as well as petitions, law suits, and attempts to deny renewal of licenses to certain television stations.

So far the crusade appears to have been effective and the networks are clearly becoming concerned. In August five television producers expressed the view that "the industry is slowing violence to a degree that is dangerous," and that "we are going to be faced with a plastic television that is going to breed a plastic society." It was also suggested that the pendulum may be swinging too far in the other direction, that we may see a return of censorship, and that even *Hamlet* and *Roots* will be banned for being too violent. So far, however, these fears remain unfounded. And, while there has been some reduction in the number of violent programmes, we are as yet in no danger of

becoming a plastic society, and indeed it appears that the networks are replacing hate with lust and crime with sex.⁶

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Occasional Review

Regional secure units and interim security for psychiatric patients*

ROBERT BLUGLASS

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Patients who need an element of security as part of their care and management are referred to psychiatrists from the general population as well as from courts, penal institutions, and legal agencies. If mentally abnormal offenders are defined simply as those who are put on hospital orders they are a small proportion of all offenders. Using this definition the Butler Report¹ indicated that in 1973 psychiatric disposals accounted for less than 0.5% of the 736 860 convictions occurring in one year (excluding motoring offences). Less than 1% of admissions to all hospitals receiving mentally disordered patients were from courts or penal establishments (on hospital orders). These figures, however, give a distorted view of the problem. The statistics exclude those who were refused admission to psychiatric hospitals from the courts and do not take account of a sizeable group of mentally disordered individuals who are from time to time offenders and who do not qualify for hospital orders. There are also many people in the community who have not offended but need secure care from time to time.

Background

The special hospitals (in England Broadmoor, Rampton, Moss Side, and Park Lane) admit patients on compulsory orders who need treatment and management under conditions of special security because of their dangerous, violent, or criminal propensities. Before 1959, however, most mental hospitals had locked wards. Thus offender

patients and difficult non-offender patients who were a problem of management and needed some degree of security (but not as much as the special hospitals provide) were easily accommodated. The nursing and medical staffs had a long tradition of caring for them and had acquired considerable skill, and they found few patients too violent, threatening, or dangerous to cope with. The policy of unlocking doors and dispensing with restrictive methods of care developed during the 'fifties with the introduction of a new range of psychiatric drugs, a new approach to occupational and industrial therapy, the concept of community care, greatly improved staffing, and other measures.

This movement was encouraged by the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency and by the eventual provisions of the 1959 Mental Health Act. In 1961 a Ministry of Health report² welcomed the open-door principle, but was convinced that security arrangements should continue to be provided in some regional NHS psychiatric hospitals (although not necessarily all) and that regional health authorities should provide various types of unit, including some secure units, so that patients could be transferred between them as necessary. It also recommended special diagnostic centres that would admit patients presenting specially difficult problems for assessment, treatment, and research. These recommendations were accepted by the Government.³ In fact only one centre materialised, at the Northgate Clinic in Hendon (in 1968), and this soon became a specialised adolescent unit.

During the 'sixties and on into the 'seventies the open-door policy was adopted by psychiatric hospitals throughout the country, and with the results predicted by the 1961 working party. NHS hospitals were increasingly reluctant to admit patients from the courts on the grounds that security was not provided and its reintroduction would adversely affect the vast majority of patients who did not need it (86% of whom were admitted to hospital informally). Many of these patients from the courts did not in fact need secure arrangements but despite this they were increasingly unwelcome. The problem was eventually made worse by the development of district general hospital psychiatric units, which many psychiatrists find unsuitable for difficult or unpredictable patients and for offenders (though not all agree). No provision had been made in them for the care of chronic patients or those needing security, and they did not therefore replace the mental illness hospitals.

Consequently, offender patients, including those who do not necessarily require conditions of special security, have been increasingly admitted to the special hospitals. In order to obtain admission their dangerousness tends to be exaggerated. The special hospitals in turn have found it more and more difficult to discharge their recovering patients to NHS hospitals (even though they have ceased to be

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Midland Centre for Forensic Psychiatry, All Saints' Hospital, Birmingham

ROBERT BLUGLASS, MD, FRCPsych, consultant forensic psychiatrist (also senior clinical lecturer in forensic psychiatry, University of Birmingham)

dangerous) en route to the community, and this has further increased the pressure on their beds. Moreover, judges have often had to send people inappropriately to prison instead of hospital, and the pressure on prisons therefore has also increased. In 1969 a bill to provide units standing midway between special hospitals and psychiatric hospitals failed to get further than a first reading.

In July 1974 the Committee on Mentally Abnormal Offenders¹ issued an interim report⁴ echoing the 1961 advice by recommending as a matter of urgency NHS regional secure units (initially with 2000 places) to fill the "yawning gap" between the service provided by the overcrowded special hospitals and the NHS hospitals providing no security at all. Concurrently, an internal working party of the DHSS (chairman, Dr J Glancy)⁵ examined the need for secure accommodation in NHS hospitals and also recognised a need for secure units for a small proportion of the psychiatric hospital population, recommending 1000 beds in England and Wales.

In July 1974 the then Secretary of State for Social Services, Mrs Barbara Castle, announced the Government's acceptance of the recommendation of both committees that urgent action should be taken to provide 1000 secure places in the first instance. She emphasised that these units should be established as soon as possible, and that interim security arrangements must be made for the care of the patients in NHS psychiatric hospitals until the new units were established.

In October 1975 the Butler Committee produced its final report¹ and expressed its concern that no progress had been made in establishing the units. One important reason for this was thought to be the lack of funds to run the units—regional health authorities were understandably reluctant to divert funds from other areas for this purpose. The Butler Committee therefore recommended that central funds should contribute to the cost of the units. This was eventually accepted by the Government in January 1976, when £5m was made available. This special allocation to RHAs was to be used to provide interim secure accommodation until the units were established, when these funds would be used to run them.

Progress in establishing regional secure units and interim secure arrangements

REGIONAL SECURE UNITS

In her circular⁶ of July 1974 the Secretary of State indicated that all regional health authorities should have started construction (or adaptation of existing premises) by 1976-7.

In fact some six or seven units are in a planning stage but no building has yet started, and most are probably a long way from this position. Many obstacles have to be overcome—in particular, planning within a limited budget for a very specialised unit with a high staff:patient ratio; dealing with the local opposition of existing hospital staffs and local population; negotiating with the unions; and the reluctance of some RHAs to promote a unit of this kind when they are short of funds for other developments, which some regard as more worthy.

Most regions that have established planning teams appear to be approaching the problem by proposing a single unit, usually purpose-built along lines recommended by the reports (Butler,¹ Glancy,⁵ and the DHSS guidelines⁷) and ranging in size from about 25 to 100 beds. South-east Thames RHA, however, has taken a different approach to that advocated by the Government.⁸ This RHA considers that the size of the problem is not clear and that a building on its own is not a solution to it. The function of such a unit must relate to its turnover of patients and relationship to supporting facilities in the community and in surrounding NHS psychiatric hospitals. A smaller unit than advocated for assessment, interim rehabilitation or treatment, education, and specialist support will, it is hoped, be complemented by less secure facilities in the psychiatric hospitals. The funds would be spent on a scheme that would aim at providing varying degrees of security and care. This plan relies, however, on the co-operation of a large body of professional and ancillary staff. It remains to be seen if this can be achieved. Evidence from other regions suggests that such co-operation would be extremely unlikely because of the conflict of opinion about the need for special facilities for mentally disturbed offenders.

INTERIM ARRANGEMENTS

Personal inquiry and replies to parliamentary questions show that little progress has been made in establishing interim arrangements. In a reply to a question on 23 June 1977 Mr Moyle, Minister of State,

DHSS, indicated that for 1976-7 the regions spent only £351 263 on secure facilities (see table). The remainder was either carried over to the next financial year or was spent as general revenue.

The financial allocation was increased in step with inflation in 1977-8, but little progress is thought to have been made since 1976-7 in spending this money for the purpose for which it was intended. In fact, in 1976 several areas used it as a stopgap to meet bills or paint wards, or even diverted and spent it outside the mental health sector. For 1977, after questions had been asked, the Department indicated that the finance must be spent on psychiatry even if it could not be spent on interim security. Interim secure units have been established in three hospitals—Knowle Hospital, Fareham, which opened in January 1977; Prestwich Hospital, Manchester; and Rainhill Hospital, Liverpool. The Prestwich unit partially opened in September 1976 but has been restricted by union opposition and conflict ever since. Rainhill has had similar problems.

Use of DHSS special financial allocation for secure accommodation

Regional health authority	Amount of special allocations 1976-7 (£)	Amount spent on secure facilities (£)	Other use of allocation
Northern	347 000	Nil	Total carried over 1977-8
York	398 000	56 000	Balance carried over 1977-8
Trent	510 000	Nil	Total spent as general revenue
East Anglia	210 000	Nil	Total carried over 1977-8
NW Thames	386 000	22 000	Balance carried over 1977-8
NE Thames	415 000	Nil	Total carried over 1977-8
SE Thames	403 000	4086	Balance distributed as general revenue
SW Thames	325 000	1793	Balance used to offset over spending of overall revenue
Wessex	296 000	139 000	Balance distributed as general revenue
Oxford	246 000	Nil	Total carried over 1977-8
S Western	352 000	Nil	Total carried over 1977-8
W Midlands	582 000	30 000	£56 000 spent on other facilities. Balance carried over 1977-8
Mersey	280 000	50 384	Balance carried over 1977-8
N Western	459 000	48 000	Balance carried over 1977-8

THE PROFESSIONS' REACTION

The professions have generally expressed acceptance of the proposals for secure units. The Royal College of Psychiatrists, Royal College of Nursing, and the trades unions (the Confederation of Health Service Employees, the National Union of Public Employees, and the TUC) have given official support. The MIND organisation (National Association for Mental Health) gave qualified support.⁹ Some people, however, expressed frank opposition to the principles proposed. The distinguished forensic psychiatrist the late Dr Peter Scott argued that security is indicated only to control dangerousness and that mentally abnormal dangerous offenders who do not need to go to special hospitals should be treated within psychiatric units in prisons, which should receive the benefit of any financial resources available. He considered that NHS units would retard the development of better prison facilities.¹⁰ Scott predicted¹¹ that regional secure units would eventually become increasingly selective, as psychiatric hospitals are now, and would fail to care for the more difficult patients who present the main problem or make any significant impact on the problem as a whole.

Current problems and difficulties

TYPES OF PATIENT

Misunderstanding about the purpose of regional secure units is widespread. Many of those concerned in planning or consultation have had little to do with the problem of the disturbed and difficult psychiatric patient or abnormal offender and hold widely differing views about the role of the unit or the type of patient for which it would cater. Mr J Callaghan, MP (Middleton and Prestwich), has

rightly stated¹² that there was an apparent lack of precision about the type of patient to be accommodated in the new units. Because of this (referring to the unit at Prestwich Hospital) "fears have been expressed locally," he said, "about the possibility of patients who are dangerous, violent, or criminal being transferred from the special hospitals to the Prestwich security unit." A scheme for a unit in the grounds of the Royal Earlswood Hospital, Surrey, led to newspaper references to the proposed unit as a "mini-Broadmoor" for the "criminally insane" and 14 Members of Parliament registered their opposition to it. The local evening paper in Birmingham referred to a proposed unit in that city in similar terms. Difficulties of a like kind have faced the planners of a unit in Devon.

The Glancy and Butler Reports¹⁶ have described the types of patient who would be considered for admission; but psychiatrists, nurses, administrators, and the DHSS differ in their interpretation of these guidelines and in their own conception of who will be admitted. The Butler Committee said that the units should not accept "aggressive psychopaths or any patients who would be an immediate danger to the public at large." The Glancy Report frankly stated that "there is a very real difficulty in defining those who should be admitted to the secure units, not the 'elderly wanderer,' the 'severely mentally handicapped,' or the 'patient difficult only during an acute phase of an illness.'" Clearly there is a general lack of agreement about the type of patient that would be admitted to a regional secure unit and in what way such a patient would differ from those admitted to special hospitals.

Lack of familiarity with difficult patients and imprecise proposals undoubtedly lead to fear and anxiety on the part of some planners, staff in adjacent hospitals, and the community. These are understandable fears based on varying degrees of misunderstanding or ignorance and a genuine anxiety. Fantasies of murderers and rapists on the rampage in local housing estates have not always been relieved by good public relations and education.

SUPPORTING AND COMPLEMENTARY PSYCHIATRIC SERVICES

Equally the existence of the proposals has now led to the belief by some that all difficult patients will be accommodated in secure units and that the NHS psychiatric hospitals need have no further concern with their problems. But 20 secure beds per million population can cope only with a small proportion of difficult patients unsuitable for special hospitals. The remainder must be accommodated and cared for in NHS psychiatric hospitals under these proposals, as they are supposed to be at present. If the NHS hospitals do not accept this responsibility any plan to develop secure units will fail. The only alternative is to develop new facilities on a far larger scale, which would be expensive and unrealistic.

Both reports envisaged the regional secure units as part of a regional forensic psychiatry service, of which the unit would be the centre. The units would support and complement care in the NHS hospitals and the special hospitals and there would be an easy movement between them. Little emphasis has been given to developing the units as part of a comprehensive service that includes all three elements—special hospitals, NHS hospitals, the secure units themselves—and a fourth element, a forensic service in the community.

FUNDING

One difficulty in achieving this aim is the present policy of placing the unit in an NHS area where it will have to compete financially with all other local resources. This inevitably leads to an unsympathetic response from local personnel. The Department has not taken a lead in fostering the units as part of such a comprehensive forensic service, and only the South-east Thames RHA has shown an understanding of the problem.

The reports and the Department's guidelines recommend a high staff:patient ratio and facilities for relatively small units for treatment, rehabilitation, and security, which are bound to be very expensive if they are to be effective. The capital funds that are offered, though generous, are not sufficient. In addition (and most important), the special revenue allocation will meet only a proportion of the units' running costs. Local health authorities will understandably be reluctant to meet the balance out of their overall budget—probably none will do so.

LONG-TERM CARE

Furthermore, little or no thought has been given to those patients who need long-term care in hospital. The units are for a relatively

short stay. Anxieties about the long-term implications have been expressed but not answered. Who will care for these people? Will the NHS psychiatric hospitals? Or will the units become eventually long-stay hospitals, so that there will soon be little room for admissions and all the difficulties described will recur? The relation of the special hospitals to the new service will also change.

INTERIM SECURE ACCOMMODATION

Many of the difficulties apparent in the planning of regional secure units are equally evident in establishing interim security accommodation in existing hospitals. Again, fears have been expressed about the type of patient to be accommodated.¹³

Nursing and ancillary staff now expect the pay lead if they are to work in such units, but to attract this lead the units have to be designated as special units by the regional health authorities. Staff caring for patients in NHS hospitals in the ordinary way would not attract the lead. But this situation has also led to some staff refusing to admit patients (who would have been easily managed in the past) on the grounds that they would not receive the extra pay, their accommodation is not designated, or they do not have secure accommodation in the hospital. The Confederation of Health Service Employees has suggested that there is a growing risk to staff from violent or potentially violent patients, which justifies this attitude and which they claim has resulted from understaffing, restricted funding of psychiatric hospitals, and a failure of the law to provide protection. Disagreements about pay and conditions in the Prestwich unit have led to a continued problem in opening the unit completely and running it.

One of the profound difficulties (perhaps the most profound) in establishing regional secure units or interim accommodation are the views of psychiatrists about security, secure units, and closed wards. Both reports presume that regional secure units will be acceptable to both local staff and community if they are adjacent to existing hospitals, that the psychiatric profession as a whole will accept the concept of interim security, and that patients will be transferred freely between secure and open hospitals. The DHSS continues to maintain that consultant psychiatrists have a responsibility to admit all types of patient except those needing maximum security. A recent document from the Royal College of Psychiatrists¹⁴ (which was agreed by the DHSS) repeats this view and says that the open-door policy should be regarded as an "approach to treatment rather than a factual description of the physical arrangements at the hospital."¹⁵

The facts are that in England the views of most psychiatrists have changed radically during the past decade and particularly since the Glancy and Butler Reports (with their promises of alternatives).¹⁶ Psychiatrists are now generally united and resistant in their opposition to secure units in their hospitals, to closed doors, and to the continuing care of disturbed or potentially violent patients or those with personality disorders. The range of this resistance varies but is general. There is a pronounced division between the views of psychiatrists about their responsibilities to these patients, who include abnormal offenders, and the expectations of the DHSS (and the earlier reports). Many consultants who might be more sympathetic to this group of patients now consider their authority has been undermined by multi-disciplinary decision making, the threat of public inquiries, the reorganisation of the NHS, and the Hospital Advisory Service's activities.

These opinions of the psychiatrists are reflected in the attitude of many nursing staff, who express similar views but often take the main criticism for refusing patients. Generally disturbed behaviour is less tolerated and skills in managing it are being lost with the dismantling of facilities for such patients. In one region, for instance, the number of beds in locked wards has dropped by 40% during five years.¹⁶

The attitudes of both psychiatrists and nurses have been reinforced by the recommendations for secure units, which they expect will relieve them from the difficulties of caring for the more difficult patients in due course. The recommendations are interpreted by some as confirming that alternative facilities are in sight and that these patients are unsuitable for ordinary hospitals.

Consultants jealously and justifiably retain their right to make clinical decisions based on their own judgment. If a patient cannot be offered facilities for care and treatment then the psychiatrist will indicate that he cannot be offered a bed. Technically, an area medical officer (representing the managers) can direct that a patient is admitted. But the area medical officer cannot direct that a consultant takes clinical responsibility for the patient against his clinical decision and his considered judgment. Although a certain amount of pressure can be exercised, eventually the attitude of such psychiatrists and hospitals

must be accepted. There is nothing to be gained by attempting to impose a policy on unwilling staffs.

SPECIAL HOSPITALS

As a reaction to the above difficulties the special hospitals find it increasingly difficult to obtain beds in NHS hospitals for recovered patients who are no longer dangerous but need rehabilitation near to their homes. In a written answer earlier in 1977 the Minister of State, Mr Roland Moyle, stated that of 184 special hospital patients who were awaiting transfer to NHS hospitals 99 had been waiting one year or less, 57 for between one and two years, 17 for between two and three years, and 11 for longer than three years. The minister had indicated in a written answer (26 October 1977) to Mr Robert Kilroy-Silk that some hospitals refused admissions because of the attitude of trade unions, while others refused for mixed reasons.

PRISONS

Psychiatrists and prison medical officers who consider that an accused person requires a hospital order find it increasingly difficult to obtain accommodation in NHS or special hospitals. As a result, to quote the *Report on the Work of the Prison Department 1976*,¹⁷ "mentally ill people are entering prisons and borstals in increasing numbers and people of previously good personality, whose offences frequently stem solely from their illness, are now being refused admission to psychiatric hospitals and are, instead, being received or detained in (prison) establishments." The report indicated that the prisons hold "some hundreds of offenders" who should be in hospital. They cannot be properly cared for in prison, and it is wrong in principle that they are there. The difficulty in obtaining beds for mentally disordered offenders appears to have resulted in a drop in referrals. The number of hospital orders is falling as prison medical officers meet with increased resistance on the part of psychiatric hospitals to admit the patients,¹⁸ and transfers from prison to hospital under the Mental Health Act of mentally ill persons can rarely take place, even though transfers are recommended. It was recently reported¹⁹ that there are 900 prisoners in prison at any one time whom prison medical officers consider should be in psychiatric hospital care and that there are 3500 offenders passing through prisons annually who are in this category. The prison doctors were said to be sceptical about the present plan for regional secure units.

SURVEYS OF THE PROBLEM

The Glancy Committee attempted to assess the need for secure accommodation⁵ but acknowledged that the results from their survey of all regional hospital boards in 1970 were unreliable. In November 1976 the Oxford University department of psychiatry reported²⁰ the results of a survey carried out in the Oxford Region in 1975 (population 2 074 000). This is the most thorough and carefully conducted analysis that has been attempted and aimed to determine how many people might be suitable for secure treatment short of that provided by the special hospitals. The six-month survey collected information on 193 possible patients from all sources (prisons, hospitals, special hospitals, and the probation service). Forty-one individuals were already in suitable care; 125 required further facilities, which were not currently available. Only 26 were considered to need a security unit for the mentally ill, and 37 a secure training unit for the mentally handicapped. The remainder could be placed in various other possible ways and generally without secure conditions.

Discussion

The patients who need secure conditions for their care and management are those who exhibit dangerousness or potential dangerousness. A dangerous person has been defined by Scott²¹ as one who shows a tendency to risk or bring about destruction or injury that is severe, irreversible, unpredictable, or untreatable. Such individuals need care in conditions of maximum security in prison or in special hospitals. By no means all who have been very destructive continue to be dangerous if their condition is easily recognised and treatable—for example, some murderers, arsonists, and sexual offenders. They can often be

cared for without difficulty in open conditions or simply with a higher staff:patient ratio.

The main problem concerns a much larger group (of ill-defined size) who are not dangerous but are often difficult, uncooperative, uncontrolled, or asocial—those who may drink, take drugs, upset other patients, or break the institutional rules. They are the ones that Scott called the "embarrassing" or "unrewarding" patients. They may or may not also be obviously mentally ill or mentally handicapped, or have frank psychopathic or severe personality disorder. Many of this group were previously given asylum by mental hospitals but now they are increasingly rejected, and they form the basis of much of the present problem.

The evidence suggests that secure treatment facilities are required only for a few patients who present difficulties in management. The main problem is the care of the remainder—a much larger group.

Most of these patients would be accommodated if it were still accepted that many need long-term care in mental hospitals. "Asylums are still needed," said the *British Medical Journal* in 1976,²² using the word in its original "caring" sense. The *BMJ* quoted then (as it had in 1974) Mr John Pringle, of the National Schizophrenia Fellowship, who is concerned about the fate of patients with chronic schizophrenia discharged into the community. "The closure of mental hospital wards," he said, "which at least provided the basic minimum shelter and life support goes on, leaving nothing in their place." The *Lancet* agreed²³: "At a time when we must do more with existing resources, the locked ward deserves further thought." Reviving part of the mental hospital as an area that is at once therapeutic and controlling would be a mature and sensible step welcomed by some psychiatrists and probably also by many nursing staff. New approaches of this type within the mental hospital are essential if any solution is to be found to our current difficulties.

Much can be achieved by improved staffing and facilities without returning to a locked-door mentality. This does not mean so much secure accommodation as a recognition that more intensive care and a carefully constructed daily programme is indicated for these patients. Planning should move away from the emotive secure accommodation towards providing better conditions and long-stay accommodation. The notion of special care accommodation in the mental hospital, with its restricted admission policy, special staff payments, and separatist outlook, has already proved unpopular and unwelcome in many hospitals and even destructive in its repercussions.

Solving this problem calls for flexibility of movement between psychiatric hospitals, special hospitals, and the community. The focal point should be the psychiatric hospital. Forensic psychiatry services, outpatient clinics, and supporting services should back up and complement the institutions in close collaboration with the probation services. This will, of course, need more financial support and a higher priority than is offered at present.

Planning should concentrate more on developing services and improving their interdependence and move away from a pre-occupation with bricks and mortar. *Regional secure units alone will simply create new problems unless their relationship to other services is more clearly defined and understood.* Indeed the need for secure units would have to be questioned if psychiatric hospitals were to return to their traditional role. The secure unit would then play a smaller part as a specialist assessment clinic and centre coping with short-term difficulties. Smaller units of this kind are more realistic and could probably be established with present finances. They could be staffed more easily, with a smaller number of psychiatrists and skilled nurses, and they could form the basis for developing community services.

The alternative to this approach is the present policy, which must be more clearly defined. Regional secure units and forensic psychiatric services will in effect have to take over the responsibilities of the psychiatric hospitals for chronically disturbed and "unrewarding" patients. This will require a massive injection of finance, beyond the resources at present available. It will mean

more beds, open as well as semi-secure. Arrangements must also be made to ensure that these services, if established, continue to be properly financed. One of the dangers of the present programme is that the new units would soon become dumping grounds for the most undesirable patients and might receive the lowest funding in competition with more attractive services, as prisons and mental hospitals always did in the past. It would perhaps be necessary for the DHSS to manage such a service directly (as with the special hospitals).

This approach could succeed only if sufficient accommodation were provided to cope with the whole problem, not simply the very few patients who need security.

A third solution is to build more special hospital accommodation. Park Lane Hospital when complete will only relieve overcrowding in Broadmoor, which itself is then to be rebuilt. Further maximum security facilities would be a logical alternative to a network of regional secure units but would fail to provide for the problems presented by those who are not dangerous.

A fourth answer, suggested by Scott,²⁴ is to put our resources into developing treatment facilities in prisons, where he felt much expertise still resided. There are sound arguments for this proposal, but it is unlikely to find much general support and would require a change in philosophy that is unlikely to be acceptable.

Finally, it has been seriously suggested that consultants who refuse to provide treatment on the grounds of personal prejudice and misconceptions should be challenged in a test case to decide if this refusal is indeed "reasonable."

Our present difficulties have much to do with changing attitudes and sympathies within the profession. They are also a reflection of discontent created by all the Health Service's problems of funding, staffing, and reorganisation. The least attractive and least vocal of our patients are the first to lose out, and there is a danger of their becoming pawns in a political game. The present policies should therefore be re-examined. The Butler Committee recommended the constitution of a national advisory body to keep under review the progress made in carrying out its recommendations, "to report where problems are arising and to assist towards solutions." This has never been

established. Perhaps now is the time for such a body to be set up with executive powers to deal with these issues.

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Contemporary Themes

Cost of outpatient chemotherapy

K C CALMAN, J G McVIE, M SOUKOP, M RICHARDSON, J DONALD

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Over the past ten years cytotoxic drugs have been used increasingly in the treatment of patients with advanced malignant disease. As combinations of drugs have become more effective

there has been mounting pressure to use such agents in more and more patients. This applies not only to the lymphomas and leukaemias, where advances have been most encouraging, but also to the more common solid tumours such as lung, breast, gastrointestinal, and ovarian cancers, where progress has also been made. The potential number of patients who may be given chemotherapeutic agents, therefore, could be very large indeed.

Of even greater significance is the promise shown by early drug treatment. Some success has already been obtained in the solid tumours of childhood,¹ breast cancer,^{2,3} osteosarcoma,⁴ and lymphomas.⁵ Clinical trials are now exploring the potential of this new idea for almost-all adult solid tumours.

Usually cytotoxic drugs are given on an outpatient basis, so saving the cost of inpatient care. Although such drugs have

Department of Clinical Oncology, Gartnavel General Hospital, Glasgow G12 0YN

K C CALMAN, MD, PhD, professor

J G McVIE, MB, MRCP, senior lecturer

M SOUKOP, MB, MRCP, senior registrar

M RICHARDSON, BSC, MPS, principal pharmacist

J DONALD, BSC, MPS, staff pharmacist