child and family's behalf, to a bereavement counsellor (TABLE 3).

Staff support

Only half of the units surveyed reported that they held regular staff support group meetings. The topics discussed by these groups were predominantly bereavement and work related stress. In seven groups only nurses and doctors attended, but in the other six, staff from other disciplines were invited as appropriate.

Comments from a number of units without staff support groups indicated that this had been tried in the past but groups had lapsed due to lack of interest. There were also a couple of observations to the effect that although there was no formal staff support group as such, unit staff very much valued regular social occasions organised for them as a group.

In answer to a specific question about whether staff were offered debriefing in the event of the death of a child, 19 out of 26 units (73%) replied in the affirmative, but this was routine practice in only 11 units (42%). Debriefing was variously provided by medical staff, usually the consultant; by psychosocial personnel or by a combination of the two (TABLE 4).

Bereavement follow-up

All units reported that they routinely offered a follow-up appointment after the death of a child, except when it made more sense to ask a local paediatrician to provide bereavement follow-up eg when a family lived some distance from the PICU. Appointments were most commonly held with the consultant alone (n=11), although seven units indicated that a nurse would also attend and 8 units that a member of the psychosocial staff or the liaison nurse would normally be present in addition to the doctor. Of those units who gave details of the timing of this appointment (n=16) the majority (n=13) offered an appointment at around 6 weeks after a death.

A) Frequency of debriefing	
	Number of PICUs
Not provided	7 (27%)
Provided occasionally	8 (31%)
Provided routinely	11 (42%)
B) Profile of staff providing debriefing	
Medical staff only	5
Psychosocial personnel only	6
Combination of the above	8
Total	19

TABLE 4. Staff debriefing after the death of a child on PICU.

In terms of subsequent follow-up, only a minority of units routinely provided bereavement counselling, although this was available through the hospital by arrangement in most cases if necessary (TABLE 5).

A total of 12 PICUs (46%) reported that they were currently running bereavement support groups for parents. These were usually held at one to two month intervals although one unit held an annual group, combined with a remembrance service and two units mentioned additional groups they ran occasionally for siblings and for the newly bereaved.

Information only provided on services outside hospital	4 (15%)
Bereavement counselling available through hospital if necessary	15 (58%)
Bereavement counselling routinely provided	5 (19%)
Bereavement group for parents	12 (46%)
N.B: Data available for 24/26 PICUs	

TABLE 5. Bereavement support made available to families by PICUs.

DISCUSSION

These results indicate that the vast majority of PICUs in the UK are regularly involving psychosocial personnel in the care of their patients, although such personnel are not necessarily formally allocated to the units and, in some units, the work of support and follow-up is concentrated largely in one person's job description, namely that of the specialist liaison nurse.

It is encouraging that most units are setting regular time aside to discuss psychological aspects of their patients' care, but disappointing that less than 1 in 5 have a regular dedicated psychosocial meeting along the lines of a multi-disciplinary forum described in other paediatric settings⁶. This may, of course, relate to the size of some units, which may have only two or three beds occupied at any one time.

There was less emphasis on formal mechanisms for staff support, with a couple of units commenting that they would like to provide more, but had found the take up rate very poor. Research in this area shows that intensive care nursing staff groups can be more cohesive and supportive than other groups of nurses⁷, and it was clear from some of the comments that the kind of support most valued by staff was of a social nature

after work. It is important not to get complacent about the inevitable strain of this type of work and to make it a priority to foster the right sort of psychological climate in the unit. All levels of staff, including senior medical staff, should have regular opportunities to reflect on the effect their work has on their own psyches. In this connection it is appropriate to mention again the concept of the psychosocial meeting which often provides just such a safe space to air frustrations, and to catch up on discharged survivors or bereaved families with whom the psychosocial staff maintain contact.

Lastly, as would be hoped, units see it as part of their duty to provide feedback to bereaved parents. However there are wider issues about subsequent follow-up, particularly when a death has been very sudden and the family was not known to any other part of the health service prior to admission. The services available for bereavement support in the event of a child death are very patchy. In many cases the General Practitioner will be called upon to provide support for many months, if not years, after a child's death but it cannot be assumed that the family will want support from this quarter. Indeed a survey reporting on the concerns of parents at a six week follow-up bereavement clinic at Great Ormond Street Children's Hospital⁸, found that a significant proportion of families were not on speaking terms with their GP at this point, because they felt their doctor had been negligent in some way in the time leading up to the child's admission.

It is to be hoped that the involvement of staff from the psychosocial disciplines continues to grow as a direct function of its usefulness to units and that, in the future, the increased involvement of psychologists and psychiatrists in relevant research will lead to a greater understanding of the psychological effects of PICU admission on children and their families. Research is also clearly specifically needed both to establish whether psychological intervention has a demonstrable effect on later psychological outcome, and which groups of families are most at risk for adjustment problems and therefore, presumably, most in need of support.

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