centre and community support.

Outcome. I have simply divided this into short-term, long-term and the evaluation of possible modifying factors such as compliance with medication, effect of environmental change and the availability of community care.

New attacks of illness. This is to remind trainees to comment on the possibility of prevention and might include the use of depot preparations or lithium, community nursing and the education of the patient and relatives concerning the nature of the illness.

I am not unaware of the apparent naivety of the above approach, but I hope it may be helpful to those who have been glad of the Finn and German on the famous Olympus Towering Tops.

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Clinical credibility of the Special Hospitals

DEAR SIRS

I am tempted to rise to the bait offered by Dr Chiswick in his challenging article (*Bulletin*, August 1982, **6**, 130-2). I would take issue with him on factual matters and on the opinions he expresses, but shall restrict myself at present to informing members of the College that a Special Committee of the College's Council has been examining in detail the role and function of the Special Hospitals and is currently finalizing its report which will be submitted to Council in the new year.

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Special Committee on the Special Hospitals
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DEAR SIRS

Dr Derek Chiswick's recent article (*Bulletin*, August 1982, **6**, 130-2) contains several propositions which are likely to be the subject of some dispute amongst his colleagues within forensic psychiatry in general, and within the Special Hospitals in particular. Not all, for example, will be able to accept his assertions concerning the 'arbitrariness of admissions to such institutions', or that the prediction of dangerousness is not a 'legitimate medical task'.

However, it is to two of Dr Chiswick's other assertions, which seem to me to be related, that I should like to draw attention. First, he states that psychiatrists are 'medical underwriters of preventive detention'. Secondly, in recommending the establishment of a specially constituted health authority to administer the Special Hospitals, thus ending their regulation by the Department of Health, he states 'its first task must be the redefining of a function in a form that is clinically realistic'.

His first point is beyond dispute, but it is not only forensic psychiatrists who preventively detain. All general psychiatrists will have experience of the use of orders for the compulsory admission for observation or treatment of the mentally disordered. Indeed, the Mental Health Act (1959) specifically provides for the involuntary hospitalization of those with mental disorder who are considered to be a risk to themselves or to others. For some patients, such as those whose potentially dangerous behaviour arises in response to abnormal psychopathology (such as delusions or hallucinations), the appropriateness for compulsory detention on a short-term basis is, at least for most psychiatrists, an issue that compels little debate. The critics of contemporary psychiatry would seem to have at least some of their concerns adequately represented in the proposals of the Mental Health (Amendment) Bill, which will reduce the maximum duration of certain compulsory admissions, and increase patients' access to Mental Health Review Tribunals, even for patients detained under Section 25. (The practicability of this latter proposal is not under consideration here.)

But compulsory detention of mentally disordered individuals poses greater problems in the Special Hospitals. In terms of their source and broad diagnostic category (in Mental Health Act, 1959 terms) most new patients to, say, Broadmoor Hospital come from the courts and suffer from mental illness. By the time transfer or discharge recommendations are made for such patients they will frequently have spent longer in hospitals than had they served straight prison sentences. This is not of itself unduly surprising. For the Special Hospital psychiatrist, however, transfer or discharge of patients with mental illness will not concern so much consideration of legal or penal factors as clinical progress and some estimate of the reduction in dangerousness. While an overall improvement in mental state can be fairly readily assessed by a clinician, the difficulties of predicting subsequent behaviour, especially while the patient is in hospital, can be considerable. 'Preventive detention', then, in the absence of substantial grounds for appropriate optimism, becomes an unfortunate necessity.

The situation is less clear and even less satisfactory in the case of the 'psychopath'. The logical and nosological pitfalls of the term are all too familiar to psychiatrists (Gunn and Robertson, 1976) and others (DHSS and Home Office, 1975), and yet this designation of putative mental disorder strides through successive generations of English mental health legislation. The current Mental Health (Amendment) Bill changes little in this respect. The new idea of a 'treatability' clause is unlikely to differ in practice from the implications of the tag 'and requires or is susceptible to treatment', appended to the definition of 'psychopathic' disorder in Section 4 of the Mental Health Act, 1959. Admittedly, at various stages during the compulsory detention of such an individual indication of continued treatability will need to be

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