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CORRESPONDENCE

Correspondents are asked to be brief

Secure Hospital Units

SIR,—In their letter (24 August, p. 519) Mr. M. R. Bury and Dr. J. A. O. Russell ask which patients should be treated in the regional secure units proposed by the Butler Committee. Part of the answer, as I am sure they would agree, is that these units should form part of a forensic psychiatric service, itself well integrated with the rest of the psychiatric services, and be capable of providing treatment, and where necessary guaranteeing long-term inpatient care and supervision, for the substantial number of mentally ill patients now being denied these things. Though in an ideal world staffing would be raised to a level such that these patients could all be contained in open wards, in practice many psychiatric hospitals find that they are now unable to accept any sort of responsibility for patients whose offences and potentiality for antisocial behaviour give rise to anxiety. This situation is causing increasing concern to the community if not to those running progressive but selective services.

Thus when there were no longer any permanently closed wards available in the Oxford region representatives of the courts, the Prison Medical Service, the Probation Service, general practitioners and social service departments told a working party that it was they who were having to care for these difficult patients and all expressed dissatisfaction about the inability of the psychiatric services to provide an effective response to their needs.[1] This dissatisfaction is shared by prison medical officers, who in London at least are finding it increasingly difficult and sometimes impossible to obtain beds for mentally disordered offenders.[2] Recently in the Court of Appeal the Lord Chief Justice stated that it was not right for a trial judge to be faced with the stark choice of imposing a long prison sentence as an alternative to a hospital order to a non-secure hospital.[3] Similar opinions have been expressed in the Crown courts.[4 5]

The reluctance of regional boards to provide facilities, as recommended by the Ministry of Health in 1961,[6] and of consultants to accept the admittedly anxiety-provoking responsibility for treating mentally abnormal offenders has undoubtedly not only increased the number of such people in prison but also added to the pressure on the special hospitals. The extent of the overlap between the populations of conventional and special hospitals is perhaps not always appreciated but can be illustrated by the fact that 70% of Broadmoor admissions have previously been psychiatric inpatients, though of course the proportion directly transferred is far smaller.[7] Applications from all sources for special hospital beds have risen steadily from 311 in 1961 to 582 in 1973. Until 1970 a quarter of these applications were rejected; since then the rejection rate has increased until in 1973 it reached 50%.[8] At Broadmoor the yearly number of admissions following homicide has not increased, while admissions following lesser offences have risen dramatically.[9] These figures probably indicate that the special hospitals are having to accommodate many patients who are by no means exceptionally dangerous and who would formerly have been retained in conventional hospitals.

Recently applications have been received from hospitals lacking closed wards which have stated that unless Broadmoor accept certain disturbed psychotic inpatients the only alternative was discharge to the community. In this climate of opinion it is hardly surprising that conventional hospitals have become equally reluctant to accept patients from the special hospitals, thus blocking these beds and adding to the total problem.

The question posed by Mr. Bury and Dr. Russell is therefore probably not best answered in terms of diagnostic or even administrative categories and I would suggest that their first priority should be the ascertainment, as was done in the Oxford region, of the number of mentally ill people known to the penal system, the social services, and indeed the voluntary bodies who need short- or long-term psychiatric treatment but who are not getting it because they have been rejected by the psychiatric services. Clearly if the psychiatric services as at present organized can find their way to reabsorbing all such patients without closed wards or the new "medium secure" facilities, let them do so; if not then the need for them will have been demonstrated.

Lastly, it is surely worth mentioning that the region Mr. Bury and Dr. Russell work in has had a rate of acceptance for beds in special hospitals well above the national average from 1961 onwards and the number of unsuccessful applications has also been high.[10] Could this not also indicate a need for "medium secure" beds in their area?—I am, etc.,

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1 Oxford Regional Hospital Board, *Report of a Working Party on Individuals Requiring Security*. Oxford Regional Hospital Board, 1971.
2 Home Office, *Report of the Work of the Prison Department 1972*, Cmnd 5375, par. 220. London, H.M.S.O., 1973.
3 *The Times*, 24 April 1974, p. 18. Regina *v.* Horan.
4 *The Guardian*, 30 October 1973, p. 6. Regina *v.* Semp.
5 *Reading Evening Post*, 24 September 1974. Regina *v.* King.
6 Ministry of Health. *The Treatment of Psychiatric Patients under Security Conditions*, H.M. (61) 69. London, M.O.H.
7 Parker, E., *An Inquiry into the Reliability of Special Hospital Case Records with Reference to the Recording of Previous Psychiatric Hospitalisations and Criminal Histories*. London, Special Hospitals Research Unit (Department of Health and Social Security), 1973.
8 Department of Health and Social Security. Personal communication.
9 Black, D. A., *A Decade of Psychological Investigation of the Male Patient Population of Broadmoor*. London, Special Hospitals Research Unit (Department of Health and Social Security), 1973.
10 Treves Brown, C., *Assessment of Regional Differences in Rates of Referral for Special Hospitals Placement*. London, Special Hospitals Research Unit (Department of Health and Social Security), 1973.