urgently or to schedule replacement for a convenient time in the near future depends upon this information, which cannot usually be obtained at present. When one cell in the Vario pacemaker fails the discharge rate alters appreciably (as in most other pacemakers) and the new voltage can therefore be deduced. It will of course be necessary to calculate the threshold after application of the magnet taking into consideration the reduced amplitude of the initial impulse.

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Contemporary Themes

Solutions to the Problem of the Dangerous Offender

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In so far as the dangerous offender can be classified as mentally abnormal, the Mental Health Act of 1959 permits him to be transferred from court or prison to hospital. This solution has been a clear failure for two reasons. The hospitals (other than special hospitals and a few special units, usually of sub-normality hospitals¹) do not want these patients; 150 transfers a year of psychopathic patients is scratching the surface of the problem. The fact that the administrative possibility exists of transferring the difficult prisoner to hospital removes therapeutic responsibility from the prisons and effectively retards the therapeutic capacities which they so obviously possess, and should develop.

Flexibility

It has been argued that if the needs of the dangerous offender lie between hospital and prison, then let him be in hospital when he needs treatment and in prison when he does not—that is, keep the custodial prison and the therapeutic hospital and shuttle the convict-patient between the two. This is the solution favoured by the Lord Chief Justice in *Regina v. Horan*² and in his remarks when sentencing Ian Ball who shot four men while attempting to kidnap Princess Anne. He indicated that the time may be approaching when such dangerous patients, even though mentally abnormal, should be subject to an indeterminate prison sentence to secure the protection of the community, and that any requisite treatment should be through temporary transfer to a secure hospital. Since the establishment of new methods of reviewing discharge from special hospitals under the Aarvold Committee a hospital order—with restriction of release unlimited in time to a special hospital—theoretically should and does provide just as effective protection for society as prison. But the scheme lacks an essential element in that it fails to stimulate therapeutic endeavours within the prison system.

The Department of Health and Social Security, after long cogitation, has produced its answer.³ Faithful to the philosophy

of the Mental Health Act it proposes semisecure units in association with mental hospitals, at the rate of 20 places per million of population. These are to be staffed by forensic psychiatrists; they are to be small (50 to 100 patients), and they will be short term (18 months). It is recognized that they must be staffed very generously in "quantity and quality." Forensic psychiatrists, like any good parents, are expert at being firm without being retributive and would welcome such units, which would certainly be interesting and rewarding. Nevertheless, this Janus-like capacity to control and at the same time encourage is basic to all psychiatry, which may be emasculated if it delegates too far. Security is immensely expensive, materially and in staff. The hospital system is already desperately short of nurses. It is acknowledged that these units would need highly experienced and skilled grades of nurses, and these would be very difficult to find. Most important, the units, even before the first is open, are showing unmistakable signs of selecting the nicer band of the psychiatric spectrum of patients—who are to be short term and requiring only intermediate degrees of security.

Disadvantages of Units

These units may go some way to meet the parochial needs of hospitals, but they will not relieve overcrowdings in special hospitals and they will do nothing for the mentally abnormal, long-term dangerous convicts who are so difficult to help in any constructive way in the prisons. The units will do nothing at all to encourage therapeutic developments in prisons and, indeed, are likely to retard any such effort. If the units ever succeed in opening in significant numbers (which is doubtful) they would only be repeating the same basic errors which led to their conception and would be a costly drain on the system. The fault was not in the Department's report but in its terms of reference. The problem should have been considered by a joint committee of the Prison Department and the D.H.S.S. and perhaps with lawyers and social service administrators as well.

The situation, then, is that the present discrete prison and hospital systems both fail to meet the practical requirements of dangerous persons. To shuttle the inmate between the two is impracticable and inefficient. To make the hospitals like prisons will not be tolerated. It remains to make the prisons more like hospitals, and thus to fulfil the requirements of the law and of the protection of society, while doing as little harm

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to the offenders as possible, and while offering them what help is available—not just on the medical model of passive treatment, but supporting and retraining in how to live more successfully in a community. This policy has many advantages. The whole range of security establishments, together with personnel who already understand security methods is available without the expense of new building. The open prisons, which are often half empty, would be invaluable staging posts. It is economical of staff and we know from Dr. Gray's experience at Grendon that ordinary grades of prison officer make effective therapeutic agents if properly led. Above all it will end the pretence that the prisons, especially the long-term prisons, are not already full of abnormal personalities for whom little is done.

Right Image

The practical measures for implementing such aims are less important than the policy, for the law is already so flexible that most objectives can be achieved without new legislation. It is a common mistake that major reforms in the criminological field can be achieved by legislation, and that provisions will automatically follow. Unless the scene has been prepared, they will not. It would perhaps help if approved parts of the prison system could be designated as hospitals (a suggestion which I made six years ago) so that hospital orders could be effected either in prison or hospital. It would help also if the special hospitals were united with the prison system, as they were to some extent until recently: their approach, and their staff (who could share training programmes and undertake temporary exchanges with prison staff) would help to change the image of the system. The prison medical service should merge with the national service, and the forensic psychiatrists, instead of running esoteric little units in the health service, should treat patients in prisons thus bringing a benevolent medical influence within the reach of any prisoner needing it

and leavening the prison lump, which has badly needed it for a long time.

There are of course difficulties and criticisms of such a policy. It is said that the community needs its punitive prisons. There is no good evidence that this is so, and much to suggest that so long as the offender is removed and rendered safe, the community is uninterested in what happens to him. It is not for a moment suggested that every prisoner needs medical treatment though it is important to try to reduce the risk of doing actual harm. The point is made in the D.H.S.S. report³ against developing psychiatric services in prisons, that it would be unfair on "those who have committed no offence but who otherwise present similar problems to those raised by an offender." But there is no suggestion that psychiatric hospitals should cease to accept some such patients, whose number in all probability is exceedingly small. Is it better to leave a few technical non-offenders to be treated in the mental hospitals, or to withhold any form of treatment from a large number of prisoners who urgently need it?

Lord Butler's Committee on the Mentally Abnormal Offender has a great responsibility and opportunity which may not recur for a long time. Will it repeat the mistake of part V of the Mental Health Act and try to force a reluctant mental health service to cope with dangerous persons, by following the expedient lead of the D.H.S.S., and by tinkering with the law which is adequate as it stands? Or will it look beyond immediate administrative difficulties, and give us a bold lead which will enable the Home Office and D.H.S.S. to work together in developing the resources of the prison system?

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Shigella dysenteriae and Shigella boydii in England and Wales during 1972 and 1973

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Summary

During 1972 and 1973 the Salmonella and Shigella Reference Laboratory examined 133 strains of *Shigella dysenteriae* and *Shigella boydii* isolated from patients in England and Wales. Of those infected 89 had recently travelled abroad and a further seven had been in close contact with travellers recently returned to this country. Though these subgroups were of little numerical significance they are of considerable epidemiological interest. The increase in tourism from the British Isles to North Africa and Asia is likely to lead to an increased incidence of infections due to these organisms, both in travellers infected abroad and in their contacts within the British Isles.

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Introduction

The genus *Shigella* is divided into four subgroups: *Sh. dysenteriae*, *Sh. flexneri*, *Sh. boydii*, and *Sh. sonnei*. The annual report of the Chief Medical Officer for 1972¹ shows that of those cases of bacillary dysentery in England and Wales which were confirmed by the isolation of *Shigella* 99% were due to *Sh. sonnei* or *Sh. flexneri*. *Sh. dysenteriae* and *Sh. boydii* are rarely isolated in England and Wales but serotypes of these subgroups are indigenous in parts of Asia and Africa.

During 1972 and 1973 the Salmonella and Shigella Reference Laboratory maintained a special surveillance on reported isolates of *Sh. dysenteriae* and *Sh. boydii* in England and Wales. Efforts were made to obtain cultures of these organisms and detailed biochemical and serological studies were made.

Incidence of *Sh. dysenteriae* and *Sh. boydii*

Altogether 133 strains gave the biochemical reactions of *Shigella*² and serologically belonged to subgroups *Sh. dysenteriae* or *Sh. boydii*, which contain 10 and 15 serotypes respectively. Among the 133 strains isolated in England and Wales in 1972-3 there were 16 isolates of *Sh. dysenteriae* serotype 1 (*Sh. shigae*), 17 of