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Editorial

UK low secure units in the spotlight

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A recent tragic event, in which a male patient absconded from a secure unit in the South West of England and committed a serious sexual assault, has thrown the media spotlight onto low secure units (LSUs). Following the incident there was widespread coverage of the story in the local and national media; including the release of information, obtained by the BBC through the Freedom of Information Act, on the number of absconsions from LSUs across the country.

It is always necessary to pause, reflect upon and learn from such tragic incidents. It's also worth reflecting that the history of psychiatry is such that, in the UK at least, national policy development is often powerfully shaped by tragedy and scandal in mental health care.

That being said, it is vital that responses to such incidents are measured and proportionate. A simplistic response might be to advocate that greater levels of physical security need to be applied in order to prevent patients from absconding. However managing risk in psychiatric patients is complex and simple solutions rarely suffice.

The nature of many LSUs is that they are the setting from which patients with complex risk issues are successfully discharged into the community. The process of discharge is usually carefully considered and tested out through use of leave. The consideration and management of risk, to others and the patient, is an integral part of successful discharge planning.

Some of these patients have spent many years in secure environments and the prospect of discharge can be difficult for them to cope with. It is a reality that some patients will abscond as the controls and restrictions upon them are relaxed. Arguably it is an unavoidable consequence of the nature of low secure environments. LSUs are designed to have sufficient security to impede rather than prevent escape. No level of physical security will prevent a patient from 'absconding' by failing to return from leave.

Using absconding rates as a measure of an LSU's quality of care is, therefore, but a small part of a larger picture. It is better, surely, to measure quality by considering all aspects of clinical care rather than by concentrating just on security issues, important as they are. Clinical audit has an important role, as part of wider clinical governance, in demonstrating quality. To that end we have an audit by Kelbrick and Haw in this issue.

On a different tack, revisions to the Mental Health Act 1983 have recently come into force in England and Wales. The key changes to the legislation have been summarised elsewhere (Department of Health, 2008). Amongst the changes introduced are a broader definition of mental disorder and the introduction of Community Treatment Orders (CTOs). Both of these changes may have an impact on LSUs and psychiatric intensive care units (PICUs).

The broader definition of mental disorder could mean that individuals whose mental health difficulties previously fell outwith the

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legislation will now be subject to detention. Individuals with personality disorder may be one such group.

The UK Government's policy is to improve both quality and ease of access to treatment for people with personality disorder (Department of Health, 2003). It is also highly relevant that the National Institute of Health and Clinical Excellence (NICE) is currently consulting on draft guidance on the treatment of both antisocial personality disorders and borderline personality disorder (NICE, 2008).

The article by Muthukumaraswamy et al. in this edition describes patterns of aggressive behaviour on an LSU. Currently the vast majority of patients on such units are likely to have a primary diagnosis of major mental illness. However the changes to the Act may mean that LSUs and PICUs start to admit more individuals with personality disorders associated with risks of violence or self harm such as antisocial personality disorder and borderline personality disorder respectively. On that basis, it may be that antisocial personality disorder and borderline personality disorder become more common presentations on LSUs and PICUs.

Such patients present different challenges compared to patients with major mental illness. Dilemmas such as coping with negative attitudes from staff towards a group who have traditionally been excluded from services may arise. In such circumstances there will be a need for clear clinical leadership on LSUs and PICUs. In this issue Ingle opines on that very issue.

The use of CTOs may also impact upon PICUs and LSUs. CTOs will allow some groups of detained patients to be discharged from hospital to live in the community subject to certain conditions. If the clinical picture begins to deteriorate, an individual on a CTO can be recalled to hospital promptly without having to deteriorate to the level previously required for detention under the Act.

If CTOs prove effective they may ease the discharge of patients who previously would have remained detained in hospital through fears of non-compliance and disengagement from treatment were they to be discharged from section and from hospital. Thus CTOs may, by providing alternatives to prolonged admission for detained patients, lead to falling lengths of stay in hospital.

Turning to the rest of the content in this issue we have a review, by Pratt et al., of the pharmacological issues relevant to achieving a 'gold standard' in the use of rapid tranquillisation. This article builds nicely, if you'll excuse the pun, on the existing guidance on the subject (NICE, 2005).

Demographics is also a feature of this issue, with articles by Beer et al. on the demographics and other characteristics of referrals to a low secure service and by Brown et al. on demographics and outcomes for patients admitted to PICUs in England.

A welcome piece of user involvement is the Solomons et al. article on user-led user-staff meetings in a challenging behaviour unit. We also have an article by Berg looking at the times of day at which referrals to a Norwegian acute psychiatric unit arrive and various associated issues including length of stay. Finally there is an interesting piece on the little known area of PICUs within medium security by Adams and Clark.

Good reading!

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