continue giving BCG to all children born into Asian immigrant households and to tuberculin-negative child contacts of infectious patients.

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Secure units

As recently as the 1950s most psychiatric hospitals kept patients in fairly secure conditions, with long stays and locked doors accepted as routine. All that changed with the advent of the major tranquillisers and the informal attitudes stimulated by the Mental Health Act 1959. Wards are now generally open and the whole emphasis of treatment is on getting patients out of hospital and into the community.

These changes have benefited patients with mental illness—with a few thousand exceptions: the persistently aggressive and those with behavioural disturbances. Some of these patients are mentally handicapped; some are offenders; all are difficult to manage—and none are suitable for treatment on an open general ward, where their presence distresses other patients. Yet six years after the Butler report[1] recommended the building of security units in the NHS for mentally abnormal offenders unsuitable for general hospitals, little progress has been made. Most such persons finish up either in one of the four special hospitals or in prison.

The widespread criticism earlier this month of the failure of NHS hospitals to accept the transfer of patients from Rampton[2] has brought the issue back into the public eye. The reason that NHS hospitals refuse these patients[3] is plain enough. As the Royal College of Psychiatrists states in its report[4] on secure facilities, "the open-door policy in many psychiatric units has been important in reducing the fear and stigma of mental disorder. Many people, including doctors and nurses working in psychiatric hospitals, have been concerned that the admission of significant numbers of mentally abnormal offenders will reverse this trend." Nurses and doctors are all too aware that physical restraint of patients who may—even very occasionally—be disruptive can lead to public criticism and calls for inquiries. In those circumstances many units have taken the cautious, pragmatic approach and refused such patients admission.

What are the alternatives? So-called difficult patients can be treated by the staff of ordinary psychiatric hospitals—as is evident from the success of the interim facilities opened in three regions as a temporary measure.[5] Experience in these small units, adapted from existing wards, has shown that they can cope with difficult patients provided that the staff ratio is high and that all concerned have a commitment and enthusiasm for the work. Young staff of both sexes working in an enthusiastic multidisciplinary team can achieve much more than old-fashioned custodial care.

Specialist units of this kind with little in the way of physical security could be established in many more psychiatric hospitals if their staff agreed—and that is one solution to the present difficulties, but it depends on attitudes being changed among both psychiatrists and mental nurses. The other choice is for the DHSS to press on with a policy based on secure units. But the NHS regions are all desperately short of money and such a building programme will be expensive. More important, funds will need to be earmarked to pay the nurses and ancillary staff at special high rates. Sadly, few of the patients suffering in the present inadequate conditions have articulate relatives or friends to exert political pressure on their behalf, and without sustained pressure the prevarication of the past six years seems likely to continue.

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