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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Secure units

SIR,—Consultants will find your leading article (29 November, p 1446) on secure units very wide of reality. Many patients in the so-called community are living under very primitive conditions, and their lives are useless. In consequence they have committed crimes, often petty, some very serious, and the prisons are overcrowded.

Many people would justify the assertion that current psychiatric policies are disastrous whether looked at in human or in economic terms. The drug bill is enormous and the side effects are often unnecessary. Seriously ill patients have been deprived of efficient mental health services while the minor illnesses—most of which would have got better spontaneously—have had great care.

The gap between the institutionalised patient in the special hospital and prison and useful life in the community is now greater than it ever was and is increasing. Greater specialisation in life coupled with unemployment makes it more difficult for the patient to bridge the gap. He still has the problem of relationships, social graces, occupation, VAT, and income tax to manage and resolve. Nor is the community any healthier—if we take as indices of mental health and wellbeing such factors as suicide, murder, or terror few would feel happy or safe—especially in Leeds.

Gone are the vibrant therapeutic communities—St Johns, Lincoln, Warlingham Park, Runwell, Moorhaven. Who is left to help ill and disturbed youngsters to find a role in a more difficult world? Large numbers have certificates which are worthless in an empty job market. Who will help these patients find a purpose and transform that purpose into a useful role in real life? Clearly the function of the special hospitals has a new dimension and a new urgency. The necessity for a U turn in mental health policies is recognised by the judiciary, general practitioners, and the prison service.

JOHN HARDING PRICE

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SIR,—Your leading article (29 November, p 1446) discussed the problems of finding beds in NHS hospitals for psychiatric patients who display persistent aggression or behavioural disturbance. Considerable blame for this difficulty is laid upon the Mental Health Act 1959 and the current trends away from providing conditions of physical security in local mental hospitals; and among the patients who suffer because of it are special hospital patients who have been approved for transfer to an NHS facility. As was widely reported, Boynton[1] recently found 122 such patients in Rampton alone, of whom 92 had been awaiting transfer for more than six months.

I believe that it is important to acknowledge that reluctance to accept such patients is not a recent phenomenon and is really as old as mental hospitals themselves. Gunn[2] has described that even Broadmoor Hospital, which had opened as a criminal lunatic asylum in 1863, had in 1874 refused to admit any further insane male convicts because of the trouble and security problems which they caused. For the next 11 years they were kept in the penal system until the restriction was ended. A Scottish document of 1847[3] records