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Editorial

Hard times in low security and psychiatric intensive care

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Storm clouds are gathering over the National Health Service (NHS) in the UK. As a consequence of the global credit crunch and economic downturn, there have been cutbacks across public services in the UK. The NHS has not been spared and, like other public services, is facing reductions in budgets which will affect both commissioning and provider organisations. Mental health budgets are often amongst the first to be targeted. This situation is not unique to the UK and will be familiar to clinicians worldwide.

In the UK healthcare staff are having to deal with pay freezes, reductions in pension benefits, no recruitment to vacant posts and redundancies. The Health Unions are advocating on behalf of their members and, for the first time in a generation, there is talk of sustained industrial action. It would not be surprising, therefore, if morale within the healthcare workforce drops. Low secure units (LSUs) and psychiatric intensive care units (PICUs) are challenging environments in which to work and rely on high morale to deliver effective care.

Along with the economic woes, unemployment has reached a 17 year high of 2.68 million with unemployment amongst the young being particularly pronounced. These difficulties are likely to have an adverse effect on the mental health of the nation and may lead to increased demands for mental health services. This will be difficult at a time when mental health services are being cut back.

Historically economic difficulties and rising unemployment are associated with rising crime rates. Although there have been plans to try to reduce the prison population in the UK, this has not been achieved. Nevertheless this remains the longer term plan and it is likely that LSUs will form part of the strategy to reduce the prison population by offering an alternative to custody for mentally disordered offenders.

The Department of Health is due, imminently, to publish new guidance on standards and usage of LSUs. It is widely expected that LSUs will be required to either affirm that they meet the new, higher, standards in order to continue as LSUs or to rebrand themselves as 'locked recovery units'. For units which might struggle to meet the new standards, this latter option is likely to be preferred. As such it is anticipated that LSUs will become more forensic in their focus and may move closer, in both structure and function, to medium secure units.

In addition, commissioning arrangements for LSUs are changing. It is now confirmed that in England commissioning will move away from local commissioners to a National NHS Commissioning Board. This is likely to lead to more consistent commissioning arrangements across the country with less variation in practice between different LSUs.

With such changes it is vital that clinicians remain engaged in influencing the commissioning process so that their experience and knowledge of delivering services can help commissioners to commission high quality services.

Whilst there may well be advantages to a more centralised commissioning structure it is also important that patient centred care remains centre stage within both commissioning and delivery of care. To this end it is hoped that centralised commissioning still allows for the commissioning of services that are responsive to local need.

So, for many reasons, these are challenging times. The financial difficulties will require that treatment in LSUs and PICUs is as efficient as possible. Such efficiencies will require best use of the evidence base. This Journal, through publishing contemporaneous research and articles on current practice, will assist clinicians and commissioners in delivering high quality and efficient care.

On that theme, this issue of the Journal contains a number of interesting articles on diverse topics such as psychopharmacology, patient safety and risk assessment. Of particular interest are a thought provoking article by Innes (2012) on how, despite NICE guidance, there remains wide variation in the physical monitoring of patients who have received rapid tranquillisation, and a piece by Øvreeide & Bervoets (2012) describing psychiatric intensive care units in Belgium.

References

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