given, but one might be tempted to speculate on the reliability of such pronouncements after the passage of many years of detention.

How many years are needed to establish 'treatability'? How long is needed to effect such treatment? Although, according to at least one source (Dell, 1978), the mean length of stay (about seven years) in Special Hospitals is reportedly shorter than for those with mental illness, this is a very long time to occupy a hospital bed if the treatment is not effective or only marginally so. And many patients with severe personality disorder (without other mental disorder) will spend far longer in Special Hospitals. A lesser response to treatment, with implication of continued dangerousness, will, presumably, be one of the factors lengthening the stay.

But would it not be preferable to return to the prisons those 'psychopaths' who do not respond to treatment, rather than detain them in hospital indefinitely to the advantage of none? A recent report (Home Office, 1981) shows that only 13 'psychopaths' were transferred to psychiatric hospitals under Sections 72 and 73 between 1978 and 1980, whereas 86 were so dealt with under Sections 60 and 60(65).

There were 274 admissions to Broadmoor hospital between 1978 and 1981 inclusive, of which there were only 39 (14 per cent) admissions under Section 72. Among these 39 were only 7 'psychopaths', who thus comprised only 2.5 per cent of all admissions in that period, Since 'psychopaths' comprise a much larger proportion of the Broadmoor (and other Special) Hospital populations, it might then be assumed that most come from the courts and that, in the event of complete therapeutic failure, the hospital is stuck with the patient, and vice versa.

If, at a conservative estimate, only 50 'psychopaths' in Special Hospitals fail to respond to their treatment during ten years of detention then five centuries of patient time will have been in vain, the more tragically since this will have been at the expense of so many individuals who might have benefited. A solution to this problem, which could occur without any alteration to the law, would be far greater use of Section 72 of the Mental Health Act, 1959, transferring 'psychopaths' who have offended from prison to hospital, instead of taking them directly from the courts. In this way the motivated 'psychopath' could be assessed and treated in the Special Hospitals and eventually returned, whatever the outcome of psychiatric intervention, to prison. There will inevitably be those whose circumstances are exceptional and these should be dealt with as such. But perhaps if the prisons, rather than the courts, were the main source of such patients, and if the emphasis was more on treatment rather than custody, the clinical credibility of the Special Hospitals would be somewhat less in doubt.

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The opinions expressed are those of the author and do not necessarily reflect those of Broadmoor Hospital, the Institute of Psychiatry or the DHSS.

DEAR SIRS

Whilst welcoming Dr Chiswick's article on the Special Hospitals (*Bulletin*, August 1982, **6**, 130-2), his statement that, due to their vague terms of reference, they are out of phase with current psychiatric thought requires further discussion.

The therapies used and the indications for their use are no different from those used elsewhere, but the Special Hospitals are separated from the mainstream of psychiatry by being managed directly by the DHSS and by their attitude to security, giving it precedence over therapy. The attitude regarding security is unfortunate as in a different setting the security could be an aid to therapy as well as being a safeguard to the general public. It is easy when the security aspects are as well stressed as they are in a Special Hospital to come to rely on custodial care rather than active therapy, and the poor links with other psychiatric care agencies make it even easier.

Another way to view the position is to realize that patients are admitted to Special Hospitals because of mental abnormality and because of supposed dangerousness but not because the Special Hospitals are thought to have the expertise to treat cases any more effectively than other hospitals. The staff accept patients for these reasons unlike staff in local hospitals who tend to reject patients they find difficult to treat on the grounds that there is no point in taking the untreatable into hospital.

The Special Hospitals would be ideally placed to deal with these difficult patients and to develop appropriate treatment programmes if only their isolation and their obsession with security could be overcome. The Special Hospitals have excellent facilities, they have an adequate number of wards to be able to institute different types of regime and different degrees of security and they have excellent occupational facilities not seen elsewhere in the health service. As these facilities are not put to the best use, the Special Hospitals tend to silt up with patients who have come to the end of their treatment programme and who are by now institutionalized. Unfortunately their potential dangerousness to the general public is often still as much a matter of speculation as it was on admission. It is not surprising that other hospitals or community services normally willing to take discharged psychiatric patients are unwilling to take them from Special

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Hospitals.

Special Hospital staff find difficulty in giving real help to patients when they cannot relax security and they cannot dissociate from it, as the same staff are responsible for security as are responsible for therapy. A relaxation of security is generally assumed to involve an increase in danger to the public but it is difficult to see that this would be so as part of a carefully worked-out therapeutic programme. Security would be relaxed in a controlled manner rather than in the somewhat haphazard way at present where a patient may have to wait a long time for a place in another hospital or for other accommodation and then be moved suddenly after little preparation.

To avoid wastage of resources and to help our patients, action is needed to integrate the Special Hospitals into their appropriate place in the NHS. The newly-opened and opening secure units take and will continue to take patients that they feel they can treat and who will respond within a reasonable period. They will treat them making use of a flexible security system and many of their patients will be those who at one time would have been admitted to Special Hospitals. The Special Hospitals' only future now is to find ways of treating those patients hitherto regarded as untreatable. If they do not then they must accept that they are providing a purely custodial and preventive service.

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Forthcoming Events

The **Institute of Family Psychiatry** is holding a two-day course in family psychiatry for trainee psychiatrists on 16 and 17 June 1983 at the Institute of Family Psychiatry, Ipswich Hospital. Programmes and application forms are available from the Secretary, The Institute of Family Psychiatry, Ipswich Hospital, 23 Henley Road, Ipswich IP1 3TF.

The **Association for Child Psychology and Psychiatry** will be holding the following scientific meetings in 1983. 5 January: 'Allergy, diet and behaviour'—Eric Taylor; 2 February: 'Why do teenagers take overdoses?'—Keith Hawton; 2 March: The Chairman's Address—Philip Graham; 6 April: The Emanuel Miller Lecture ('The concept of inner experience')—Mary Warnock; 4 May: 'Origins of the personal relation and the strange case of autism'—Peter Hobson; 1 June: 'Impact of bereavement on children: a follow-up study—Dora Black. All meetings will take place at 7.00 pm at the Institute of Child Health, 30 Guildford Street, London WC1. Information: Jim Stevenson, Honorary Secretary, Association for Child Psychology and Psychiatry, 4 Southampton Row, London WC1B 4AB.

The **Royal Society of Medicine's Section of Psychiatry** will be holding the following meetings in 1983. 7 February (2.15 pm): 'Behavioural and cognitive therapy'—Professor I. Marks, Dr A. Ghosh, Professor M. Gelder; 8 March (2.00 pm): 'The Sutcliffe case: medico-legal issues'—Professor R. Bluglass; and 'Mental Health Act'—Professor J. Gunn and team; 12 April (3.00 pm): 'Psychiatric disorders in general practice and obstetrics'—Professor E. Paykel, Dr P. Freeling, Dr L. I. Sireling, Professor R. E. Kendell. Information: Sections Office, RSM, 1 Wimpole Street, London W1M 8AE.

The **African Psychiatric Association** is holding an international conference on 'Training in Psychiatry for Developing Countries' at the Rutherford College, University of Kent, Canterbury from 17 to 22 July 1983. Details for submission of abstracts and general information: Dr A. C. Raman, St Augustine's Hospital, Chartham, Canterbury, Kent CT4 7LL.

The **Centre for Personal Construct Psychology** (founded 1981) offers two basic general courses in the theory, methods and applications of personal construct psychology. A 20-week, part-time course will commence on 11 January 1983 and the first unit of a 3-unit course will run from 31 January to 3 February 1983. Information and application forms: Director of Centre, Dr Fay Fransella, 132 Warwick Way, London SW1V 4JD (Telephone: 01-834-8875).

The **8th International Congress of Group Psychotherapy** will take place from 21 to 28 April *1984* in Mexico City. The Chairman of the Programme Committee is Dr Ramon Ganzarain, The Menninger Foundation, Box 829, Kansas 66601, USA and the Chairman of the Local Organizing Committee is Dr Luis Feder, Corregidores 1429, Mexico L10 DF, Mexico. All enquiries should be directed to them or else to Dr Malcolm Pines, 1 Bickenhall Mansions, Bickenhall Street, London W1H 3LF and Dr Jay Fidler, PO Box 327, Three Bridges, NY 08887, USA.

A **Workshop in Psychodrama** will be held by Marcia Karp, Graduate of Moreno Academy, at the Warneford Hospital from 25 to 27 February 1983. Further information: Dr S. Bloch, Department of Psychotherapy, Warneford Hospital, Oxford OX3 7JX (please enclose an s.a.e.).

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