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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Mentally ill offenders in prison

SIR,—In describing the case of Wendy Porter your legal correspondent evaded the real issue (9 February, p 447). The special hospitals will admit only patients who are a serious danger to the public if at large, but they are spacious, have excellent facilities, and cater well for patients whose treatment must be measured in years. The new regional secure units are small and do not expect that the patients' stay will be much over 18 months. They will take in patients who are not considered a serious immediate danger if they escape.

Ms Porter has an intelligence quotient of 65, and from what has been reported in the press I assume she suffers from mental impairment. She burnt down a printing works in 1981 to the tune of £100 000 and on being refused admission to a special hospital by the Department of Health she went to St Andrews' Hospital under a three year probation order. On discharge from there in 1984 she was still acting disruptively and St Andrews' would not have her back, saying that she would not respond to treatment. Thus she needs the facilities of a special hospital but may well not need the level of security provided. The regional secure unit would provide the correct level of security but not the facilities. So the Wendy Porters of this world land up in prison, where they are persistently disturbed and tax the patience of the prison staff to the limit and, indeed, may have a serious effect on the morale of those who care for them in prison.

Clearly your correspondent feels that if the suggestions of the Butler committee were enacted whereby those charged with an offence were found "not guilty" if there was evidence of severe mental illness or severe subnormality then this kind of situation would not arise. I cannot see how he reaches that conclusion in the case of Ms Porter. Neither type of secure unit will accept this type of patient, and they will be left on remand in prison while controversy about their disposal rages.

The Department of Health, of course, is not unaware of this problem and says the regions must provide facilities. This might be feasible if two or three regions join together to build a suitable hospital. But what they build would resemble another special hospital, although with less security. I cannot for a moment see the regions being prepared to do this. It seems to me that the responsibility for providing care measured in years for Ms Porter and her like rests with the Department of Health. Ms Porter has in fact now gone to Moss Side, a most excellent hospital. I suggest the department looks seriously at the possibility of using Moss Side specifically for this group of severely behaviourally disordered patients who do not need to retreat behind the massive walls of other special hospitals.

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Limited list

SIR,—Now that the amended list of prescribable drugs has been published (2 March, p 725) it is apparent that the Minister has been less than open about his intentions. They cannot have been to save money, as his published figures are inaccurate, certainly in relation to my own prescribing, which I have no reason to think is any better than my neighbour's. So why the list? It must be the beginning of a move to prevent too many new preparations coming on to the market, or the first of a series of raids on the profession, and we should do well to beware the future.

From 1000 consecutive prescription items I found that 152 would have been disallowed by following the original list. Of these, there are reasonable alternatives to 93 on the new list, and, of the remaining 59, 43 were for cough mixtures, four for other benzodiazepines, four for antacids (I occasionally use Aludrox SA), three for analgesics (for difficult patients who benefit from a new name on the bottle), and two for Orovite (used occasionally in the undernourished elderly).

But where is the saving of money? I shall still prescribe for many of those patients who had the 59 items listed above. For example, I like Phensedyl, now disallowed; if I prescribe Phenergan in its place the cost is identical. I often prescribe opiate squill linctus and ipecacuanha and morphine mixture, neither of which is more expensive than codeine linctus or ammonium chloride mixture (and the one is more constipating and the other more nauseating). Where is the saving on antacids? I happen to like Andursil, now disallowed, but I can substitute Maalox or Gaviscon, both more expensive.

There may be some saving on analgesics. I