less than 10%. Such differences could be because of different methods of including patients. Mortality is, however, likely to improve in hospitals where a special interest is taken in these patients.

Should special units for patients with acute upper gastro-intestinal bleeding be established in district general hospitals? About 50 000 such patients are admitted to hospital annually in Britain; an average district general hospital might therefore expect four or five such admissions a week, too few to justify a special unit. Furthermore, the proposal aims at reducing mortality, and as deaths are virtually confined to elderly patients the logic would be that the units should be particularly reserved for the elderly. Even if the resources for such developments were available few would argue that this would be sensible medicine.

There are, however, important lessons to be learnt from the experience of the special units. Perhaps their most important virtue is the improved collaboration between physicians and surgeons. Audit is also easier. The Australians consider that early endoscopy is important,⁵ and, although in Britain patients investigated endoscopically and radiologically show no differences in mortality,¹⁰ more recent data show that the prognostic value of endoscopy is likely to have an important impact on management. Thus ulcers with visible vessels in their base have a high incidence of serious rebleeding (and so patients often need an operation), whereas those without stigmata rarely rebleed.^{11,12}

We cannot be complacent about managing acute upper gastrointestinal bleeding, and the results in district general hospitals may be worse than is realised. Most hospitals now have a physician with an interest in gastroenterology, who could improve the management of these patients. A first step would be to review results in individual hospitals, both retrospectively and prospectively from endoscopy records. Endoscopy is clearly the best investigation, and in most patients is best done on the morning after admission. This service should be easily organised in most district general hospitals and will provide as high a diagnostic yield as more urgent investigation.¹³ The few patients whose bleeding is very severe and continuous may need more urgent investigation.

A surgical policy needs to be established in each hospital, bearing in mind that there are no controlled data to guide us. When surgery is performed rarely or very often harm is done, and a satisfactory policy will lie between these extremes. Such a policy needs to be fully discussed and agreed and changes made in the light of experience. Despite the lack of important recent advances in managing patients with acute upper gastrointestinal bleeding we do now have a better understanding of the management that is available. We should be able to use this knowledge to improve treatment and thereby increase the chances of our patients surviving.

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Hospices for children?

During the past decade many institutions—some termed hospices—have been established in Britain to care for adults with terminal illness. They have been started because the requirements of such patients and their relatives are not usually best met in a busy acute medical or surgical ward. In many districts buildings have been constructed or converted (within or without the National Health Service) to cater for the terminally ill, and these are supported by domiciliary medical, nursing, and other services. Such developments have been a success. So should similar services be set up for children?

Prolonged terminal illness is rarer in children than in adults. Most infants and children who die in Britain do so from acute infections or cot deaths in the first year of life or from accidents thereafter; some also die in the neonatal period from prematurity or its complications. Most district hospital children's departments have arrangements for helping the parents and relations of such patients (although the bereaved parents of children killed in accidents may not always be directed to them). Three groups of children do, however, have conditions that may cause them to die slowly: some with major congenital malformations; others with malignant disease or major organ failure resistant to treatment or for whom treatment is not suitable; and those with progressive neurodegenerative disease. The number of such children is small—perhaps half a dozen a year in a health district—but they pose substantial management problems.

Services for these families are now well established in some districts, and their success has helped others who have been developing their own. The idea of establishing hospices for children is recent: Helen House in Oxford has a national reputation, and other hospices are planned. These projects have caused concern among professionals: is there a real need for a hospice movement similar to that for adults, or is it a well intentioned but misguided idea that will result in charitable donations being made to a project of questionable benefit to children? A recent symposium sponsored by the Help the Hospices charity with the help of the Royal College of Physicians of London and the British Paediatric Association tried to answer these questions. Various schemes for helping such children and their families were discussed, and the conclusion was that plans for widespread development of such hospices should be resisted (although the absence of a consumer voice on the platform should be noted) since no more than four would be needed in Britain.

The matter should, however, be considered by health districts, which should review their services for dying

children and their families, including the suddenly bereaved. They should agree general principles for management based on the proposition that such services should be provided within the child's home or as close to it as possible. These principles can be adapted to suit the individual case. If a family prefers care to be given in hospital then the arrangements will need thought: children's wards are staffed to cater for a fast throughput, and continuity and a more measured pace of care will be needed for such longer staying patients. If physical separation from the hurly burly of the ward is required some adjacent building should be considered; this perhaps is where the charitable impulse might be diverted.

My view is that institutional arrangements are second best to home care and that children's doctors, nurses, and social workers and other parents should be able to offer this to such families. (Perhaps the most important is domiciliary night nursing: sleeplessness is most destructive of parental morale.) Given the brief, the responsibility, and the means they will do a good job: perhaps that is the message for ministers.

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Regional secure units: arriving but under threat

The mid-1970s saw the coming together of two attempts to deal with the lack of secure psychiatric facilities for the mentally abnormal offender and the dangerous inpatient who had not offended. The 1974 Glancy report was concerned with the disturbed or aggressive patient (whether as offender or not) and recommended that each regional health authority should provide secure inpatient facilities.¹ At the same time the needs of the mentally abnormal offender were being studied by the Butler committee, which was set up after the tragic case of Graham Young, a mentally abnormal offender who committed murder after being released from Broadmoor.² This committee was so concerned by the "yawning gap" in service provision that in an interim report it recommended that each regional health authority should plan and build regional secure units.³ The Butler committee succeeded where others had failed for three reasons.⁴ Firstly, the inappropriate detention of mentally abnormal offenders in the prisons and special hospitals coupled with the absence of any National Health Service alternative was by then too serious to ignore. Secondly, the interim report recommended that central capital should be made available for the regions and the final report that some of the revenue costs should be met by central funding.⁵ Both suggestions were accepted by the government, but unfortunately a few errant regions used the money for other purposes,⁶ which delayed implementation. Thirdly, by 1975 there were a few forensic psychiatrists eager to take advantage of the joint appointments between the National Health Service and Home Office recommended in the 1964 Gwynne report.⁸

Although the delays in opening regional secure units were criticised,⁹ recent studies have shown how complicated the take up rate of an innovation is in a complex system such as the National Health Service.^{11 12} Even those regional health authorities committed to the policy were held up for various reasons: difficulties in finding a suitable site; opposition from professional hospital staff, health service unions, and local communities; and the slowness of the Department of Health and Social Security planning process.

The regional health authorities that rushed into building a unit (and the first one opened in 1981) were those without a forensic psychiatrist, and there were thus problems with the building design and the poor siting. The siting problems meant that the forensic psychiatrists who were eventually appointed had difficulties forming links with the courts, probation service, prisons, and district psychiatric services. The DHSS was interested in the units but less interested in the network of forensic services necessary to support the units; these, the DHSS believed, were the managerial and financial concern of the individual regional health authorities.¹³ When forensic psychiatrists participated in the planning it was often slower because they viewed inpatient work as only one part of comprehensive assessment and advisory services and were keen to make plans for both.

Ten of the 14 regions in England eventually opened interim secure units providing a subregional service, and the first three served as successful models for the rest.¹⁴⁻¹⁷ But these temporary units closed in regions that opened regional secure units, and there are now 14 permanent secure units (5 in South East Thames region) admitting patients.

Various models have been adopted. The West Midlands regional health authority will have one service base, and its two successful interim secure units will close when the 100 bed regional secure unit opens in 1987. A more complicated model is the South East Thames Regional Health Authority scheme, which has a 30 bed regional secure unit and four 15 bed area (secure) clinics. Mersey Regional Health Authority, with the most compact region, has a 50 bed regional secure unit and a community service base in the centre of Liverpool. South West Thames Regional Health Authority will have only a single small regional secure unit but has promoted a network of backup facilities by upgrading ward areas in hospitals all around the region.

There have been problems in opening beds in each commissioned regional secure unit because of difficulties in recruitment, particularly of nurses; and when it was stated in the House of Commons in 1982 that 120 beds in regional secure units had been *completed* in England only 20 places were in fact *staffed* and operational. Though any statement will soon be out of date, there are a total of about 460 completed permanent places in England and Wales, and about 400 are operational.

Regional secure units should be able to meet regional requirements as well as the smaller interim secure units did on a subregional scale, but forensic services may become isolated as inpatient psychiatric services are dismantled in the name of community care. Regional secure units may become locked miniasylums blocked by chronic difficult patients with nowhere else to go. This might lead to the sort of back pressure on special hospitals and prisons that led to regional secure units developing in the first place. If this happens then those few psychiatrists who suggested in the mid-1970s that mentally abnormal offenders would be better served by "bold" development in the prison system¹⁸ than by the Butler