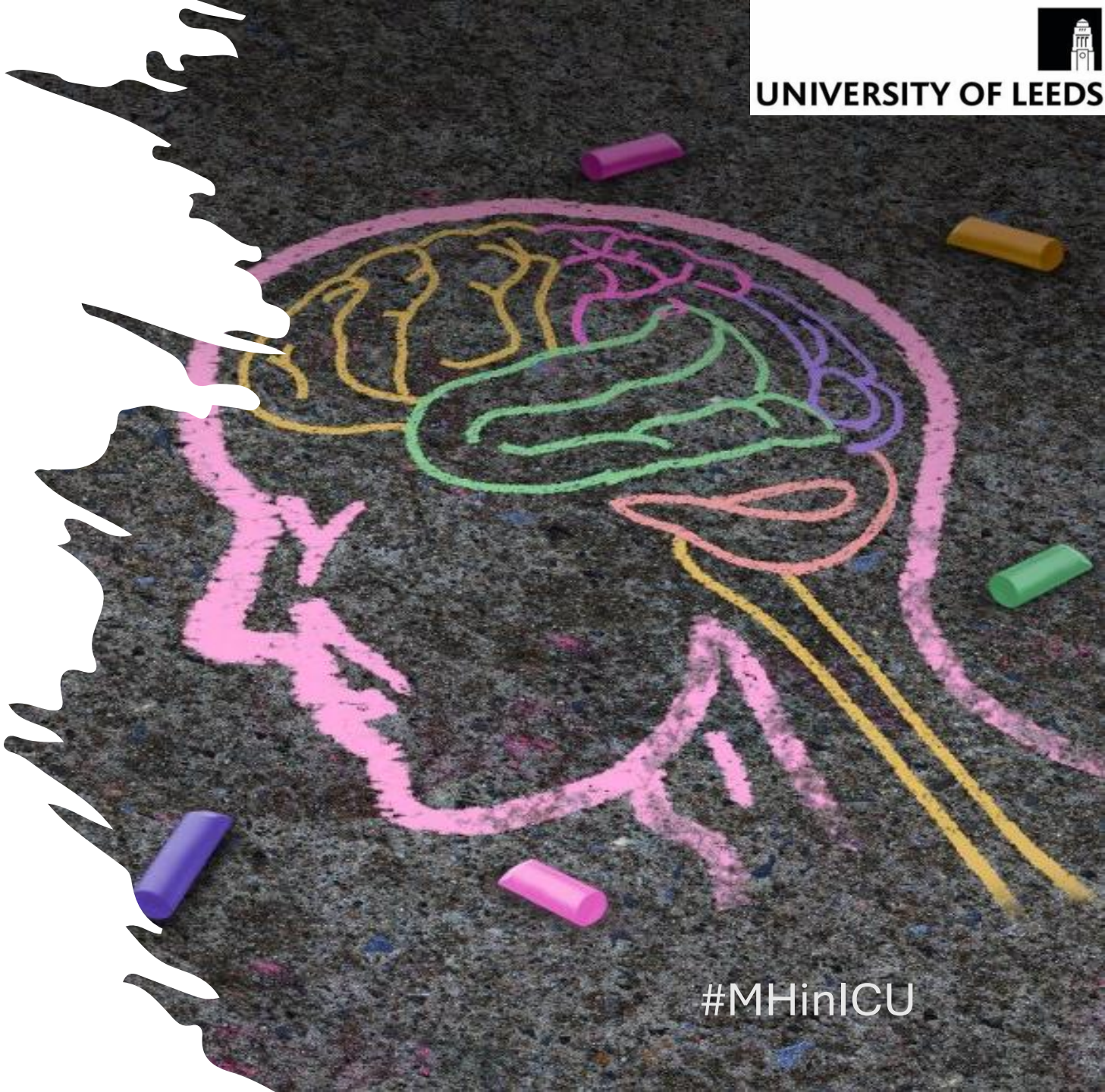
Exploring critical care nurses' perceptions and experiences of patients with co-morbid mental health disorders.

Dr Angela Teece & Professor John Baker
University of Leeds



Background

- The prevalence of patients with a MH disorder in intensive care units (ICU) is roughly twice that of other secondary care areas (King et al., 2020).
- This patient group can be disenfranchised from the healthcare system due to stigma (Corfee et al., 2020; Jacob et al., 2021; Perry et al., 2020).
- Nurses' perceptions of MH patients in the Emergency Department have been studied, and were associated with avoidance, misconceptions, and perceived lack of skills to manage this patient group (Sacre et al., 2022), however, it was unclear if similar issues were present amongst critical care nurses.
- An integrative review was undertaken in 2024. The search yielded only eight studies suitable for inclusion, of which six were empirical research. Four themes were identified:
- 1) 'Those types of patient', 2) Patients with mental health disorders are all violent and aggressive, 3) 'They' don't belong in ICU, and 4) 'They' need someone with special skills. The themes explored issues of preconceptions, stigma, and 'othering' (Teece & Baker, 2025).
- Recruitment began in June 2025 for a small qualitative study to explore UK nurses' perspectives and experiences.

Review results and the perspectives from my own study.

- The results from my review made for difficult reading – the language used by participants 'othered' MH patients and perpetuated stigma.
- This patient group were viewed with fear and lack of understanding or empathy.
- Participants described a lack of knowledge around MH patient management, and feeling unprepared to manage them in practice.
- **The initial results from my interviews feel quite different.** Participants have described similar feelings of fear and unpreparedness, but there is an eagerness to learn and develop practice. The language used was far more inclusive too, and changes in perspective were clear. MH was seen as a serious illness.

'Those kind of patients'

- **'Othering'** language was prevalent amongst the studies reviewed.
- Othering refers to the rendering of one group into one homogenous mass (**‘the other’**), then placing them in opposition to another privileged group who hold professional and social power (**‘the one’**, in this case, ICU staff).
- **Social difference** is therefore established and reproduced through methods such as the language used to subjectively describe patients with a MH diagnosis (Corfee et al., 2019).
- Patients were described variously as **‘the self-harmers’, ‘the suicide attempts’, ‘mental health patients’, ‘dangerous patients**’ (Patterson et al., 2023) and **‘these people’** (Corfee et al., 2019).
- Patients admitted following DSH were especially subject to stigma and othering. Corfee et al. (2019) noted that nurses appeared to regard them as ‘*ineffectual stewards of their own health concerns’* and **blamed** this patient group for their admissions.
- This language can be the result of **compassion fatigue** (Patterson et al., 2023).
- **In my study:** ‘Othering’ language was less prevalent, and MH patients we largely viewed with compassion.

Patients with mental health disorders are violent and aggressive

- Patterson et al. (2023) found that nurses associated **‘dangerousness’** with MH patients and believed that they were more likely to exhibit violent and aggressive behaviours. Such patients were assumed to **‘cause problems’**, and, in contrast to ICU patients without a co-morbid MH disorder, be culpable for any aggressive behaviour.
- Nurses described feeling 'nervous' when allocated to a patient with a MH disorder (Weare et al., 2019; Murch, 2016). Some of these feelings could be linked to stereotyping.
- A participant in the interviews held by Corfee et al. (2020) explained how MH patients need **‘double safety’** compared to other patients. This is achieved through the removal of devices which could be potentially used as weapons and having chemical and physical restraints within easy reach.
- **In my study:** There were clear concerns regarding the risk such patients pose to themselves and staff. Participants discussed the importance of being prepared and looking for sources of danger. Close supervision was advocated.

'They' don't belong in ICU

- The challenge of developing a **therapeutic rapport** between nurse and patient was linked to the physical ICU environment (Murch, 2016), with nurses commenting that they also **lacked time** to fully engage with the needs of a patient with a MH disorder (Weare et al., 2019) who had **‘complex emotional baggage and problems’** (Patterson et al., 2023).
- The physical environment was described as a **'foreign place'** (Patterson et al., 2023).
- A minority believed that DSH had no place in ICU: A participant in the interviews undertaken by Corfee et al. (2019) stated that ICU was **‘in the business of saving lives’**. A socially constructed image of ICU is placed in opposition to the stereotyped homogeny of MH patients.
- Such views are incongruent with the professional identity of the nurse, and may be linked to **burnout and cause further guilt and distress.**
- **In my study:** The ICU environment was regarded as unsafe and frightening. There was a clear acknowledgement that MH disorders are as serious as physical illness.

'They' need someone with special skills

- Nurses felt **inadequately prepared and skilled** to deal with patents with a MH disorder (Bone & Smith, 2012) and wanted **further educational support** (Murch, 2016).
- They expressed a fear of saying **‘the wrong thing’** (48.7%, *n*=19) (Weare et al., 2019) and a reluctance to approach the patient in case they caused them to become upset (Corfee et al., 2020).
- A participant in the Patterson et al. (2023) study commented that MH and ICU nurses have very different skillsets, and that **‘no-one feels equipped to manage a patient who sits in both spaces’.**
- Additional help was requested. This could be a registered mental health nurse (Weare et al., 2019) or a psychiatrist (Aktaş and Arabacı, 2023).
- **In my study:** There was an agreement that 24hr support from specialist MH services was required. Education was also suggested, but it was unclear how this might be delivered due to the vast scope of the topic.

Conclusions and further work

- I finished writing my review feeling quite despondent. I was ready to hear similar sentiments and ideas in my interviews, but that has not been the case.
- There is a clear appetite for increased education (but how, and where?), perhaps a clear care pathway, and increased input from MH liaison services. Nurses experience frustration with poor and patchy MH provision post-discharge from ICU which can lead to repeated and escalating admissions.
- There was evidence of inclusive language and practice, but an acknowledgement that this patient group has distinct needs.
- Some participants discussed educational initiatives or care pathway planning.
- I plan to finish analysis soon and write this study up for publication.
- **Next year, I hope to acquire funding to support a patient-focused study.**

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